OFFICE
of the
STATE CORONER
for
WESTERN AUSTRALIA

ANNUAL REPORT
2021-2022

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Dear Attorney

ANNUAL REPORT 2021-2022

In accordance with section 27(1) of the *Coroners Act 1996* I submit my report on the operations of the Office of the State Coroner for the year ended 30 June, 2022.

Yours sincerely

R V C FOGLIANI
STATE CORONER

30 September 2022

Table of Contents

STATE CORONER'S OVERVIEW 3
Executive Summary of Outcomes ... 3
Structure of the Report ... 4
The Coroner's Court of Western Australia – information available to the public ... 5
The focus over the 2021/22 year: The Backlog of coronial cases, Coronial Case Management System, Reform, Restructure and CT Scanner ... 5
Backlog ... 6
Coronial Case Management System ... 6
Internal Restructure ... 7
CT Scanner ... 7
Report on inquests that are required by law to be held (mandated inquests) ... 8
(a) Mandated inquests - persons held in care immediately before death 8
(b) Mandated inquests – where it appeared the death was caused, or contributed to, by any action of a member of the police force. 9
(c) Mandated inquests – suspected deaths 9
Report on inquests that are held pursuant to an exercise of discretion by the coroner (discretionary inquests) ... 10
The Coronial Counselling and Information Service ... 10
The Death Prevention Role and the Coronial Ethics Committee ... 11
Acknowledgements ... 12
Office Structure ... 13
Table A – Office Structure ... 13
Registry and Statistics ... 13
Table B – Overview of Work ... 15
Table C – Cases Closed ... 16
Table D – Deaths reported and cases completed ... 17
Table E – Findings on manner of death ... 18
Post Mortem Examinations ... 19
Objections to Post Mortem Examinations ... 19
Table F – Reported deaths and outcomes of objections ... 20
Pathologist Recommended External Post Mortem Examinations ... 21
Table G - Outcomes in PRE (Pathologists Recommended External Post Mortem Examinations) ... 21
Coronial Counselling and Information Service Functions ... 22
Table H – Counselling Statistics ... 23
Coronial Ethics Committee Functions ... 24
Table I – Projects and recommendations ... 25
Principal Registrar and Coroner's Registrars ... 26
Counsel Assisting the Coroner ... 26
Police Assisting the Coroner ... 27
Table J – Total number of inquests ... 28
Deaths that Appeared to be Caused, or Contributed to, by any action of a member of the Police Force ... 32
Table K – Deaths caused or contributed to by any action of a member of the police force ... 32
SUSPECTED DEATHS ... 34
Table L – Missing Persons ... 34
PERSONS HELD IN CARE ... 36
Table M – Persons held in care ... 37
PERSONS HELD IN CARE – specific reports ... 39

State Coroner’s Overview

<u>Executive Summary of Outcomes</u>

Under section 8 of the *Coroners Act 1996* (Coroners Act) one of my functions is to ensure that the State Coronial system is administered and operates efficiently. The outcomes for the Office of the State Coroner for 2021/22 are outlined below:

- Backlog of cases increased from 810 as at 30 June 2021 to 1315 as at 30 June 2022.
  - Of those 1315 backlog cases:
    - 59 were backlog inquest cases.
    - 968 were cases where no further finalisations were possible at the Coroner’s Court as at 30 June 2022 because the coroner was awaiting completion of aspects of the coronial investigation by external entities.
    - 288 cases were pending analysis at the Coroner’s Court before finalisation.
  - By continuing to list the oldest cases for inquest wherever possible, the statistics show a greater than usual time to hearing; however, this also reflects that, appropriately, the older matters are being progressed as a priority.
  - A total of 2359 investigations were finalised in 2021/22:
    - 2300 finalised by administrative finding of which 971 (42%) were backlog cases.
    - 59 finalised by inquest of which 55 (93%) were backlog cases at the time of completion and 51 were mandated inquests.
    - 1333 (57%) of the cases finalised were under 12 months old.
    - 1026 (43%) of the cases finalised were over 12 months old.
  - The number of inquests finalised increased from 57 in 2020/21 to 59 in 2021/22.
  - The total number of administrative findings finalised increased from 1937 in 2020/21 to 2300 in 2021/22; this is compared to 2637 in 2019/20 compared to 2231 in 2018/19 compared to 2259 in 2017/18.
  - The number of total cases on hand over 24 months old increased to 9.0% in 2021/22, compared to 7.6% in 2020/21 compared to 7.9% in 2019/20, compared to 7.19% in 2018/19, compared to 6.6% in 2017/18.
  - Reports of deaths to the coroner increased to 2944 in 2021/22 compared to 2942 in 2020/21, compared to 2573 in 2019/20, compared to 2452 in 2018/19, compared to 2291 in 2017/18. The number of deaths reported remains high with the increase since 2017/18 equating to a growth of 653 matters, or 28% over that period.

- The number of cases on hand was 3687 at 30 June 2022 compared to, 3117 at 30 June 2021 compared to 2067 at 30 June 2020 compared to 2280 at 30 June 2019, compared to 2127 at 30 June 2018.

- The number of death certificates received in 2021/22 was 1614 compared to 1425 in 2020/21, compared to 1129 in 2019/20 compared to 1458 in 2018/19 compared to 1280 in 2017/18. These are cases where the coroner has determined that the reported death does not require further investigation and the doctor's death certificate is accepted.

- Counselling and Information Service contacts and referrals increased from the previous reporting year, at 9974 in 2021/22, compared to 5856 in 2020/21, compared to 10304 in 2019/20, compared to 10239 in 2018/19, compared to 10781 in 2017/18.

- The number of objections received to the performance of post mortem examinations for the purpose of investigating deaths increased to 489 in 2021/22 compared to 475 for 2020/21 compared to 447 for 2019/20 compared to 386 in 2018/19 compared to 320 in 2017/18.

- The number of non-invasive post mortem examinations was 771, compared to 787 in 2020/21, compared to 247 in 2019/20, compared to 273 in 2018/19 and 261 in 2017/18.

- Law Reform Commission recommendations 55 and 56 were enacted on 21 September 2018, resulting in s 19A enabling a coroner to make an early determination to discontinue an investigation into certain natural cause deaths, and s 25(1A) enabling a coroner to issue early non-narrative findings subject to public interest considerations. With the benefit of three full financial years, this has resulted in 956 findings being completed under s 19A in 2021/22, compared with 600 in 2020/21 and 647 in 2019/20. There were 331 findings completed under s 25(1A) in 2021/22, compared with 242 in 2020/21 and 267 findings in 2019/20.

Structure of the Report

The first part of this Report provides statistical and other information on the operations of the Office of the State Coroner in the past financial year ended 30 June 2022 (2021/22).

The second part of this Report contains the specific reports that I am required to provide on the death of each person held in care under s 27(1) of the Coroners Act.

The legislative requirement to provide a specific report on the death of each person held in care reflects the community's concern with the quality of the supervision, treatment and care of persons who have been taken into care and/or persons whose freedoms have been removed by operation of law. They include children the subject of protection orders, persons under the custody of police, prisoners and involuntary mental health patients.

Investigations that have not been finalised are not the subject of a specific report. An investigation is finalised when the coroner has made the findings required, if possible, to be made under s 25(1) of the Coroners Act. Generally, in approximately 97% of cases, an investigation is finalised without holding an inquest. An inquest is part of an investigation.

The Coroner's Court of Western Australia – information available to the public

It is said that the role of the Coroner's Court is to speak for the dead and to protect the living. This two-fold role is a vital component of a civil society.

As an independent judicial officer, the coroner investigates a reportable death to find how the deceased died and what the cause of death was. It is a fact-finding exercise, aimed not at apportioning blame, but at establishing the circumstances attending the manner of the death. It is in the public interest for there to be a careful and thorough review of the information so that a sudden, unnatural or unexplained death is properly investigated and the cause and manner of that death is properly found and recorded.

A significant function of the Coroner's Court is to provide an opportunity for grieving relatives and friends of the deceased to witness the proceedings involving their loved ones at a public inquest, in open court. For people who are emotionally distraught and suffering intense feelings of loss, the Coroner's Court can provide much needed answers about how their loved one died and in some cases, whether isolated or systemic changes may be introduced so as to avoid a death in similar circumstances in the future. It may be a comfort to know what happened to their loved one; it has the possibility of allaying rumours or suspicion; it may show that no other person caused or contributed to the death; it may show otherwise; it may explain complex medical procedures that had previously not been understood or known by the family; it may shed light on the quality of medical care afforded to the deceased; it may increase medical knowledge and awareness. It provides much needed information.

In these cases the principles of open justice serve the grieving family and friends of the deceased as well as the witnesses, persons involved in the care of the deceased and the wider community who has an interest in the proceedings.

When an investigation is finalised other than by inquest, the coroner's record of investigation is referred to as an administrative finding.

There were 2300 administrative findings finalised by coroners in the 2021/22 year comprising 97.5% of all reportable deaths investigated for this year. For these matters the coroner makes findings on the evidence before him or her, in chambers. They are not public proceedings. These findings are provided to the deceased's next of kin and they are not published on the Coroner's Court website.

There were 59 inquests finalised by coroners in the 2021/22 year comprising 2.5% of all reportable deaths investigated for this year. As Inquests are public proceedings, the coroner takes evidence in open court (unless otherwise ordered). The coroner's written findings are published on the Coroner's Court website. Where the coroner has made a recommendation, the written response by the Minister or responsible entity is also published on the website.

The focus over the 2021/22 year: The Backlog of coronial cases, Coronial Case Management System, Reform, Restructure and CT Scanner.

Backlog

As with the previous reporting years, much of the effort across all levels at the Office of State Coroner has been aimed towards addressing the accumulated backlog of cases. The backlog cases are determined by reference to the date that a reportable death is reported to the coroner. When the date of that report is more than 12 months old, that case enters into backlog and becomes a priority.

The backlog is a dynamic figure because cases are constantly being finalised and equally, at the 12 month anniversary, cases are also coming into backlog, on a daily basis. As outlined in the Executive Summary, as at 30 June 2022 the overall backlog stood at 1315. The backlog for which the Coroner's Court remained responsible stood at 347 (being 59 inquest cases and 288 cases pending analysis at the court).

A total of 968 backlog cases were not able to be progressed by the Coroner's Court because the Coroner's Court was awaiting the completion of investigations by external entities.

The older cases are not necessarily able to be investigated by a coroner in the order of the date of the report of the death. Other factors impact upon the prioritisation of cases, most significantly the complexity of the investigation and/or the availability of witnesses or other evidence. Another factor that may result in prioritisation is where a matter connected with a death raises an issue of concern in the area of public health or safety.

Coronial Case Management System

Following the implementation of the Integrated Court Management System (ICMS) on 10 February 2020 at the Coroner's Court, with the benefit of two full financial years, the court was able to continue its progress towards a fully electronic case management file.

This has allowed the court at Perth to provide expedited assistance to regional locations through real-time file transfers and the subsequent completion of coronial investigations.

As foreshadowed in last year's report, the electronic case management system has now transitioned to the use of electronic outbound documents, orders and authorisations that were enabled by amendments to the *Coroners Regulations 1997*.

With outbound documents, orders and authorisations now being entirely electronic, the court will focus on its transition to the electronic receipt of incoming documents from external entities. The eCourts portal has been developed and completed in order to receive electronic documents from external entities. Further consultation and testing is ongoing between the Court and those entities to commence the process of document receival via the eCourts portal and other platforms.

This is part of a process of continual improvement. The ICMS allows for a broader access to file records, so that multiple functions may be carried out on the one matter. It also enhances search capabilities to assist with retrieval of records and responses to queries.

With an electronic case management system in place, the Court is better able to conduct dynamic and robust business reporting and analysis in order to make informed strategic decisions in relation to practices and procedures of the Court.

The statistical records for the backlog cases referred to in this report have been drawn from the ICMS as at 30 June 2022. At the time of writing this report some minor data entry errors were identified and have since been corrected.

Reform

On 21 September 2018, recommendations 55 and 56 made by the Law Reform Commission of Western Australia in its *Review of Coronial Practice in Western Australia, project no. 100*, January 2012 were enacted. The Coroners Act was amended to include s 19A, enabling a coroner to make an early determination to discontinue an investigation into certain natural cause deaths and s 25(1A) enabling a coroner to issue early non-narrative findings subject to public interest considerations. The enactment of ss 19A and 25(1A) has increased efficiency, reduced unnecessary delays and delivered more timely responses and outcomes to the families of the deceased. This process commenced in the Perth Coroner's Court 10 December 2018, and after being trialled, it was extended to the Regional Courts on 5 March 2019. With the benefit of three full financial years, this has resulted in 956 findings being completed under s 19A and 331 findings under s 25 (1A) for 2021/22, compared with 600 findings completed under s 19A and 242 findings under s 25(1A) for 2020/2021.

Further amendments to the Coroners Act are being drafted in accordance with the recommendations made by the Law Reform Commission of Western Australia.

Internal Restructure

An internal review into the structure of the Coroner's Court was completed in 2019 and resulted in an adapted structure being implemented in stages including throughout this reporting year.

The adapted structure aims to ensure that there is better utilisation of existing resources and reduction in the duplication of functions. It is expected that it will lead to officers undertaking duties that are comparable with their classification level.

CT Scanner

On 5 June 2019 the Attorney General, Hon Mr John Quigley MLA attended the official inauguration of the long awaited CT scanner at the State Mortuary. Installation of the CT scanner fulfils recommendation 102 of the *Review of Coronial Practice in Western Australia, project no.100*, by lessening the need for full invasive post mortem examinations in certain cases. The CT scanner greatly enhances the scope of forensic pathology, thereby improving the quality of services to the community and I thank the Attorney General for his support.

The range of cases that may be more efficaciously progressed under the reform process has been expanded now the dedicated CT scanner is available to the forensic pathologists at the State Mortuary, due to the depth and quality of information afforded by this medium at an early stage.

I acknowledge the efforts of PathWest in supporting the usage of the CT scanner, developing processes and their continued expertise in this area.

The number of CT scans performed over the course of the 2021/22 financial year followed the general trend of reportable deaths, averaging 256 scans being performed per month.

For the financial year ended 30 June 2022, a total of 3066 CT scans were performed which is an increase of 106 CT scans from the previous year, or 3.6%.

Report on inquests that are required by law to be held (mandated inquests)

Under s 22(1) of the Coroners Act, a coroner who has jurisdiction to investigate a death must hold an inquest under the circumstances specified in that section.

Where the Coroners Act mandates the holding of an inquest, the inquests are sometimes referred to as "mandated inquests" although that term is not used in the legislation.

Overall there were 59 investigations finalised by inquest in the past financial year and of those, a total of 52, being 88%, comprised investigations where an inquest was mandated by law.

The 52 mandated inquests were finalised by coroners in the following categories and these are described below:

- 26 mandated inquests in relation to persons held in care immediately before death;
- 15 mandated inquests in relation to the suspected deaths of missing persons, one of whom was an involuntary mental health patient at the time she absconded; and
- 11 mandated inquests where it appeared that the death was caused, or contributed to, by an action of the police force.

(a) Mandated inquests - persons held in care immediately before death

A deceased will have been a "person held in care" under the circumstances specified in section 3 of the Coroners Act. They include children the subject of a protection order under the *Children and Community Services Act* 2004, persons under the control, care or custody of a member of the Police Force, persons in custody under the *Prisons Act* 1981 and involuntary patients under the *Mental Health Act 2014*.

Under s 3 of the Coroners Act, all Western Australian deaths of persons held in care are reportable deaths.

In the past financial year there were 26 investigations of deaths of persons held in care finalised by mandated inquest. Of those:

- 19 investigations were finalised by inquest in respect of deaths of persons held in custody under the *Prisons Act* 1981;
- 2 investigations were finalised by inquest in respect of a child who was the subject of a protection order under the *Children and Community Services Act 2004*;

- 5 investigations were finalised by inquest in respect of the death of an involuntary patient within the meaning of the *Mental Health Act* 1996;

In respect of all of the 26 investigations of deaths of persons held in care finalised by mandated inquest this past reporting year, the coroner was required under s 25(3) of the Coroners Act to comment on the quality of the supervision, treatment and care of the person while in that care. In 8 cases, the coroner expressed concern about aspects of supervision, treatment and/or care (Edgill, M and Scott, J and Craig, R and Duturbure, B and Williams, J and Brockliss, R and Roe, J and Lane, A).

Under s 27(1) of the Coroners Act, my annual report is required to include a specific report on the death of each person held in care. Tables of the 26 investigations into deaths of persons held in care that were finalised by inquest in the past financial year (Table M) appear at pages 38 to 39 of this report. Following that Table, at pages 39 to 78 are the specific reports on the deaths of each person held in care.

(b) Mandated inquests – where it appeared the death was caused, or contributed to, by any action of a member of the police force.

There were a total of 11 inquests in this category :

- 10 investigations were finalised by mandated inquest where it appeared that the death was caused, or contributed to, by any action of a member of the police force; and
- One investigation was finalised by mandated inquest where it appeared that the death was caused, or contributed to, by any action of a member of the police force and where the deceased was a child who was the subject of a protection order under the *Children and Community Services Act 2004.*

In 8 instances, the coroner found that the police did not cause or contribute to the death. In 2 instances, the coroner found the police in effect caused the death but were acting lawfully and reasonably or their actions were justified by the circumstances (Tong, L and Jack, D).

In 1 instance the coroner found actions or omissions by police contributed to the death (Child JP).

The Table of the 11 investigations (Table K) appears at pages 32 to 33 of this Report.

(c) Mandated inquests – suspected deaths

There were 15 investigations into the suspected deaths of missing persons finalised by mandated inquest.

Where a person is missing and the State Coroner has reasonable cause to suspect that the person has died and that it is a reportable death, the State Coroner may direct that the suspected death of the person be investigated. Where such a direction has been given, under s 23(2) a coroner must hold an inquest into the circumstances of the suspected death.

In each instance, the coroner found that the death of the missing person had been established beyond all reasonable doubt.

A Table of the 15 investigations (Table L) appears at page 34 of this Report.

Report on inquests that are held pursuant to an exercise of discretion by the coroner (discretionary inquests)

Under s 22(2) of the Coroners Act, a coroner who has jurisdiction to investigate a death may hold an inquest if the coroner believes it is desirable. These inquests are sometimes referred to as "discretionary inquests," although that term is not used in the legislation.

In exercising the discretion under this statutory function the coroner will have regard to whether an inquest will assist in reaching the findings required to be made, if possible, under s 25(1) of the Coroners Act and/or whether there are reasons for highlighting issues of public health or safety in connection with the death. The coroner will also take account of the reasons provided by any person who makes a request for an inquest under s 24(1) of the Coroners Act. Of the 59 investigations finalised by inquest in the past financial year, a total of 7, being approximately 12%, comprised investigations where the inquest was discretionary.

A Table of all of the investigations that were finalised by inquest appears at pages 28 to 31 of this Report. The mandated inquests are marked as such, leaving the remainder on that Table, a total of 7, as the discretionary inquests.

The Coronial Counselling and Information Service

Under s 16 of the Coroners Act, the State Coroner is to ensure that a counselling service is attached to the Coroners Court of Western Australia. Any person coming into contact with the coronial system may seek the assistance of the counselling service and, as far as practicable, that service is to be made available to them.

Over this reporting year, the Coronial Counselling and Information Service has focussed on its core function which is to ensure, as far as practicable, that persons coming into contact with the coronial system are able to speak with an experienced counsellor who will endeavour to address their questions and concerns and explain the coronial process to them.

The range of services provided by the Coronial Counselling and Information Service and statistical information on work output is set out at pages 22 to 23 of this Report.

The Death Prevention Role and the Coronial Ethics Committee

Over the course of a coronial investigation important information is gathered about the cause and manner of death, including the circumstances attending the manner of death. This is reflected in the findings of the coroners, though not exclusively so. The material gathered, including in the form of statistics where that is amenable, can provide vital information about matters such as the prevalence of disease, it may reflect upon the state of mental health within the community, and can be of invaluable assistance in identifying where resources could usefully be applied to provide the most effective assistance, with the ultimate aim of preventing deaths in the future in similar circumstances.

Only the coronial findings on inquest are made public, and they comprise less than 3% of all investigations. Following an inquest a coroner may make specific recommendations in connection with the death that may result in practices being changed, for example at hospitals or at workplaces, to assist in preventing similar deaths in the future. This is part of the death prevention role of the coroner.

The Office of the State Coroner has a working relationship with the Department of Health, the Patient Safety Surveillance Unit (PSSU). Their specialist medical consultant reviews coronial findings and related information. The salient points are de-identified and selected summaries are published in the booklet "From Death We Learn" which is then distributed to relevant clinical areas.

The Office of the State Coroner has also entered into a working relationship with the Therapeutic Goods Administration (TGA) in recognition of the importance of identifying any reportable deaths that may have been associated with the use of medicines, vaccines or medical devices. To assist the TGA with monitoring the safety of therapeutic products, the Office of the State Coroner has developed a notification system whereby relevant information is de-identified and provided to the TGA. There were 127 such notifications to the TGA this financial year.

The working relationships with the PSSU and the TGA are also in furtherance of the coroner's death prevention role.

For reasons of confidentiality, a considerable amount of coronial information that may potentially assist in the prevention of future deaths is not accessible to the public, nor generally to persons conducting research.

There are occasions where, under strict guidelines, access to specific types of information may be made available to persons conducting research connected with the death prevention role. This is done through the Coronial Ethics Committee attached to the Coroner's Court of Western Australia. The Coronial Ethics Committee considers incoming requests for coronial data and makes recommendations to me on the ethical considerations involved in proposed research projects or matters touching on the use of coronial information.

Pursuant to paragraph 8 of the Guidelines for the Coronial Ethics Committee, I am required to report annually on the operations of the Coronial Ethics Committee, including a specific report on any recommendation of the Coronial Ethics Committee which I have rejected. The report on the operations of the Coronial Ethics Committee during the past reporting year appears at page 24 to 25 of this Report.

Acknowledgements

I wish to acknowledge the ongoing and assiduous efforts to finalise investigations and reduce the backlog on the part of Deputy State Coroner Sarah Linton, Coroner Michael Jenkin and Coroner Philip Urquhart. Their application and dedication reflects their strong commitment to their important service to the community through the coronial system.

Every Magistrate in Western Australia is contemporaneously a coroner and I acknowledge their considerable efforts in the area of coronial work.

All of the staff members at the Coroner's Court of Western Australia have been exceptionally dedicated to one of the central tasks of the court, which is to try and find answers for grieving family members and to communicate that with accuracy and sensitivity. They have shown an unwavering and attentive commitment to this task and I acknowledge their ongoing efforts.

Every member of the police force of Western Australia is contemporaneously a coroner's investigator. The Coroner's Court of Western Australia continued to be well supported by all of the coroner's investigators, including those at the Coronial Investigation Squad, by the forensic pathologists, neuropathologists and other PathWest staff, and the toxicologists and other ChemCentre staff. I use this opportunity to express my gratitude to these officers and staff members in all of these agencies that ably assist the Coroner's Court on a daily basis. I am grateful for the assistance of a number of officers from the Department of Justice over the past year in connection with the continued progression of the reform proposals. These initiatives take time and energy and the Coroner's Court has been well served by their efforts.

I am pleased to present the 2021/22 Annual Report of the Office of the State Coroner.

R V C FOGLIANI
STATE CORONER

Office Structure

An internal review into the structure of the Coroner's Court was completed in 2019 and resulted in an adapted structure being implemented in 2020/21. Since the implementation of the adapted structure in 2020/21, the Court has added a further two FTE in January 2022, being a Coroner's Registrar to assist the Registry Manager with coronial delegation tasks and also an additional customer service officer. Both positions were necessary in managing the increasing workload at the Court.

The Coroner's Court of WA comprises the State Coroner, Deputy State Coroner, two Coroners and funding for 25 non-judicial FTE.

Table A – Office Structure

Coroners and Inquest staff	***Management and Registry Staff***	***Counselling and Information Service***
State Coroner	Principal Registrar	Senior Coronial Counselling and Information Officer
Deputy State Coroner	Office Manager	Coronial Counselling and Information Officer x 2
Coroner x 2	Registry Manager	
Counsel Assisting x 3	Assistant Registry Officer	
Listings Manager	Resource and Administration Officer	
Chambers Administrator	Findings Clerk x 2	
Customer Service Officer x 3	Coroners Registrar x 1 Customer Service Officer x 6	

Registry and Statistics

The Registry is the repository of the statistical information concerning the work of the Coroner's Court of Western Australia. Registry staff members record the salient details of the coroner's findings, including the deceased's name, date of death, the cause and manner of death and date of the coroner's finding.

The legal requirements to report a death that is or may be a reportable death to the coroner are set out in section 17 of the Coroners Act. Under s 19 of the Coroners Act, a coroner has jurisdiction to investigate a death if it appears to the coroner that it is or may be a reportable death. One of the functions of the State Coroner is to ensure that all reportable deaths reported to a coroner are investigated.

A reportable death is a Western Australian death that occurs in the circumstances set out in s 3 of the Coroners Act and includes a death that appears to have been unexpected, unnatural or violent or to have resulted, directly or indirectly, from injury; that occurs during an anaesthetic,

or as a result of an anaesthetic (and is not due to natural causes); of a person who immediately before death was a person held in care; that appears to have been caused or contributed to while the person was held in care; that appears to have been caused or contributed to by any action of a member of the Police Force; of a person whose identity is unknown; and/or where the cause of death has not been certified by a doctor in accordance with the *Births, Deaths and Marriages Registration Act* 1998.

Under s 14 of the Coroners Act every member of the Police Force of Western Australia is contemporaneously a coroner's investigator. They investigate the reportable deaths and prepare a report for the coroner.

The coroners investigate the reportable deaths and if possible, make findings in relation to the cause and manner of death.

With capable guidance from the Registry Manager (Coroner's Registrar), the Registry has been responsible for the administration of the coronial files upon the initial report of the occurrence of a reportable death and upon finalisation of the coroner's investigation, either by administrative finding or by inquest.

At all levels in the Coroner's Court, the main focus in the past financial year continued to be on clearing the backlog of coronial cases (that is cases where the death was reported to the coroner 12 months ago, or more). Staff members within the Registry close the coronial files after the coroner has finalised the investigation.

The number of cases about to enter into backlog in any given month is calculated; and the Coroner's Court endeavours to finalise more than that number in an effort to prevent the backlog from increasing. A total of 2944 reportable deaths were reported to the coroner for full investigation in the past financial year and 2359 cases were completed representing a clearance rate of 80%.

With regard to the 2359 cases completed in the past reporting year the breakdown is as follows:

- 2300 – the number of investigations finalised by administrative finding, of which 971 (42%) were backlog cases, and

- 59 - the number of investigations finalised by inquest, of which 55 (93%) were backlog cases.

At the conclusion of the reporting year, the cases on hand referred to the Coroner's Court of Western Australia for investigation by a coroner amounted to 3687, of which 1315 were backlog cases (over 12 months old).

The backlog increased from 810 in 2020/21 to 1315 in 2021/22. The number of cases where no further finalisations were possible as at 30 June 2022 because the coroner was awaiting completion of aspects of the coronial investigation by external entities increased from 627 in 2020/21 to 968 in 2021/22.

Of the 1315 backlog cases, 55 were backlog inquest cases.

The following Tables provide an overview of the work of the Coroner's Court in the 2021/22 year.

Table B – Overview of Work

CASES RECEIVED	*PERTH*	*COUNTRY*	*TOTAL*
Full Investigation	**2156**	**788**	**2944**
Death Certificates	**1380**	**234**	**1614**

CASES COMPLETED	*PERTH*	*COUNTRY*	*TOTAL*
Finalised by Inquiry	**1561**	**739**	**2300**
Finalised by Inquest	**44**	**15**	**59**
TOTALS	**1605**	**754**	**2359**

BACKLOG	*PERTH*	*COUNTRY*	*TOTAL*
	1132	**183**	**1315**

CASES ON HAND	*PERTH*	*COUNTRY*	*TOTAL*
	3023	**664**	**3687**

FINALISATION RATIO		
Finalised by Inquiry	**97.5%**	**2300**
Finalised by Inquest	**2.5%**	**59**

Table C – Cases Closed

Table C below shows the age of a coronial file when closed calculated from the date of death. It will be seen that 56% (1333) of files were closed in under 12 months and 44% (1026) of files were over 12 months old at closure (i.e. backlog files).

	INQUIRY		INQUEST	
TIMELINES	*PERTH*	*COUNTRY*	*PERTH*	*COUNTRY*
< 3 mths	**92**	**183**	**0**	**0**
3-6 mths	**302**	**173**	**0**	**0**
6-12 mths	**368**	**211**	**4**	**0**
12-18 mths	**417**	**116**	**0**	**0**
18-24 mths	**212**	**21**	**8**	**4**
>24 mths	**170**	**35**	**32**	**11**
TOTALS	**1561**	**739**	**44**	**15**

Table D – Deaths reported and cases completed

Table D below shows the total number of deaths reported and cases completed during the 2021/22 year for Perth and Regional WA.

TOTAL NUMBER OF DEATHS REPORTED TO THE CORONER			
Death certificates			1614
Metropolitan deaths	2156		
Regional deaths	788		
• **Albany**		142	
• **Broome**		50	
• **Bunbury**		242	
• **Carnarvon**		36	
• **Islands**		3	
• **Geraldton**		85	
• **Kalgoorlie**		83	
• **Kununurra**		25	
• **Northam**		63	
• **Port Hedland**		59	
TOTAL NUMBER OF REPORTABLE DEATHS	2944		
CASES COMPLETED	**PERTH**	**COUNTRY**	**TOTAL**
Finalised by Inquiry	1561	739	2300
Finalised by Inquest	44	15	59
TOTALS	1605	754	2359

Table E – Findings on manner of death

Table E below shows the statistics relating to coroners' findings on the manner of death for the past five financial years. They represent investigations that were finalised by a coroner in those financial years, either by administrative finding or by inquest.

MANNER OF DEATH	*2017-2018*	*2018-2019*	*2019-2020*	*2020-21*	*2021-22*
Accident	811	830	663	455	418
Misadventure	40	25	33	19	17
Natural Causes	908	868	506	298	264
No Jurisdiction	4	5	6	7	7
Open Finding	116	81	124	69	73
Self Defence	3	2	2	1	3
Suicide	392	421	434	252	231
Unlawful Homicide	48	61	55	51	59
Section 19A (Natural Causes)	N/A	N/A	647(a)	600 (a)	956 (a)
Section 25 (1A)	N/A	N/A	267(b)	242 (b)	331 (b)
TOTALS	**2322**	**2293**	**2737**	**1994**	**2359**

Section 19A and s 25 (1A) findings were only in effect for a full financial year as from 2019/20, and continue to be separately accounted for in 2021/22.

(a) These are findings where the coroner determines under s 19A that the death is due to natural causes and therefore is not required to continue to investigate.

(b) These are findings where the coroner determines under s 25(1A) that there is no public interest in finding how death occurred.

Post Mortem Examinations

Under s 25(1)(c) of the Coroners Act a coroner investigating a death must find, if possible, the cause of death.

Under s 34(1) of the Coroners Act, if a coroner reasonably believes that it is necessary for an investigation of a death, the coroner may direct a pathologist or a doctor to perform a post mortem examination on the body. A post mortem examination is a detailed medical examination of the body of a person who has died, undertaken for the purpose of investigating the death.

Post mortem examinations for the Coroner's Court of Western Australia are performed at the direction of the coroner by experienced forensic pathologists. They prepare a confidential report for the coroner and provide an opinion on the cause of death. The post mortem report may also provide information that is relevant to manner of death. The coroner takes this information into account when making a finding.

Under s 36 of the Coroners Act, any person can ask the coroner who has jurisdiction to investigate a death to direct that a post mortem examination be performed on the body. If the coroner refuses the request an application may be made to the Supreme Court for an order that a post mortem be performed. Applicants have two clear working days after receiving the coroner's notice of refusal to apply to the Supreme Court unless an extension of time has been granted by the Supreme Court.

Objections to Post Mortem Examinations

Under s 37 of the Coroners Act, except where the coroner decides that a post mortem examination must be performed immediately, the senior next of kin may object to the conduct of a post mortem examination.

The senior next of kin in relation to the deceased means the first person who is available from the categories of persons referred to in s 37(5) of the Coroners Act, in the order of priority listed in that sub section.

A Coroner's brochure entitled "When a person dies suddenly" is served upon the senior next of kin by attending police officers as soon as possible following a death. That brochure explains the procedure for making an objection to the conduct of a post mortem examination. The senior next of kin may give notice of an objection to a post mortem examination to the Coronial Investigation Squad of the Western Australia Police, seven days a week from 7 am to midnight, or directly with the Coroner's Court of Western Australia during office hours.

The reasons for objections to a post mortem examination by a senior next of kin vary from person to person. In the normal course they are discussed with a member of the Coronial Counselling and Information Service who will convey them to the coroner. In a number of cases the coroner, after considering the other evidence that could assist in determining the likely cause of the death, will accept the objection and no internal post mortem examination will be performed.

In other cases, the coroner after carefully considering the reasons for the objection may nonetheless decide that a full internal post mortem examination is necessary and will overrule the objection. The coronial counsellor communicates the coroner's decision and reasons for over-ruling the objection to the senior next of kin. Also, under s 37(1) of the Coroners Act, the coroner must immediately give notice in writing of that decision to the senior next of kin and to the State Coroner. Within two clear working days of receiving notice of the coroner's decision (or before the end of any extension of time granted) the senior next of kin may apply to the Supreme Court for an order that no post mortem examination be performed. The Supreme Court may make an order to that effect if it is satisfied that it is desirable in the circumstances.

With the availability of the dedicated CT scanner at the State Mortuary as from 5 June 2019, the range of cases that are able to be considered for this objection process is expanded, thereby helping to alleviate some of the stress and anxiety for families who wish to object to full internal post mortem examinations. In the 2019/20 year, 2141 CT scans were performed, 2960 in 2020/21, and 3066 CT scans were performed in 2021/22.

The discussions between the senior next of kin and the members of the Coronial Counselling and Information Service are a vital component of the process for objections. The counsellors have experience in dealing compassionately with sensitive matters and are cognisant of cultural issues that may impact upon decision making in this area. The work of the Coronial Counselling Information Service is further addressed at pages 22 to 23 of this Report.

Table F – Reported deaths and outcomes of objections

Table F below shows the number of post mortem examinations and the number of objections received in the 2021/22 year and the outcomes:

REPORTED DEATHS	
Immediate post mortem	**32**
No objection to post mortem	**2376**
Objection to post mortem	**489**
No post mortem conducted (missing person, death certificate originally issued or by order of coroner etc)	**47**
NUMBER OF REPORTED DEATHS	**2944**

OBJECTIONS TO POST MORTEMS	
Objection accepted	**446**
Objection withdrawn	**41**
Objection Overruled	**2**
TOTAL OBJECTIONS TO POST MORTEMS	**489**

Pathologist Recommended External Post Mortem Examinations

Consistent with the Law Reform Commission of Western Australia's recommendations 100 to 103 in its *Review of Coronial Practice in Western Australia, project no. 100* and pending external review of this component of the recommendations, the State Coroner has implemented the scheme to support the forensic pathologist's use of the least invasive procedures that are available and appropriate in the conduct of post mortem examinations.

The process involves forensic pathologists recommending to the coroner, where considered appropriate, that an external post mortem examination together with a review of available medical records and/or toxicological information is sufficient to enable them to form an opinion on cause of death. In each instance the senior next of kin are consulted, and the coroner makes a decision as to whether to approve the forensic pathologist's recommendation.

Before the availability of the CT scanner, the types of cases that were able to be considered for this external examination process were more limited to instances of obvious trauma and cases where the deceased had died in hospital, with well documented medical records including pre-mortem imaging. With the availability of the dedicated CT scanner at the State Mortuary as from 5 June 2019, the range of cases that are able to be considered for this process is significantly expanded. They can now include a greater range of trauma cases, and also cases where the deceased has died in circumstances that appear to be natural causes.

Table G below shows the number of pathologist recommended external post mortem examinations approved by the coroner, and the number of instances where the coroner has directed a full internal post mortem examination.

Table G - Outcomes in PRE (Pathologists Recommended External Post Mortem Examinations)

PATHOLOGIST RECOMMENDED EXTERNAL (PRE)	
PRE recommended by Pathologist	**821**
PRE approved by Coroner	**771**
PRE not approved by Coroner - Full PM	**45**
PRE rejected by next of kin - Full PM	**5**
PRE approved – Partial PM	**0**
TOTAL PATHOLOGIST RECOMMENDED EXTERNAL	**821**

Coronial Counselling and Information Service Functions

The State Coroner's obligation under s 16 of the Coroners Act is to ensure that a counselling service is attached to the court. This is met through the Coronial Counselling and Information Service (CCIS). Any person coming into contact with the coronial system may seek the assistance of the CCIS and, as far as practicable, that service is to be made available to them.

In early 2022, the name of the Coronial Counselling Service (CCS) was changed to the Coronial Counselling and Information Service (CCIS) to better reflect its functions.

The CCIS provides information, counselling, and liaison to those affected by sudden death and to numerous government and non-government agencies. The CCIS is available Monday to Friday during normal court business hours.

Over the past reporting year, the coronial counselling and information officers have spent many hours communicating with people who come into contact with the Coroner's Court. They aim to impart clear and accurate information, with compassion and they have a deep understanding of grief and loss.

Coronial counselling and information officers provide information to the next of kin about the progress through the coronial system of the investigation into their family member's death. They explain the process and the timelines involved when a senior next of kin objects to a post mortem examination, discuss tissue retention issues, provide advice on body release dates, and facilitate connections to agencies that may assist with other aspects of the process.

Coronial counselling and information officers are able to facilitate the viewing of selected case material from the coronial files to assist next of kin to better understand what happened to their family member. This process involves supporting the next of kin during the viewing as appropriate and being available to answer questions.

The Perth based CCIS provides its services in a variety of ways including in person and by telephone. In addition, CCIS has continued to maintain productive links with counselling services available in regional and/or remote areas to ensure locally based services are available. At any time that WA has been in lockdown due to COVID-19, CCIS has continued to provide service delivery to its clients, with the majority of work undertaken by telephone contact.

The discussions with CCIS are targeted to and supportive of the client's immediate needs. Referrals for longer term counselling options may be explored with clients as required.

CCIS also facilitates a culturally relevant counselling and information service for culturally and linguistically diverse (CALD) clients.

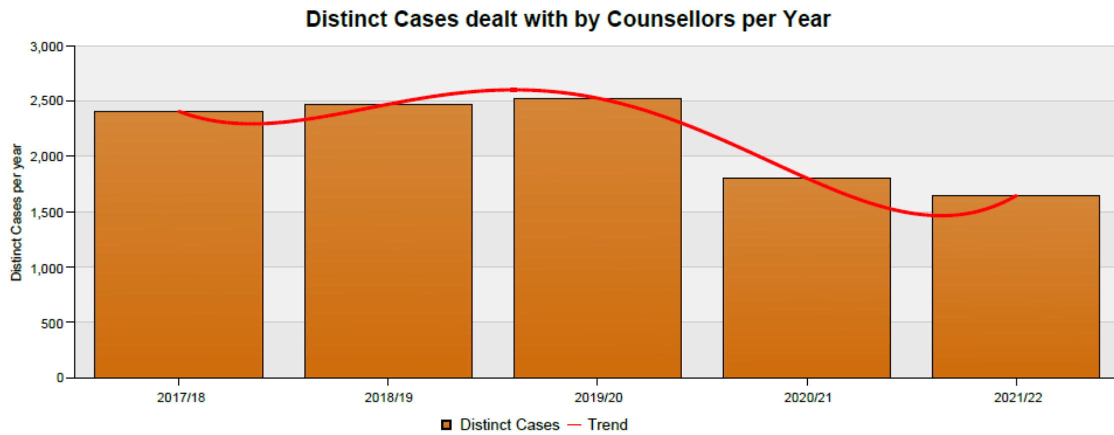
The CCIS FTE includes three full-time staff. Currently, CCIS is staffed by a Senior Coronial Counselling and Information Officer who is a registered Psychologist and one Coronial Counselling and Information Officer who has extensive experience in working with grief and loss. Recruitment is currently in progress for a second Coronial Counselling and Information Officer, and the position is temporarily filled pending that recruitment.

Table H – Counselling Statistics

The total number of Counselling and Information Service contacts for 2021/22 was 9974.

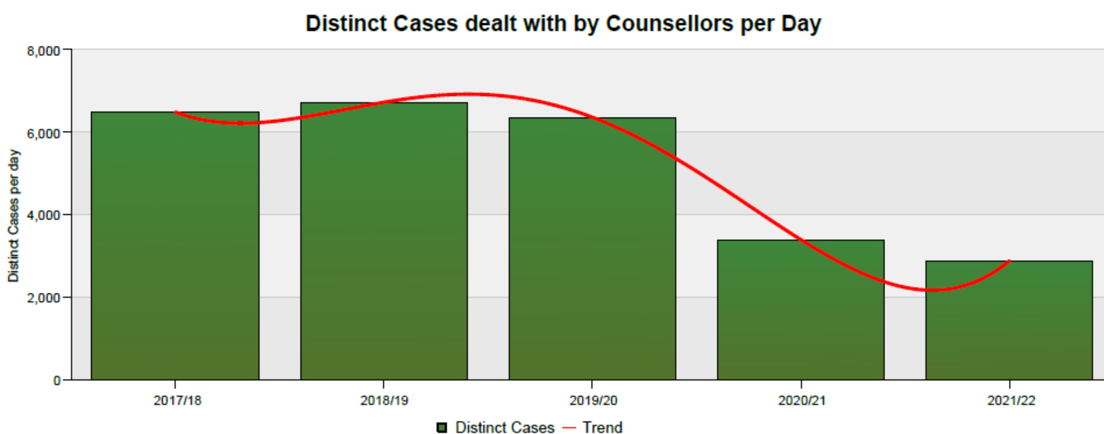
The following two graphs show the total number of individual cases that CCIS has been involved in where the number of cases worked on per year has been counted only once over the entire year.

The Coroner's Court has had 2944 reportable deaths over 2021/22. The CCIS have had contact with next of kin in respect of 1646 distinct cases over the year though not necessarily all related to the 2944 reportable deaths within 2021/22.



	2017/18	2018/19	2019/20	2020/21	2021/22	% Change
Distinct cases dealt with by counsellors per year	2,407	2,471	2,526	1,803	1,646	-8.7%

As CCIS service delivery would usually involve more than one contact per case, the following graph demonstrates the total number of cases when each case is counted per working day rather than per year. This figure better demonstrates the volume of client contacts that is undertaken by CCIS, and indicates that for each case there is at least more than one contact.



	2017/18	2018/19	2019/20	2020/21	2021/22	% Change
Distinct cases dealt with by counsellors per day	6,489	6,724	6,361	3,400	2,890	-15.0%

Coronial Ethics Committee Functions

The Coronial Ethics Committee was established pursuant to s 58 of the Coroners Act and operates in compliance with the National Health and Medical Research Council's National Statement on Ethical Conduct in Human Research and its associated guidelines.

Coronial data is confidential. An application for the provision of coronial data must be accompanied by a detailed written submission to the Coronial Ethics Committee. Applications are primarily made for research purposes. On average, this past reporting year, the Coronial Ethics Committee has met bi-monthly to consider applications. In decision-making, the Committee members attempt to strike a balance between family concerns (including privacy, confidentiality, and consent issues), and the benefits of research to the community at large. Once an application has been considered, the Coronial Ethics Committee makes its recommendation to the State Coroner about whether the coronial data sought should be released, and under what conditions.

The membership of the Coronial Ethics Committee is drawn from a range of representative categories to allow for a broad cross section of views to be considered during discussions. The Coroner's Court of Western Australia is well served by the considerable work done by Coronial Ethics Committee members, who volunteer their time. The subject matter is sensitive and the Committee makes a vital contribution to the coroner's death prevention role.

The members of the Coronial Ethics Committee for the 2021/22 year are as follows:

Committee Member	Membership Category
Dr Jodi White	Chairperson, Forensic Pathologist, PathWest
Mr Philip Urquhart	Coroner
Associate Professor Jennet Harvey	Member with relevant research experience (Until 9 June 2022)
Ms Christine Pittman	Member with relevant professional experience (Until 7 April 2022)
Dr Natalie Gately	Member with relevant research experience
Dr Thomas Hitchcock	Member with relevant research experience (Approved leave of absence from December 2021 to June 2022)
Dr Rosemary Coates AO	Member with relevant research experience (Until 2 December 2021).
Ms Antoinette Fedele	Lawyer (From 6 October 2021 to Current)
Dr Astra Lees	Member with relevant professional experience (From 9 June 2022 to Current)

Associate Professor Jennet Harvey and Ms Christine Pittman resigned from the Committee with both members having made a substantial contribution over many years. Their considerable efforts are very much appreciated and acknowledged.

Upon rotation, one of the counsel assisting acts as Secretary to the Committee who is supported administratively by one support officer.

Owing to the effects of COVID-19 meetings from December 2021 onwards were conducted remotely. The meetings in August and October 2021 were in person.

This past reporting year, the Coronial Ethics Committee met six times and addressed the following number of projects, as indicated in Table I below. The State Coroner did not reject any of the Ethics Committee's recommendations.

Table I – Projects and recommendations

Number of Projects Considered	Number of projects approved	Number of projects not approved	Deferred
14	10	0	0
Number of Requests for renewal Considered	**Number of Requests for renewal Approved**	**Number of Requests for renewal Not approved**	**Deferred**
11	10	1*	0
Number of Amendments	**Number of amendments approved**	**Number of amendments not approved**	
50	49	1	0

*Rejected renewal request was later approved as a new project.

Principal Registrar and Coroner's Registrars

Coroner's registrars are appointed under s 12 of the Coroners Act and one of the registrars performs the functions of the Principal Registrar. All registrars have statutory functions under s 13 of the Coroners Act and they exercise the powers or duties of a coroner that are delegated to them by the State Coroner in writing under s 10 of the Coroners Act. Over the 2020/21 year there have been 12 coroner's registrars at the Coroner's Court in Perth, all of whom exercise a range of specific delegated functions under s 10 of the Coroners Act. They exercise their delegations contemporaneously with their other functions.

In addition, registrars of Magistrates Courts may act as coroner's registrars if an investigation is held at a courthouse where the Magistrates Court sits.

A coroner's registrar's delegated functions under s 10 and statutory functions under s 13 include, but are not limited to, receiving information about a death which a coroner is investigating other than at an inquest, issuing summonses, requiring witnesses to attend at inquests, directing that a pathologist or a doctor perform a post mortem examination, authorising the release of the body following the post mortem examination and authorising tissue donations under the *Human Tissue and Transplant Act* 1982.

The coroner's registrars also have specific delegated functions empowering them to restrict access to a place where the death occurred, or where the event which caused or contributed to the death occurred. Of necessity, arrangements are in place so that a coroner's registrar is contactable at any time of the day or night, every day of the year.

The Principal Registrar is the coroner's registrar who deals with incoming notifications and requests to the Coroner's Court and assesses those incoming matters for referral to the State Coroner where they involve complexities and/or the exercise of non-delegated statutory functions.

The Principal Registrar executes the State Coroner's directions in relation to the conduct of coronial investigations. The Principal Registrar represents the State Coroner at a variety of internal and external forums/meetings. On behalf of the State Coroner, the Principal Registrar liaises with members of the Western Australia Police Force, officers from the Department of Health, the Western Australian Ombudsman, and numerous other government and non-government agencies. The Principal Registrar also provides education and information sessions to health and legal professionals and other organisations as part of a community education strategy.

Counsel Assisting the Coroner

The Coroner's Court has an FTE establishment of three counsel who assist the coroners in the conduct of their inquests. They are legal practitioners, and they appear in court as counsel assisting the coroner. They present the evidence and examine and cross examine witnesses. They prepare the matters for inquest, compile the coroner's brief, and they liaise with family members and interested persons in the lead up to the inquest, to ensure that all relevant material is placed before the coroner at the inquest, in order to assist the coroner in making the findings under

s 25(1) of the Coroners Act. They also assist the coroner in formulating recommendations to prevent deaths arising in similar circumstances. Where necessary or desirable, they are involved in the gathering of further evidence for the coroner.
The counsel assisting also provide advice and recommendation to the State Coroner upon statutory requests for inquests (under s 24 of the Coroners Act), that may be made by any person.

On rotation, one of the counsel assisting acts as the Secretary to the Ethics Committee.

Police Assisting the Coroner

The four police officers attached to the Coroner's Court serve as a critical link between the Coroner's Court and the Coronial Investigation Squad of the Western Australia Police Force.

There is one sergeant, and a senior constable who carry out the dual roles of appearing as assistant to the coroner at inquests and providing assistance to the coroners in the preparation of matters for inquest, including the gathering of evidence where necessary and serving of summonses.

There are two constables, one senior constable and one first class constable, who continue to operate the triage system, that supports the making of determinations by the coroner under s 19A and s 25(1A) of the Coroners Act. One officer is responsible for the metropolitan area and one for regional Western Australia. This system seeks to fast track certain types of cases, to bring about an early resolution for the families. It is noted that a total of 1287 such findings were completed by the coroners over this reporting year.

Together the police officers attached to the court assist the coroners in the exercise of the statutory functions under the Coroners Act, including the gathering of further evidence (including under compulsion), the provision of supplemental information from governmental departments and medical and technical experts, assistance to coroners in other jurisdictions at the direction of the State Coroner, liaison with inquest witnesses, and quality assurance on the more complicated reports to the coroner. They provide assistance to all police officers state-wide, in relation to advice and guidance on matters of coronial procedure, jurisdiction and authority, to generate consistency in approach to coronial investigations.

Table J – Total number of inquests

Table J below shows the total number of inquests **(59)** finalised in the 2021/22. An inquest is finalised when the coroner signs the inquest finding.

Name of Deceased	*Date of Death*	*Inquest Date*	*Finding*	*Date of finding*
^GERRARD-LATHAM Dean Jesse	Between 2 and 4/12/2018	27-28/4/2021	Misadventure	23/7/2021
^RILEY Chad	12/5/2017	30/11/2020 and 25/5/2021 to 1/6/2021	Misadventure	30/7/2021
***MILLS** Alex Carl	16/5/2019	27/7/2021	Natural Causes	6/8/2021
***SZABO** Lajos	3/2/2019	27/7/2021	Natural Causes	6/8/2021
#PINCHER Willie	Between 1/9/1965 and 30/11/1965	4/8/2021	Open Finding	6/8/2021
***YOUSSEF** Hassan Mohamed	8/11/2018	29/7/2021	Natural Causes	6/8/2021
^MARTIN Scott William	14/1/2017	7-9/12/2020	Unlawful Homicide	10/8/2021
#CARR Desmond Francisl	On or about 2/8/1979	4/8/2021	Open Finding	11/8/2021
***BABY E**	1/2/2020	20/7/2021	Natural Causes	26/8/2021
***EDGILL** Marshall Ruben	7/5/2017	6/7/2021	Natural Causes	6/9/2021
WENSLEY Amy Lee	26/6/2014	9-19/2/2021	Open Finding	9/9/2021
***HECTOR** James David	19/8/2019	29/7/2021	Natural Causes	10/9/2021
***SCOTT** Jeremy Michael	3/7/2017	26-27/8/2021	Natural Causes	14/9/2021
***CRAIG** Robert Charles	31/1/2018	23-24/8/2021	Natural Causes	29/9/2021
^DRAGE Christopher and **^SIMPSON** Trisjack	10/9/2018	15-19/3/2021	Accident	12/10/2021

Name of Deceased	*Date of Death*	*Inquest Date*	*Finding*	*Date of finding*
***BROCKLISS** Russell David	8/6/2019	29-30/4/2021	Natural Causes	22/10/2021
***ROE** Joseph Thomas	21/9/2017	3-4/8/2021	Natural Causes	1/11/2021
#JOHNSON Peter	On or about 17/10/2019	28/10/2021	Suicide	31/11/2021
MISS T	25/12/2016	19-20/5/2021	Natural Causes	29/11/2021
^TONG Ly Minh	22/11/2018	21-22/9/2021	Homicide by way of self-defence	29/11/2021
***WANI** Elia	21/5/2019	30/11/2021	Suicide	3/12/2021
***SATHITPITTAYAYUDH** Damien	20/8/2018	15 to 16/9/2020	Natural Causes	4/11/2020
*** CHILD J**	25/4/2017	15-17/6/2021	Suicide	15/12/2021
***TILBURY** James Alexander	4/7/2019	7/12/2021	Natural Causes	21/12/2021
^ CHILD JP	8/2/2018	23-25/2/2021 and 12-13/4/2021	Accident	21/12/2021
***DUTURBURE** Brett Ashley	14/11/2019	14/12/2021	Suicide	22/12/2021
***WELLS** Terrence Alexander Penman	12/12/2018	10/8/2021	Natural Causes	5/1/2022
***RYAN** Louisa Betty	16/5/2018	29/9/2021	Accident	6/1/2022
***YOUNG** Peter Johnnie	29/3/2019	7/12/2021	Natural Causes	14/1/2022
^WILLIS Shaun Andrew	8/3/2019	5-6/10/2021	Suicide	127/1/2022
#LIVESEY Carole	3/10/2017	6-8/9/2021	Open Finding	25/1/2022

Name of Deceased	*Date of Death*	*Inquest Date*	*Finding*	*Date of finding*
***ROMAN** Robert William	10/5/2018	18/8/2021	Natural Causes	4/2/2022
#YANG Fuh Jinn	4/8/1984	25/1/2022	Accident	9/2/2022
#CHAVEZ Winston Abalona	8/5/2009	25/1/2022	Open Finding	9/2/2022
#CHEN Pei Yao	6/10/2014	8/2/2022	Open Finding	9/2/2022
#HOU Hok Cheun	23/3/1989	8/2/2022	Open Finding	9/2/2022
#TOMIOKA Yaritosai	On or about 5/10/1972	8/2/2022	Open Finding	9/2/2022
#YAN Naing Aung	4/2/2019	24/1/2022	Suicide	10/2/2022
***STRETTLES** Jeffrey Lee	8/8/2019	13/1/2022	Natural Causes	14/2/2022
#McCLOY Victoria Leigh	23/11/2019	10/2/2022	Accident	23/2/2022
#MITCHELL Crispin	On or about 20/2/1987	24/2/2022	Accident	25/2/2022
***WILLIAMS** Jordan James	24/8/2018	18-20/1/2022	Suicide	25/2/2022
***NGUYEN** Van Tho	10/1/2020	23/2/2022	Natural Causes	3/3/2022
#GRUBB Michael Richard	16/8/2019	11/2/2022	Accident	28/3/2022
EDWARDS Morgan John	15/8/2018	14-18/2/2022	Natural Causes	28/3/2022
#HO Dinh Loi	2/3/2020	22/3/2022	Misadventure	28/33/2022
^WYNNE Cherdeena Shaye	9/4/2019	13-17/9/2021	Accident	1/4/2022
^ MS B	25/5/2019	21/2/2022	Unlawful Homicide	13/4/2022
#AL SAIDI Faycal	2/12/2020	31/3/2022	Misadventure	13/4/2022

Name of Deceased	*Date of Death*	*Inquest Date*	*Finding*	*Date of finding*
***DRLESKI** Boris	22/5/2019	9/3/2022	Accident	13/4/2022
***McCRACKEN** Kevin Ernest	11/7/2020	27/4/2022	Natural Causes	20/5/2022
***OTRANTO** Salvatore Giovanni	9/6/2020	17/5/2022	Natural Causes	8/6/2022
^JACK Desmond Edward	28/3/2019	10-11/5/2022	Homicide by way of self-defence	9/6/2022
BUSKE Hans-Juergen Friedrich **and** **POLLARD** Anne Maree **and** **GREEN** Brian Patrick **and** **GREEN** Thelma Jacinta	On or about 9/11/2019 14/9/2020 15/9/2020 15/9/2020	23-26/11/2021	Accident	17/6/2022
***LANE** Ashley Adrian	26/4/2019	24-26/5/2022	Natural Causes	21/6/2022

 # = Missing person (15)

*** = Person held in care (26)**

^ = Death that appeared to be caused or contributed to by any action of a member of the police force (11)

The balance of the matters listed (7) were discretionary inquests

Total Inquests : 59

I acknowledge the considerable assistance rendered by the Coroner's Court's Listing Manager and my Administrator in their management of the court's listing requirements, their preparation of matters for hearing and all of the guidance they provide to staff members for the preparation of inquest briefs.

The Tables appearing after Table J (Tables K, L, and M) are subsets of the information contained in Table J, and the following Tables all relate to mandated inquests.

DEATHS THAT APPEARED TO BE CAUSED, OR CONTRIBUTED TO, BY ANY ACTION OF A MEMBER OF THE POLICE FORCE

Under s 22(1)(b) of the Coroners Act, a coroner who has jurisdiction to investigate a death must hold an inquest if the death appears to be a Western Australian death and it appears that the death was caused, or contributed to, by any action of a member of the Police Force.

Table K – Deaths caused or contributed to by any action of a member of the police force

Table K below shows the number of inquests **(11)** finalised in 2021/22 year into deaths that appeared to be caused, or contributed to, by any action of a member of the Police Force.

Name of Deceased	*Date of Death*	*Inquest Date*	*Finding*	*Date of finding*
GERRARD-LATHAM Dean Jesse	between 2 and 4/12/2018	27-28/4/2021	Misadventure [Police Pursuit]	23/7/2021
RILEY Chad	12/5/2017	30/11/2020 and 25/5/2021 to 1/6/2021	Misadventure [Police Response]	30/7/2021
MARTIN Scott William	14/1/2017	7-9/12/2020	Unlawful Homicide [Police Response]	10/8/2021
DRAGE Christopher and **SIMPSON** Trisjack	10/9/2018	15-19/3/2021	Accident [Police Pursuit]	12/10/2021
TONG Ly Minh	22/11/2018	21-22/9/2021	Homicide by way of self-defence [Police Shooting]	29/11/2021
CHILD JP	8/2/2018	23-25/2/2021 and 12-13/4/2021	Accident [Police Evade]	21/12/2021
WILLIS Shaun Andrew	8/3/2019	5-6/10/2021	Suicide [Police Response]	27/1/2022
WYNNE Cherdeena Shaye	9/4/2019	13-17/9/2021	Accident [Police Response]	1/4/2022
MS B	25/5/2019	21/2/2022	Unlawful Homicide [Police Pursuit]	13/4/2022
JACK Desmond Edward	28/3/2019	10-11/5/2022	Homicide by way of self-defence [Police Shooting]	9/6/2022

In 8 instances, the coroner found that the police did not cause or contribute to the death. In 2 instances, the coroner found the police in effect caused the death but were acting lawfully and reasonably or their actions were justified by the circumstances (Tong, L and Jack, D). In one instance the coroner found that police caused or contributed to the death (Child JP).

The coroners' findings and the responses appear on the website of the Coroner's Court of Western Australia.

SUSPECTED DEATHS

Under s 23 of the Coroners Act where a person is missing and the State Coroner has reasonable cause to suspect that the person has died and that the death was a reportable death, the State Coroner may direct that the suspected death of the person be investigated. Where the State Coroner has given such a direction a coroner must hold an inquest into the circumstances of the suspected death of the person, and if the coroner finds that the death of the person has been established beyond all reasonable doubt, into how the death occurred and the cause of the death.

Table L – Missing Persons

Table L below shows the number of inquests (**15**) finalised in 2021/22 year into suspected deaths.

Name of Deceased	*Date of Death*	*Inquest Date*	*Finding*	*Date of finding*
PINCHER Willie	between 1/9/1965 and 30/11/1965	4/8/2021	Open Finding	6/8/2021
CARR Desmond Francis	On or about 2/8/1979	4/8/2021	Open Finding	11/8/2021
JOHNSON Peter	on or about 17/10/2019	28/10/2021	Suicide	31/11/2021
LIVESEY Carole	3/10/2017	6-8/9/2021	Open Finding	25/1/2022
YANG Fuh Jinn	4/8/1984	25/1/2022	Accident	9/2/2022
CHAVEZ Winston Abalona	8/5/2009	25/1/2022	Open Finding	9/2/2022
CHEN Pei Yao	6/10/2014	8/2/2022	Open Finding	9/2/2022
HOU Hok Cheun	23/3/1989	8/2/2022	Open Finding	9/2/2022
TOMIOKA Yaritosai	On or about 5/10/1972	8/2/2022	Open Finding	9/2/2022
YAN Naing Aung	4/2/2019	24/1/2022	Suicide	10/2/2022
McCLOY Victoria Leigh	23/3/1989	10/2/2022	Open Finding	23/2/2022
MITCHELL Crispin	On or about 20/2/1987	24/2/2022	Accident	25/2/2022

Name of Deceased	*Date of Death*	*Inquest Date*	*Finding*	*Date of finding*
GRUBB Michael Richardi	16/8/2019	11/2/2022	Accident	28/3/2022
HO Dinh Loi	2/3/2020	22/3/2022	Misadventure	28/3/2022
AL SAIDI Faycal	2/12/2020	31/3/2022	Misadventure	13/4/2022

In all of the cases the coroner found that the death of the person had been established beyond all reasonable doubt.

The coroners' findings and the responses appear on the website of the Coroner's Court of Western Australia.

PERSONS HELD IN CARE

Under s 3 of the Coroners Act a "person held in care" means:

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

(i) the CEO as defined in s 3 of the *Children and Community Services Act* 2004; or
(ii) the Chief Executive Officer of the department of the Public Service principally assisting the Minister administering the *Prisons Act* 1981 in its administration; or
(iii) a member of the Police Force;

or

(aa) a person for whom the CEO as defined in the *Court Security and Custodial Services Act* 1999 is responsible under ss 10, 13, 15 or 16 of that Act, whether that person is at a custodial place as defined in that Act, is being moved between custodial places or escapes, or becomes absent, from a custodial place or during movement between custodial places; or

(b) a person admitted to a centre under the *Alcohol and Other Drugs Act 1974*; or

(ca) a resident as defined in the *Declared Places (Mentally Impaired Accused) Act 2015* s 3;

(c) a person

(i) who is an involuntary patient under the *Mental Health Act 2014*; or
(ii) who is apprehended or detained under that Act; or
(iii) who is absent without leave from a hospital or other place under section 97 of that Act; or

(d) a person detained under the *Young Offenders Act 1994*;

Table O overleaf shows the number of inquests **(26)** finalised in 2021/22 into deaths of persons held in care.

In accordance with s 27(1) of the Coroners Act, the specific report on the death of each person held in care appears after Table O, together with the report into the death of Child JP, at Table L, making a total of 27 case reports.

Table M – Persons held in care

Table M below shows the number of inquests (**26**) finalised in 2021/22 year into Deaths of persons held in care.

Name of Deceased	*Date of Death*	*Inquest Date*	*Finding*	*Date of finding*
MILLS Alex Carl	16/5/2019	27/7/2021	Natural Causes	6/8/2021
SZABO Lajos	3/2/2019	27/7/2021	Natural Causes	6/8/2021
YOUSSEF Hassan Mohamed	8/11/2018	29/7/2021	Natural Causes	6/8/2021
BABY E	1/2/2020	20/7/2021	Natural Causes	26/8/2021
EDGILL Marshall Ruben	7/5/2017	6/7/2021	Natural Causes	6/9/2021
HECTOR James David	19/8/2019	29/7/2021	Natural Causes	10/9/2021
SCOTT Jeremy Michael	3/7/2017	26-27/8/2021	Natural Causes	14/9/2021
CRAIG Robert Charles	31/1/2018	23-24/8/2021	Natural Causes	29/9/2021
BROCKLISS Russell David	8/6/2019	29-30/4/2021	Natural Causes	22/10/2021
ROE Joseph Thomas	21/9/2017	3-4/8/2021	Natural Causes	1/11/2021
WANI Elia	21/5/2019	30/11/2021	Suicide	3/12/2021
SATHITPITTAYAYUDH Damien	20/8/2018	15-16/9/2020	Natural Causes	4/11/2020
CHILD J	25/4/2017	15-17/6/2021	Suicide	15/12/2021
TILBURY James Alexander	4/7/2019	7/12/2021	Natural Causes	21/12/2021
DUTURBURE Brett Ashley	14/11/2019	14/12/2021	Suicide	22/12/2021

Name of Deceased	*Date of Death*	*Inquest Date*	*Finding*	*Date of finding*
WELLS Terrence Alexander Penman	12/12/2018	10/8/2021	Natural Causes	5/1/2022
RYAN Louisa Betty	16/5/2018	29/9/2021	Accident	6/1/2022
YOUNG Peter Johnnie	29/3/2019	7/12/2021	Natural Causes	14/1/2022
ROMAN Robert William	10/5/2018	18/8/2021	Natural Causes	4/2/2022
STRETTLES Jeffrey Lee	8/8/2019	13/1/2022	Natural Causes	14/2/2022
WILLIAMS Jordan James	24/8/2018	18-20/1/2022	Suicide	25/2/2022
NGUYEN Van Tho	10/1/2020	23/2/2020	Natural Causes	3/3/2022
DRLESKI Boris	22/5/2019	9/3/2022	Accident	13/4/2022
McCRACKEN Kevin Ernest	11/7/2020	27/4/2022	Natural Causes	20/5/2022
OTRANTO Salvatore Giovanni	9/6/2020	17/5/2022	Natural Causes	8/6/2022
LANE Ashley Adrian	26/4/2019	24-26/5/2022	Natural Causes	21/6/2022

In 8 cases, the coroner expressed concern about aspects of supervision, treatment and/or care (Edgill, M and Scott, J and Craig, R and Duturbure, B and Williams, J and Brockliss, R and Roe, J and Lane, A).

In addition to the cases outlined in Table M there is a case summary in respect of Carole Livesey (Table L) who was an involuntary mental health patient at the time she went missing.

The coroners' findings and the responses appear on the website of the Coroner's Court of Western Australia.

The individual cases summaries follow.

PERSONS HELD IN CARE – specific reports

Alex MILLS
Inquest held in Perth 27 July 2021, investigation finalised 6 August 2021

Alex Mills (Mr Mills) died on 16 May 2019 at Fiona Stanley Hospital. The Deputy State Coroner found that the cause of death was due to sepsis, with osteomyelitis and infective endocarditis, and that death occurred by way of natural causes. Mr Mills was 79 years old.

Immediately before death Mr Mills was a "person held in care" under section 3 of the *Coroners Act 1996* because he was a sentenced prisoner, and pursuant to the *Prisons Act 1981* he was in the custody of the Chief Executive Officer of the Department of Justice.

Mr Mills was received into custody with a complex medical history. He experienced a number of severe acute illnesses once in custody, including several episodes of infection requiring hospitalisation. The infection progressed to osteomyelitis and then to systemic infection, from which he did not recover. Mr Mills died in hospital, where he received all possible available medical care. He was made palliative while in hospital, when it became clear there were no more treatment options available.

The Deputy State Coroner was satisfied Mr Mills medical care was comparable, or better, to what Mr Mills could have received in the community.

An issue of concern was the fact that Mr Mills was not considered for release on the Royal Prerogative of Mercy when he became terminally ill. This has been identified as an issue in a number of inquests involving deaths in custody, as there was an issue with staffing in the Sentence Management of Unit for a considerable period of time, which meant there was no staff member allocated to complete this task. The Coroner noted it was unlikely Mr Mills would have been recommended for release given his personal circumstances, but there was an acknowledged failure on the part of the Department to follow the relevant procedure. Since that time, a staff member has commenced in the Sentence Management Unit to perform this important role, so the Deputy State Coroner was reassured this issue should not reoccur.

The Deputy State Coroner made no recommendations.

The Finding is on the website of the Coroner's Court of Western Australia.

Lajos SZABO
Inquest held in Perth 27 July 2021, investigation finalised 6 August 2021

Lajos Szabo (Mr Szabo) died on 3 February 2019 at Bethesda Hospital. The Deputy State Coroner found that the cause of death was from metastatic adenocarcinoma of the lungs, and that death occurred by way of natural causes. Mr Szabo was 65 years old.

Immediately before death Mr Szabo was a "person held in care" under section 3 of the *Coroners Act 1996* because he was a sentenced prisoner, and pursuant to the *Prisons Act 1981* he was in the custody of the Chief Executive Officer of the Department of Justice.

When he was first admitted to prison in November 2017, he was in generally good health and he remained so until the end of 2018. On 7 December 2018, Mr Szabo complained of acute chest pain and shortness of breath. An ECG was conducted and he was reviewed by a doctor, who noted his recent bloods were abnormal with indication of infection. He was first treated for an infection, but when his condition did not improve, he was transferred to St John of God Hospital Midland by ambulance for urgent medical review. Mr Szabo underwent a CTPA, which showed a cavitating mass in the upper lobe of the right lung and enlarged lymph glands in the mediastinum and neck, suggestive of malignant process. Mr Szabo was discharged back to prison on 11 December 2018 with an appointment to see a respiratory specialist in a few days' time.

On 13 December 2018, Mr Szabo was informed by the specialist he had non-small cell lung cancer. It was felt his lung cancer was most likely related to his lifelong smoking of cigarettes. He was reviewed by the Radiation Oncologist at Sir Charles Gairdner Hospital on 14 December 2018 and a course of radiotherapy was commenced on 17 December 2018. Mr Szabo was registered on the Department's terminally ill register on 27 December 2018.

Mr Szabo developed a number of infections in January 2019, which interfered with his cancer treatment. By 17 January 2019, he was bedbound and it was recommended he commence palliative care. Mr Szabo was admitted to Bethesda Hospital for end of life care on 22 January 2019, where he reported he was ready to die and did not want any life prolonging treatment. He was kept comfortable until he died on 3 February 2019.

The Deputy State Coroner was satisfied Mr Szabo received a high level of medical care while in custody that was equal to, or above, what he would have received in the community.

An issue of concern was the fact that Mr Szabo was not considered for release on the Royal Prerogative of Mercy when he became terminally ill. This has been identified as an issue in a number of inquests involving deaths in custody, as there was an issue with staffing in the Sentence Management of Unit for a considerable period of time, which meant there was no staff member allocated to complete this task. The Deputy State Coroner noted it was unlikely Mr Szabo would have been recommended for release given his personal circumstances, but there was an acknowledged failure on the part of the Department to follow the relevant procedure. Since that time, a staff member has

commenced in the Sentence Management Unit to perform this important role, so the Deputy State Coroner was reassured this issue should not reoccur.

The Deputy State Coroner made no recommendations.

The Finding is on the website of the Coroner's Court of Western Australia.

Hassan Mohamed YOUSEFF
Inquest held in Perth 29 July 2021, investigation finalised 6 August 2021

Hassan Mohamed Youseff (Mr Youseff) died on 8 November 2018 at Fiona Stanley Hospital. The Deputy State Coroner found that the cause of death was from complications of gastrointestinal haemorrhage due to cirrhosis of the liver, secondary to hepatitis B, and that death occurred by way of natural causes. Mr Youseff was 55 years old.

Immediately before death Mr Youseff was a "person held in care" under section 3 of the *Coroners Act 1996* because he was a sentenced prisoner, and pursuant to the *Prisons Act 1981* he was in the custody of the Chief Executive Officer of the Department of Justice.

Mr Youseff was a prisoner who had been receiving medical treatment for various significant health conditions while in custody, including liver failure. It had been identified that he was at risk of internal bleeding and had a shortened life expectancy. He spent a lot of time in his cell due to his poor health.

Mr Youseff was transferred urgently to hospital by ambulance from Casuarina Prison on 6 November 2018 after he reported feeling sick and began coughing blood. Mr Youssef was admitted to Fiona Stanley Hospital and underwent an emergency gastroscopy. He was then transferred to the intensive care unit for ongoing care. His condition continued to deteriorate, and he developed organ failure. In consultation with Mr Youssef's family, a decision was made to withdraw active support and he died in hospital in the presence of his family.

The Deputy State Coroner was satisfied Mr Youseff's received the same standard of medical care he could have expected to receive in the community.

An issue of concern was the fact that Mr Youssef was not considered for release on the Royal Prerogative of Mercy when he became terminally ill. This has been identified as an issue in a number of inquests involving deaths in custody, as there was an issue with staffing in the Sentence Management of Unit for a considerable period of time, which meant there was no staff member allocated to complete this task. The Deputy State Coroner noted it was unlikely Mr Youssef would have been recommended for release given his personal circumstances, but there was an acknowledged failure on the part of the Department to follow the relevant procedure. Since that time, a staff member has commenced in the Sentence Management Unit to perform this important role, so the Deputy State Coroner was reassured this issue should not reoccur.

The Deputy State Coroner made no recommendation.

The Finding is on the website of the Coroner's Court of Western Australia.

Baby E (Name Subject to Suppression Order)
Inquest held in Perth 20 July 2021, investigation finalised 26 August 2021

Baby E died on 1 February 2020 at Rockingham General Hospital. The cause of death was from complications of VATER syndrome and sacrococcygeal teratoma. The Coroner found the manner of death was by way of natural causes. Baby E was seven months old.

Immediately before her death, Baby E was a "person held in care" under the *Coroners Act 1996* because she had been taken into care by the Director General of the Department of Communities, pursuant to the *Children and Community Services Act 2004*.

Baby E's mother used illicit drugs throughout her pregnancy and, due to concerns for Baby E's safety he was taken into provisional care and protections of the Department's CEO on 8 July 2019. Baby E's grandmother was approved as the appropriate carer for him in the community and he was discharged from PCH just in time for his only Christmas.

Baby E was born prematurely with an imperforate anus, absent left kidney, dysplastic right kidney, and spinal abnormalities which were attributed to VATER syndrome. Baby E after his birth had an urgent bowel and kidney surgery and was required to wear a colostomy bag and had to be fed through a nasogastric tube for the duration of his short life.

The Coroner was satisfied that the Department of Communities provided a standard of care, supervision and treatment of Baby E was appropriate.

The Coroner made no recommendations.

The Finding and any responses to those recommendations are on the website of the Coroner's Court of Western Australia.

Marshall Ruben EDGILL
Inquest held in Perth 6 July 2021, investigation finalised 6 September 2021

Marshall Ruben Edgill (Mr Edgill) died on 7 May 2017 at Albany Health Campus. The Coroner found that the cause of death was from combined effects of acute-on-chronic respiratory disease and cardiomegaly and that death occurred by way of natural causes. Mr Edgill was 38 years old.

Immediately before death Mr Edgill was a "person held in care" under section 3 of the *Coroners Act 1996* because he was a sentenced prisoner, and pursuant to the *Prisons Act 1981* he was in the custody of the Chief Executive Officer of the Department of Justice.

On 7 May 2017, during the afternoon prison muster, prison officers were alerted by Mr Edgill's cell mate, that Mr Edgill was in his cell on the top bunk bed not breathing. Prison officers entered the cell and failed to get a response from Mr Edgill. They called a Code Red medical emergency. When prison officers could not get a response from Mr Edgill they moved him out of the cell and commenced CPR. A prison medical staff member attached a defibrillator and oxy viva to administer breaths to Mr Edgill. An ambulance was called and Mr Edgill was transferred to the Albany Hospital where resuscitation efforts were unsuccessful.

The inquest focussed on the medical care provided to Mr Edgill while he was a prisoner, with emphasis upon the treatment of his suspected obstructive sleep apnoea.

The Coroner was satisfied with the care, supervision and treatment which Mr Edgill received while he was in custody. The Coroner did identify the failure of the Department to have Mr Edgill seen by a prison medical officer for a medical assessment during his last two periods of incarceration, and this failure was acknowledged by the Department. The Coroner was satisfied that the Department had taken adequate steps to improve their services, but noted the ongoing resourcing limitations and the challenges of providing intermittent care to persons coming in and out of the prison system.

The Coroner made no recommendations.

The Finding is on the website of the Coroner's Court of Western Australia.

James David HECTOR
Inquest held in Perth 29 July 2021, investigation finalised 10 September 2021

James David Hector (Mr Hector) died on 19 August 2019 at Bethesda Hospital. The Deputy State Coroner found that the cause of death was from bronchopneumonia and upper airway obstruction in a man with end-stage oral cancer, and that death occurred by way of natural causes. Mr Hector was 47 years old.

Immediately before death Mr Hector was a "person held in care" under section 3 of the *Coroners Act 1996* because he was a sentenced prisoner, and pursuant to the *Prisons Act 1981* he was in the custody of the Chief Executive Officer of the Department of Justice.

Mr Hector was diagnosed with squamous cell cancer in his mouth in 2006. He underwent treatment and the cancer was successfully removed. The oral cancer returned in 2017 and Mr Hector again received treatment, which appeared to successfully remove the cancer. However, a recurrence of the cancer was detected again in his mouth in February 2019, which then progressed. Mr Hector was not in custody at the time the cancer was detected again, but he returned to custody in May 2019. On his readmission to prison on remand for new offences, the prison health services were already aware of his history of cancer. During a nursing admission assessment on 20 May 2019, it was noted that Mr Hector was receiving palliative care for his mouth cancer, but when in the community he frequently failed to attend his appointments. Mr Hector was transferred to the Infirmary at Casuarina Prison, where his health needs could be more easily met.

In July 2019 Mr Hector had a brief hospital admission for pneumonia before he returned to prison. It became clear that the tumour in his mouth was continuing to grow. He was transferred to Bethesda Hospital to receive palliative care on 24 July 2019. He was able to receive visits from family before his death on 19 August 2019.

The Deputy State Coroner was satisfied the care, supervision and treatment which Mr Hector received while he was in custody was a high level of medical care.

An issue arose at the inquest in relation to why Mr Hector was not either released on bail, or alternatively transferred to hospital closer to his home and family in Kununurra, prior to his death. In relation to the question of bail, the Casuarina Prison Superintendent did contact Mr Hector's lawyer to suggest they approach the District Court to make a bail application. Steps were taken for this to occur, but unfortunately the bail application was not listed until 19 August 2019, the day of Mr Hector's death. In relation to a transfer to a facility closer to home, the Department did explore the option of transferring Mr Hector to Kununurra Hospital or Derby Hospital, but unfortunately neither facility was willing to accept him as a patient, given his high care needs. The Deputy State Coroner was satisfied the Department had, therefore, taken appropriate steps to try to facilitate Mr Hector's early release or transfer to a hospital closer to home, although sadly neither option was able to be completed prior to his death.

The Deputy State Coroner made no recommendations.

The Finding is on the website of the Coroner’s Court of Western Australia.

Jeremy Michael SCOTT
Inquest held in Perth 26 August to 27 August 2021, investigation finalised 14 September 2021

Jeremy Michael Scott (Mr Scott) died on 3 July 2017 at St John of God Hospital, Bunbury. The Coroner found that the cause of death was from metastatic rectal carcinoma, and that death occurred by way of natural causes. Mr Scott was 63 years old.

Immediately before death Mr Scott was a "person held in care" under section 3 of the *Coroners Act 1996* because he was a sentenced prisoner, and pursuant to the *Prisons Act 1981* he was in the custody of the Chief Executive Officer of the Department of Justice.

Prison records show that Mr Scott had complained of rectal and/or anal symptoms from at least 2006 and that a prison medical officer documented that Mr Scott a long-standing history of haemorrhoids but had had declined a rectal examination. On 17 September 2015, Mr Scott was seen by a prison medical officer and he reported feeling haemorrhoid inside his rectum on the left side "*that was not very big*". He again declined a rectal examination and no further action was taken. Mr Scott was seen by another prison medical officer on 20 November 2016, and described feeling a large, soft mass which he assumed was a haemorrhoid. He again declined a rectal examination and was referred to a consultant surgeon.

Although the referral to the surgeon had been marked "urgent" and there was an expectation he would be seen within 30 days, Mr Scott was not reviewed until 1 March 2017, some 100 days after the referral had been made. Scott described a 12-month history of anal pain on defecation and intermittent bleeding. The surgeon thought it was likely Mr Scott required treatment for an anal fissure and scheduled him for sphincterotomy procedure in May 2017, although the procedure was later postponed until July 2017.

Mr Scott was seen at the prison medical centre on 26 May 2017 and he complained of constipation and urine retention. He was described as anxious and very distressed by a prison nurse and was taken to Bunbury Regional Hospital (BRH) for review. The registrar who saw Mr Scott noted he described "excruciating pain" and says she performed a rectal examination but found nothing of concern. Mr Scott was given analgesia and discharged back to prison.

Following the results of blood tests on 21 June 2017, Mr Scott was taken back to BRH. By that time, he was confined to a wheelchair and was experiencing ongoing pain. He underwent an examination under anaesthesia on 22 June 2017, and a surgeon detected

an 8 cm mass just inside his anus. Tests confirmed that the mass was cancerous and Mr Scott was diagnosed with rectal carcinoma with liver and lung metastases.

Active treatment was ceased and on 30 June 2017, Mr Scott was transferred to the palliative care unit at St John of God Hospital, Bunbury where he remained until his death on 3 July 2017.

Although the coroner was satisfied that Mr Scott's care, supervision and treatment whilst he was incarcerated were appropriate until September 2015, from that time on, the coroner found there were several missed opportunities to diagnose Mr Scott's rectal cancer.

The coroner noted that these missed opportunities were clearly regrettable and may have deprived Mr Scott of the possibility of a cure for his cancer, or at the very least treatment that might have prolonged and/or improved the quality of his life.

The Coroner made two recommendations, directed towards timely progression of medical referrals to external agencies, and the prioritisation of annual health reviews for vulnerable and older prisoners.

The Finding and any responses to those recommendations are on the website of the Coroner's Court of Western Australia.

Robert Charles CRAIG
Inquest held in Perth 23 August to 24 August 2021, investigation finalised 29 September 2021

Robert Charles Craig (Mr Craig) died on 31 January 2018 at Bethesda Health Care. The Coroner found that the cause of death was from disseminated malignancy (advanced lung carcinoma and mouth carcinoma) in a man with co-morbidities including chronic obstructive pulmonary disease, and that death occurred by way of natural causes. Mr Craig was 73 years old.

Immediately before death Mr Craig was a “person held in care” under section 3 of the *Coroners Act 1996* because he was a sentenced prisoner, and pursuant to the *Prisons Act 1981* he was in the custody of the Chief Executive Officer of the Department of Justice.

Following a history of toothache and jaw pain, Mr Craig was diagnosed with oral cancer in January 2017 and further scans identified he also had lung cancer. He was referred to Fiona Stanley Hospital (FSH) where he underwent surgery to remove the tumour from the floor of his mouth and received radiotherapy to treat his lung cancer. However, due to a breakdown in communication between clinics within FSH, Mr Craig did not receive the most appropriate form of chemotherapy to maximise radiotherapy for his lung cancer, nor did he receive radiotherapy and/or chemotherapy following the surgical removal of his oral cancer.

The errors in Mr Craig’s treatment were eventually detected on 18 July 2017, by which time it was too late for him to undergo post-operative radiotherapy for his oral cancer. Instead, Mr Craig was referred for palliative chemotherapy for his lung cancer.

On 25 January 2018, Mr Craig’s condition deteriorated and he was transferred to BHC the following day for end-of-life care. He died there in the presence of family members on 31 January 2018.

Although the coroner was satisfied Mr Craig’s supervision whilst he was incarcerated was appropriate, the coroner found that the care and treatment Mr Craig received in relation to his cancers was suboptimal and not in accordance with his treatment plan.

The Coroner also noted that it appears that even if Mr Craig had received the correct treatment, the aggressive nature of his lung cancer meant that the outcome in his case would not have been significantly different.

The Coroner made two recommendations directed towards improvements in the quality of medical notes and the recording of reasons for medical referrals.

The Finding and any responses to those recommendations are on the website of the Coroner’s Court of Western Australia.

Russell BROCKLISS
Inquest held in Broome 29 April to 30 April 2021, investigation finalised 22 October 2021

Russell Brockliss (Mr Brockliss) died on 8 June 2019 at Broome Regional Hospital. The Deputy State Coroner found that the cause of death was consistent with acute cardiac arrhythmia in a man with cardiomegaly, focal coronary atherosclerosis and elevated body mass index (obesity), and that death occurred by way of natural causes. He was 52 years old.

Immediately before his death, Mr Brockliss was a "person held in care" under the *Coroners Act 1996* because he was subject to an Involuntary Patient Order made under the *Mental Health Act 2014* (WA). Mr Brockliss had a longstanding mental health illness precipitated by illicit drug use, and was recorded as being diagnosed with treatment resistant schizoaffective disorder. He was on regular depot antipsychotic medication as part of his treatment. When unwell, Mr Brockliss could be aggressive, and his parents noted this often occurred when his depot medication was due. Mr Brockliss had also been diagnosed with several serious physical health issues, which were difficult to manage due to his mental health condition, and had led him to be at increased risk of cardiovascular diasease.

On 7 June 2019, Mr Brockliss was taken to Broome Hospital by police after a relapse. His depot medication dose was overdue. Mr Brockliss was initially calm but then became aggressive towards staff. He had to be sedated and was then made an involuntary patient and admitted to the High Dependency Unit of the Mabu Liyan Mental Health Unit. Mr Brockliss had been a patient in the Mabu Liyan unit on more than one occasion in the past so was known to some of the staff. Mr Brockliss was supposed to be kept under close observation by nursing staff with visual checks every fifteen minutes. Mr Brockliss was discovered by a nurse performing such a check just before 8.40 am on 8 June 2019 in a lifeless state. Attempts to revive him were unsuccessful. Despite purportedly being checked regularly, the evidence suggests Mr Brockliss had actually been deceased for some time before he was discovered.

Whilst acknowledging the difficulties in taking observations of Mr Brockliss while he was in an agitated state, the Deputy State Coroner commented that the monitoring of Mr Brockliss' physical health appeared to have been less than ideal during this last admission. The Deputy State Coroner concluded there was a missed opportunity to identify Mr Brockliss' deteriorating state prior to the discovery that he was no longer breathing.

The Deputy State Coroner found that steps had properly been taken by WACHS as a result of Mr Brockliss's death to address the issue of inadequate physical observations while a patient is held in the High Dependency Unit, but they were still hampered by the poor design of the unit.

The Deputy State Coroner made one recommendation in relation to redeveloping the Mabu Liyan High Dependency Unit in order to ensure the safety of the staff and patients.

The Finding and any responses to those recommendations are on the website of the Coroner's Court of Western Australia

Joseph Thomas ROE
Inquest held in Perth 3-4 August 2021, investigation finalised 1 November 2021

Joseph Thomas Roe (Mr Roe) died on 21 September 2017 at Sir Charles Gardiner Hospital. The Coroner found that the cause of death was from combined effects of acute-on-chronic respiratory disease and cardiomegaly and that death occurred by way of natural causes. Mr Roe was 50 years old.

Immediately before death Mr Roe was a "person held in care" under section 3 of the *Coroners Act 1996* because he was a sentenced prisoner, and pursuant to the *Prisons Act 1981* he was in the custody of the Chief Executive Officer of the Department of Justice.

Just after midnight on 18 September 2017, Mr Roe's cell mate heard Mr Roe making strange sounds and saw him shaking and then vomiting. Mr Roe's cell mate pressed the cell's emergency button. Prison officers responded to the cell call and contacted medical staff to meet at Mr Roe's cell.

A prison nurse attended the cell and assessed Mr Roe who was unconscious. He was taken to the prison's infirmary where the call was made for an ambulance. The ambulance took Mr Roe to Fiona Stanley Hospital, where he was seen immediately and was intubated and ventilated. Scans suggested Mr Roe had a ruptured brain aneurysm. Mr Roe was then transferred to the specialist neurosurgical unit at Sir Charles Gairdner Hospital. There was no improvement in Mr Roe's condition when sedation was withdrawn, and further intervention was deemed futile.

The Coroner was generally satisfied with the care, supervision and treatment which Mr Roe received while he was in custody. The Coroner did identify that prison staff did fail to call a Code Red medical emergency when it was ascertained that Mr Roe was unconscious and having seizures, however, the Coroner was satisfied this failure did not contribute to his death.

The Coroner made no recommendations.

The Finding is on the website of the Coroner's Court of Western Australia.

Elia WANI
Inquest held in Perth 30 November 2021, investigation finalised 3 December 2021

Elia Wani (Mr Wani) died on 21 May 2019 at Armadale Kelmscott District Memorial Hospital. The cause of death was from acquired methaemoglobinaemia in association with sodium nitrite toxicity. The Coroner found the manner of death was by suicide. He was 29 years old.

Immediately before his death Mr Wani was a "person held in care" under the *Coroners Act 1996* because he was subject to a Community Treatment Order (CTO) made under the *Mental Health Act 2014.* He had been diagnosed with bipolar affective disorder and experienced a number of manic relapses predominantly related to non-compliance with his medication regime.

In 2013, Mr Wani diagnosed with bipolar affective disorder in 2013. Although he was treated with medication, he experienced a number manic relapses requiring hospitalisation, and these relapses were predominantly related to his non-compliance with his medication regime. Mr Wani's last admission to hospital was in October 2018. He was discharged home on a CTO on 8 October 2018 and managed by his local community mental health team. Mr Wani's treatment plan involved monthly reviews with his consultant psychiatrist and fortnightly meetings with his care coordinator. By February 2019, Mr Wani was receiving monthly injections of antipsychotic medication and reported feeling much better. He was last reviewed by his consultant psychiatrist on 7 May 2019 at which time he seemed to "*doing well*". On 17 May 2019, the Mental Health Tribunal extended Mr Wani's CTO for a further three months.

On 10 May 2019 Mr Wani made an online purchase of a product containing sodium nitrite from a food ingredient supplier in Melbourne. It is unclear when the package arrived at his home. When ingested, sodium nitrite causes the iron in the haemoglobin molecule to oxdise. This can cause death. Sodium nitrite and a related substance, sodium nitrate are both used as meat preservatives (amongst other things) and are widely available.

On 20 May 2019, Mr Wani received his regular depot injection and his next appointment was scheduled for 5 June 2019. Mr Wani went to bed at about 9.15 pm and was heard snoring at about 11.20 pm. This was unusual and when family members checked on him, they found Mr Wani to be unresponsive. When ambulance officers arrived, his respiration and heart rate were very slow and his oxygen saturation was low. Mr Wani was taken to the Armadale Kelmscott District Memorial Hospital, but despite the efforts of his family, ambulance officers and hospital staff, Mr Wani could not be revived.

The coroner was satisfied that the decision to place Mr Wani on CTOs, after his hospital discharges was appropriate in view of his non-compliance with medication and his lack of insight into the need for treatment for his mental health condition. The coroner was also satisfied that the supervision, treatment and care Mr Wani received whilst he was the subject of a CTO was of a good standard.

The Coroner made two recommendations directed towards restrictions upon the availability of sodium nitrate (similar to sodium nitrite) and warnings as to their potential usage in the context of self-harm and suicide.

The Finding and any responses to those recommendations are on the website of the Coroner's Court of Western Australia.

Ohm SATHITPITTAYAYUDH
Inquest held in Perth 8 to 9 December 2021, investigation finalised 15 December 2021

Ohm Sathitpittayayudh (Mr Sathitpittayayudh) died on 13 August 2018 at Karnet Prison Farm. The Coroner found that the cause of death was cardiac arrhythmia with acute circulatory failure in a man with acute drug effect/toxicity (5F-ADB). This occurred essentially after ingesting the synthetic cannabinoid product known as "Kronic". Death occurred by way of accident. Mr Sathitpittayayudh was 38 years old.

Immediately before death Mr Sathitpittayayudh was a "person held in care" under section 3 of the *Coroners Act 1996* because he was a sentenced prisoner, and pursuant to the *Prisons Act 1981* he was in the custody of the Chief Executive Officer of the Department of Justice.

On 12 August 2018 Mr Sathipittayayudh completed his shift as head cook in the kitchen at Karnet at about 2.00 pm. During the shift he showed no signs of being affected by illicit substances and completed all allocated tasks to his usual high standard. During a muster check at 6.30 pm, Mr Sathipittayayudh was standing by the door of his hut in accordance with prison rules and appeared to be in good health. A welfare check was conducted at 8.30 pm which was described as being "*unremarkably quiet*".

At about 10.05 pm prison officers conducted a further routine muster check. One of the officers lifted the observation hatch on Mr Sathipittayayudh's hut door to look in, but found his view was obscured by a jacket that was hanging on a hook inside the door. The officer entered Mr Sathipittayayudh's hut and found him lying on his bed in the foetal position, with his head "slightly bedded" in his doona. Mr Sathipittayayudh was unresponsive. The officer and his partner started CPR and called a Code Red medical emergency. Other staff came to assist and resuscitation efforts continued until ambulance officers arrived and confirmed that Mr Sathipittayayudh had died.

The coroner found that the standard of supervision, treatment and care provided to Mr Sathipittayayudh during his incarceration was appropriate, and that his medical care was commensurate with community standards.

The Coroner made one recommendation directed towards delivering targeted education to prisoners on the potentially lethal consequences of taking Kronic.

The Finding and any responses to those recommendations are on the website of the Coroner's Court of Western Australia.

Child J (Name Subject to Suppression Order)
Inquest held in Broome 15 June to 17 June 2021, investigation finalised 15 December 2021

Child J died on 25 April 2017 at Djugun in Broome. The Deputy State Coroner found that the cause of death was ligature compression of the neck. The Deputy State Coroner found the manner of death was by way of suicide. Child J was 15 years old.

Immediately before death, Child J was a 'person held in care' under the *Coroners Act 1996* because he was placed in the provisional care of the Director General of the Department of Communities, pursuant to the *Children and Community Services Act 2004*.
Child J lived with his mother in his early years, but she struggled to care for him due to her health and social issues. As a result, Child J was taken into the care of the Department of Communities when he was only a couple of years old and placed into foster care. He lived with the same foster family in Broome for a large part of his life, as well as spending some periods in the care of various family members.

There were concerns about Child J's behaviour, development and speech from an early age. It was suspected he might have Foetal Alcohol Spectrum Disorder, as a result of exposure to alcohol in utero, as well as neurodevelopmental issues due to early exposure to trauma. He was referred to paediatric and mental health services many times over the years. There is evidence that Child J began self-harming when he was as young as 6 or 7 years old. When he was approximately 12 years old, there appeared to be further deterioration in his mental state and he was diagnosed with clinical depression.

Child J was very distressed and unsettled in early 2014 and a number of placements were attempted to try to find an environment for him where he might settle. Child J moved to live with his father in Carnarvon in about May 2014 and he showed a significant improvement in his mental health for the next year and half while living there. However, in January 2016 Child J returned to Broome and indicated he no longer wished to live with his father. He moved in with his maternal aunt and her family in Broome and he appeared to settle into family life with them. By all accounts, he was generally happy at school and at home at that time.

However, in March 2017, Child J's first relationship ended and he struggled to cope. On the evening of 24 April 2017, Child J sent a text message to his former foster mother indicating that he was struggling. She interpreted the message as relating to his feelings over the break up and reassured him it would be alright. In the early hours of 25 April 2017, Child J left the house with a rope and hanged himself from a nearby tree. He was found by two passers-by who cut him down, but he could not be revived. No suicide note was found, but his mobile phone was found to contain various messages and a screen shot of an illustration of how to tie a noose. Beside him was a photograph of Child J and his former girlfriend.

The Deputy State Coroner found the quality of the supervision, treatment and care that Child J received while in care was reasonable and appropriate in the circumstances. However, the Coroner noted that there were missed opportunities for more to have been done for Child J in terms of assessment and treatment for his health issues. Further, the Coroner noted that Child J's mental state and ability to forge supportive relationships was likely to have been adversely affected by the large number of placements and case managers he had over the years while in care.

The Deputy State Coroner made no recommendations.

The Finding is on the website of the Coroner's Court of Western Australia.

James Alexander TILBURY
Inquest held in Perth 7 December 2021, investigation finalised 21 December 2021

Mr James Tilbury (Mr Tilbury) died on 4 July 2019 at Bethesda Hospital. The cause of death was from early pneumonia in an elderly man receiving terminal palliative medical care for a brain tumour (atypical meningioma). The Deputy State Coroner found the manner of death was by natural causes. He was 77 years old.

Immediately before his death, Mr Tilbury was a "person held in care" under section 3 of the *Coroners Act 1996* because he was a sentenced prisoner, and pursuant to the *Prisons Act 1981* he was in the custody of the Chief Executive Officer of the Department of Justice.

Mr Tilbury was held in custody at Casuarina Prison towards the end of his life. He had been diagnosed with prostate cancer and chronic obstructive pulmonary disease and he began to experience recurrent bouts of pneumonia and urinary tract infections. At times he stopped eating, drinking and taking his medications and received counselling and other interventions to encourage him to care of himself. It became clear that he was coming towards the end of his life and he was reviewed by a palliative care team in June 2018. He was not commenced on palliative care at that time, although he did receive morphine as part of his treatment.

On 31 May 2019, a clinical nurse visited Mr Tilbury in his cell after he failed to attend the morning medication round. The nurse found him sitting on his bed holding an oxygen mask. He appeared confused and unsure how to put the oxygen mask on. His clothes were soiled and he was unable to voice what was wrong, but said he had a headache. Mr Tilbury was transferred by ambulance to Fiona Stanley Hospital for medical treatment. Mr Tilbury was diagnosed with a large brain tumour and moved to Sir Charles Gairdner Hospital that same day.

Mr Tilbury underwent further investigations, including CT scans of his chest, abdomen and pelvis, which showed no sign of malignancy. His tumour was thought to be a meningioma. He was managed with medication to reduce the brain swelling and anti-epileptic medication to prevent seizures. Prison Health Services were notified that Mr Tilbury was assessed as too high risk for neurosurgery, so the non-surgical option of oncology was to be discussed. Mr Tilbury indicated to the doctors that he did not want to pursue further investigations or oncology treatment.

On 6 June 2019, Mr Tilbury returned to Casuarina Prison as his condition had stabilised. He was cared for in the Casuarina Infirmary until 21 June 2019, when he began to experience an increase in shortness of breath, swelling to his ankles and confusion. He was transferred to Fiona Stanley Hospital again for further treatment and assessment and was then transferred back to Casuarina Prison on 22 June 2019.

On 24 June 2019, Mr Tilbury was transferred to Bethesda Hospice by ambulance so he could receive palliative care. He was kept comfortable until his death on 4 July 2019.

The Deputy State Coroner was satisfied that Mr Tilbury's supervision, treatment and care whilst in custody was of a high standard and generally better than he would have received if he had been in the community.

The Deputy State Coroner did not make any recommendations.

The Finding is on the website of the Coroner's Court of Western Australia.

Brett Ashley DUTURBURE
Inquest held in Perth 14 December 2021, investigation finalised 22 December 2021

Mr Brett Asley Duturbure (Mr Duturbure) died on 14 November 2019 at Wyndham Work Camp (WWC). The cause of death was ligature compression of the neck. The Coroner found the manner of death was by way of suicide. He was 29 years old.

Immediately before death Mr Duturbure was a "person held in care" under section 3 of the *Coroners Act 1996* because he was a sentenced prisoner, and pursuant to the *Prisons Act 1981* he was in the custody of the Chief Executive Officer of the Department of Justice. Mr Duturbure was in custody at Wyndham Work Camp.

Mr Duturbure was admitted to Broome Regional Prison (BRP) on 12 August 2017. During his intake assessment he denied previous or current self-harm or suicidal ideation. Although Mr Duturbure told the intake officer at BRP that he had been incarcerated at Darwin Prison (DP) in the Northern Territory, no attempt was made to obtain records relating to that incarceration. Records obtained from DP and the Royal Darwin Hospital, after Mr Durturbure's death, disclosed that he had threatened self-harm in 2005 and attempted to take his life in 2007 and 2010.

At his request, Mr Duturbure had been transferred to West Kimberley Regional Prison (WKRP) so he could visit his partner who was also imprisoned at the WKRP. On 28 August 2017, Mr Duturbure was seen by the Prison Counselling Service (PCS) and he denied any previous or current self-harm or suicidal ideation. WKRP records indicate Mr Duturbure maintained regular employment and completed educational and vocational training. He received visits from his partner and was in regular phone contact with his family.

On 5 September 2019, Mr Duturbure referred himself to PCS. He subsequently attended several counselling sessions, during which he disclosed issues relating to his childhood, anger management and relationship difficulties with his partner. On 1 October 2019, Mr Duturbure discontinued counselling and requested a transfer to the WWC. His request was granted and Mr Duturbure arrived at WWC on 18 October 2019.

On the evening of 13 November 2019, Mr Duturbure was sitting on the veranda of his unit talking and interacting with others and was last seen alive during the evening muster at 10.00 pm. At 5.00 am on 14 November 2019, a fellow prisoner found Mr Duturbure hanging from a tree with a garden hose around his neck. Prison officers were alerted and cut Mr Duturbure down, starting CPR and calling emergency services. Ambulance officers arrived and took over resuscitation efforts, but Mr Duturbure could not be revived.

The coroner found that the quality of medical care provided to Mr Duturbure while was incarcerated was commensurate with the standard of care he would have received in the general community.

However, the coroner found that the Department of Justice's failure to obtain records relating to Mr Duturbure's previous periods of incarceration meant that the quality of

supervision, treatment and care it provided to him whilst he was imprisoned in Western Australia was potentially of a lower standard than might otherwise have been the case.

The Coroner made one recommendation directed towards the importance of obtaining prisoners' records of incarceration (including medical records) where they have been incarcerated in another State or Territory prison.

The Finding and any responses to those recommendations are on the website of the Coroner's Court of Western Australia.

Terrence Alexander Penman WELLS
Inquest held in Perth 10 August 2021, investigation finalised 5 January 2022

Mr Terrence Alexander Penman Wells (Mr Wells) died on 12 December 2018 at Fiona Stanley Hospital. The cause of death was from metastatic oesophageal neuroendocrine carcinoma. The Coroner found the manner of death was by way of natural causes. He was 61 years old.

Immediately before death Mr Wells was a "person held in care" under section 3 of the *Coroners Act 1996* because he was a sentenced prisoner, and pursuant to the *Prisons Act 1981* he was in the custody of the Chief Executive Officer of the Department of Justice. Mr Wells was in custody at Casuarina Prison.

On 14 June 2018, Mr Wells had an appointment with an oncologist at Bunbury Regional Hospital where he was advised that he had a high grade tumour and that such tumours tended to be aggressive. Mr Wells was keen to commence chemotherapy and a regime of carboplatin and etoposide was recommended. Mr Wells was advised by the oncologist that it was unlikely he would survive the nine years before his scheduled release from prison. Mr Wells' chemotherapy treatment began on 18 June 2018.

On 12 November 2018, Mr Wells was admitted to the emergency department of Broome Regional Hospital. The following day, he was transferred to Fiona Stanley Hospital where dehydration secondary to dysphagia was diagnosed. A smaller stent was inserted and investigations revealed the growth of the primary tumour as well as metastatic lesions. He was discharged from Fiona Stanley Hospital to Casuarina Prison on 16 November 2018.

On 21 November 2018, Mr Wells was reviewed by the Metropolitan Palliative Care Consultancy Service. On 30 November 2018, Mr Wells complained of back pain to the prison doctor. The following day, when that pain could not be controlled, Mr Wells was referred to the emergency department at Fiona Stanley Hospital for pain management. He was returned to prison later that day. On 2 December 2018, Mr Wells was taken to the emergency department of Fiona Stanley Hospital where he was admitted under the acute medical team and changes were made to his analgesia regime.

On 10 December 2018, Mr Wells was upgraded to Stage 4 on the Department's Terminally Ill List, after a discussion with his treating doctors at Fiona Stanley Hospital. Palliative care was provided, including a subcutaneous syringe driver. Mr Wells died at 2.35 am on 12 December 2018.

The Coroner was satisfied that Mr Wells received an appropriate standard of supervision, treatment and care while in prison. His death was due to the rapid progress of his oesophageal cancer which was diagnosed in April 2018.

The Coroner did not make any recommendations.

The Finding is on the website of the Coroner's Court of Western Australia.

Louisa Betty RYAN
Inquest held in Perth 29 September 2021, investigation finalised 6 January 2022

Ms Lousia Betty Ryan (Ms Ryan) died on 16 May 2018 at Fiona Stanley Hospital. The cause of death was from aspiration pneumonia with respiratory failure complicating medical management of major depression with catatonia in an elderly lady with underlying heart disease. The Coroner found the manner of death was by way of natural causes. She was 89 years old.

Immediately before her death Ms Ryan was a "person held in care" under the *Coroners Act 1996* because she was on an involuntary treatment order under the *Mental Health Act 2014*.

Ms Ryan had developed a number of comorbidities which included atrial fibrillation, pulmonary oedema, Type 2 diabetes, Parkinsonism, recurrent urinary tract infections and recurrent falls. Ms Ryan moved into an aged care facility in 2016. Her most notable health issue was a long electroconvulsive therapy to treat her catatonic depression. This was administered on an involuntary basis due to her inability to give consent to the treatment and risks to her health.

By late April 2018, Ms Ryan's health had significantly deteriorated, including resistance to eat or drink. Due to further rapid decline, she was admitted to Fremantle Hospital on 10 May 2018 and under a recommendation by the inpatient psychiatrist at Fremantle Hospital, she was made an involuntary patient.

After further decline, Ms Ryan was transferred to Fiona Stanley Hospital on 16 May 2018 where she later died at 10.30 pm. Following her latest ECT treatment and complications following, the Coroner found Ms Ryan's death had occurred by way of accident. The Coroner noted the high risk nature of the ECT treatment given her age and multiple co-morbidities, but also noted her previous poor response to pharmacological interventions.

The Coroner was satisfied that the care, supervision and treatment Ms Ryan received was appropriate in the circumstances given her age and comorbidities.

The Coroner did not make any recommendations.

The Finding is on the website of the Coroner's Court of Western Australia.

Peter Johnnie YOUNG
Inquest held in Perth 26-28 August 2020, investigation finalised 22 December 2020

Mr Peter Johnnie Young (Mr Young) died on 29 March 2019 at Fiona Stanley Hospital. The cause of death was from complications of alcohol and hepatitis C related liver disease. Coroner found the manner of death was natural causes. He was 23 years old.

Immediately before his death Mr Young was a "person held in care" under section 3 of the *Coroners Act 1996* because he was on remand, and pursuant to the *Prisons Act 1981* he was in the custody of the Chief Executive Officer of the Department of Justice. Mr Young was in custody at Casuarina Prison.

In April 2018, Mr Young was charged with a serious offence while he was already on bail for another serious offence. As a result, he was remanded in custody. Mr Young was initially held in prisons in the Kimberley Region. He was comprehensively reviewed by doctors within the prison, as well as receiving treatment at Derby Hospital. Mr Young was eventually transferred from the Kimberley Region to Casuarina Prison in October 2018, due to ongoing behavioural issues that created a security risk. Prior to his transfer, Mr Young had undergone a culturally appropriate cognitive assessment that indicated he had good cognitive functioning. The significant improvement was attributed to Mr Young being unable to access alcohol while in custody. His other medical conditions appeared generally stable.

While in the care of Casuarina Prison, Mr Young was reviewed by a psychiatrist, but there appears to have been little ongoing medical review of his physical health due to a number of cancelled appointments. Some of the appointments were cancelled by Mr Young and some due to a lack of health staff. On 29 March 2019, Mr Young was transferred to Fiona Stanley Hospital by ambulance after he suddenly deteriorated. On admission, he was noted to be very unwell due to his advanced liver disease and was admitted to the Intensive Care Unit with poor prognosis. On 25 March 2019 he became more unwell with altered mental state and multi-organ failure. His life support was turned off and he died on 29 March 2019.

Overall, the Deputy State Coroner was satisfied with the supervision, treatment and care provided to Mr Young. However, the Coroner emphasised the importance of the Department providing sufficient resourcing to enable medical staff to provide ongoing management for prisoners with chronic health issues. Further, the Department should take active steps to notify all family members as quickly as possible when a prisoner's health suddenly deteriorates.

The Deputy State Coroner did not make any recommendations.

The Finding is on the website of the Coroner's Court of Western Australia.

Carole LIVESEY
Inquest held in Perth 6 to 8 September 2021, investigation finalised 25 January 2022

Ms Carole Livesey was last seen on 3 October 2017 at the Rockingham Salvation Army premises in Coolongup. Ms Livesey had been brought there by a member of the public after she had apparently tried to drown herself in the ocean. Earlier that day, Ms Livesey had absconded from Rockingham Hospital, where she was being held on an involuntary treatment order under the *Mental Health Act 2014*.

An inquest was directed to be held pursuant to s 23 of the *Coroners Act 1996* as Ms Livesey was a missing person and there was reasonable cause to suspect she had died and her death was a reportable death. Once it was determined that she had died, an inquest was also required to be held as immediately before her death, Ms Livesey was a "person held in care" under the *Coroners Act 1996* because she was on an involuntary treatment order under the *Mental Health Act 2014*.

The Deputy State Coroner ultimately found that Ms Carole Livesey (Ms Livesey) died on 3 October 2017 at an unknown place. The cause of death was unascertained. The Deputy State Coroner made an open finding as to the manner of death. Ms Livesey was 50 years old.

Ms Livesey had been admitted to Rockingham General Hospital as an involuntary patient on 8 September 2017 with a diagnosis of anorexia nervosa and depression, and on a background of a recent suicide attempt. Ms Livesey had a long history of disordered eating and excessive exercise routine and she was regarded as being at high risk of suicide or self-harm. While in hospital, Ms Livesey was generally not compliant with eating meals or taking nutritional supplements prescribed to her.

Ms Livesey was eventually moved from a closed ward to an open ward, but with a one-to-one nurse special monitoring. Ms Livesey was required to remain seated in a wheelchair to prevent her exercising and was fed by a nasogastric tube. On 3 October 2017, Ms Livesey expressed an interest in going on an escorted group walk around the grounds of the hospital. Her request was granted, and she was allowed to go into the grounds in her wheelchair with the one-to-one allocated nurse. It was somewhat unclear if permission was obtained from her treating doctor first for this outside walk, but it was generally agreed that if her treating doctor had been asked, the approval would have been granted in any event.

Ms Livesey was sitting in the wheelchair and being pushed by an agency assistant nurse when she suddenly got up and fled the hospital grounds. One of the staff escorting the patients ran after her and tried to call her back, but Ms Livesey continued running until she was out of sight. The hospital management were notified, and an absconding alert was raised at 10.15 am. Police received an absconding report at about 11.10 am indicating Ms Livesey was a high-risk mental health absconder. Police went to her house, but there was no sign Ms Livesey had been home. Her husband was contacted and reported she had not contacted him.

At 12.47 pm that same day, Ms Livesey was brought in by a member of the public to the Rockingham Salvation Army. She was found near the beach and was soaking wet. It appeared she had deliberately walked into the water and was possibly suicidal. She was still wearing a hospital band, so the hospital was contacted. Staff at the hospital advised they would contact the police to collect Ms Livesey. Staff from the Salvation Army provided Ms Livesey with dry clothes and food and tried to keep her occupied while they waited for the police to arrive. Unfortunately, police were delayed due to resourcing issues and Ms Livesey soon became suspicious and restless and indicated she wanted to leave. At 2.24 pm, Ms Livesey left the Salvation Army facility. Two volunteers followed her for a short period, in the hope that police would arrive and they could direct them to her whereabouts, but were unable to effectively continue. Ms Livesey was last seen walking along the road. There has been no confirmed sighting of her since, and her body has never been recovered. Her husband indicated he was certain she would have contacted him if she was still alive.

The Deputy State Coroner found that Ms Livesey is deceased and was satisfied with the supervision, treatment and care provided to Ms Livesey while she was subject to the involuntary treatment order.

The Deputy State Coroner did not make any recommendations.

The Finding is on the website of the Coroner’s Court of Western Australia.

Robert William ROMAN
Inquest held in Perth 18 August 2021, investigation finalised 4 February 2022

Mr Robert William Roman (Mr Roman) died on 10 May 2018 at Rockingham General Hospital. The State Coroner found the cause of death was subdural haematoma in a man with diabetes mellitus and chronic kidney disease (requiring dialysis). The manner of death was by way of natural causes. He was 55 years old.

Immediately before death, Mr Roman was a 'person held in care' under section 3 of the *Coroners Act 1996* because he was a sentenced prisoner and, under the *Prisons Act 1981,* he was in the custody of the Chief Executive Officer of the Department of Justice. Mr Roman was serving his sentence at Casuarina Prison.

Mr Roman had an extensive past medical history that included type 2 diabetes, end stage renal failure, ischaemic heart disease and chronic obstructive pulmonary disease.

On 10 May 2018, immediately before his death Mr Roman had been undergoing his regular dialysis treatment for end stage renal failure at the Fresenius Dialysis Clinic in Rockingham, having been taken there from Casuarina Prison by the custodial officers. During his afternoon dialysis session, Mr Roman became progressively unwell and unexpectedly collapsed. He was taken by ambulance to Rockingham General Hospital where a CT scan showed a right subdural haematoma (brain bleed). Unfortunately, he was not able to be revived, and he died later that night.

The State Coroner after reviewing the evidence noted the Department of Justice had made some improvements since Mr Roman's death to support families of prisoners receiving timely notification of the deterioration in a prisoner's health.

The State Coroner also was satisfied the care provided to Mr Roman was appropriate and noted that his complex medical needs were attended to.

The State Coroner also noted that Mr Roman's deterioration at the Fresenius Dialysis clinic was rapid and unexpected. There was no history of loss of consciousness such as would give rise to a concern about a potential neurological condition.

The State Coroner did not make any recommendations.

The Finding is on the website of the Coroner's Court of Western Australia.

Jeffrey Lee STRETTLES
Inquest held in Perth 13 January 2022, investigation finalised 14 February 2022

Mr Jeffrey Lee Strettles (Mr Strettles) died on 8 August 2019 at St John of God Hospital, Midland. The Coroner found the cause of death was complications in association with advanced malignancy (hepatocellular carcinoma), end-stage liver disease (cirrhosis) and generalised sepsis in a man under medical palliative care. The manner of death was by way of natural causes. He was 52 years old.

Immediately before death, Mr Strettles was a 'person held in care' under section 3 of the *Coroners Act 1996* because he was a sentenced prisoner and, under the *Prisons Act 1981,* Mr Strettles was in the custody of the Chief Executive Officer of the Department of Justice. Mr Strettles was serving his sentence at Acacia Prison.

Mr Strettles was initially admitted to Hakea Prison on 19 October 2017. On admission he was noted as having multiple pre-existing health issues, including liver cancer, liver cirrhosis, hepatitis C, peripheral neuropathy and depression. He was a smoker and had a long history of alcohol and polysubstance abuse. Mr Strettles advised staff he had a history of mental health issues and had attempted suicide in the past with the latest attempt only five days prior to his incarceration. Mr Strettles was placed on the At Risk Management System (ARMS) and remained on a moderate ARMS placement until 31 October 2017, when he was identified as having no thoughts of self-harm.

On 22 November 2017, Mr Strettles was transferred to Acacia Prison. Medical records indicate that during his incarceration at Acacia and Hakea Prisons he attended the prison medical centres for various minor medical issues and received treatment for his hepatitis C, which was successfully treated and eradicated in July 2019. Mr Strettles' pre-existing health complications regarding his liver began to rapidly progress by June 2018. On 26 June 2018, an MRI showed a new lesion on his liver and he was diagnosed with multifocal hepatocellular carcinoma. On 23 April 2019, Mr Strettles was listed as Stage 3 on the Department's Terminally Ill List. Although the treatment and care which he received at the medical centre in Acacia and tertiary hospitals were of a high order, Mr Strettles' liver complications were too advanced for him to be cured.

Mr Strettles' health continued to deteriorate and on 31 July 2019 he was transferred from Acacia Prison to St John of God Hospital, Midland with a fever and in a confused state. He underwent scans which revealed a destructive mass lesion on the right side of his brain, and he had developed end stage liver failure and sepsis. Mr Strettles' condition did not improve and he was reviewed by the hospital palliative care team on 2 August 2019. Apart from palliative care, all treatment was ceased and the decision was made to keep him comfortable. On 5 August 2019, Mr Strettles was listed as Stage 4 on the Department's Terminally Ill List. He remained at St John of God Hospital, Midland until he died on 8 August 2019.

The Coroner, after reviewing all of the evidence, was satisfied that the care, supervision and treatment from the Department was of the same standard a person living in the general community would expect to receive.

The Coroner did not make any recommendations.

The Finding is on the website of the Coroner's Court of Western Australia.

Jordan James WILLIAMS
Inquest held in Kalgoorlie 18 to 20 January 2022, investigation finalised 25 February 2022

Mr Jordan James Williams (Mr Williams) died on 24 August 2018 at Kalgoorlie Health Campus (KHC). The cause of death was from head and neck injuries. The Coroner found the manner of death was by way of suicide. He was 20 years old.

Immediately before his death Mr Williams was a "person held in care" under the *Coroners Act 1996* because he was on an involuntary treatment order under the *Mental Health Act 2014*. Mr Williams was an inpatient in the mental health unit at Kalgoorlie Health Campus.

Following the death of his mother in 2016 and his father in February 2018, Mr Williams' mental health declined and he began using illicit drugs. In about July 2018, Mr Williams recommenced his apprenticeship but his employment was terminated on 17 August 2018, due to his erratic behaviour at work. The same day, his former employer became concerned for Mr William's mental state, and contacted Police. However, when police spoke to Mr Williams at his home, he showed no signs of distress and his housemates raised no concerns for his welfare.

On 20 August 2018, Mr Williams' housemate contacted police because she was concerned about his behaviour. Police attended and Mr Williams said he was struggling and had been hearing voices who were telling him to hurt himself. He agreed to be taken to KHC for assessment, where he was diagnosed with psychosis and admitted to a surgical ward because the mental health unit at KHC (the MHU) was already at capacity.

At about 12.45 pm on 22 August 2018, Mr Williams returned to the ward after escorted leave following a visit from family members. He was crying inconsolably and saying he wanted to die. Mr Williams was reviewed by his treating psychiatrist and later by the psychiatric registrar. Mr Williams' antipsychotic medications were increased, his escorted leave was cancelled.

On 23 August 2018, Mr Williams was transferred to the MHU when a bed became available. After he attempted to harm himself with hot water and to abscond from the MHU, he was made an involuntary patient at 3.15 pm when he was placed on Inpatient Treatment Order under the MHA.

At about 6.00 pm on 24 August 2018, Mr Williams absconded from the MHU by scaling the rear fence of the attached courtyard. He was apprehended by security guards in the vicinity of the railway tracks at the rear of KHC and returned to the MHU.

At about 7.30 pm, Mr Williams was given permission to go into the courtyard to recover cigarettes he had previously given to other patients. He was accompanied by a nurse and a security guard. Whilst he was in the courtyard, some of the patients were kicking a football and Mr Williams and the security guard joined in. Suddenly, Mr Williams ran to the rear fence of the courtyard which he again scaled. The security guard chased after Mr Williams but was unable to stop him from running onto railway tracks at the rear of

KHC. Mr Williams was struck by a train as he lay on the tracks and died from the catastrophic injuries he sustained.

Although the coroner was satisfied that the standard of treatment and care provided to Mr Williams during his admission was appropriate, the coroner found that the standard of supervision Mr Williams received was demonstrably sub-optimal.

The Coroner made three recommendations, directed towards increasing the perimeter security around KHC and around the railway line, and also directed towards the construction of a purpose built mental health facility at KHC.

The Finding and any responses to the recommendations is on the website of the Coroner's Court of Western Australia.

Van Tho NGUYEN
Inquest held in Perth 23 February 2022, investigation finalised 3 March 2022

Mr Van Tho Nguyen (Mr Nguyen) died on 10 January 2020 at Bethesda Claremont Private Hospital. The cause of death was metastatic lung cancer, with palliation. The Deputy State Coroner found the manner of death was by way of natural causes. He was 59 years old.

Immediately before death Mr Nguyen was a "person held in care" under section 3 of the *Coroners Act 1996* because he was a remand prisoner, and pursuant to the *Prisons Act 1981* he was in the custody of the Chief Executive Officer of the Department of Justice. Mr Nguyen was in custody at Casuarina Prison prior to being transferred to hospital.

Mr Nguyen was a lifelong cigarette smoker. In December 2018, while visiting family in Vietnam, Mr Nguyen was diagnosed with suspected lung cancer. He immediately quit smoking, but his lung cancer was already very advanced. Mr Nguyen's diagnosis was confirmed after he returned to Australia and he commenced to receive chemotherapy treatment as an outpatient in the community under the care of medical specialists at Fiona Stanley Hospital.

In May 2019, Mr Nguyen was charged with drug-related offences. Bail was set, but Mr Nguyen was remanded in custody as he could not meet the surety condition. He was housed at the infirmary at Casuarina Prison and his medical care for his cancer continued to be managed in consultation with his specialist at Fiona Stanley Hospital, including attending outpatient appointments at the hospital and a number of hospital admissions.

Despite chemotherapy and radiotherapy treatment, Mr Nguyen's cancer spread to other parts of his body and he became increasingly unwell. In November 2019, Mr Nguyen indicated to his doctors that he no longer wished to pursue active treatment. On 6 December 2019, Mr Nguyen was admitted to Bethesda Claremont Private Hospital for end of life care, where he remained until his death.

The Deputy State Coroner was satisfied that Mr Nguyen's supervision, treatment and care in custody was satisfactory and that his medical care was of a high standard. The Deputy State Coroner did express some concern at the failure to document steps to alert Mr Nguyen's lawyer and family to the possibility that they might make an application to vary Mr Nguyen's bail conditions, given his terminal illness. There was evidence the attempts to provide this information were hindered by the fact it was the Christmas period and in the end, Mr Nguyen died on the day of his next scheduled court appearance. The Deputy State Coroner commented that the Department needs to take more robust steps at an early stage to fulfil its requirements under the relevant policy to notify family and counsel when a remand prisoner is terminally ill.

The Deputy State Coroner made no recommendations.

The Finding is on the website of the Coroner's Court of Western Australia.

Boris DRLESKI
Inquest held in Perth 9 March 2022, investigation finalised 13 April 2022

Mr Boris Drleski (Mr Drleski) died 22 May 2019 at Balga. The cause of death was bronchopneumonia and combined drug toxicity. The Coroner found the manner of death was by way of accident. He was 45 years old.

Immediately before his death Mr Drleski was a "person held in care" under the *Coroners Act 1996* because he was subject to a Community Treatment Order made under sections 76 and 79 of the *Mental Health Act 1996.* He had been diagnosed with schizophreniform psychosis and chronic drug use and he was subsequently diagnosed with treatment resistant chronic paranoid schizophrenia and anti-social personality disorder. His mental health conditions were complicated by his non-compliance with prescription medication and persistent polysubstance use, including heroin, methylamphetamine, cocaine and cannabis.

A CTO was required in Mr Drleski's case because he was non-compliant with his medication, lacked insight into his mental health conditions and lacked the capacity to make treatment decisions about his mental health. The Coroner was satisfied that that the decision to place Mr Drleski on successive CTOs was justified on the basis that this was the least restrictive way to ensure that Mr Drleski was provided with appropriate treatment for his mental health conditions.

Mr Drleski may have benefitted from a long-term admission to a facility where his mental health and polysubstance use issues could have been tackled together, however, no such facility was available. Since Mr Drleski's death, a facility known as a secure extended care unit (SECU) has been designed for the treatment of patients with severe and chronic mental health illnesses who have co-occurring polysubstance use issues and/or challenging behaviours. Treatment in the SECU will be provided on an involuntary basis with the aim of transitioning patients into a "community care unit", which would offer long-term treatment, rehabilitation and recovery care.

The Coroner found that Mr Drleski's management whilst he was an involuntary patient at Graylands Hospital and whilst he was the subject of a CTO was reasonable, when considered in the context of the resources available to his clinical teams at the relevant time.

The Coroner did not make any recommendations.

The Finding is on the website of the Coroner's Court of Western Australia.

Kevin Ernest McCRACKEN
Inquest held in Perth 27 April 2022, investigation finalised 20 May 2022

Mr Kevin Ernest McCracken (Mr McCracken) died on 11 July 2020 at Bunbury Regional Hospital. The cause of death was hypertensive and valvular heart disease. The Deputy State Coroner found the manner of death was by way of natural causes. He was 58 years old.

Immediately before death, Mr McCracken was a 'person held in care under section 3 of the *Coroners Act 1996* because he was a sentenced prisoner and, under the *Prisons Act 1981,* Mr McCracken was in the custody of the Chief Executive Officer of the Department of Justice. Mr McCracken was serving his sentence at Bunbury Regional Prison.

Mr McCracken had a number of significant medical conditions when he was admitted on remand to Hakea Prison on 7 March 2015. He already had a complex cardiac disease, which included heart valve replacement surgery in 1990, aortic arch surgery in 1997 and a severe ventricular hypertrophy. In addition, he had been diagnosed with hypertension, pulmonary embolism, gastro-oesophageal reflux, osteoarthritis in the lumbar spine and osteoporosis. Mr McCracken also had complex regional pain syndrome in his right leg, following an injury in a 2013 workplace accident which resulted in chronic pain and issues with mobility. At the time of his admission into prison, Mc McCracken took daily blood pressure medications, analgesia and warfarin.

On 11 July 2020, Mr McCracken was housed in the pre-release unit at Bunbury Regional Prison. At about 3.10 pm, Mr McCracken walked into the kitchen area, paused for a moment, and then fell face-forward onto the floor. Another prisoner grabbed his arm as he fell, in an attempt to break his fall, and placed Mr McCracken in the recovery position. Assistance for prison staff was called for and three prison officers quickly attended the kitchen with resuscitation equipment, including a defibrillator. A short time after that, a prison nurse also attended. The nurse instructed staff to call a Priority 1 ambulance and commenced CPR. St John Ambulance received the call and arrived at the prison at 3.32 pm. Ambulance officers observed that Mr McCracken was in ventricular fibrillation, despite multiple shocks and doses of adrenaline being administered. His condition deteriorated to asystole prior to being placed in the ambulance. Resuscitation efforts were maintained in transit to Bunbury Regional Hospital. Despite extensive resuscitation attempts, Mr McCracken was pronounced dead at the Bunbury Regional Hospital at 4.24 pm.

The Coroner was satisfied that the supervision, treatment and care of Mr McCracken was appropriate while he was in custody.

The Coroner did not make any recommendation.

The Finding is on the website of the Coroner's Court of Western Australia.

Salvatore Giovanni OTRANTO
Inquest held in Perth 17 May 2022, investigation finalised 8 June 2022

Mr Salvatore Giovanni Otranto (Mr Otranto) died on 9 June 2020 at Fiona Stanley Hospital. The cause of death was complications following myocardial infarction and its treatment in a man with multiple severe co-morbidities. The Deputy State Coroner found the manner of death was natural causes. He was 69 years old.

Immediately before death, Mr Otranto was a ‘person held in care under section 3 of the *Coroners Act 1996* because he was a sentenced prisoner and, under the *Prisons Act 1981,* Mr Otranto was in the custody of the Chief Executive Officer of the Department of Justice. Mr Otranto was serving his sentence at Casuarina Prison.

Mr Otranto was first admitted to Hakea Prison as a new remand prisoner on 5 April 2019. He spent a week at Hakea before being transferred to Casuarina Prison, where he was housed in the infirmary due to his multiple complex health conditions. Mr Otranto was already prescribed a large number of regular medications and the same medical management was continued once he was in custody, adjusted as necessary by the prison doctors in consultation with his specialist. Due to his multiple and serious co-morbidities, Mr Otranto was placed on the Terminally Ill Register as Stage 1 at an early stage. On 3 June 2020 his status was escalated to Stage 4 due to his rapidly deteriorating health.

On the morning of 30 May 2020, Mr Otranto complained to the health staff of chest pain and shortness of breath. It was suspected that he was suffering a heart attack. He was transferred by ambulance under ECG monitoring to Fiona Stanley Emergency Department and it was confirmed he had suffered a heart attack. He was admitted for treatment. He suffered renal complications while in hospital and was commenced on dialysis.

On 1 June 2020, following a further episode of chest pain and lowered oxygen saturations, Mr Otranto was transferred to the Coronary Care Unit. On 3 June 2020, while still at in that unit, it was noted he was drowsy and delirious. It was suspected that he had aspirated, and he was commenced on intravenous antibiotics.

On 5 June 2020 following a stent to Mr Otranto’s right subclavian artery, he was returned to the ICU, intubated and ventilated. On 9 June 2020, ICU records state that Mr Otranto was suffering from worsening cardiogenic shock, which is considered a grave diagnosis. Mr Otranto was considered too unwell to undergo further investigations or further coronary intervention. His prognosis was deemed to be poor. In consultation with his family, it was confirmed that he was to be recorded as not for cardiopulmonary resuscitation or reintubation. Mr Otranto died that evening at 10.25 pm.

The Deputy State Coroner was satisfied that the supervision, treatment and care of Mr Otranto was appropriate while he was in custody.

An issue of concern was the fact that Mr Otranto was not considered for release on the Royal Prerogative of Mercy when he became terminally ill. This has been identified as an issue in a number of inquests involving deaths in custody, as there was an issue with staffing in the Sentence Management of Unit for a considerable period of time, which meant there was no staff member allocated to complete this task. The Deputy State Coroner noted it was unlikely Mr Otranto would have been recommended for release given his personal circumstances, but there was an acknowledged failure on the part of the Department to follow the relevant procedure. Since that time, a staff member has commenced in the Sentence Management Unit to perform this important role, so the Deputy State Coroner was reassured this issue should not reoccur.

The Deputy State Coroner did not make any recommendation.

The Finding is on the website of the Coroner's Court of Western Australia.

Ashley Adrian LANE
Inquest held in Perth 24 to 26 May 2022, investigation finalised 21 June 2022

Mr Ashley Adrian Lane (Mr Lane) died on 26 April 2019 at Kalgoorlie Regional Hospital (KRH). The cause of death was acute exacerbation of chronic obstructive pulmonary disease (bronchial asthma). The Coroner found the manner of death was by way of natural causes. He was 56 years old.

Immediately before death, Mr Lane was a 'person held in care under section 3 of the *Coroners Act 1996* because he was a remand prisoner and, under the *Prisons Act 1981,* Mr Lane was in the custody of the Chief Executive Officer of the Department of Justice. Mr Lane was incarcerated at the Eastern Goldfields Regional Prison.

During a risk assessment conducted during the reception process, Mr Lane advised he did not have any serious health issues. However, he had a Ventolin puffer in his possession and disclosed that he had asthma and liver issues. In fact, medical records several days later showed he had chronic obstructive pulmonary disease.

During his incarceration at EGRP, Mr Lane experienced periodic exacerbations of his asthma which were managed with Ventolin and steroidal medication. On the evening of 8 March 2019, Mr Lane experienced a near fatal exacerbation of his asthma and was taken to KRH. He was discharged after three days, but it appears that nobody at EGRP realised that this incident demonstrated that his asthma was poorly controlled and that Mr Lane needed to be referred to a respiratory physician for ongoing management.

On 23 April 2019, Mr Lane was permitted to have a Ventolin nebuliser in his cell overnight and he told nursing staff that this had provided him with relief. The fact that Mr Lane now required Ventolin overnight was a clear indication that his asthma was poorly controlled, but again this was not appreciated by clinical staff at EGRP. On 25 April 2019, Mr Lane advised a prison nurse that his nebuliser was not working and she identified that an essential component was damaged and sourced a replacement. The replacement part was placed in a box at the front gate and although the nurse expected that the part would be delivered to Mr Lane immediately, this did not occur.

At 1.32 am on 26 April 2019, Mr Lane used the emergency call button in his cell to alert officers to the fact that he was having trouble breathing. Although the officers eventually provided Mr Lane with the replacement part for his nebuliser, Mr Lane's condition quickly deteriorated and he collapsed in his cell. The cell door was unlocked and Mr Lane was taken to a common area where CPR was commenced. Although Mr Lane was transferred to KRH where resuscitation efforts continued, he could not be revived.

The coroner found that although Mr Lane's medical treatment was often commensurate with standards in the general community, his medical conditions were not managed holistically, and that Mr Lane should have been placed under the care of a respiratory physician.

The Coroner made eight recommendations directed towards the better management of prisoners with serious medical issues, and the delivery of effective first aid.

The Finding and any responses to the recommendations is on the website of the Coroner's Court of Western Australia.