AISHWARYA ASWATH AND COHEN FINK — CORONIAL INQUESTS

Amendment to Notice of Motion

HON NICK GOIRAN (South Metropolitan) [1.09 pm]: Pursuant to standing order 62, I seek leave of the house to move my motion on notice in an amended form.

[Leave granted.]

Motion

HON NICK GOIRAN (South Metropolitan) [1.12 pm]: I move —

That this house —

(a) expresses its deep regret at the deaths of Aishwarya Aswath and Cohen Fink and tenders its profound sympathy to members of their respective families in their bereavement;

(b) notes that section 22(1)(d) of the Coroners Act 1996 states that the Attorney General may direct a coroner who holds jurisdiction to investigate a death to hold an inquest if the death appears to be a Western Australian death; and that this section has caused confusion for some grieving families who have sought an inquest;

(c) acknowledges that the Deputy State Coroner made a determination on 14 May 2021 that an inquest will be held into Aishwarya's death;

(d) further acknowledges that the Solicitor-General has advised that once a coroner has decided not to hold an inquest, the Attorney General does not have the power to overrule that decision and direct that an inquest be held as is the case following the death of Cohen Fink and the decisions of the Coroner's Court in 2020 and 2021;

(e) notes that no Western Australian Attorney General has ever exercised the power of direction since the act was enacted in 1996; and

(f) notes that the Attorney General will urgently request the Department of Justice to advise as part of its statutory review into the Coroner's Act 1996 whether section 22(1) ought to be amended to avoid confusion about its operation.

At the outset, I thank the house for its courtesy in allowing me to proceed under standing order 62. I will provide a brief explanation to members shortly about the sequence of events that led to the necessity to utilise that mechanism in our standing orders. However, before I do so, at the outset I want to acknowledge the families of both Aishwarya and Cohen. I will provide further reflections on that momentarily, but whilst I deal with the matter of acknowledgments, I also want to acknowledge at the outset the cooperation of the Attorney General's office, in particular the parliamentary secretary and the Attorney General's chief of staff, and that includes those who were involved in drafting the answer to the question without notice from yesterday, which I will unpack momentarily.

Members, in general summary, the reason for the motion that is currently before us for our consideration is that these two tragedies, these two cases that have become well known in recent times in our state, have highlighted a problem with the Coroners Act 1996. At the absolute best, the problem is that the statute has caused confusion for grieving families seeking an inquest. At worst, it has created false hope for those families. I ask members to consider for a moment and endeavour as best as we can as humanly possible to stand in the shoes of these two families. As I consider their cases, I express my regret about the two deaths and also tender my sympathy to the members of the respective families in their continued bereavement.

If we consider the first of the two cases—I say first not in a chronological sense but in the way that it has been presented in this motion—it involves the death of a young seven-year-old girl at Perth Children's Hospital. Any of us who are parents may have some appreciation for the feeling of this particular family. As I understand it, and as it has been reported widely, they took their young daughter to Perth Children's Hospital. Regardless of which side of politics one sits, we can all acknowledge that Perth Children's Hospital is a first-class, world-class facility and to say that it would be heartbreaking for any family to take their child to such a facility and leave with their seven-year-old dying does not even begin to properly express the feelings of the family. The family felt an urgent need to take their seven-year-old child to a world-class facility, no doubt feeling helpless and wanting the best medical treatment. Walking into this facility, and just by looking around at the amenity, people are blown away by its sheer size and modernity. It was only last week that I had cause to attend Perth Children's Hospital for my own personal reasons. As I sat there last week, I could not help but reflect for a moment on what it must have been like to be the parents of Aishwarya at the time.

In contrast to that, but no doubt with the same feelings of sadness, I turn to the death of Cohen Fink. I have never met the Fink family. At this point, I acknowledge the work of my predecessor Hon Michael Mischin. The members who were here during his valedictory speech will recall that the honourable but now former member explained to the chamber precisely the sequence of events that occurred in this matter and the lengths that he had gone to ensure that the process for an inquest was facilitated. Hon Michael Mischin was at pains to say that he was not necessarily casting a view about whether or not there should be an inquest in a particular matter but that it should at least have the opportunity to be heard. He approached me after the election and asked me to specifically take on this as a matter of interest, and I am pleased to do so on his behalf.

This death was the suicide of a year 12 student. Again, I ask members, particularly with their own children—maybe some have a child in year 12—to contemplate for a moment the suicide of a year 12 student. Again, as I reflect on my own experience, I recall a couple of years ago having to attend the funeral of a peer of my daughter, a high school student but not a year 12 student, who had suicided. My attendance at that funeral that day still sticks very clearly in my mind. It was very difficult, as a peer of the parent of that child, to contemplate what was in the mind of the child at the time, and that sense of hopelessness and desperation. In the same way, I ask members to contemplate what it must be like for the Fink family at this time as they continue to grieve the loss of their son Cohen. Understandably, after such tragedies, both families are seeking answers. Any one of us would do the same. In both cases, they have had to resort to calling for an inquest. It is worthwhile being familiar with the triggers for an inquest. In particular, I take members to section 22 of the Coroners Act 1996, which is at the very heart of the confusion and what I have described as false hope surrounding this matter. Section 22(1) of the Coroners Act 1996 states —

> 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 then sets out six criteria that, if they exist, if they are present, mandate that the coroner must hold an inquest. Those six criteria are as follows —

> (a) the deceased was immediately before death a person held in care; or
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> (b) it appears that the death was caused, or contributed to, by any action of a member of the Police Force; or
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> (c) it appears that the death was caused, or contributed to, while the deceased was a person held in care; or
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> (d) the Attorney General so directs; or
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> (e) the State Coroner so directs; or
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> (f) the death occurred in prescribed circumstances.

It is important to note that there is no discretion on the part of the coroner. If one of those six preconditions exist, the legislation makes it very clear that a coroner must hold an inquest. Why has this matter caused some confusion and, as I have described, false hope? If we look at the fourth of the six criteria, the legislation sets out that one of the preconditions is "the Attorney General so directs". The language is very clear in the statute: if the Attorney General so directs, the coroner must hold an inquest. It is no wonder that this has caused confusion for some grieving families who have sought an inquest. The way in which these two matters have progressed highlights very much the problem at hand.

I take members to the first of the two cases—the death of Aishwarya Aswath. No doubt, most members would well know that this highly publicised death and the circumstances that occurred thereafter resulted in calls for an inquest. As it so happens, thanks to the parliamentary secretary and those responsible for the answer given to the question without notice yesterday, we now know that on 14 May this year, the Deputy State Coroner determined that an inquest will be held into Aishwarya's death. I am pleased that the family will now have the inquest that it has been seeking. It is all about a matter of timing. Now that the Deputy State Coroner has determined that there will be an inquest into Aishwarya's death, plainly, regardless of the wording in section 22, there is no purpose in the Attorney General directing that an inquest take place. No Attorney General is going to direct the coroner to hold an inquest into a death that the coroner has already determined they will be holding an inquest into. In the case of Aishwarya, this statutory power in section 22(1)(d) becomes irrelevant because of a matter of timing.

However, if we consider for a moment the circumstances surrounding the death of Cohen Fink, a different situation emerges. We find that the Attorney General was given advice, as outlined in an answer to a question asked yesterday, but in fairness to the Attorney General, my recollection is that this is already on the public record as a result of answers previously provided. The response that was provided yesterday states —

> The Solicitor-General has advised that once a coroner has decided to not hold an inquest, the Attorney General does not have the power to overrule that decision and direct that an inquest be held. Therefore, in the late Cohen Fink's case, the Attorney General has no power to direct that there be an inquest.

This is where the confusion arises for grieving families because there is no indication whatsoever in our statute that that is the case.

As the shadow Attorney General, I want to acknowledge that the Solicitor-General has provided this advice to the Attorney General and that it would be, at best, very difficult for any Attorney General to proceed, notwithstanding that advice. That said, the statute and the language is clear: if the Attorney General so directs, a coroner must hold an inquest into the death. There is no mention at any point in section 22 or anywhere else that one of the preconditions is whether a coroner has already made a determination; hence, the calls in recent times with respect to Aishwarya's death. If it is the case in Western Australian law that an Attorney General has the power to direct that an inquest be held only before a coroner has made a determination, then if it was urgent, if that power was going to be used, it would be exercised before the coroner made the determination. As I said earlier, as it now happens, thankfully for Aishwarya's family, this is no longer an issue because the Deputy State Coroner has already determined that an inquest will be held. What if the Deputy State Coroner had determined not to hold an inquest? What if the Deputy State Coroner had come to the same conclusion that the Coroner's Court has concluded in the Fink case—that is, that it will not hold an inquest? Suddenly, we would find ourselves in a situation in which, according to the Solicitor-General, the Attorney General would not have the power to exercise this power of direction to hold an inquest. The question immediately becomes: in what circumstances would an Attorney General ever use this power of direction given that as the coroner is an independent officer, the coroner has the ability to gather information, consider the matter on its merit and make a determination? Is an Attorney General going to intervene before that time? One would think that the purpose behind the provision is that if the Attorney General were of the view that the coroner had made an error, the Attorney General could direct the coroner to proceed with an inquest anyway. Regardless of whether that interpretation is correct, the state of the law in Western Australia, according to the Solicitor-General, is that no such power exists, and this is what causes the confusion and the false hope for families. I ask members again to consider that very carefully, and to try to stand in the shoes of the Fink family at this time. It would be exasperating, I think, to be in a situation in which they continue to fight for an inquest, they can see that the statute says in plain language that the Attorney General has the capacity to direct the coroner, yet the advice of Western Australia's senior lawyer is that no such power exists.

To put this in some context for members, there was a very helpful article in WAtoday of 26 May. I encourage members, if they have not already read the article, to familiarise themselves with it. It is titled "'Our kids are dying': Perth parents' search for answers from school over son's suicide ends up in Supreme Court". I will quote selectively from this article, firstly as a consequence of a lack of time and also because I am mindful that this call by the Fink family for an inquest is presently before the Supreme Court. I wish them the very best in their endeavours. That said, as recently as this week a decision was handed down by the coroner, and the Fink family have provided that information to me. The Coroner's Court of Western Australia wrote to the solicitors representing the Fink family on 27 May.

I return to the WAtoday article. What particularly attracted my attention were the following remarks in the article —

> While Premier Mark McGowan announced last week the government was "working with the Coroner" to fast-track a coronial investigation into Aishwarya Aswath's death, the Finks were disappointed they hadn't received the same support.
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> "What does it take to get an inquest?" asks a frustrated Mr Fink.

Further along in the article, there is a paraphrased quote that reads as follows —

> A government spokesperson said while unexpected deaths of young people were always tragic, the State Coroner was an independent officer of the court.

I do not know who that government spokesperson was. Yes, they are stating a matter of fact that the State Coroner is an independent officer of the court, but that type of language will only further exasperate the Fink family. We have a situation in which the Premier of Western Australia is seen, or at least perceived, to be "working with the Coroner" in one case, but not working with the coroner in another. The government spokesperson resorted to the shield of, "Well, the State Coroner is an independent officer of the court." Yes, we know that, but if the purpose of that statement by the spokesperson is to highlight and underscore the independence of the role of the State Coroner, the question becomes: why is Premier McGowan working with the coroner in one case and not in another? This causes further distress to a grieving family—exacerbated, as I say, by the language of the Coroners Act 1996 and the Attorney General's apparent power of direction, which seemingly can never be used.

Members will recall that I asked them to try as best they could to stand in the shoes of the parents. As I said earlier, in the case of Aishwarya's parents, notwithstanding all the grief that they continue to experience, they will at least be pleased that a decision has been made for an inquest to proceed. That is not the case for the Fink family.

On Monday, I received an email from the Fink family. As I said earlier, they had been liaising with my former colleague, Hon Michael Mischin. After being made aware of the fact that he had referred this matter to me, they wrote to me on Monday. I want to quote from a particular section of this email. I think it highlights exactly how the family must be feeling. It is not the case that every Western Australian death will result in an inquest; that can never be the case, nor would it be an appropriate use of resources. One of the criteria by which determinations are made as to whether there will be an inquest is whether there can be some systemic lessons learnt and some positive can emerge from a tragic death.

In the email I received earlier this week, this comment is made —

> Cohen took a pocketknife to school we were contacted …

I pause there to remind members that "we" are the two parents in question. Their son, at one point in time, took a pocketknife to school and there was concern on the part of the school—rightly so—and they were contacted. They go on to say that Cohen —

> … didn't do his last English assessment we were contacted …

Their second example was about an academic assessment that he had not finished; it was an English assessment. Concern was shown by the school and it contacted the parents. They then give a third example to highlight the problem here, which is —

> … 3 of his teachers had concerns for his mental health and that's fine, no need to contact us.

If members are trying to understand the exasperation of the Fink family, this chronology of events includes three different episodes in this young person's life—what I would describe as the pocketknife episode, the English assessment episode and the concerns for his mental health. In the pocketknife episode, the school went out of its way to contact the parents because of its concerns, and rightly so. In the English assessment episode, the school was concerned that it was not finished, so it contacted the parents, again rightly so. For those in the chamber who are parents: would you not want that to happen? If your child is rocking up at school with a pocketknife, would you not want to be contacted about it? If your child did not complete their last English assessment, would you not want to be contacted about it? In both of those episodes, the school has done the right thing and engaged with the family. But when it came to three teachers having concerns for his mental health, the family was not contacted. No wonder there is distress on the part of the family.

In the Fink case, the Coroner's Court has already been found, by its own admission, to have been in error. At some earlier point in time—according to my notes it was 2020—the Coroner's Court made a determination, but that determination was subsequently set aside due to an error on the part of the Coroner's Court. That resulted in a fresh examination and consideration of matters. The Fink family, having expended what appears to be a large sum of money getting legal assistance, sought in November last year for the coroner to reconsider the matter with the benefit of the new information. Incidentally, that information was provided by way of freedom of information requests. Today is not the day to have a debate about some of those elements, including why the information was not available at first instance; the point is that in November last year, the Fink family's lawyers wrote to the Coroner's Court and sought a re-examination of this matter. Under the legislation, if there has been no decision made by the coroner after three months, Western Australians have a very narrow time in which to apply to the Supreme Court. This is found in section 24(2) of the Coroners Act 1996, which states —

> Within 7 days after receiving notice of the refusal, or if a reply to a request for an inquest to be held has not been given within 3 months after the request was made, the person may apply to the Supreme Court for an order that an inquest be held.

The Fink family availed itself of that window of opportunity. I understand the matter is now before the Supreme Court and a decision is due to be made as early as next month. We all wait for that decision with interest, no doubt none more so than the family. It again highlights the problem that the act says that the Attorney General has an opportunity or a power to direct. Under the interpretation provided by the Solicitor-General, that power can only ever be utilised if a decision has not yet been made by the coroner. If a decision has been made not to hold an inquest, the only recourse available to a family is to apply to the Supreme Court. As we can see from section 24, that window is seven days. I acknowledge at this point that my recollection is that the government identified this last year and expressed that it intended to reform this area; indeed, it may be looking to expand that window from seven days to, I think, 30 days. The parliamentary secretary will potentially be in a position to clarify that for us. It is no doubt an overdue reform. I will welcome it when it comes before the house, and we will examine it at that stage. In the meantime, the existing window is only seven days, and we continue to have this confusion for grieving families who feel they can apply to the Attorney General to expedite things only to find that, in practice, no such power exists.

It is largely for those reasons that I am pleased to see there will be a way forward here. I revert to my earlier acknowledgement of the cooperation that has occurred with the Attorney General's office, particularly over the last 48 hours. Members will note that the final limb of the motion notes that the Attorney General will urgently request the Department of Justice to advise, as part of its statutory review into the Coroners Act 1996, whether section 22(1) ought to be amended to avoid confusion about its operation. It was presumptuous of me to move that, but I hasten to add that it has been done with the concurrence of the government through discussions behind the chair. I understand there is certainly an intention on the part of the Attorney General to do so, if it has not already occurred. I thank the government for that, because we need to have a way forward for this.

We have a law in Western Australia, the plain words from the Parliament in the statutes, that indicates that the Attorney General has a power of direction to effectively order that an inquest take place. That power has been agreed to by the Parliament. It would no doubt provide great comfort to grieving families to know that there is at least one person in government to whom they can go, if all else fails, to plead their case with a view to an inquest taking place. There is no point having that plain language in the legislation if a non-parliamentarian then determines that no such power exists. If that is going to be the case, in my view it calls for urgent reform and clarification. It is unfair to continue to allow grieving Western Australians to be misled. I am not suggesting for a moment that it has been done with any intent. It is certainly not a matter that falls at the feet of any government, because it has been with us since 1996. As was explained yesterday by the parliamentary secretary in answer to a question without notice, the records of the Department of Justice indicate that there is no record of any Attorney General ever utilising that power since it was put in place in Western Australia in 1996. This does not fall at the feet of any particular government. The point is that these were plain words agreed to by the Parliament. Those plain words would give comfort to any grieving Western Australian family, yet in practice we find that those plain words mean nothing. Under the current interpretation, there is really no conceivable circumstance in which the Attorney General is ever going to use that power. If that is the case, let us be transparent about it. Let us be honest with the people of Western Australia. Let us not give grieving families false hope. I am pleased to note that there is an appetite on the part of the Attorney General and his office to urgently consider this matter.

I also add that the Coroners Act is currently under review. Members may be aware that it has become common practice in many pieces of legislation to enshrine a section mandating that there be a statutory review of the legislation after a particular period of time—often five years, but not necessarily. Just such a provision exists in the Coroners Act 1996. I am led to believe, pursuant to an answer provided by the government to a former member of this place, Hon Alison Xamon, only last month, that the statutory review of the Coroners Act is currently underway. That being the case, I can think of no better place for this matter to be considered than in that current statutory review. I hope that all the circumstances outlined here today and, indeed, those that members were aware of leading into today, whether through some of the work done by the member for Vasse on behalf of Aishwarya's family, by Hon Michael Mischin on behalf of the Fink family or by any other member who has been involved in advocating for these matters, again highlight the need for expedition in this area.

It cannot be one of those situations in which we are here today, on 2 June 2021, and potentially may have a unanimously agreed motion by the Legislative Council recognising this problem, expressing its concern and agreeing on a way forward, but then we never hear anything further about it. This cannot be one of those cases. I am fully committed, as I promised my learned friend Hon Michael Mischin, to follow this matter through. Obviously, I cannot inject myself in the Supreme Court proceedings, nor would it be appropriate to do so. That will take its course and we will see what the results of that matter are. However, we can make sure that the problems have been highlighted. We can call on the government to review them and persuade it that the review is urgent, and then we can follow up to make sure it gets done and commitments are followed through. I ask members to give their strongest consideration to supporting the motion before the house. I am confident that every member of this place will want to express deep regret over the deaths. I am confident that every member of this place, whether or not they have the opportunity today, wants on behalf of the whole house to tender their profound sympathies.

I would like to think that members have been persuaded that there is a problem with our legislation. I would like to think that members have been persuaded that the problem has caused confusion for grieving families. I would like to think that members have been persuaded that in fact it has created false hope, not through any malicious intent on the part of any legislator or public servant in Western Australian history, but the outworking of the interpretation of the legislation has resulted in false hope, and that members have been persuaded that this government is taking this matter seriously, is committed to reviewing this matter as a matter of urgency and, in due course, reporting to the house on the outcome of those reviews. I would like to think that this is the type of matter that can receive bipartisan support. I commend the motion to the house.

HON SUE ELLERY (South Metropolitan — Leader of the House) [1.51 pm]: I want to add my support for this motion on coronial inquests. I indicate that the government will provide a more thorough response, but I want to make some comments about one area in particular. I want to publicly express my deepest sympathy to both families.

However, as Minister for Education and Training, I have had the most involvement with the family of Cohen Fink. In the lead-up to this long weekend, the Fink family will revisit the trauma that occurred to their family two years ago. Their 17-year-old son, Cohen, who attended Warnbro Community High School, died by suicide on the morning of Tuesday, 4 June 2019, after this same long weekend. It is clear to me that in the course of the correspondence from the Fink family wanting answers to why this terrible thing happened to their beautiful son, in the information that was provided to me and that I then provided to the Finks and to others who contacted me about this, there were several gaps in the communication between the school and Cohen's parents in the lead-up to his death. In particular, certain information should have been noted in the school's records but was not. If rectified, those gaps in communication may not have prevented Cohen's death; nevertheless, they should not have occurred.

To make this family's grief worse, in the immediate period following Cohen's death, communication with the family from the school, and then more broadly from the Department of Education, was not to the level I would have expected. I have had several opportunities to express my sympathy to the Fink family, and they met earlier this year with my chief of staff. None of that acknowledgement by me that standards were not met can assuage the grief of Cohen's family.

As we know, this matter is before the court. The Fink family is pursuing the next level of opportunity available to them to have a decision reversed. Although I do have access to more information about the details of this, given that the matter is before the court, it is not appropriate for me for lay all of that before the house, other than to say that this was a terrible, terrible tragedy for this family. I do think the school and the department could have done better. I am not sure we can go beyond that to say that that directly resulted in his death. However, this is a terrible weekend for that family because they would be thinking of what they and others could have done in the days leading up to this long weekend. I will leave my comments there and reiterate my deep sympathy to their family, and also to the family of Aishwarya Aswath.

HON MATTHEW SWINBOURN (East Metropolitan — Parliamentary Secretary) [1.56 pm]: I rise to give the response on behalf of the government. I indicate at the outset that the government will support the amended motion on the statutory powers of the Attorney General. I thank Hon Nick Goiran for the work we did behind the chair to be able to bring forth the motion before the house that both our parties and the National Party can support. Given the gravity and weight of this matter, it is important that we are able to do that. I encourage members on the crossbench to also support this motion in these circumstances. The power of that cannot be underestimated for the families, who undoubtedly will listen to the contributions that are made today.

I would like to pass on my deep sympathies and condolences to the families of Cohen and Aishwarya. It is difficult to express in words the level of feeling that most people have for the circumstances that both those families are going through. We can say things such as, "I can imagine the pain and suffering." However, I am not sure any of us can truly imagine what those people have had to go through with the loss of their beloved child. For whatever it is worth, I pass on to them my deepest sympathies.

I will say at the outset that it is not my intention for any of my comments to come across as callous or insensitive to their circumstances, and if at any stage that does happen, I apologise in advance because that is certainly not the way that I intend to deliver them. For my part, the circumstances of Aishwarya Aswath's death particularly hits home for me. I have spoken in this place before about the circumstances of my son Mitchell and the experience we had with, first, Princess Margaret Hospital for Children and now Perth Children's Hospital. For context, I will elaborate on that further. Mitchell, my 16-year-old son, was diagnosed in 2015 with a number of tumours, which had to be removed from his body and subsequently metastasised in his liver. The journey my wife and I took with Mitchell in getting diagnosis led us invariably through the emergency department of Princess Margaret Hospital for Children and we cannot say that that experience was pleasant in any way or gave us confidence in some of the practices of the hospital at that time. That was in 2015. My wife, particularly, presented with Mitchell on numerous occasions with him suffering from severe headaches, nausea and vomiting. He was not digesting food and he had blood in his vomit. He was failing to thrive and it was a very stressful time for us.

We presented to the emergency department, as all parents do in those stressful circumstances, to seek help for our very sick child. At times it was during the day; at times it was in the middle of the night. Each time we presented, we went through the stress and anxiety that Aishwarya's parents obviously went through while waiting in the emergency department waiting room for our turn to be seen. In the old waiting room at Princess Margaret Hospital for Children, we could essentially see everybody else who was waiting. We could see all the people who had come in before us who got seen before us and we were anxious and frustrated because, of course, the needs of our own children are our first priority. That is what we go in there for. We cannot avoid that. If they have not already, I hope that parents here do not have to go through that anxiety, impatience and stress, which is very hard to cope with and deal with. We went through that with Mitchell in the emergency department to get on the other side. We were already very experienced with the hospital because Mitchell had a range of other complex health needs that meant that we had been regular visitors to the hospital, but those visits to the emergency department were never any less difficult.

I would describe the state of mind when waiting as "Should I say something? Should I go up and speak to the nurse and say, 'What about us?' Should I say it is our time and that our child is the sickest, as far as I can see?" Aishwarya's parents—their circumstances are well known and on the public record—clearly had that anxiety. They did something. They asked for help and that help was not as forthcoming as it absolutely should have been. I understand that part of their trauma. One of the other things is that over a period of six weeks, we kept turning up to the emergency department and kept trying to get treatment. We did not get a diagnosis of the severity of Mitchell's underlying condition. It later metastasised because it was not treated as early as it could have been, and we live with the guilt that if we had said something more forceful at the time, would he not be lumped with what is essentially a death sentence for his condition? We live with that day in, day out. I know that my wife, Glenda, struggles with that daily and it is something that will never go away. He was in hospital again over the weekend. He presented to the emergency department, and again we had that experience through that emergency department. We ask those questions of ourselves every time it happens. To the family of Aishwarya, as much as I can, I feel your pain. I think your story, unfortunately for many people, is not unfamiliar when it comes to emergency departments. That is the context in which I look at this matter.

I also look at the circumstances of Cohen Fink and I think about my son Harrison, who completed his ATAR last year. My wife and I are very proud of Harrison, but he is a very insular person; he keeps to himself. We do not know a lot about what is going on his life because he chooses not to share it with us. We worry and have worried about him through his ATAR process. Again, I cannot imagine what the Fink family has gone through with what happened to Cohen, but I certainly understand the journey that they were on with him until his unfortunate and untimely death. I will say this: the publicity surrounding the deaths of children can trigger significant grief for those in our community who have also lost children. It is appropriate that the media and, indeed, this chamber exercise caution in their reporting and discussion of the deaths of children. I would encourage anybody listening today who is experiencing grief or trauma as a result of these deaths to seek whatever help and support they can. That help is obviously available through services such as Lifeline. Do not leave it; ask for help. Put your hand up.

I will now turn to the parts of the motion that deal with the more technical parts of the Coroners Act. Hon Nick Goiran brought this motion forward today in its amended form. I agree with him about the confusion and false hope that arises out of section 22(1)(d) of the Coroners Act and acknowledge that the wording about what powers the Attorney General has to direct the coroner is not as it perhaps seems on first reading. The section provides that —

> (1) A coroner who has jurisdiction to investigate a death must hold an inquest if the death appears to be a Western Australian death and —
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> …
>
> (d) the Attorney General so directs; …

As I said, at first glance it appears that the Attorney General has an independent power to direct the coroner to hold an inquest in Western Australia. However, unfortunately, as is often the case with statutory provisions, the answer does not lie in a simple reading of the provision in isolation. This is unfortunate, for the reasons that Hon Nick Goiran pointed out, in the sense that it gives families false hope that the Attorney General can direct the coroner to hold an inquest in circumstances in which he simply does not have the power to do so.

Last year, following requests from families to hold inquests on matters relating to particular deaths, the Attorney General sought advice from the Solicitor-General. Although it is not the usual practice for ministers and government officials to publicly discuss the contents of the legal advice they receive from the Solicitor-General, in this instance there was such significant public interest for the Attorney General to exercise this power for these cases that on 27 October 2020 he issued a media statement discussing the effect of the advice. In particular, the media statement noted —

> The effect of the advice is that, as a coroner has decided not to hold an inquest into these deaths, the executive does not have the power to overrule that decision and direct that an inquest be held.
>
> The power in the Coroners Act is not intended to be used to overrule a coroner's decision not to hold an inquest. It should only be used in exceptional circumstances where a coroner has not yet decided on whether an inquest should be held, where there is an obvious and immediate public interest in an investigation.

I seek to table a copy of that document.

[Leave granted. See paper 246.]

Hon MATTHEW SWINBOURN: The media statement went on further to an example of when such powers might be used, such as when a cluster of coronavirus deaths might have occurred; obviously that is topical at the moment. The Attorney General could then direct that an inquest into all those deaths occur before the coroner makes a decision to hold an inquest. That would be the basis on which the Attorney General might be able to use that power—when no

such decision has been made. In a practical sense, this means that in the case of Cohen Fink, as the Coroner's Court had decided not to hold an inquest into Cohen's death, the Attorney General was unable to override that decision. He was simply functus officio, I think is the official term. He had no power to do so.

I note the comments made by Hon Nick Goiran regarding the public comments that had been made, referring to the words of a government spokesperson about the help that was being provided in Aishwarya's case when the government had been providing information to the coroner to inform the coroner's decision about whether to hold an inquest. This was not intended to influence the Coroner's Court's decisions, as it is independent from government and there are very sound reasons for that. The government wanted to be kept informed about what the State Coroner's decision was. However, in the Cohen case, by the time the matter was brought to the Attorney General's attention by Hon Michael Mischin, the coroner had already decided, so that power was not available in those circumstances. It was not within the scope of the government to do any work with the coroner in the same way it had done in Aishwarya's case, because that decision had already happened; effectively, the train had left the station.

I note, and it has been noted, that Cohen's parents, Pamella and Chris Fink, have brought an action in the Supreme Court on the refusal by the coroner to order an inquest into their son's death. New and non-legally trained members may have heard comment being made several times about us refraining from making comments about matters that are before the court—the sub judice rule. I think it is important to warn members that, in any contributions they wish to make, they should be careful about the nature of their comments when matters are before the courts. Standing order 52 provides some guidance in that regard, but beneath the sub judice principle is the general idea that we should let the independent judiciary and court system make its decisions free from our judgement and without seeking to influence either the judge or witnesses. In Aishwarya's case, witnesses will undoubtedly be called, so expressing views here in this place about what specifically should and should not have happened needs to be carefully considered because of the influence that might have on witnesses and the pressure that might be suggested to be brought to bear on the coroner and others. I caution members about that. It is not a prohibition against us speaking about these matters, but important principles underlie us not commenting heavily, or even in passing, on matters that are currently before the courts. Regarding Hon Nick Goiran's motion as amended, I am sure he has not fallen foul of that requirement. He is obviously very conscious, as a legal practitioner, about the sub judice requirement.

Following Aishwarya's death, the State Coroner undertook an investigation to determine whether an inquest should be held. This included consultation with the family to ascertain their views on whether an inquest should be held. As I said, in relation to Cohen, the State Coroner's decision was made before the Attorney General was aware that the family wanted an inquest to be undertaken. The State Coroner ultimately decided to hold an inquest into the death, and at no point did Aishwarya's family ask the Attorney General to direct that there be such an inquest. According to advice from the Department of Justice, no Western Australian Attorney General has ever directed a coroner to hold an inquest under the Coroners Act 1996. Although it is difficult to know whether such a direction has been made interstate, because these things are not often made publicly available, no examples have been able to be found of Attorneys making such directions in other states or territories. We are not talking about a circumstance in which there is a very well-worn path of Attorneys General—politicians—directing the coroner's courts in Australia to conduct inquests.

Hon Nick Goiran referred to reforms that are being looked at in this area, and he is correct. The Coroners Act is currently under review and a previous Law Reform Commission report was published in 2012 regarding the Coroners Act. If members are interested, I suggest they read the Law Reform Commission's report because invariably it does excellent, very comprehensive reports on these matters. One area that has been identified is the time frame arising from the section 24 notice of refusal, or the three months and failure to make a decision, which flows for the seven days that people have to make an appeal to the Supreme Court to review the coroner's refusal or failure to make a decision to hold an inquest. I think there is a general consensus that it is considered the seven-day time frame is simply too short. We are dealing with families that are in a deep state of grief. They have to come forward within seven days and make a decision about whether to expend what is usually a very large amount of money to appeal to the Supreme Court to challenge the decision of the coroner, and often the basis is quite narrow because the coroner is thorough in their approach. It is a bit rich to ask them to make that decision within only seven days. There is a view to increasing that period to at least 30 days.

This is part of a much broader reform project that is currently being progressed by the State Solicitor's Office in conjunction with the Department of Justice and the Attorney General's office. These wideranging reforms have been largely drawn from the Law Reform Commission's 2012 report titled *Review of the coronial practice in Western Australia*, as well as an earlier statutory review. It is worth noting that the Law Reform Commission did not make any recommendations on section 22(1)(d). It is not dealt with in the report in any detail and it obviously was not present in the minds of people in the community to seek further clarification or reform around the Attorney General's purported power under that section. It simply was not on the Law Reform Commission's radar as it undertook its significant review of the legislation and nor was it on the radar of the Department of Justice when it undertook its

statutory reviews into the legislation. Fortunately, in one sense, a statutory review is currently on foot. It is almost complete. It provides the opportunity for the Attorney General to specifically ask the Department of Justice to consider whether section 22(1) ought to be amended to avoid the confusion and false hope that it is currently giving. I have been advised that the Attorney General's office has today raised the matter with the Department of Justice and asked it to be included in the statutory review. On the basis that we have proceeded with a motion that the house can support, we can see that the Attorney General has asked the Department of Justice to include this, as is asked in the motion. It is my expectation that the department will bring an open mind to the questions and consider whether it is best for the families who are going through a very difficult time and navigating uncharted waters while considering the relationship between the courts and the executive. The statutory review will be tabled in this chamber, of course, once it is completed. Members will have the opportunity to debate any recommendations that are put forward by the department. Further, as we know, wideranging reforms to the Coroner's Act are currently on the horizon, so this chamber will again have the opportunity to debate, in detail, any proposed amendments to the legislation once they are brought forward. I once again express to the families of Cohen and Aishwarya my deepest condolences, and I commend the motion to the house.

HON TJORN SIBMA (North Metropolitan) [2.16 pm]: I rise to make only a very brief contribution to this very substantial and sensitive motion. I want to commend, firstly, my colleague Hon Nick Goiran for bringing the matter to the chamber's consideration. I also absolutely commend Hon Matthew Swinbourn and the Attorney General and the government more generally for working on an amended motion, which I think absolutely meets the public interest. It does so at a time of grief and confusion. Absolutely, I personally express my regret at the deaths of both children. I am a father of young children. Luckily for me, my children are in good health but I have spent more time in hospital emergency departments than I ever thought I would. I cannot ever contemplate the depth and darkness of the grief of these families. I can hope only that they find their peace. That is a peace I expect will be made—I hope it is made—in their own time. It is a reflection on the fragility of life. I would not condemn any parent here; we are all imperfect parents. We will always live with the shadow of doubt and regret because nothing we will ever do for our children will ever be good enough. I suspect that that feeling is felt amongst a sea of other feelings of the parents of both Aishwarya and Cohen.

What we can do in this chamber, I think, is deal with issues of great sensitivity and import in a manner that is befitting of the dignity and purpose of this house of review. I think a motion such as this reflects well on every single member. That is an observation I make of both the sentiment underlying this motion and its substantive point about avoiding the promise of false hope—of cutting through obfuscation and interpretation, which would allow a grieving parent to assume that there is some course or an appeal to higher power that will give them an answer to a question that might, indeed, be answerable in its full scope. Nevertheless, it also underlines the importance of the house of review because we should, wherever possible, review laws with the end user in mind. We could never possibly contemplate every possible contingency that may eventuate from the clauses and subclauses of the bills that we will pass in this parliamentary session. It absolutely behoves us to look at these laws with the end user in mind because none of our products—if I can use that terminology—will ever be perfect, but there are certainly improvements on drafts of bills that are presented through ministers by departments. Yes, these bills are drafted by expert public servants, but also by fallible human beings, and I think it is a reminder to us to discharge our obligations in a considered and judicious manner.

I look forward to, hopefully, some clarification or resolution around the different interpretation of section 22(1). I think it is absolutely vital, and I hope that that work can be undertaken expeditiously and thoroughly. I do not wish to detain the chamber any further with my contribution, other than to take a moment of reflection on what the full and true purpose of this chamber is. It is not to avoid issues that are difficult or that may generate, quite understandably, deep and almost uncontrollable reactions; we must deal with these issues in a sober and considered matter. I wish to commend, again, the contributions of both Hon Nick Goiran and Hon Matthew Swinbourn. Member, on behalf of—I think I can do this—this side of the chamber, I again wish you, Mitchell, Harrison and your wife, Glenda, all the best with your family's journey. We are absolutely with you.

HON DONNA FARAGHER (East Metropolitan) [2.21 pm]: I also rise to say a few words on the motion before us. In so doing I wish, as other members on both sides of the house have already done, to express my very sincere condolences to both families in their continued bereavement following the tragic loss of their children. I wish to align myself with comments made by the members who have spoken today, and I am sure also those who have not spoken, with regard to this very sensitive and tragic issue that we are talking about today.

It is certainly not my custom or practice to speak in this place on individual cases, and I think that is generally the case for most members—particularly when those cases are extremely sensitive or, indeed, complex. I agree very much with the comments made by the parliamentary secretary in that we have a responsibility, as members in this place, to always be extremely cautious in raising matters, whether it relates to children or adults, but perhaps most particularly when it relates to children. I am also very mindful of the fact that—respecting both matters—the case

of Cohen Fink is currently before the Supreme Court, so I will very much confine my comments. In saying that, I think it is important for me to say a few words, particularly as it relates to the Fink family.

In my previous role as the shadow Minister for Education and Training, the Fink family had corresponded with me over the past year or so. In that correspondence, they continued to express their very deep concerns and frustration. More recently, during the election campaign, I met with representatives from the group Accountability for Children in Education WA, to which Cohen's father, Chris, attended. Hon Sue Ellery indicated that the group has met with her office as well. After initially bringing their concerns to my attention, I wrote to the Minister for Education and Training. It was perhaps not too long after that, I believe, that the family made contact with Hon Michael Mischin. It was at that time that much of the correspondence and contact between the opposition and the family appropriately reverted to Hon Michael Mischin, given his role as the then shadow Attorney General, albeit that Michael continued to keep me and my office abreast of his advocacy. I, too, want to acknowledge, as Hon Nick Goiran has done, the significant efforts that Hon Michael Mischin made on behalf of the family whilst he was in this place.

Essentially, as Hon Nick Goiran has stated, the coroner determined not to hold an inquest and advised the family accordingly in January of last year. It was the view of Cohen's family, and it still is, that the decision taken by the coroner was not correct and did not adequately consider the available evidence. In response, the family requested—and this was supported by Hon Michael Mischin—that the Attorney General direct the State Coroner, pursuant to section 22(1)(d) of the Coroners Act 1996, to hold that inquest. That request remained with the Attorney General for some time. It was made, I think, back in February last year, and a formal response was provided to both the Fink family and Hon Michael Mischin in late October. As I understand it, on the same day that the letter was provided to them, the ministerial statement to which the parliamentary secretary referred was also released. It has been summarised and canvassed by other members already, but, essentially, within that statement, the Attorney General advised that upon advice from the Solicitor-General he effectively did not have the power to make such a direction, in part, given the timing of when the request was made.

I will say, and it certainly has been discussed here today, that that response has elicited a great deal of confusion and has created different views, if I can put it that way, with respect to the operation of the act. That is noted in part (c) of the motion that now is before us. In a debate held in this place on 10 November, Hon Michael Mischin said this in relation to this matter —

> Ultimately, the Attorney General informed the Finks by way of a letter dated 27 October, which was sent to them and to me, saying that he would not be directing the coroner to hold an inquest. The reason for that is essentially this: in the Coroners Act 1996 there is an apparent power for the Attorney General to direct the coroner. That power is unqualified. It says that he "may" do so. No limitations are placed upon it. The Attorney General's next point was that it has not been used before in order to direct an inquest. There had been inquiries interstate and research was conducted, and it was found that the power had not been used before in that manner in any other jurisdiction. There is no case in Australia in which it has been used in that way, but then, of course, there is no case in Australia in which it cannot be used in the manner sought. The conclusion that the Attorney General has drawn is that the power is not meant to be used in that way, but he has given us no reasoning about why not, other than, he claims, that it would be perceived as the executive overriding a judicial or quasi-judicial independent officer.

He went on to say —

> … the idea that it is because this clear power has not been used before in this fashion is not an answer. It is not interference in a decision; it is simply a direction to hold an inquest when the Attorney General has been persuaded that there is a public interest that the coroner may not have taken into account in their decision and that an inquest ought to be held, particularly if further evidence is acquired that was not before the coroner. I submit that the Attorney General's decision was wrong. That power is there for precisely that purpose.

It is not for me to say whether the perspective of Hon Michael Mischin was correct, and, certainly, an alternative view was put by the Solicitor-General and accepted by the Attorney General. But it is clear, even through that exchange, that there is confusion, which is felt by not only grieving families, but also learned former members of this place. There was further confusion following the Attorney General's response to a question asked by the member for Vasse in the other place. Essentially, he said—I will check the *Hansard*—that he could request the coroner to hold an inquest at any time. Perhaps the distinction is request versus direct but, notwithstanding that, I think we would all agree that that causes confusion.

Obviously, in amongst all of this, the family has made a series of freedom of information applications and has again sought—Hon Nick Goiran indicated this—an application for the coroner to undertake an inquest. Of course, as has been said today, an application is also with the Supreme Court for a request for an order for an inquest. With all this in mind, I simply say this: it is not for me nor, indeed, any member of this place to determine the outcome of that application in the Supreme Court or the outcome of an inquest should one be held. It is quite obviously clear that

the family wants an inquest to be held. Either way, this motion and the way that this debate has been handled today is important, particularly in view of the confusion that arises from section 22(1)(d). It seems, in plain English, that there is the ability to do that, but we have conflicting advice in that regard and that absolutely needs to be resolved. The fact is that the confusion is there and it is real, so I certainly endorse a commitment by the government and the Attorney General to urgently review this section in the context of a broader review. Certainly, gauging the comments made today in this house, it is one that the entire house endorses. It is important for grieving families to know what avenues of appeal are available and, in having a review, hopefully, we will be able to get that clarification.

HON JAMES HAYWARD (South West) [2.32 pm]: I also add my support for the motion. I pass on my condolences to both families who have been through absolutely tragic and terrible circumstances. I thank the opposition speakers today for their forthright honesty and sincerity in dealing with these very sensitive matters. I commend them for what has been shared in this house today.

Interestingly enough, whilst they are different examples of tragedy, there are similarities between the two families. One of those similarities is the difficulties each of them had after the incidents and their experiences in dealing with government agencies. One of the things I said in my maiden speech was that I honestly believe the government is here to serve the people; the people do not serve the government. It is our job to find a way forward to make sure that government departments serve the people. Two Western Australian families have been under tremendous stress, and no doubt continue to be, due to their experiences. They have had to struggle with dealing with the government to try to find a way forward to get the answers that they seek. That is not an uncommon situation. We all know that we can do government better; I have no doubt that that is why we are all here—to find a way forward.

I have thought about Cohen's family and the amount of resources and level of sophistication they had to use to embark on their journey to get answers. Quite frankly, many Western Australian families would not have the resources or the ability to find their way to the Supreme Court to fight for the right for an inquest, and that is why it is so important that we think about what is being done here with sober minds. We need to find a way that our community can be best served so that other people who perhaps do not have the resources, wherewithal or confidence to battle the system can find better outcomes for their families. We need to service them better as a government and a community, which, I believe, is our role and what we need to do. That is pretty much all I want to say. We need to get on with this as best we can. I am thrilled that there is support for this motion across the chamber because it has been made quite evident that it is really important.

HON DR BRIAN WALKER (East Metropolitan) [2.36 pm]: I thank Hon Nick Goiran and Hon Matthew Swinbourn for their contributions to the debate on the motion. I want to add a face to the debate today. We have been talking about the law as it applies to individuals who have suffered great distress. After the death of my father when I was 17, I recall accompanying my mother to lawyers and banks and the legalities of trying to access the money in the bank account of someone who was dead and could not sign the paperwork. The distress it caused was minor in comparison with the distress faced by these two families. I call to mind also—I cannot provide the names or the place because I do not have permission to do so—a mother whose son was unwell and sought help.

This happened in another state. The son presented to an emergency department in some distress and was discharged without treatment. He presented again and was in a terrible state. Again, he was rejected because the staff had too much to do; they were not as capable and as experienced as the staff here in Perth. Patients in some distress have been sent to emergency departments only to find that they are not listened to; they are given Panadol and sent away when what they need is something a whole lot more than a pat on the back and, "You'll be all right, my dear. See your GP." This young man was discharged from an emergency department a second time. The mother was deeply distressed and called the first responders to help. She then booked a flight. She drove from the country to Perth Airport and caught a flight to Sydney. She drove a car from the airport to her son's residence and arrived before the first responders to find her son's body. I remember blaming myself for killing my father because I put the cream into his coffee first. How much more do we, as parents, blame ourselves when something like this happens? We ask, "What more could I have done?"

I thank Hon Nick Goiran for bringing this matter to our attention. We need to make it much easier to access these results. I only hope that the result of a coroner's inquest is that we get some measure of responsibility and accountability and not what we see as a passing of the buck and a situation in which no-one is responsible in that never-ending circle. We hope that the families get some resolution and answers to their questions of, "What more could have been done?", "What more could I have done?", and, "What else could be done so that no-one else suffers this?" I ask that the coroner take this into account so that the families get some resolution. I commend the motion to the house and thank the honourable member who moved it.

HON NICK GOIRAN (South Metropolitan) [2.29 pm] — in reply: At the outset, I thank honourable members across the chamber for their expressions of support. It is greatly appreciated. I would like to hope that it will be of some very small comfort to families as they continue to experience their profound suffering and grief during their

time of bereavement. There are often few things that we can do as members of Parliament but if we can do this small thing collectively as Legislative Councillors, I am pleased that we can achieve that.

As we conclude this debate, I also acknowledge the remarks of the Leader of the House, Hon Sue Ellery, in her capacity as Minister for Education and Training, and her brief description of her experience engaging with the Fink family. I acknowledge that, quite rightly, the minister was unable to elaborate further because, as we both mentioned earlier, this matter is currently before the Supreme Court, and we need to allow that process to be fulfilled.

Further to my earlier remarks, I particularly want to thank Hon Matthew Swinbourn not only for his remarks today, but also for his cooperative facilitation of this matter over the last 48 hours. I note that he has once again helpfully brought his own personal experience to this matter, not only with respect to his son Mitchell but also to Harrison—two very different experiences. Like all of us, these types of motions and the two different elements of these cases make us reflect on our own personal experiences. I thank the member for that. I particularly want to thank him for his agreement at the heart of this motion; that is, this problem that has been uncovered is causing confusion and creating false hope. As I said at the beginning of my remarks earlier this afternoon, that is really the genesis of this matter. What has pleased me most about the progress of this motion this afternoon is that there seems to be a universal agreement that that type of confusion and false hope is not what any of us want; it is not one of the outcomes that we want from legislation passed in this place.

I also thank the parliamentary secretary for drawing our attention to the Attorney General's media release of 27 October last year. The Attorney General set out a precis of the advice that he received from the Solicitor-General, indicating that this power could only be used in certain exceptional circumstances. With respect to that media release, I agree with the Attorney General that it was prudent for him to obtain that advice; that is an appropriate course of action. As I said earlier, I acknowledge that the advice exists. I am not in a position to say that I concur with it.

Earlier, Hon Donna Faragher—I thank her for her comments as well—very succinctly summarised the position outlined by Hon Michael Mischin, a former Attorney General and former shadow Attorney General of Western Australia, whose view on this matter I prefer. I say that not in any sense because he is a former colleague of mine or a member of the Liberal Party. As some members who have been here for a long time would know, Hon Michael Mischin and I did not necessarily agree with each other on many occasions. I say that because I prefer his interpretation of the statute, which simply relies on the plain words that are there. As he mentioned previously, the plain words are there without any qualification. It appears, on the face of it, to be an unqualified power. He quite rightly drew to our attention that there is an absence of case law, which would suggest a different form of interpretation. That said, we still acknowledge and respect the advice that has been provided by the Attorney General. If that advice is correct and that is to be the preferred interpretation of the statute, it only further underscores the need for reform. Clearly, that is a matter that has the agreement of the Attorney General, hence his media release of 27 October last year. I note that that media release ends with this quote from the Attorney General —

> "An extension of time to appeal will be included in a package of wide-ranging reforms to the Coroners Act that are already in the drafting process and which I hope to present to the Parliament next year, if the McGowan Government is re-elected."

I look forward to the presentation of that bill. I note that the media release of October last year states that the drafting process is already underway, yet I note that the Coroners Act is currently under review—the statutory review is currently taking place. I thank the parliamentary secretary for the advice that today the Attorney General asked the Department of Justice to expressly consider this particular issue as it concludes its consideration of the statutory review. I confess that it is not readily apparent to me how the drafting process was already underway last year when there is a statutory review in train, not to say that the two things cannot happen concurrently. Certainly, they can. I would like to think that whatever bill is ultimately presented to the Parliament, including these proposed extensions of the time to appeal, as was discussed earlier, at the very least, if nothing else, this particular issue will be addressed. From my perspective, what cannot happen is for the status quo to remain. We cannot have a situation in which the statute continues to mislead and cause confusion. If it is intended that this power of direction is retained by the Attorney General, for example, for the reason that is provided in the media release—that he might be able to direct the coroner to investigate all coronavirus deaths in a particular aged-care facility without having to wait for the coroner to determine whether each death should be investigated—and that is considered to be reason enough to retain the power, we still need to make sure that the interpreted qualification of the power is placed in the statute so there can be no further confusion in that respect.

I also want to thank the parliamentary secretary for drawing to our attention the work of the Law Reform Commission. I think the work was done in 2012. Its report has, in part, been the genesis towards the upcoming package of reforms. I look forward to debating that when the matter ultimately comes before the chamber.

I also want to acknowledge and thank Hon Tjorn Sibma for his contribution. He recounted his experience as a father but, importantly, I acknowledge the points of bipartisanship in matters like this that he underscored and for all of us to avoid false hope for those of us in our community. What I particularly liked about his contribution, which

I think is a helpful reminder for all of us, is that we need to consider legislation with the lens being what it is like for the end user. The end user needs to be in mind. That is the point that was made by Hon James Hayward in his contribution. He effectively asked us: who has the means in our community to be able to launch these Supreme Court proceedings? It is all very well for a Parliament to create these so-called remedies in a statute but if these remedies are so impossible for the ordinary Western Australian to access, it is really no remedy at all. Perhaps that is once again a case for why the power of direction should be retained. Again, if that will be the case, it needs to be in plain, clear words so that we do not rely on particular interpretations by particular solicitors in Western Australia.

I also want to thank Hon Dr Brian Walker for his contribution to this debate this afternoon, his candid explanation or recounting of his own personal experience of his father's death, and his very honourable and humble recognition that the distress that he experienced at that time was not the same as what is being experienced by these families. He went on to explain another case he had been involved in with regard to the young man who had been discharged. I again appreciated very much the question he posed for us—the type of question that any parent in this situation would be asking. Members will recall that when we started the debate, I asked them to try, to the best of their ability, to place themselves in the shoes of the families. I think what Hon Dr Brian Walker said is quite right. We would all be asking the question: what more could I have done? In many respects, it is a difficult thing to reflect upon if you are a parent of a child who has died far too early—in the case of Aishwarya at the age of seven, and in the case of Cohen, as a year 12 student. It is difficult for those families and difficult for all of us to try to put ourselves properly in their shoes.

That said, I want to thank members for their support for the motion. I commend the motion to the house and I thank members for the way in which it has been handled.

Question put and passed.