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CORONER'S COURT OF WESTERN AUSTRALIA

OUR REF: 0025/2017

YOUR REF: A738951

Ms J. M. Freeman, MLA
Chair
Education and Health Standing Committee
Parliament House
4 Harvest Terrace
WEST PERTH WA 6005

Dear Ms Freeman

Re: **Invitation to attend a hearing regarding the Kimberley youth suicide inquest**

Thank you for your letters dated 14 and 20 February 2019 to the State Coroner regarding the Kimberley youth suicide inquest and your invitation to attend a hearing on 3 April 2019. I note you subsequently invited a response either in person at a hearing, or in writing by April 3.

The State Coroner has asked me to respond in writing on her behalf.

In relation to the questions posed in your letter dated 20 February 2019, I respond as follows:

Question 1

The Coroner's Court does not have a post-report engagement strategy and after an inquest finding has been delivered and released into the public domain the functions of the court cease. Prior to the Kimberley inquest offers of assistance with regard to interpreters and counselling support were made to the families concerned. This was reiterated during the course of the inquest hearings.

All but one of the families was represented by the Kimberley Community Legal Service (KCLS). In some cases, that representation was in collaboration with the Aboriginal Legal Service. After the finding was delivered the KCLS

advised of their intention to arrange interpreter services and of their intention to use those services to assist families in explaining the coroner's findings.

The remaining family was not represented by lawyers (in respect to the child referred to in Case 6) but rather was assisted by Anglicare, at the behest of the Coronial Counselling Service, who went to great lengths to offer assistance to the family before and after the delivery of the finding.

In relation to the coroner's recommendations, a copy of the finding and recommendations was sent to the responsible minister(s).

The Coroner's Court has no role in the implementation of recommendations and cannot enforce compliance.

Whether recommendations are acted upon is a matter for those to whom the recommendations were directed.

Question 2

Inquest findings are published on the Coroner's Court website. Responses to recommendations are also be published once they become available. These responses are attached to the webpage of the relevant findings as PDF documents which make the details within the PDF unsearchable. Presently, visitors to the website can only search for text within the finding and not text within the PDF responses.

Going forward the Coroner's Court will commence using the Integrated Courts Management System (ICMS) as its case management system. This will provide functionality to manage case matters which includes aspects such as managing documents, listings and decisions. The move to ICMS will enable the users to enter inquest findings and recommendations within ICMS and no longer outside of a system.

Once inquest findings are published they will be available within the eCourts Portal and users will be able to search for specific text within a finding e.g. witness name, and will also be able to search the text within the responses to recommendations. The eCourts portal can be found at:

https://ecourts.justice.wa.gov.au/eCourtsPortal/

The estimated time for the ICMS development to be completed is July 2019 but is subject to change.

CORONER'S COURT OF WESTERN AUSTRALIA

I trust you find the above information useful and please do not hesitate to contact me if you require any further information or assistance.

Yours faithfully

Gary Cooper
PRINCIPAL REGISTRAR

1 April 2019

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