CORONERS AMENDMENT BILL 2017

Second Reading

Resumed from 30 August.

HON ALISON XAMON (North Metropolitan) [2.15 pm]: I had completed most of my contribution to the second reading debate on the Coroners Amendment Bill 2017 the last time we debated it, but I want to reiterate a particular concern the Greens have with the timing of the passage of this bill and other outstanding recommendations for reform in this space. To reiterate, the Greens support this legislation. I was speaking about the concern that we might inadvertently end up with a gap in the legislation because recommendations 17 and 18 of the Law Reform Commission of Western Australia's report have not been addressed. It is from that report that these proposed amendments to the legislation arose in the first place. I expressed the concern that as a result of the amendments we are debating today, if a death occurs from natural causes after the deceased received or sought health care and the death was not the reasonably expected outcome or the person might not have died had they received the health care that could reasonably have been expected to be provided, the coroner could choose to discontinue the investigation. As I expressed previously, I believe this was not envisaged or recommended by the Law Reform Commission. In the Greens' view it is in the public interest that the coroner thoroughly investigates healthcare-related deaths, even when they arise from natural causes, and we in fact consider it to be essential for the proper oversight of our healthcare services. I will also note recommendations 1 and 2 of the review into section 57. Recommendation 1 states —

> It is recommended that consideration be given to rewriting the *Coroners Act 1996*.

Recommendation 2 states —

> It is recommended that consideration be given to restructuring the *Coroners Act 1996* to be better aligned to the coronial processes.

I want to know whether there is any intention at this stage to rewrite the Coroners Act, as was originally envisaged to be required as part of wholesale reform within this space.

Finally, I just want to say that the Greens of course support removing unnecessary delay in the dealings of the Coroner's Court for all the reasons I previously articulated. This is unquestionably an area in which we want to ensure that things run smoothly as possible. Hopefully, this piece of legislation will assist the coroner to be able to do that. We are concerned to ensure that there are not any unforeseen consequences as a result of not taking the holistic approach to the reform recommended by the Law Reform Commission. We need to see broader reform in this space, so I hope that the minister is in a position to advise the house whether we are going to see additional reforms within, hopefully, this term of government. With those few words, the Greens indicate that we will support the legislation.

HON CHARLES SMITH (East Metropolitan) [2.18 pm]: I rise to say a few words on this Coroners Amendment Bill 2017, which I am pleased to say that I and One Nation, and indeed the crossbench, support. The bill deals with a very important issue, that being the delays in processing natural deaths. This is an issue I know only too well. Every police officer dreads going to a sudden-death job, not just because of having to deal with the deceased and the circumstances of the death, but also due to the sheer volume paperwork atop such an unpleasant call-out. Every frontline officer dreads the seemingly never-ending coronial inquiry.

The routine practice in coronial investigations is to conduct a post-mortem, along with obtaining things such as toxicology reports, tissue analysis, witness statements and medical reports—all of which heavily involve a frontline police officer, particularly in regional and rural Western Australia. Members may not know that there is no coronial investigation unit in the bush and a standard frontline police officer has to carry out the sudden death investigation, which can take anywhere from six to 12 months, or even longer. Atop this, they are still expected to undertake their frontline duties whilst conducting the investigation.

In my experience, many coronial investigations have to be initiated by the police simply because a local GP or emergency doctor in the regions did not have the confidence to issue a death certificate, even when the deceased is elderly, frail or in ill health. In the majority of delayed cases, a post-mortem would reveal that the deceased died of natural causes and there was absolutely nothing at all suspicious or noteworthy surrounding the death. Obviously, that is seen as a waste of time for all parties concerned and puts unnecessary stress on a grieving family. Therefore, it is promising that this McGowan government is starting to respond to my and my party's call to provide more support to our police, especially out in the bush. I think that it is very important for the government and the minister to do something positive for police, as the government is now viewed by the agency and the public as anti-police, soft on crime and out of touch.

In sum, the proposed amendments to the act are intended to free up the time taken on sudden death investigations so that the police and the coroner can investigate the deaths that ought to be investigated more thoroughly. It will remove unnecessary work, save resources on cases in which no investigation is necessary, and give grieving families the peace to bury and honour their loved ones. In addition to these amendments, I also call for a dedicated computerised tomography scanner for the coroner's department, as this would significantly enhance the speed of inquiries and not keep grieving families wondering about when they can arrange their goodbyes.

HON RICK MAZZA (Agricultural) [2.22 pm]: I rise to make some comments on the Coroners Amendment Bill 2017, which was read into the house in August last year, so it has been on the notice paper for some time. As Hon Charles Smith pointed out, the crossbench supports the bill. The Law Reform Commission of Western Australia identified a number of problems affecting the coronial system in WA, including lengthy delays in the completion of coronial cases, which increased the distress of grieving families. Under the current act, there is an obligation to investigate all deaths reported to the State Coroner. A high number of deaths come under the category of being due to natural causes and, therefore, are not contentious. I support the proposed amendments to remove the obligation to investigate or continue to investigate when a death has been deemed by the coroner as being from natural causes and comes under the definition of "reportable deaths" solely because it appears to have been unexpected.

The amendments also seek to remove the need for the coroner to produce a detailed narrative when there is no duty to hold an inquest and the coroner determines that there is no public interest in making a detailed finding into how the death occurred. This should go some way to reducing delays in the coronial process. I am pleased to see that the obligation to investigate will stay in place, under circumstances in which there has been a duty to hold an inquest, if a person dies while under anaesthetic. This safeguard goes some way to providing comfort to family members that a proper investigation will take place under such circumstances.

According to the State Coroner, there was a backlog of some 347 cases as at 30 June 2017. That comprised 136 inquest cases and 194 cases in which no further finalisations were possible as of June 2017, because the coroner was awaiting completion of aspects of the coronial investigation by external entities. Seventeen cases were with counsel assisting for review or advice, as directed by the State Coroner, on deaths reported.

Any changes that we can make to legislation that will lead to a better and more efficient process that uses new techniques and technology will be a step in the right direction. I am interested in finding out the outcome of the procedure for non-invasive post-mortem examinations, which were piloted and introduced during 2016–17, resulting in 227 coronial approvals of pathologist-recommended external post-mortem examinations, as cited in the Office of the State Coroner's annual report. One alternative to non-invasive procedures is the use of a computerised tomography scanner. My understanding is that in the past the coroner has had to use a hospital scanner, which a lot of living people might find a little eerie. The government has seen fit to buy a scanner for the coroner to undertake non-invasive post-mortems, together with the provision of another $1.2 million over the next three to four years for staffing maintenance and other costs. The records of the scan can be kept long term, providing for an investigation to be reopened without having to exhume a body to do so. This will go a long way in saving the deceased's relatives from unnecessary distress. It will also alleviate the trauma caused to persons who oppose post-mortems for religious or cultural reasons.

I understand that residents in nursing homes, unless held in care under particular acts, would not be considered a person held in care. I ask the minister to make some comment and provide assurance that a person residing in a nursing home who is not considered a person held in care would have their death examined if they, for example, died in their sleep. I also ask the minister to make a comment on what would happen in such circumstances to assure the public that people will not fall through the cracks in the new regime.

Recommendation 60 in the "Review of Coronial Practice in Western Australia: Final Report" of 2012 recommended —

> That the State Coroner produce guidelines that specify by example the types of cases that fall into the definition of 'person held in custody' and 'person held in care' in the Coroners Act.

I understand that the guidelines will not be developed until after this legislative reform is completed, so I would like to see something in those guidelines. In conclusion, I support this bill.

HON NICK GOIRAN (South Metropolitan) [2.27 pm]: I rise to contribute to the debate on the Coroners Amendment Bill 2017. As has already been indicated by my learned friend Hon Michael Mischin, the opposition is supporting the Coroners Amendment Bill 2017. I have been waiting more than a year to debate and discuss this bill. Notwithstanding that the opposition is supporting this bill, I note that it was introduced into the Legislative Council on 22 August last year, and here we are now on 18 September 2018. For the benefit of Hansard, I have not misspoken. Yes, it was 2017. The bill was introduced into this place in 2017 and here we are now, more than 12 months later, seeking to conclude the second reading debate.

At the outset, I indicate that I cannot be brief this afternoon, because although I also support the passage of this bill, I have two concerns. I will outline those concerns in a moment and I hope that the government will be able to address them. I anticipate that is unlikely to be done during the course of the second reading reply and that we will go into Committee of the Whole to interrogate those concerns a little further. I will outline them in a moment, but, at the outset, as I say, I support the passage of this bill for a number of reasons, not the least of which is that, as I understand the policy of the bill, it seeks to expedite coronial investigations. Some of the contributions that have already been made this afternoon have highlighted that and used that as a platform for supporting the passage of the bill, and I concur with those remarks.

I note also that the genesis of the Coroners Amendment Bill finds itself in the Law Reform Commission's report from 2012 and that the bill allegedly seeks to implement recommendations 55 and 56 of the Law Reform Commission's report. I would like to know from the honourable minister, the Leader of the House, who has the conduct of the bill in this place, the status of the other recommendations arising from the Law Reform Commission's 2012 report, but that is not one of my two primary areas of concern this afternoon.

The first of my primary areas of concern is for the government to satisfy me that the bill truly does give legislative effect to recommendations 55 and 56 of the Law Reform Commission's report. It is important to note here that the government asserts in its second reading speech that the passage of this bill will give legislative effect to those recommendations and I seek to test that, particularly recommendation 56.2. For the benefit of members who are unfamiliar with those recommendations from the Law Reform Commission, recommendation 56.2 can be found at page 79 of the Law Reform Commission's report and reads —

> 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.

I need to be satisfied by the government, when it says that this bill seeks to give legislative effect to recommendations 55 and 56, where precisely in this bill recommendation 56.2 is being given legislative effect. For reasons that will become obvious to members in a moment, I, of course, support recommendation 56.2 of the Law Reform Commission's report. I would like to see it given legislative effect but I want to be satisfied that that is indeed what will happen when the government tells us that that is what it is seeking to do.

On my second area of concern, I want to ask: is there any risk at all that this bill will lead to the unintended consequence of some unexpected deaths no longer being investigated? Members may be aware that for the last at least six or seven years in this place, I have been pursuing a matter to do with deaths of Western Australian babies who, in my view, were left to die. After six years of exposing the non-reporting of some of those infant deaths, the very last thing I want to see is us pass a piece of legislation that would see that reporting occur, but no investigation. I continue to have concerns that for many years now there has not been compliance with Western Australia law and there has not been compliance with reporting to the coroner, and I want to ensure that this bill does not worsen that past practice. I want to see the practice meet the law; I do not want to see the law lessened to the practice that has been occurring.

By way of some background, from my perspective, the history that has led to this starts with a judgement, if you like, given in an inquest in the Northern Territory. I want to spend a moment to recount to members my summary of the inquest into the death of baby Jessica Jane in the Northern Territory. In summarising that inquest, it is important for members to be aware that baby Jessica Jane was delivered alive on 14 July 1998 at Darwin Private Hospital following an attempted abortion between 22 and 23 weeks gestation. She died 80 minutes later. Her death was reported to and investigated by the coroner. The findings were released on 10 April 2000. Jessica Jane's abortion was approved by Dr Henry Cho on the basis of the psychological distress of the mother. In this particular case, the attending nurse was left alone and was shocked when the baby she had delivered began to cry and showed strong signs of life. She wrapped the baby in a blanket and called the doctor, who dismissed her concerns for the baby. During the inquest, the nurse said, and I quote from paragraph 12 of the inquest report, "I desperately wanted to do more, but felt my hands were tied." The coroner said, again quoting from the same paragraph —

> There were no procedures or protocols in place for her to refer to. None of her supervisors were available to help her; she tried to telephone them but to no avail.

Sadly, 80 minutes after the delivery, Jessica died. After some argument, the coroner of the Northern Territory came to the view that the death of a live born infant following an attempted termination is, in fact, a reportable death. The coroner gave this explanation, and I quote from paragraph 3 of the coroner's report —

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

The coroner also agreed that the death was unnatural. I would like us to interrogate the terms "unexpected" and "unnatural" a little further. Indeed, the coroner goes on at paragraph 4 to say —

> The evidence revealed that the birth and inevitable death of the baby due to prematurity was caused by artificial means. That is to say, the death was contrary to nature.

At the time of the inquests, the Northern Territory coroner also expressed concern that no procedures or protocols were in place at the hospital concerning the treatment and care of children who survived the termination procedure. During the inquest, the professor who was the head of obstetrics and gynaecology at Westmead Hospital in Sydney and a professor of obstetrics and gynaecology at Sydney University said —

> … if we had the circumstance where … a foetus … or a child—infant as it becomes at the time of birth, would be afforded full—full access to neonatal resuscitation if it was considered that the child had any prospect of survival …

The coroner responds —

> So would you say that there should be protocols in hospitals around Australia, if they're not around Australia?

The professor replied, "Yeah."

The coroner went on and said —

> That are in place such that when there is unexpected deliveries of babies, people aren't caught by surprise in terms of what to do?

The professor replied, "Yes, I think that should be the case."

In the coroner's assessments of Dr Henry Cho's actions, he said, and I quote —

> He should have alerted the nurse of the possibility of a live birth, he should have given her directions in relation to the baby on the telephone, he should have then attended on the baby himself or arranged attendance on the baby by a medical practitioner, he should have assessed the infant not just in regard to viability but in relation to alleviating stress, suffering and other possible problems.

That quote can be found at paragraph 32 of the inquest report.

The coroner made three recommendations: firstly, that protocols be put in place to ensure that children who survive termination procedures are assessed for gestational age and viability by a medical practitioner or paediatrician; secondly, that the management and staff of all hospitals and clinics in the Northern Territory and medical practitioners should be made aware of their legal obligations to report the deaths of such children to the coroner; and, thirdly, that the protocols should apply to all hospitals and clinics. Members who want to find those recommendations can look at paragraph 34 of the inquest report. In the conclusion of the inquest in relation to the role of the coroner, the point is made that the public has a right to be informed and take part in any debate, and the coronial process is the means by which people are informed. Indeed, the coroner says at paragraph 35 —

> This is why it is important that these deaths be reported to the coroner.

Indeed, the coroner's view, as stated in paragraph 37, is as follows —

> The fact that her birth was unexpected and not the desired outcome of a medical procedure should not result in her and babies like her being perceived as anything less than a complete human being. The fact that her death was inevitable should not affect her entitlement to such care and attention.

This may well seem like an obvious conclusion. However, we know that these standards are not currently applied in Western Australia. How can I be so brazen as to allege that? I draw to members' attention some information that was first uncovered in the thirty-eighth Parliament—remember, we are in the fortieth Parliament—when Hon Ed Dermer uncovered some information. He asked question on notice 3211 on 15 February 2011; at least that is the date that the question was answered. Hon Ed Dermer asked —

> (1) Since the enactment of the *Acts Amendment (Abortion) Act, No 15 of 1998* has any instance been reported of an abortion procedure in Western Australia resulting in the birth of a live child?
>
> (2) If yes to (1), how many such instances have been reported and in which years did the instances occur?

The answer came back —

> (1) Yes.
>
> (2) As at 20 January 2011, a total of 14 incidences of abortion procedures resulting in the live birth of a child have been reported between July 1999 and June 2010.

Hon Ed Dermer, quite understandably not being satisfied with leaving the matter there, asked a question the following month. On 15 March 2011, he put a question on notice, which in part stated —

> Has a protocol been advised or directed for the care of children born alive, as a result of abortion procedures in Western Australia?

The answer that came back on 5 April 2011 was —

> The protocol used in these circumstances is that defined in the Neonatology Clinical Care Unit … Neonatology Clinical Guidelines, Section 20: 'Palliative Care and Death of a Neonate': …

The following month, on 24 May 2011, Hon Ed Dermer asked, in part —

> In any of the 14 incidences referred to above, was treatment of the child not withdrawn?

The answer that came back stated —

> No treatment was reported as being performed in any of the 14 incidences.

As far back as the thirty-eighth Parliament—as far back as 2011—we know that in Western Australia at least 14 babies were born alive and left to die in Western Australia. We know that because of the work undertaken by Hon Ed Dermer in the thirty-eighth Parliament.

What transpired after that is that, quite understandably, numerous Western Australians were very concerned about what Hon Ed Dermer had uncovered. At that point there was some correspondence between the Coalition for the Defence of Human Life and the then State Coroner in July 2012. I have in my possession a copy of a letter that was sent from the State Coroner to the Coalition for the Defence of Human Life. It states —

> I refer to your letter of 11 July 2012 in which you advise that you are reporting the deaths of 14 infants that occurred in Western Australia between July 1999 and June 2010 subsequent to the live birth of those infants following an abortion procedure.
>
> You wish to know whether any of the deaths have previously been reported and, in the event that they have been, seek my advice on any subsequent investigation and findings.
>
> I note that with your letter you attach a detailed letter from Dr Kim Hames MLA dated 21 September 2011 relating to the concerns you have expressed and a petition relating to the matter.
>
> I am not aware of any of the deaths to which you refer having been reported to a coroner.
>
> Based on the response provided to you by Dr Hames in his letter of 21 September 2011, I infer that that the terminations of pregnancy in question resulted from either a severe medical condition in the infant, or a severe medical condition that threatened the life of the mother. I further infer in the context of the information contained in your letter, to the effect that no treatment was reported as having been performed, that it was determined in each case that death was expected.
>
> In the above circumstances it would appear that a decision was made that the deaths were not reportable as they did not come within the definition of "reportable death" contained in section 3 of the Coroners' Act 1996.
>
> I propose to write to the Director General of Health and to forward a copy of your letter and the attachment to him with a view to confirming that the inferences that I have drawn are correct. In the event they are not correct, I shall advise you of any developments. If they are correct, then the deaths were not reportable and I do not have jurisdiction to investigate them.
>
> I thank you for drawing your concerns to my attention.
>
> Yours faithfully,
>
> A N HOPE
>
> STATE CORONER

In 2011, Hon Ed Dermer uncovered that at least 14 babies were born alive and left to die in Western Australia. The Coalition for the Defence of Human Life reported the matter to the coroner and, in 2012, the then coroner concluded that the deaths did not come within the definition of "reportable death". Without going on to the further chronology just yet, if that is where the situation is left, it is most unsatisfactory that the death of these Western Australian citizens is not to be investigated. I want to make sure that the bill that we are seeking to pass today does not worsen that situation either by way of law or by way of interpretation of the current coroner.

To finish off that episode, the coroner did write back to the Coalition for the Defence of Human Life. I have a copy of the next letter, dated 14 August 2012, when the then coroner stated —

> Thank you for your letter dated 2 August 2012 in which you expand upon the issues raised in your letter of 11 July 2012 to which I responded by letter dated 19 July 2012.
>
> This is to advise you that I have this day received a letter from the Acting Director General of the Department of Health relating to the matter in which he has advised me that: —

He then goes on to quote from that letter —

> "A review of all cases was undertaken by King Edward Memorial Hospital (KEMH) and in all cases of termination of pregnancy greater than 20 weeks, there were significant foetal abnormalities that were incompatible with life. All cases referred to were managed appropriately and in accordance with correct procedures and policies."
>
> In the above circumstances it appears that the deaths were not reportable and I have no jurisdiction to take the matter further.
>
> I thank you for drawing your concerns to my attention.
>
> Yours faithfully,
>
> Alastair Hope
>
> State Coroner

It is clear that in 2011 Hon Ed Dermer uncovered 14 Western Australian babies born alive, left to die. It is clear that when those deaths were brought to the State Coroner's attention in 2012, his view was that the deaths were not reportable and that he had no jurisdiction to take the matter further.

I certainly was not satisfied to leave things at that point and members may be aware that Hon Ed Dermer retired from Parliament in the lead-up to the next election. In the thirty-ninth Parliament, I pursued the questions where Hon Ed Dermer had left off. As a government backbencher, I asked multiple questions on notice and without notice about these matters, but I will draw members' attention to just one question that I asked. An answer to question on notice 2946 was received on 13 May 2015. I asked —

(a) since the enactment of the *Acts Amendment (Abortion) Act 1998*, how many instances have been reported of an abortion procedure in Western Australia resulting in the birth of a live child;

(b) was treatment reported as being performed in any of the incidences;

The answer that came back was —

(a) A total of 20 instances of abortion procedures resulting in the live birth of a child have been reported between July 1999 and December 2014.

(b) No treatment was reported as being performed in any of the 20 instances.

When Hon Ed Dermer asked his question, which took us till 20 January 2011, at that point we knew that 14 babies had been born alive, left to die. By the time we got to the end of December 2014—four calendar years; all of 2011, 2012, 2013 and 2014—the number increased to 20 babies. Another six Western Australians had been born alive and left to die.

Obviously, I was disturbed and distressed by the continuing growth in numbers, so I wrote to one of the Legislative Assembly's committees—the Community Development and Justice Standing Committee. The chair at the time was the member for Girrawheen, Margaret Quirk, MLA. I pleaded with that committee to investigate this matter because it had some capacity to interrogate the coroner of the day. I thank that committee and its chair at the time, Margaret Quirk, MLA, for taking up that matter. I have in my possession a copy of the letter that was given to the committee by the principal registrar, Mr Cooper, from the Coroner's Court of Western Australia. The date of the letter is 3 November 2016. Time will not enable me to go through all of it this afternoon, but I will say that the letter includes the following answer to this question. The committee asks —

> **a) If the baby had a condition that was compatible with life but was allowed to die, could this be considered a reportable death?**

The answer, in part, comes back from the principal registrar saying —

> If the baby was born alive and the death was unexpected, unnatural or violent, or resulted directly or indirectly from injury it would be a reportable death.

This type of language is more consistent with what the Northern Territory coroner said at the inquest of Jessica Jane, talking about unexpected and unnatural circumstances. Yet this is in 2016 and the position seems to have shifted somewhat from when the Coalition for the Defence of Human Life reported the 14 deaths to the then coroner who said, "No, sorry; I don't have jurisdiction in this matter. It's not a reportable death." The question is

whether these are reportable deaths or not. Will this bill affect that in any way? Will they still be reportable if they are at the moment?

In the current Parliament—the fortieth Parliament—I again pursued this matter. Remember that when I asked the last question in 2015, we knew that 20 Western Australian babies had been born alive, left to die. In this Parliament, I asked the parliamentary secretary representing the Minister for Health a question on notice and a response was provided to me on 15 June 2017. It was a multi-part question, and one part was —

> (2) I refer to the cases of babies who show signs of life after an abortion procedure, and I ask:
>
> (a) what is the total number of these cases between 20 May 1998 and 31 December 2016;

The answer that came back was —

> (2) (a) As at 19 May 2017, a total of 27 cases of abortion procedures resulting in a live birth have been reported between July 1999 and December 2016.

In the thirty-eighth Parliament, Hon Ed Dermer uncovered that 14 babies had been born alive and left to die in Western Australia. When I asked the question in the thirty-ninth Parliament, that figure had increased to 20 babies. When I asked last year in this fortieth Parliament, the number had increased once again to 27 babies. In the answer, it becomes clear that there was no record of medical intervention or resuscitation in any of the cases. I asked a subsequent question on 13 March this year. It was answered on 10 April 2018. It becomes clear that out of those 27 babies born alive, left to die in Western Australia, six were induced at 26 weeks' gestation or later who showed signs of life. Members may well ask what the current state of the law is in Western Australia with respect to these matters. That is what I would seek for us to get to the bottom of here today, if this matter is to conclude today.

I draw to members' attention section 3 of the Coroners Act, which defines what a "reportable death" means in Western Australia. It states —

> (a) that appears to have been unexpected, unnatural or violent or to have resulted, directly or indirectly, from injury; or
>
> (b) that occurs during an anaesthetic; or
>
> (c) that occurs as a result of an anaesthetic and is not due to natural causes; or
>
> (d) that occurs in prescribed circumstances; or
>
> (e) of a person who immediately before death was a person held in care; or
>
> (f) that appears to have been caused or contributed to while the person was held in care; or
>
> (g) that appears to have been caused or contributed to by any action of a member of the Police Force; or
>
> (h) of a person whose identity is unknown; or
>
> (i) that occurs in Western Australia where the cause of death has not been certified under section 44 of the *Births, Deaths and Marriages Registration Act 1998*; or
>
> (j) that occurred outside Western Australia where the cause of death is not certified to by a person who, under the law in force in that place, is a legally qualified medical practitioner;

They are the circumstances in which deaths are reportable under the law of Western Australia. It is plain to me, based upon the views that were quite sensibly articulated by the Northern Territory coroner, that the circumstances I have discussed fall under the very first category; that is, they appear to have been unexpected, unnatural or violent or to have resulted directly or indirectly from injury. That seems to be supported by the evidence given by way of letter by the principal registrar of the Coroner's Court to the standing committee of the other place in the thirty-ninth Parliament. Some people will say, "Well, look, is there any point in investigating these matters? Aren't we simply talking about babies who are going to die anyway, so why would we need to tie up the Coroner's Court with investigations into these matters?" There are two things I would say about that. The first is that I would ask people to read the inquest into Jessica Jane, in which I think the Northern Territory coroner articulated quite well why it is appropriate for these deaths to be reported. I will repeat what I said earlier. The coroner expressed this view at paragraph 37 of the inquest —

> … the fact that her birth was unexpected and not the desired outcome of the medical procedure, should not result in her, and babies like her, being perceived as anything less than a complete human being … The fact that her death was inevitable should not effect her entitlement to such care and attention.

That, I think, is the best way to articulate it, as outlined by the Northern Territory coroner in the findings released on 10 April 2000. However, I also draw to the attention of members that just because a baby is a survivor of an abortion procedure, under the law of Western Australia they would quite clearly still have all the rights and

privileges of any other Western Australian at that moment in time—that is the law of Western Australia. Even if one takes a utilitarian view of the world that there must be some substantial signs of life, I want to tell members about the case of Sarah Elizabeth Brown. Sarah Elizabeth Brown was born on 15 July 1993 in Wichita, Kansas in the United States of America. She died on 28 September 1998, some five years later. Sarah Elizabeth Brown survived an attempted abortion at 36 weeks gestation, which was performed by Dr George Tiller at his clinic, Women's Health Care Services of Wichita. The needle, which was filled with potassium chloride, was intended to stop her heart, but it pierced her brain instead. She was born alive at Wesley Medical Centre in Wichita two days later on 15 July 1993, weighing seven pounds, five ounces. Sarah was adopted by Bill and Mary Kay Brown against the advice of hospital staff, who said she would not survive. The Browns continued to speak publicly about their daughter despite the imposition of a gag order requested by Dr Tiller. The toxins permanently blinded Sarah and caused her to have a stroke at six months of age, which rendered her unable to speak. Despite that, she was happy, she laughed and she engaged with those in her life. When she died of kidney failure at the age of five, she was surrounded by family. Eight hundred people attended her funeral.

I wonder how many of the 27 Western Australian babies born alive and left to die were like Sarah Elizabeth Brown. We will not know, because not one of those cases has been reported to the coroner of Western Australia. There was an attempt to send the first 14 cases to the coroner, but the coroner of the day said, "Sorry, I don't have jurisdiction. It is not a reportable death." Is that true? When the principal registrar was asked in the following Parliament—the thirty-ninth Parliament—he told the committee chaired by Margaret Quirk, MLA, "Well, actually, these could be reportable deaths." Are they reportable or are they not? Will this bill impact in any way on the definition of what is or is not a reportable death? As I said at the outset, I, like my colleagues in the opposition, support this bill, because the purpose of the bill is to expedite coronial investigations. I wholeheartedly support the expediting of coronial investigations. What I do not want is for these types of deaths to not be reported for investigation in the first place because of some type of interpretation that might be put on some of the words we are now going to insert into the act. The former coroner interpreted it in a particular way, which was inconsistent with how the Northern Territory coroner interprets unexpected and unnatural deaths. Are we going to be doing anything here that will impact on that? For this bill to receive my wholehearted, full support, I ask the government to answer the following questions: Are these deaths that I am talking about and which Hon Ed Dermer uncovered in the thirty-eighth Parliament reportable under the law of Western Australia? Will they still be reportable if this bill passes unamended? Will they be investigated? Are these types of deaths now being reported? If they are now being reported, how did that come about? Will the 27 deaths that we already know of, because of answers in Parliament given to me earlier this year, be capable of being reported and investigated after this bill passes?

I will conclude by once again drawing to the attention of the government what was said in the second reading speech at the time this bill was introduced. The final line of the first paragraph of the second reading speech states —

> The Coroners Amendment Bill 2017 will give legislative effect to recommendations 55 and 56 of that report.

They are not my words; they are the words of Hon Sue Ellery, Leader of the House representing the Attorney General, when she introduced this bill last year. She said —

> The Coroners Amendment Bill 2017 will give legislative effect to recommendations 55 and 56 of that report.

If that is what this bill is doing, it has my support. My question remains: How does this bill give effect to recommendation 56.2? What clause gives legislative effect to recommendation 56.2? What words in this bill that we are being asked to insert into the legislation are giving legislative effect to recommendation 56.2? Recommendation 56.2 is —

> 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.

Where does this bill do that? If this bill does that, then the government has been true to its word. The second reading speech stated that it was going to give legislative effect to recommendation 56; and if that is what this bill will do, that is excellent. I look forward to the government demonstrating that that is what will be happening. Even if that is happening, which then should be supported, we need to be clear that in no way are words being inserted here and that there is no way that the interpretation of what is taking place with this amendment to the primary act will result in the deaths of Western Australian babies who, incredibly, survive an abortion procedure, are not reported to the coroner. That should never have happened in Western Australia in the first place. It has been going on for far too long. It has to stop. I want to be satisfied that we are not doing anything here today that is going to lessen the bar. I want to make sure that people report those deaths. I want to make sure that the coroner receives those reports. I want to make sure that the coroner investigates those reports and I want there to be findings in Western Australia along the lines of what the Northern Territory coroner found in the inquest into Jessica Jane.

The Northern Territory coroner made excellent recommendations that protocols should be put into place to ensure children who survive termination procedures are assessed for gestational age and viability via a medical practitioner or paediatrician. He also recommended that the management of staff of all hospitals and clinics in the Northern Territory, and medical practitioners, should be made aware of their legal obligations to report the deaths of such children to the coroner. He also recommended that protocols should apply to all hospitals and clinics. That is what we need to replicate. We need to learn the lessons from the Northern Territory that have arisen out of the inquest of baby Jessica Jane from as far back as 10 April 2000, and we must not do anything to lessen the possibility of that occurring.

HON SUE ELLERY (South Metropolitan — Leader of the House) [3.12 pm] — in reply: I thank all members who have contributed to the second reading debate and I acknowledge the expression of support for the carriage of the Coroners Amendment Bill 2017. I will touch on some of the particular matters raised by members in their second reading contributions, and there may be other questions I can answer during the course of the Committee of the Whole.

Hon Michael Mischin raised , as did a couple of other members, the issue of the proposed provision of a computerised tomography scanner. I am advised that the tender process is currently underway and that it is anticipated that the process will be complete by February 2019. Hon Michael Mischin also raised a question about the progress of certain other recommendations of the Law Reform Commission. I am advised that work is being done on those; that a cabinet submission is being developed. I am not able to explicitly set out the details of those to the house, but that work is being done and it will build on the work that the former government has already done on this matter and that has continued under the current government.

Hon Alison Xamon also raised a couple of issues about the recommendations in the Law Reform Commission report that recommend legislative change. I understand that work is being progressed on those. I think the honourable member also noted the gradual reduction in the backlog of cases. The honourable member referred to recommendations 17 and 18 in particular, which go to specific categories of anaesthesia-related deaths and health-care–related deaths. I do not have the detail of the specific matters that are being developed by the Department of the Attorney General; all I can tell the member is that work is progressing and a cabinet submission is being prepared. Hon Alison Xamon also asked whether consideration was being given to rewriting the act. I am advised, no, that is not the case.

Hon Charles Smith noted that his support was based on the intention of the bill to free up police and coroner time. Hon Rick Mazza asked questions about non-invasive techniques. I do not have that information available to me now. I can undertake to get that for him. The advisers here today may be able to add something when we go into committee, but we will see how we go. He also raised a question about the CT scanner. I have already advised members that that process is underway. He also asked whether nursing home deaths are investigated. I am advised that nursing homes deaths are investigated, and if an injury occurs or the family is concerned, for example, about treatment, nothing will change in that respect. He said that around 95 per cent of pathologist-recommended external post-mortem examinations are accepted by families and, therefore, there is no need for invasive post-mortem examinations, but we can go into that matter in committee.

Hon Nick Goiran raised an issue about recommendations 55 and 56. He wants to be satisfied that the bill before us today actually gives true effect to the recommendations of the Law Reform Commission report. I am advised that, yes, the bill does give effect to recommendations 55 and 56. Recommendation 56.2 of the Law Reform Commission report, in short, reads that the coroner may not discontinue an investigation of a deceased if the person was held in care or in custody, or the death occurred following a medical procedure. Proposed section 25(1A)(a) of the bill not change the duty to hold an inquest. The deaths of babies, as the honourable member described, are covered in section 3; the catch-all is the unnatural death provision. Proposed section 25(1A)(b) of the bill goes to the public interest for deaths following a medical procedure. Health practitioners, be they attending to routine health matters or indeed pregnancy terminations, are still required to report any and all deaths of an unexpected and unnatural nature; there is that capacity. The form currently used in these circumstances and the requirement of attending practitioners to speak directly to the coroner and to seek advice 24 hours a day, seven days a week has not changed and will not be impacted by the bill that is before us now.

There is always a potential difference between the legislation and the practice. The legislation has not changed in this respect. Hon Nick Goiran put before the house the work that he and others had done in bringing a series of questions to the attention of the previous coroner in 2011 and 2012. The previous coroner did not consider those deaths to be reportable. That was the view of the previous coroner, but it is not the view of the current coroner. The act still provides, and the coroner is of the same view, that deaths as described by Hon Nick Goiran are reportable. From the coroner's point of view, the law in that respect has not changed, and the coroner's point of view is that those are reportable. I appreciate that the honourable member may have information available to him suggesting that that is not the practice, but in the provisions of the existing legislation, and the amendments

included in the bill before the house now, there will be no change in the law. The advice provided to me is that section 3 of the Coroners Act 1996—that is, as it is now—defines reportable deaths. 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;

The definition of "reportable death" in section 3 of the act begins —

> ***reportable death*** means a Western Australian death —
>
> (a) that appears to have been unexpected, unnatural or violent or to have resulted, directly or indirectly, from injury; …

The legal advice received confirms that the death of such an infant in the circumstances described by Hon Nick Goiran—born alive—would come within the definition at paragraph (a) as being unnatural or resulting, directly or indirectly, from injury, and therefore already comes within the definition of a reportable death. This jurisdictional issue was raised with the present State Coroner when she gave evidence on 12 October 2016 before the committee referred to by the honourable member; that is, the Community Development and Justice Standing Committee. A question was asked by the member for Vasse, Libby Mettam. I may be wrong, but I think she was asking on behalf of Hon Nick Goiran, and made reference to previous questions asked in this place. The State Coroner was asked how many of the deaths that had been described had been reported to the Office of the State Coroner. The State Coroner advised the committee that none had been reported since her appointment. She undertook to seek information, and she did so. The State Coroner advises that medical practitioners had been unaware of their obligation under the Coroners Act to report such deaths, and would do so in the future. That is the advice that has been provided to me.

In respect of unexpected and unnatural deaths, in the case of a pregnancy termination, I am advised that if a baby is born living and subsequently dies, no matter how briefly the baby lived, that is deemed reportable by the current coroner, because the coroner considers it to be unnatural. There may well be a difference between what is in the law and the practice by some. I am flagging that I can give the member answers to questions about matters that fall within the jurisdiction of the coroner, and within the purview of the bill that is before us and the substantive act that it seeks to amend. However, when it comes to issues of practice, if you like, on the other side of this, which is health, I am not in a position to answer those questions. I have answered, to the best that I am able, the legal responsibilities and interpretation by the current coroner of the current Coroners Act. With that response, I commend the bill to the house.

Question put and passed.

Bill read a second time.

Committee

The Chair of Committees (Hon Simon O'Brien) in the chair; Hon Sue Ellery (Leader of the House) in charge of the bill.

Clause 1: Short title —

Hon MICHAEL MISCHIN: I have a general question about what we have heard about the computerised tomography scanner, and the way that it is meant to assist with the coroner's work, and also to clarify how central it is to the effectiveness of what is proposed by this bill. The announcements made previously, at the time that this bill was introduced and subsequently, linked this particular reform and the adoption of these recommendations with the acquisition of a CT scanner. I would like to know a bit more about the importance of that, how central it is to making these changes work effectively, and how close we are to obtaining one. I heard what the minister had to say about "some time in February next year", but I am unclear about why it is taking so long.

Hon SUE ELLERY: There are a couple of reasons. Firstly, the tendering process that was used was that of preferred provider. The agency was looking to go to a particular manufacturer. Obviously, the agency needs to go through processes, checks and balances, to demonstrate that that is the correct and appropriate procedure to forgo the normal, much broader, tendering provisions. Then, a degree of planning had to be undertaken to fit out the mortuary. The CT scanner is, if you like, a bespoke piece of equipment. It is not something that is bought off the shelf, to use the colloquial term—I am sure there is not a shelf somewhere with a bunch of CT scanners sitting on it! It is a bespoke piece of equipment, so the planning needed to be undertaken to fit out the mortuary to take account of all the special requirements has also taken some time.

Hon MICHAEL MISCHIN: I thank the member for that. Who is the preferred provider?

Hon SUE ELLERY: I am not sure I can confidently tell the member the manufacturer, so maybe I can get back to him with that information. I can tell him that the work in building a bespoke machine takes about 12 weeks, but I will have to confirm the actual manufacturer.

Hon MICHAEL MISCHIN: Given that we are looking at a bespoke piece of equipment and a preferred provider, and the minister said that there is a tendering process, what does that involve? Does it involve getting a quote for the work, or is it, having selected the provider and instructed them, waiting for the work to be completed? What stage are we at? I am a little unclear. It is not as though we are going through a general tendering process, asking who can give us the best price, with the best quality, and deliver on time and within budget; we have a preferred provider and we are saying to it that we would like it to build this piece of equipment. What are we waiting for exactly? Is it a price?

Hon SUE ELLERY: I note that there is no provision in the bill before us that deals with CT scanners, but by way of general information, it is a very specific piece of machinery. The bore, which I am advised is a doughnut-like hole, has to be large enough to accommodate the broadest range of bodies that might go through it, and it is very specific. The processes gone through were the due processes of establishing which companies were available to provide that kind of machinery, and then working through the normal processes of getting the correct approvals to go outside the broadest tendering processes.

The CHAIR: Order! Before I give the call again to Hon Michael Mischin, perhaps, if he wishes to pursue this point, he could just give an indication to the committee of how this relates to the bill. I am sure it does.

Hon MICHAEL MISCHIN: Only because there has been mention by the government about how a scanner will complement what is being proposed by the bill and how the processes in the bill will complement or facilitate the use of a scanner. I am curious as to whether this bill can achieve very much in the absence of the equipment that is being sought by the government at this stage in order to achieve its ends. At the very beginning of this process, if I may quote the Attorney General, was a headline to a newspaper article, "CT scanner to lift morgue work rate". I quote —

> A $1.4 MILLION CT scanner needed for the State's morgue, which will spare the need for many autopsies, will be funded as soon as there is money in the Budget, says Attorney-General John Quigley.
>
> Mr Quigley, pictured, said the piece of equipment would make a massive difference to the morgue and Coroner's workload, with a five-minute scan expected to detect causes of death otherwise only confirmed through a full autopsy.

I digress there for a moment to point out that having the scanner itself doing a scan is not going to obviate the need for the work that the coroner is currently obliged to do. The article goes on to say —

> "We'd like to be able to CAT-scan the body on arrival at the morgue. But that is expensive and there's been a demand for them in hospitals, but … that's our ambition when money permits," he said. "This will spare the need and the trauma for families of having the autopsy performed on the deceased."
>
> The Government is also pushing ahead with law reforms to remove the obligation for the Coroner to investigate, or continue to investigate, a death that was found to have been a result of natural causes.
>
> The changes, recommended by the Law Reform Commission in 2012, have been passed by the Lower House and Mr Quigley expects them to be given the full green light next month after Parliament resumes.

That was published in *The Sunday Times* of Sunday, 16 July 2017. Later in 2017 the Attorney General also put out a media release saying that he had brought about some of the most significant reforms to justice legislation in Western Australia since the March state election. Among those introduced were amendments to the Coroner's Act to reduce delays in the Coroner's Court and remove the unnecessary impost on the resources of the office of the State Coroner and WA Police. In the media release he goes on to say —

> "While it is disappointing that some of this legislation hasn't yet passed the Legislative Council, where Labor does not control the numbers, I hope that this will happen swiftly in the new year."

Apparently it is our fault!

The Attorney General put out another media release on 18 December 2017 in which he referred to the first CT scan. I quote —

- More than $1 million has been allocated for the improved coronial technology

That is linked to a quote from the Attorney General —

> "Earlier this year, I introduced amendments to the Coroner's Act which reduce delays and remove the current unnecessary impost on the resources of the Office of the State Coroner and WA Police.

It continues —

> "It is hoped that use of the new scanner means that fewer Western Australians will need an invasive post-mortem examination, which is often resisted by families and also goes against some cultural beliefs.

An article in *The West Australian* of 18 December last year states —

> Determining cause of death will become quicker and easier for WA's State Coroner because of a new CT scanner that reduces the need for invasive post-mortem examinations.

Again, that seems related entirely to what is being proposed here to facilitate the coroner's work. It seems to me that having a non-invasive autopsy or examination cannot necessarily be done while the law remains the same. Under the headline "Scanner cuts need for autopsies", the article continues —

> The State Government has allocated $2.3 million in its midyear economic review to buy, staff and maintain the technology which Attorney-General John Quigley said was widely used in other jurisdictions as an alternative to autopsies.

The article then quotes bits of the Attorney General's media release. There is another photograph of him, which shows him standing behind a computerised tomography scanner. It comes as a bit of a surprise that despite all this having been foreshadowed back in July last year, we are still at the stage of tendering and trying to find someone who can supply this bespoke piece of equipment. I get back to the questions of: How essential is this piece of equipment for the effective operation of what is proposed in the bill? Likewise, is the bill necessary to effectively use the piece of technology that has been made so much of over the past 14 months?

Hon SUE ELLERY: The two are complementary. I note that the bill does not refer to computerised tomography scanners or any other form of equipment. Being able to do non-invasive assessments for post-mortems means that in combination with the provisions that are set out in the bill before us, families will get results quicker. It is not critical. It is not the case that we cannot do one without the other. They are complementary.

Hon MICHAEL MISCHIN: I thank the minister. I do not want the minister to assume that I am having a go at her. I understand that she is in the position of dealing with someone else's bill. Given the summary means by which a coroner can choose to rely on, say, a pathologist's report, can the minister say that nothing much will change with the way the pathologist deals with a deceased? Will the pathologist's report still require, at this stage, some kind of autopsy to take place to provide a cause of death or is there capacity to utilise what is proposed under the bill without the necessity or use of a CT scanner?

Hon SUE ELLERY: We cannot guarantee that we will not need a full post-mortem at some stage. However, particularly when we are talking about natural causes, we anticipate that this will save significant time. The process will be significantly expedited. The forensic pathologist will form an opinion based on an examination of the medical notes and the CT images. That may well have some caveats to it. It may be subject to some other elements, but they will form that opinion. That of itself will expedite the process.

It is worth noting that it is envisaged that everybody working with this new scheme will be on a fairly significant learning curve. It is a new legislative framework and the images from the CT scanner will form a new bit of technical advice. With that working together, the operators and the staff will be on a fairly steep learning curve as they figure out the best way and the particular circumstances in which relying on those images gives us the most expedited outcome. We cannot say today that as of day one of the CT scanner operating in the mortuary, we will see instant results. Those working in the area believe, and my advice is, that these two things combined—an expedited legal framework and an expedited form of technology in the CT scanner—will mean that the whole process and results for families can happen more quickly.

Hon MICHAEL MISCHIN: I thank the minister. I appreciate that. It should not be understood that we are in any way against the acquisition of this item of equipment as a complement to not only the forensic pathology staff and department, but also the work of the coroner's office. We had initiated this before the last election and I hoped it would be in place by now. All strength to the government to be able to achieve this. With regard, though, to how it is to be used, at the moment the government is looking at an inquiry that may involve medical notes, with police obtaining, in one way or another, any records that a medical practitioner may have about a person who has died. The minister said computerised tomography images, but let us leave them aside for the moment because we do not have the equipment to do that. There are reasons, if only of perception, for why we do not use hospital equipment such as CT scanners on dead people that has been used on live people, hence the need for a dedicated piece of equipment. Otherwise, there would be, say, toxicology reports and an assessment by the pathologist of whether the death was through natural causes or otherwise. Those things would still be conducted as a matter of course. Is that correct?

Hon Sue Ellery: Correct.

Hon MICHAEL MISCHIN: It would allow the coroner to determine that the death is due to natural causes if the pathologist tells the coroner in writing that that is the pathologist's opinion. On the strength of that, the coroner can decide that they do not need to hold an inquest or continue their inquiry and they can make a determination. That can expedite the process; nonetheless, plainly, a few things do slip through. We have heard, for example, a claim by a medical practitioner that she killed one of her patients to relieve them of their suffering. The police

have been unable to identify that patient. The coroner, plainly, did not identify that patient and this proposed process would allow for a greater chance, would it not, that doctors can kill their patients outside any assisted suicide legislation without it being detected? Has there been any consideration by the coroner of how to ensure that that does not happen or how these truncated procedures might be exploited by those who want to kill others and, hopefully, not be discovered? Plainly, the medical notes did not help the coroner or the pathologist determine that this patient had been "put out of their misery". Here we are looking at an opinion even without necessarily a post-mortem. Can the minister provide any comfort to us that that will not happen?

Hon SUE ELLERY: I think we are stepping beyond what is envisaged in this amending bill before the house now. I make this point: there is nothing in this bill that changes the obligation on medical practitioners now to report according to this and other laws they are required to operate under. There is nothing in this bill before us today that in any way changes the obligations and methodology by which police have to investigate deaths that might occur, for example, in a family home or otherwise. Those obligations remain on medical practitioners and they remain on the police as well.

Hon MICHAEL MISCHIN: I thank the minister. I will not pursue that much further but I make the point that there was a medical practitioner who claimed that she had killed her patient out of very noble motives and, we are told, at that patient's request. She compiled medical notes and presumably completed what was necessary to be completed on a death certificate for the coroner or other paperwork necessary to submit to the coroner about someone in her care. The coroner was not able to identify who that was. The police have not been able to identify who that was even if, indeed, to confirm that there was such a person. Here, we are not looking at a police investigation necessarily; we are looking at a pathologist's opinion that can eliminate, we are told, the need for the police to make a full investigation. I have concerns about that. Perhaps the minister can take some advice about whether the coroner has anticipated this sort of a problem and what safeguards the State Coroner has contemplated to ensure that these sorts of cases do not slip through the net.

Hon SUE ELLERY: This does go beyond the scope of the amending bill in front of us. I have provided the answer as best I could to the honourable member that nothing changes in respect of the example he has given; nothing changes in respect of the legal obligations upon medical practitioners and the investigative responsibilities upon the police. I am not in a position to add anything further.

Hon MICHAEL MISCHIN: I thank the minister, and will move right along then.

We are talking about a reduction in the draw on resources of the State Coroner's office and of the Western Australia Police Force, presumably the coronial investigation division primarily, and other police officers. Can the minister tell us what the current backlog of coronial cases is and what she expects, say, within 12 months of the operation of this legislation, the saving in time with the expedition of cases? Has any assessment been done regarding that?

Hon SUE ELLERY: I can provide some information about the first part of the question. I cannot provide a response to the second part. At any one time, the coroner will have about 2 200 cases at hand. There is currently a backlog of 420 cases and the coroner's office is aware that police have around 600 cases coming their way. That is not a backlog with the police, it is just the cases that are coming. It is not possible to assess projected savings in either dollars or time. As I outlined to the chamber in answer to an earlier question from the honourable member, it is anticipated that there will be a very steep learning curve once the legislative framework changes and the CT scanner is available. It is anticipated that people will learn as they go when these two things change and at some point in time—it is not predicted when—there will be a clearer picture of savings and, therefore, capacity to reduce the impact on families who might otherwise have been waiting for a much longer period.

Hon MICHAEL MISCHIN: Hon Nick Goiran raised this subject, and he will no doubt pursue it also but I am at least interested in getting some flavour of what the answer might be. To what extent has the bill departed from recommendations 55 and 56 of the Law Reform Commission report and why has it so departed?

Hon SUE ELLERY: We do not accept the premise of the question that it has departed. We see this bill as giving effect to both of those recommendations.

Hon NICK GOIRAN: Which clause of the bill gives effect to recommendation 55.1?

Hon SUE ELLERY: I take the member to clause 5, which seeks to amend section 25 of the act. That is the provision that meets recommendation 55.1. With respect to recommendation 56, I provided a response in my second reading reply. I referred the member to proposed section 25(1A)(a), and then proposed section 25(1A)(b) with respect to recommendation 56.2.

Hon NICK GOIRAN: The minister says that clause 5 of the bill gives legislative effect to recommendation 55.1. Recommendation 55 on page 78 of the Law Reform Commission of Western Australia's final report "Review of Coronial Practice in Western Australia" reads —

> That the Coroners Act contain a section modelled on s 67 of the *Coroners Act 2008* (Vic)

To what extent does clause 5 differ from section 67 of the Coroners Act 2008 in Victoria?

Hon SUE ELLERY: The advice I have is that there is a difference between the Victorian provisions and the current Western Australian act in that the Victorian provisions exclude having to provide a report on the manner of death. Currently in the Western Australian provisions we are required to make findings with respect to the manner of death. I am advised that the bill before us aligns us with the Victorian provisions so that no longer in Western Australia will findings need to be made in respect of the manner of death. Although the format is different, the advice I have is that what is set out in proposed section 25 aligns us with section 67 of the Victorian provisions.

Hon NICK GOIRAN: If the minister has recommendation 55.1 of the Law Reform Commission handy, she will see that it states —

> That the Coroners Act contain a section modelled on s 67 of the *Coroners Act 2008* (Vic) enabling a coroner to make an administrative finding consisting of the identity of the deceased, the manner and cause of death, and the particulars required to register the death (that is, excluding the narrative of circumstances attending the death).

That seems to enable the coroner to do a number of things. Firstly, it enables the coroner to make an administrative finding consisting of the identity of the deceased; secondly, the manner and cause of death—let us combine manner and cause and call them part 2—and; thirdly, the particulars required to register the death. The recommendation of the Law Reform Commission is asking that the coroner be able to make an administrative finding on all three of those things. The minister has indicated that to the extent there is a difference between Western Australia and Victoria, at the moment Victorians do not need to report on the manner of death. Out of the three parts of that recommendation, that is half of part 2 about the "manner and cause of death". Is that because all the other elements—I will call them part 1, half of part 2, and part 3—are already captured in our legislation?

Hon Sue Ellery: Essentially, are you talking about the identity and cause of death?

Hon NICK GOIRAN: The identity is part 1; that is right. The cause is what I will call part 2(b). Then do not forget part 3, which is the "particulars required to register the death".

Hon SUE ELLERY: I am going to give this my best shot and I want members to forgive me for not following my mother's advice and getting a legal degree. I am advised that recommendation 55.1 of the Law Reform Commission goes to "non-narrative findings". Where recommendation 55.1 appears in the bill that is before the chamber is in the provisions of clause 5 that go to allowing the exclusion of a narrative of the circumstances attending a death. In the Victorian provisions, it is picked up in section 67(2) of the Coroners Act, which states —

> Whether it is possible or not, a coroner need not make a finding with respect to the circumstances in which a death occurred if—

It then goes on to list the particular circumstances that need to be satisfied so that they do not have to make that finding. Recommendation 55.1 of the Law Reform Commission's report goes to the non-narrative findings and the non-narrative findings appear in our proposed section 25(1A)(b), which states —

> the coroner determines that there is no public interest to be served in making a finding as to how the death occurred.

I think I should get an honorary legal degree!

Hon NICK GOIRAN: Section 25 of the primary act is entitled "Findings and comments of coroner" and section 25(1) states —

> A coroner investigating a death must find if possible —
>
> (a) the identity of the deceased; and
>
> (b) how death occurred; and
>
> (c) the cause of death; and
>
> (d) the particulars needed to register the death under the *Births, Deaths and Marriages Registration Act 1998*.

Under the provisions in clause 5 of the bill, we will insert new subsection 25(1A) underneath that section. When section 25(1) states, "A coroner investigating a death must find …", is the implication that the finding is a narrative finding?

Hon SUE ELLERY: Section 25(1)(b) of the act is effectively the narrative—how death occurred. The provisions before us in the bill allow us to dispense with that.

Hon NICK GOIRAN: Yes, okay; I think we are making progress. Recommendation 55.1 on page 78 of the Law Reform Commission of Western Australia's final report, entitled "Review of Coronial Practice in Western Australia", says —

> That the Coroners Act contain a section modelled on s 67 of the *Coroners Act 2008* (Vic) enabling a coroner to make an administrative finding consisting of the identity of the deceased, the manner and cause of death, and the particulars required to register the death (that is, excluding the narrative of circumstances attending the death).

Basically, section 25(1) of the primary act requires the coroner to make a finding of (a), (b), (c) and (d). The Law Reform Commission's recommendation 55.1 is stating that the coroner should be able to just make an administrative finding based on (a), (c) and (d). The government says that by the insertion of clause 5 of this bill in the legislation, we will be dispensing from time to time with the need for section 25(1)(b), and that is then giving legislative effect to recommendation 55.1.

Hon SUE ELLERY: Correct.

Hon NICK GOIRAN: I thank the minister. I move to recommendation 55.2 of the Law Reform Commission of Western Australia's final report. The recommendation on page 78 states —

> That the above section only applies in cases where no inquest has been held, where the deceased was not a person held in care … and where the coroner determines that there is no public interest to be served in including in the finding a narrative as to the circumstances attending the death.

Is that all captured by clause 5 of this bill, and specifically through the insertion of proposed subsection (1A)(b)? Does proposed subsection (1A)(a) have any bearing with respect to recommendation 55.2?

Hon SUE ELLERY: It is proposed paragraphs (a) and (b). If the honourable member has the Victorian act in front of him, that is set out in section 67(2).

Hon NICK GOIRAN: Recommendation 55.2 of the Law Reform Commission report states —

> That the above section only applies in cases where no inquest has been held, where the deceased was not a person held in care … and where the coroner determines that there is no public interest to be served in including in the finding a narrative as to the circumstances attending the death.

The third of those scenarios, which is that there is no public interest, is clearly captured in clause 5 of the bill, specifically, by the insertion of proposed subsection (1A)(b), which states —

> the coroner determines that there is no public interest to be served in making a finding as to how the death occurred.

I have no problem with that. But earlier in recommendation 55.2, it states that it applies only in cases when no inquest has been held. Are we sure that is captured by clause 5? It also states "where the deceased was not a person held in care". Are we sure that is captured by clause 5? That is the first two parts, which is really where the question is. I can see that the third one, on the public interest, is captured.

Hon SUE ELLERY: I need Hon Nick Goiran to go to section 22 of the act, which sets out the obligations of the coroner to hold an inquest. It lists in section 22(1)(a) that the person was held in care. This is on page 15 of the act. If the member then goes back to section 3, at the top of page 3 is a definition of "person held in care". Where clause 5 states that there is no duty to hold an inquest, that duty is defined in the two bits of the act to which I have just taken the member. Nothing in clause 5 diminishes the obligations under sections 3 and 22 of the act when read together.

Hon NICK GOIRAN: Recommendation 55.2 of the Law Reform Commission report was that recommendation 55.1 —

> … only applies in cases where no inquest has been held, where the deceased was not a person held in care … and where the coroner determines that there is no public interest to be served in including in the finding a narrative as to the circumstances attending the death.

The government has indicated that the section applies only in cases in which no inquest has been held when the deceased was not a person held in care, on the basis that clause 5 of the bill states that the coroner is not under a duty to make a finding.

Committee interrupted, pursuant to standing orders.

[Continued on page 5936.]