



**Hon Amber-Jade Sanderson MLA
Minister for Health; Mental Health**

Our Ref: 76-15235
Your Ref: A956949

Hon Peter Collier MLC
Chair
Standing Committee on Estimates and Financial Operations
Parliament House
4 Harvest Terrace
WEST PERTH WA 6005

Dear Mr Collier

I refer to your letter of 19 May 2022 seeking my assistance in responding to two matters in relation to the operations of the Office of the State Coroner.

The operation of mortuaries in Western Australia is the responsibility of the Department of Health. The operation of the State Mortuary which investigates coronial cases is managed by PathWest Laboratory Medicine WA (PathWest).

In responding to the two matters raised in your letter the advice of Dr Jodi White, Consultant Forensic Pathologist, Head of Department Forensic Pathology and State Mortuary Service, PathWest was sought by my office.

The Committee's first matter referred to page three of the Office of the State Coroner Annual Report 2020-21 which provided the total number of administrative findings finalised for the reporting year, noting that the number was at a five-year low. In providing advice to the Committee on this figure, the Attorney General referred to matters including delays in the finalisation of post-mortem reports and delays in other medical tests. The Committee has requested further information on the delays referred to by the Attorney General and how these impacted administrative findings.

Dr White advises that the provision of a cause of death (COD) and finalised report to the Coroner's Office is only one of a number of documents and reports the Coroner receives during the investigation of a death. It can take several months for a pathologist's report to be completed where the cause of death is initially undetermined at post-mortem, as the pathologist must wait for all necessary tests to be completed before these results can then be assessed and finalised by the pathologist. Depending on the complexity of the case, this final report may take even longer.

Turn around times in the completion of cases have been impacted by the large and increasing workload each year, which has a flow on effect to staffing levels and a lack of adequate functional clinical work space at the State Mortuary. Staff recruitment to add staff across the Mortuary Service has been completed and the current mortuary refurbishment project is addressing these issues. In addition, the impact of COVID-19 on current mortuary services and operations has been evident for the past two years, as it has with all areas of Health.

The second matter raised by the Committee's letter relates to the possibility of testing for sodium nitrate as part of a post-mortem.

Dr White advises that not all drugs, chemicals, toxins or poisons are able to be tested for and/or quantitated in forensic toxicology. Sodium nitrate/nitrite is such a chemical, as are helium, nitrogen gas and some pesticides for example.

There is no current methodology to detect sodium nitrate (nitrate analysis) in post mortem samples. In some nitrate/nitrite ingestion cases and where possible, the pathologist can, as an option, undertake a MetHaemoglobin analysis as slightly elevated COHb (carboxyHb) levels can be seen in some cases. In the context of providing a COD in these types of cases, the forensic pathologist works with the Coroner and the Police to consider all the findings including circumstantial and other evidence to provide a COD. Stating the COD as "consistent with" indicates to the Coroner that the COD is provided based on all the available but possibly incomplete information obtained.

I thank you for providing me the opportunity to respond to the above matters raised by the Committee.

Kind regards



HON AMBER-JADE SANDERSON MLA
MINISTER FOR HEALTH; MENTAL HEALTH

8 JUN 2022