STANDING COMMITTEE ON ESTIMATES AND FINANCIAL OPERATIONS

HEARINGS IN RELATION TO AGENCY ANNUAL REPORTS FOR 2010–11

TRANSCRIPT OF EVIDENCE
TAKEN AT PERTH
MONDAY, 19 MARCH 2012

STATE CORONER

Members

Hon Giz Watson (Chair)
Hon Philip Gardiner (Deputy Chair)
Hon Liz Behjat
Hon Ken Travers
Hon Ljiljanna Ravlich

Hearing commenced at 2.30 pm

MISCHIN, Hon MICHAEL
Parliamentary Secretary representing the Attorney General, examined:

HOPE, Mr ALASTAIR
State Coroner, sworn and examined:

The CHAIR: On behalf of the committee I would like to welcome you to the meeting this afternoon. Before we begin, you are required to take either an oath or affirmation. Could you please indicate to the committee clerk, who is just over there, if you would prefer to take the oath? There is a copy of the Bible there in front of you.

[Witness took the affirmation.]

The CHAIR: You will have signed a document entitled "Information for Witnesses". Have you read and understood that document?

Mr Hope: Yes.

The CHAIR: The proceedings this afternoon are being recorded by Hansard. A transcript of your evidence will be provided to you. To assist the committee and Hansard, please quote the full title of any document you may refer to during the course of this hearing. I remind you that your transcript will become a matter for the public record. If for some reason you wish to make a confidential statement during today's proceedings, you should request that the evidence be taken in closed session. If the committee grants your request, any public and media in attendance will be excluded from the hearing. Please note that until such time as the transcript of your public evidence is finalised, it should not be made public. This prohibition does not, however, prevent you from discussing your public evidence generally once you leave the hearing. I might ask whether you wish to make an opening statement or you would like to move on to questions.

Mr Hope: I do not really know exactly why I am here, so it probably would not be helpful for me to make an opening statement, but I am certainly happy to answer any questions.

The CHAIR: Thank you very much. Certainly, the committee has an interest in your most recent annual report on perhaps some questions with regard to the Law Reform Commission's report, just as a broad program. I am sorry if what we wanted to talk about was not clearer. Do members want to start with some questions?

Hon LJILJANNA RAVLICH: Mr Hope, I want to begin with the matter of annual reporting. There has been some concern that the annual reports for the last three financial years have been somewhat late. I wonder whether you could explain to the committee why that may be case.

Mr Hope: The last few annual reports: the annual report for 2008–09 was forwarded on 28 October 2010, the annual report for 2009–10 was forwarded on 20 October 2011 and 2010–11 was forwarded on 24 October 2011. In respect of the last two annual reports and the fact that the earlier one was also late, the situation was that, as you possibly aware, we have been absolutely snowed under with work and I saw my priority to providing a resolution for grieving families, to try to finish as many event files as I possibly could and to try to address the problems with inquests and so on. We have had some large inquests as well and I saw my first priority being to families. As I see the act, I realise I am breaching the act, but it seemed that I was breaching the act in a whole series of ways, which I have drawn to various people's attention and referred to in my various reports. I

have not been supplying an adequate coronial counselling service and we have not been able to administer the system effectively for a number of years. In that context annual reports seemed less important to me, particularly as since they have become more electronic rather than printed hard copies, we seem to get much less feedback and there did not seem to be a huge amount of interest in them either. Also with the annual reports, I take staff off their other duties to ensure that our figures are reasonably reliable. For a number of reasons we have had some IT issues and we have not really had an efficient file management system. We tended to require staff to actually go through hard copies of documents to clarify the total numbers at the end of the year, and I needed to pull somebody out of doing other work, which would have meant that every time I was going to do it, someone was being taken away from someone who was wanting to have probate or bodies being released for funerals and things like that.

The CHAIR: I will follow up on that. I just thought we also are mindful that section 27 of the act does not appear to actually include a time frame with regards to the production of the annual reports. Is that your understanding too? I am just interested because you said you were in breach of the act, but it does seem to have a fair amount of latitude there.

Mr Hope: I would have expected a reasonable amount of time to be inferred into the act and a reasonable time would not be over a year. Having said that, I have spoken to the Attorney about the situation and we have put in place arrangements to make sure that we monitor our figures so that we do not have to pull things together at the end of the year. Every month we are doing reconciliations so that this year I expect the annual report will come out straight away. Also, although the budget process has not been finalised, the Attorney General has recently advised me that a significant amount of new money will be provided to the Coroner's Court and that will enable me to set some time aside for myself to complete the own reports and make sure they are done properly. So, I am confident that the next annual report will be out within a month or so of the end of the financial year.

Hon LJILJANNA RAVLICH: Mr Hope, I must admit I have some concern with your comment that you try to get the figures reasonably reliable. What you are basically saying is that you operate two systems: you have an IT system that is not particularly reliable and then you have to back it up sometimes by going back to the manual source of data. Is that correct?

Mr Hope: Pretty much; we have never really had an efficient computerised file management system. Currently we are trialling a system from Queensland. The Queensland Office of the State Coroner has arranged for us to access its system and we are currently in the process of trying to change that system so it can accommodate the differences in Western Australia. Hopefully when that is done we will be more reliable with our figures. It is partly a matter of reliability and is partly a matter having someone to do audits to find out why there are mistakes in some of our figures.

Hon LJILJANNA RAVLICH: Can I just ask you, how can we then have confidence in the data that is provided—let us say the suicide data that goes off to the national body for inclusion in all those reports that are produced over there? Indeed, when the data is provided to the Parliament and through the Parliament to the people of this state, how can we have confidence in that data when it is only reasonably reliable?

Mr Hope: In respect of suicide data, I do not have any great confidence in figures until we have actually completed findings in respect of the various matters. That is one of the areas where there is an issue about the backlog, but with our annual reports—prior to the last one where we just indicated that matters had not been completed—we made an effort to try to determine, as best we could, reasonable figures for suicide rates by going through the ones that were actually finalised, and in respect of the ones that were not finalised, reviewing those to try to get some reasonably confident figure. Suicide rates everywhere are erratic. We are not the only ones that have problems with figures. It is a matter of interest and one of the things that often strikes me is the fact that police regularly release figures about the number of road deaths each year and, from our statistics,

their figures are always wrong; they are always low and usually by about 30 deaths per year. I think that is because we have never had an opportunity to get together and work out why there is this discrepancy, but what I assume is certainly a factor in it is the fact that there are a lot of people who survive accidents and die later. Unless major crash have been involved, police may not know that that person has died as a result of motor vehicle deaths. So when they say there were 180 motor deaths last year, it was probably really 210 or 220. But certainly that suicide rate is a matter—I mean, I mentioned a moment ago that we are getting some additional resources, which are new funding, which is terrific. One of my first plans will be to try to get on top of our administrative files, so that, from our office's point of view, we can be on top of those and give reliable suicide statistics as quickly as possible.

Hon LJILJANNA RAVLICH: Can I take you back to the tabling of the reports. You referred to them being—pretty much all three were, I think you said, given over or something in October—different dates in October.

Mr Hope: No, the 2008–09 one was October 2010, and the 2009–10 and 2010–11 ones were in 2011.

Hon LJILJANNA RAVLICH: But in the month of October, were they not?

Mr Hope: Yes.

Hon LJILJANNA RAVLICH: Does that mean you gave them to the Attorney General, because that is not the dates that they were tabled?

Mr Hope: No, that is the date of our letter forwarding them to the Attorney General.

Hon LJILJANNA RAVLICH: Yes, because the 2008–09 one was in fact tabled on 24 November 2010; the 2009–10 was tabled on 1 December 2011; and the 2010–11 was tabled on 1 December 2011. So you are saying you actually handed them over to the Attorney General's office and then it was his responsibility to get them to the Parliament?

Mr Hope: That is right. They are not usually tabled immediately. Even before, quite often our annual reports would sit for some months before they were tabled.

Hon MICHAEL MISCHIN: Madam Chair, can I ask a couple of questions which might clarify some aspects?

The CHAIR: Sure.

Hon MICHAEL MISCHIN: Mr Hope, just apropos annual reports generally, section 27 seems to provide that you are required to report annually. It does not say whether that annual period is to be calculated on a financial-year basis or a calendar year or whatever. How do you interpret that, or how do you use it as a matter of practice? What do you regard as annually in regard to reports for 2011 —

Mr Hope: We have been doing them on the financial year.

Hon MICHAEL MISCHIN: Financial years. So, your report for the 2010–11 financial year would be something you would table after 2011, but hopefully within a year of that financial year?

Mr Hope: Certainly.

Hon MICHAEL MISCHIN: Right.

Mr Hope: So I would hope that our next one will be tabled in July of this year.

Hon MICHAEL MISCHIN: Are those the only annual reports that were late or has there been a problem with annual reports generally?

Hon LJILJANNA RAVLICH: Madam Chair, I do not think we can have the —

The CHAIR: This is rather unusual to have the parliamentary secretary asking questions.

Mr Hope: But I can say the answer is yes, those are the first ones where we have got really late. The 2007–08—we sent that on 25 November 2008. So that was a few months late. Prior to that they were earlier.

Hon LIZ BEHJAT: We are a bit confused as to timings of when things are meant to be tabled. Parliamentary secretary, my understanding is that there is also a requirement that the Attorney General is required to cause a report delivered to him from the State Coroner—that the Attorney General is then required to table that within 12 sitting days of receipt of that report. Can you confirm, first, that that is right and, secondly—it seems that there has been quite a bit longer than 12 sitting days—what the reason for that has been?

Hon MICHAEL MISCHIN: Section 27(2) says —

> The Attorney General is to cause a report submitted under subsection (1) to be laid before each House of Parliament within 12 sitting days of such House after its receipt by him or her.

Now, as I understand it, the presentation of a report on 20 October 2010, I think—it was tabled, as I understand it, on 24 November 2010. I cannot tell you what the sitting days of Parliament were that year and whether it was within 12 sitting days of 20 October. The 2009–10, if I understand it correctly, was 28 October 2011, and it was tabled on 1 December 2011. Again, I do not recall what the sitting days were and whether it was within 12 sitting days. Likewise, for the one on the 2010–11 financial year—but 12 sitting days rather than 12 calendar days. It would depend on just when Parliament was sitting at that stage and whether it was done within that time. I am sorry that I cannot be more specific.

Hon LIZ BEHJAT: I just wanted to clarify that that was the case, and that was my understanding of it.

Hon MICHAEL MISCHIN: It seems to me that the act is a little bit ambiguous as to what "reporting annually" may mean.

[2.45 pm]

Hon LJILJANNA RAVLICH: I just want to quickly touch on the time to trial. In the budget papers, the time to trial for the Coroner's Court is currently 128 weeks, which is about two and a half years. Are you concerned, Coroner, that it is taking so long to come to trial? When we compare it with the Magistrates Court, for example, for criminal and civil matters the Magistrates Court is only 19 weeks; the Family Court of Western Australia, to finalise non-trial matters, is 27 weeks; the State Administrative Tribunal is 15 weeks; the District Court is 32 weeks; the Supreme Court, civil, is 19 weeks; and the Supreme Court, criminal, is 28 weeks. Here we have a situation that is totally out of whack with what is happening in the other courts.

Mr Hope: Yes.

Hon LJILJANNA RAVLICH: Can you enlighten us in relation to how much this is a problem and how we get over this hump?

Mr Hope: Time to trial is not actually all that helpful a statistic, but it does reveal what has been a grossly excessive backlog of our inquest cases that has caused me a huge amount of grief and stress over the last few years. I have been really personally distressed over the delays—the substantial delays in our inquest time. The time from death to the time of hearing is not really perhaps the most significant statistic. What I am really interested in is the time from when the case is actually drawn to our attention to the time of hearing. Sometimes there are various reasons for there being considerable delays. For example, a WorkSafe prosecution can take three years before we can actually inquest a case. But, significantly, the current stage has about 100 inquests in the backlog, and as coroners can only do about one inquest every two weeks each, there are a couple of years of backlog, and the backlog has been getting worse and worse for quite a few years. First, the reason

for that was that, initially, our recurrent funding was for only one counsel assisting—in fact, 0.8 of a counsel assisting. At the time when we only had one counsel assisting, we were trying to use police officers to do some of the inquest hearings. For example, particularly when the Ward case came on, our counsel assisting at the time, Felicity Zempilas, was tied up for a huge amount of time preparing that case—chasing through all sorts of issues, following various lines of investigation—and in the meantime the cases that were not being prepared for inquest were mounting. So we were not able to list the two coroners as much as we would have liked to. On the other hand, we were able to keep up with the administrative findings and the findings we do without inquest because our coroners had the time to do those cases. So our backlog of inquest cases grew and grew and grew. Then, in 2009, we did get some provisional funding. Before that we had provisional temporary non-recurrent funding for one counsel assisting. The problem with that was it was only on a 12-month basis, so if someone stopped before the 12 months we could not fill the position. If the person resigned in September, you would have to advertise the position for three months, which we could not fill of course. Then when the current government came in in 2009, we got some further non-recurrent funding that enabled us to recruit two further counsel assisting. We now have three counsel assisting—one permanent position and two non-recurrent funded positions—and those people are now preparing the inquests. On the other hand, we have only had two coroners and with the Christmas Island case and Operation Lantana, the Deputy State Coroner and myself were basically taken out of doing inquests for a substantial period of time. The number of inquests pending rose from an already unacceptably high level in the last year or two to over 100, which I would say we are sort of a year or two behind anyway. Yes, I am very concerned. But, finally, we actually have some funding, so we will be able to recruit two extra coroners, so with four coroners we will be able to run inquests on a regular and properly planned basis. With only two coroners, one of the other problems was that if one person was out—say, one person was on leave or ill—it only left us with one coroner, and that person was pretty much occupied with dealing with objections to autopsies, making sure bodies were released on time and directing post-mortem examinations and the like. The day-to-day work would, effectively, take that person out, so if one person was away we struggled to get any substantial inquests dealt with. This is something that has built up over a number of years.

Hon LJILJANNA RAVLICH: So you will have, with the new funding, four coroners?

Mr Hope: Yes.

Hon LJILJANNA RAVLICH: The second paragraph of page 9 of the 2010-11 annual report states —

> At the conclusion of the final financial year cases referred to a coroner which had not been completed amounted to 2,316 of which 845 were over 12 months old.

Mr Hope: Yes.

Hon LJILJANNA RAVLICH: That is a pretty significant figure, 2 316. Can you tell me, with four coroners, what sort of time frame will it be until that backlog is cleared?

Mr Hope: We have not appointed them yet, but I expect that we will be able to get rid of the backlog of administrative findings reasonably quickly. Just to give you a bit of an idea of the figures, in respect of the cases that have gone to our clerical section, where there is a draft finding prepared and the files are ready for a coroner to review and determine whether or not there needs to be an inquest and whether or not the evidence is sufficient to determine the matter if an inquest is not going to be decided, there are currently 327 of those over 12 months old. In respect of those cases, I would like to get that down to zero; I think we could probably do it within a matter of some months. I do not know exactly how many months; it depends on the people we get on board, when they can start and how we can go, but once we have four people going I would like to see that down pretty much to nothing. In respect of cases with the police, we have 236 cases that are over 12 months old that are with the coronial investigation unit in Perth, and we have 140 cases that are

with country police that are over 12 months old. I do not have a direct input into the police completion of the investigations—obviously the police have to complete their investigations before we can conduct ours—but I do know that the coronial investigation unit was recently allocated six additional staff. There were previously about 24, so that brings them to about 30, so that would enable them to start to knock back the 236. In addition, one of the problems they had was that although they were allocated the extra staff, with CHOGM a substantial number of the coronial investigation unit were taken off their work of completing files and started doing work for CHOGM, so the backlog they would have otherwise been addressing suddenly went up.

Hon LJILJANNA RAVLICH: How many were taken off police coronial investigation work to go across to CHOGM?

Mr Hope: Most of them.

Hon LJILJANNA RAVLICH: I have been to that unit, but I do not know how many there are. Would you have an indication of how many there are there?

Mr Hope: About 24.

Hon LJILJANNA RAVLICH: About 24 taken. For how long do you think they were taken off?

Mr Hope: I do not know, but things were still sort of turning over to some extent, but that certainly prevented them from addressing their backlog. But with the extra six staff they are going to have on board, I am expecting they will knock back a significant number of cases of their backlog. I am talking there about 376 cases of backlog that are over 12 months old, but the coronial investigation unit has a filing cabinet in which they put files that have not been allocated to people because they only allocate so many files to each officer. There are about 300 files sitting in that filing cabinet that have not been allocated. I could not say what the figure is today, but the last time I spoke to the officers in charge of the coronial inquiry unit, that was about it, so they have about 300 cases that are not even allocated for investigation.

Hon LJILJANNA RAVLICH: So they would have about 600 or 700 either allocated or unallocated?

Mr Hope: In total, for WA Police, I could not say exactly—probably more. I am talking about the coronial inquiry unit, and there are all the other police units that would all have files outstanding.

Hon LJILJANNA RAVLICH: Mr Hope, you do not have unallocated files, though, do you? All your files are allocated?

Mr Hope: Well —

Hon LJILJANNA RAVLICH: Do you have unallocated files?

Mr Hope: We do not use the same system that they do. Counsel assisting have all the inquest files allocated to them. In respect of our non-inquest files, they are all going through the office. For a lot of them, not much is happening.

Hon LJILJANNA RAVLICH: Why would that be so? Is it because there is no pressure from families?

Mr Hope: No, no. Even if we are going 100 per cent full steam ahead, which I hope will happen in the relatively near future—certainly if there is a proper review and we get more resources, it will definitely happen—even then there would still be quite a significant period of time when not much happens on a lot of files. We tend to have a lot activity at the beginning, shortly after a death, because as soon as a death happens we have to arrange the body transportation, which is part of our budget, and we have to organise the autopsies; we have to deal with objections to autopsies, and we have to make sure that the funerals all occur on time. That has been happening and there have been no glitches with that; that is our number one priority. But then after, when the investigation is being conducted by police, we do not usually have a great deal of input until the file comes back from the

police. So these ones that police have had for over 12 months, we might have chased them up one or two times if families have asked us about it, but the police officers have basically got the responsibility of getting the witness statements together and providing us with the investigation file. So there is a significant period of time when not a lot is happening. I mean, we are monitoring the forensic pathology, neuropathology, toxicology and so on, but while the police investigations are ongoing, the file is sitting with us and there is not much we can do about it. But we do try to have a meeting once a month with the forensic pathologists and the neuropathologists at the ChemCentre and the coronial investigation unit. We go through all the cases where a cause of death has not been determined to try to see if there are any glitches in the system that are delaying them. That is one of the procedures we have in place. In respect of the police files, if we do get more resourcing. I would like to see more directive input at an earlier stage of the police files. So if we can tell the police which files we would like to see more comprehensively investigated and which can perhaps be dealt with more quickly, that would help to direct their resources and hopefully help the police to complete their cases more quickly.

Hon LJILJANNA RAVLICH: I just want to quickly go to the "Review of Coronial Practice in Western Australia".

Mr Hope: The Law Reform Commission report?

Hon LJILJANNA RAVLICH: Yes. Page 17 states —

> Although in recent years the Coroners Court has received an increase in funding, this has been channelled into the task of reducing the very substantial backlog of coronial cases and inquests and no action had been taken to address the underlying processes and practices that may be contributing to problems experienced by the system.

Is that a fair criticism or statement, if you like?

Mr Hope: If anything, it understates the situation. With the additional funding we got in 2009—I can run through that if you like and explain what that was allocated to—essentially, that did not significantly impact on our outstanding cases anyway. We have been totally swamped by cases coming in, and that has prevented me from making administrative determinations to progress the way the Coroner's Court functions.

[3.00 pm]

Hon LJILJANNA RAVLICH: So you understood the inefficiencies were there in terms of process et cetera, but you just had no time to allocate to dealing with that as a priority.

Mr Hope: We have been reactive for a long time and we just react to the next disaster. But I certainly have a lot of thoughts about what we could do to improve things.

Hon LIZ BEHJAT: State Coroner, with your comments about being reactive as well, you mentioned that at the time of CHOGM police officers on the coronial investigation unit were taken from that unit and then put across to CHOGM. That obviously was a one-off event. I notice also in your annual report you talk about disasters, such as the SIEV vessel at Christmas Island. Obviously, then you had to drop everything and determine that. That had international interest and obviously we needed to find out what happened straightaway, so everything else gets put on the backburner. But is there any arrangement for your office—for instance, the coronial investigation unit had to leave their job to go off to CHOGM—when something like that happens, do you then get extra resources put into you for that period of time to help you then cope with your workload; and, if you do not, would that be helpful to you if that could happen?

Mr Hope: Well, it definitely would be. There were some arrangements put in place. We did get some temporary funding, although we did not really get temporary funding because the commonwealth reimbursed all of our costs for running the Christmas Island tragedy. So, some of the funding from that was applied to temporary funding for Mr Dominic Mulligan who acted as a

temporary coroner to do some administrative findings and so on, and we are hoping to retain him with this current money. But, essentially, there have been no proper plans in place to deal with these major issues and that is a big part of the problem. I mean, we were hit with a double whammy; because we now had counsel assisting, we actually took the opportunity to put on Operation Lantana, which was a case that had been bubbling away since 2005—that is, the multiple deaths from caesium chloride poisoning, which the Deputy State Coroner conducted because there were five deaths and people already had cancer and there were all sorts of issues about what their current medical condition was and whether the treatment killed them or whether they would have died anyway and so on. That was a hugely complex matter. So, we had that huge complex matter that was coming on anyway and then we had the Christmas Island thing as well. And, yes, there were no proper contingency plans, no proper plans for funding.

I am just about to go on leave, which I have notified the department of for over a year. I am going on leave for two months because I am starting to go a bit crazy. I am taking two months' leave and, under this funding that we are going to get, I understand that we will be able to appoint someone to replace me, but they just found out about it.

Hon LIZ BEHJAT: Because it seems to me that these sorts of things are natural disasters, basically. If, for instance, we look at the fires in Victoria or the floods in Queensland and New South Wales, all states then get together and go, "Okay, have some of our resources; we'll help you out". It seems to me that with these ones in particular with illegal entry vessels, they just happen to come to Western Australia, but they are really a national problem, not a Western Australian problem, so I would have thought surely then at that time we would be looking to other states to say, "We need extra people to come and help us during this time".

Mr Hope: Other states will help. We have a lot of interaction with the other states, so with the Queensland floods case, we sent people from Western Australia to assist with the identification of deceased people and so on. But, basically, only one person can be holding the inquest, and that had to be me. Basically, there had to be coroners in one jurisdiction determining which people were dead, in respect to the missing people whether it could be identified who those people were and whether they were dead. That again had to be our office; there was no mechanism by which we could have brought on board people from interstate. I mean, if there was a huge explosion—touch wood—or a plane crashed in Perth and there were multiple deaths here, all the other states would send in forensic pathologists and people like that to assist straightaway; those arrangements are in place.

Hon PHILIP GARDINER: Earlier you used the term "provisional temporary non-recurrent funding". I have not heard quite so many adjectives used to qualify a funding availability, but in a way it describes a little bit the service that you are offering because you are a responsive service. You use the word "reactive", but you are responding to other requests, are you not, all the time? Who is making those requests? It is the police on some occasions, but who else is making those requests of you in aggregate?

Mr Hope: Most of the time we are investigating on behalf of the community and we are investigating all sudden and unexpected deaths, so a lot of it comes from us; it is internal. We investigate cases to find out whether they are hidden homicides. For example, we have a number of sudden deaths that occur in hospitals as a result of adverse events and we investigate those to find out if there is something wrong. Sometimes you might inquest those of our own motion. Sometimes families write in to me and they say, "My mother went to hospital. She only went in for some minor surgery. She died. I'm not happy at all with the explanation given by the hospital." We look into that. We have the two general practitioners who work and share an FTE in our office, they give us advice about the hospital notes and we respond to the families. Sometimes we might conduct an inquest as a result of their concerns, but we are alert to all the concerns in the community. A number of people might write to me expressing concerns about, say, suicide in an area. Obviously,

we would pull out our relevant files and see if those concerns accorded with the evidence that we had obtained. But most of it comes from within; we have to have toxicology analysis, we have autopsies in most cases, police conduct an investigation. The presumption is that the death is suspicious until we have got enough evidence to be satisfied that there is a good explanation for the death.

Hon PHILIP GARDINER: So with requests coming in, do you have a categorisation of how many come from police or how many might come from a private individual like me, if my brother or mother went into hospital and so on, and how many you decide yourself? Do you have a rough breakdown of that?

Mr Hope: No. The act provides for reportable deaths and basically we investigate reportable deaths, so we actually investigate every case that is a reportable death. Reportable deaths are all sudden and unexpected deaths and they include all suicides, motor vehicle deaths, industrial deaths, accidental deaths —

Hon PHILIP GARDINER: And defined by whom?

Mr Hope: They are in the Coroners Act. The Coroners Act defines what a reportable death is, so we have to investigate all of those cases.

Hon PHILIP GARDINER: So that would not make it a very easy thing to outsource —

Mr Hope: No, no; outsourcing would not be appropriate.

Hon PHILIP GARDINER: — or getting any income. So, all the income that is going to be for your service has got to come from government?

Mr Hope: Yes; exactly.

Hon PHILIP GARDINER: My mystery is how you have got so far behind in terms of what you are able to do, and it just comes really from governments not listening.

Mr Hope: Obviously, there are all sorts of pressures on governments.

Hon PHILIP GARDINER: Yes, sure; there are competing needs, of course, and maybe it is because the people die. So then who are the people who are being adversely affected as a result of the delays? Is it relatives? Is that the main people who are being adversely affected?

Mr Hope: Clearly, the people that affect me most are the relatives and family members who are grieving and cannot get resolutions or cannot get answers. Sometimes there are delays and they take out probate and so on because we have not got a determination yet, so definitely there is a huge impact on the families of the deceased. But also we have a very positive side where we try to find answers or possibly make recommendations or comments that could prevent similar deaths occurring in future. I am concerned that we are not performing that function as well as we could either, so some of the deaths could have been avoided, if we could respond and give an answer and an explanation and a positive way forward earlier.

Hon PHILIP GARDINER: To improve practices or something like that be it wherever.

Mr Hope: Yes. Having said that, for example, just to give you an idea, in a medical death situation, a lot of families write to me in respect of deaths in hospitals. When they do, I consult with the general practitioners who work in our office and I write them detailed letters and so on. We send copies of the medical opinions, these are on cases that are not inquested, to the quality and safety section of the health department and they ensure that the message that comes from those cases goes out to the medical practitioners for whom they would be most helpful. They also put together a document, a little brochure, "From Death We Learn", which is a summary of some of these de-identified cases which they provide to every intern as they are learning their medicine so that they have an understanding of some of the current medical issues that we have become alert to. That is an important death prevention function that we have.

Hon PHILIP GARDINER: In a way, it is those recommendations that you make, which is the only efficiency you can actually bring into your service as I see it because it is pretty hard for me to see where efficiencies can be gained anywhere else. You have got to have a certain number of people to do the study to find out why people have died and so on or what caused the death. But I see in the cases in your annual report that you have got recommendations after each of those, so I presume that if those recommendations were taken up by the different departments or agencies or whomever, that is the only efficiency that you can bring to society in a way as a result of your work.

Mr Hope: We certainly bring a certainty; we bring confidence to the community that cases are being properly examined.

Hon PHILIP GARDINER: Sure, you give that, as well, I understand.

Mr Hope: Say, deaths in custody. One of the important functions we perform is providing for the community a comprehensive examination of deaths in custody to identify if there is anything about the supervision or treatment which may have contributed to the deaths.

Hon PHILIP GARDINER: But what stick do you have to wield to make sure the recommendations that you make have received some action, and sufficient action?

Mr Hope: To be honest, the most powerful stick that we have is the media; the media are very interested in our cases. If we have another case and our recommendations have just been ignored for no good reason, the person who has ignored our recommendations faces the risk of considerable adverse media attention.

Hon PHILIP GARDINER: It is the media and then the response by parliamentarians, if you like, in following it through, perhaps.

Mr Hope: There is a response which varies from government department to government department; sometimes government departments are responsive for a while and sometimes they are responsive for a considerable period to our recommendations and sometimes they do not support our recommendations. But the real power that we have comes through the media.

Hon PHILIP GARDINER: So in terms of the economic side rather than the social side, the efficiencies we get out of the service you provide is as a result of your recommendations being followed through sustainably.

Mr Hope: In respect of financial matters, yes.

Hon PHILIP GARDINER: That is what I say, in respect of financial matters. I see your recommendations are pretty varied and they relate to a whole range of different agencies often and other things as well, I know.

Mr Hope: Yes; that is right.

Hon MICHAEL MISCHIN: I understand that the coroner is dealing with it from a different aspect, but from a public policy aspect, the whole point of having a coroner is to ensure that there are no unexplained deaths and that society has a confidence that when members of that society do die, that that death is not unaccounted for. So, it is not a question simply of determining that there is a recommendation as to how you might fix it so that there is not another repeat. In many cases, you cannot fix the problem; people die under all sorts of circumstances. The important public policy consideration is that next of kin, interested members of the community, have some certainty that that person has not been the victim of a homicide or an avoidable death. I think about 97 per cent of the coroner's work is dealt with administratively by way of a finding on an investigation. I think about three per cent are a result of inquests and the subject of being responsive comes into that because you do not know when there may be cases worthy of an inquest, which is the full hearing of evidence and the receipt of evidence from witnesses and from examining witnesses. The Lantana one is an example; the other important one was the Christmas Island issue, which blew out the coroner's work by something like 50-odd cases, I think. So, there is that element.

About half of those that go to inquest, on average I believe, are those that are mandatory inquests under the act. Section 22 provides that where someone dies in care, such as a prisoner or someone that is in involuntary care, say, in a psychiatric hospital or in police custody, there has to be an inquest; there is no option of just dealing with it on the findings. So if you happen to have an unfortunate series of deaths in custody, then of course it is going to blow out the coroner's work significantly and affect any addressing of backlog. But as has been mentioned that has been addressed and there is going to be a substantial increase in funding to accommodate it in advance of the Law Reform Commission's recommendations being dealt with hopefully by the end of this year, which will form the basis for a plan for more permanent recurrent funding over a period of time for the 2013–14 budget cycle.

[3.15 pm]

Hon PHILIP GARDINER: Thanks.

Hon MICHAEL MISCHIN: Just on an aspect Hon Ljiljanna Ravlich raised about times to trial and the like. As the State Coroner has said, he looks at a criteria more meaningfully of time of death to time of hearing, if there is a hearing, or, presumably, the dealing with the inquiry. But times to trial—I mean, it depends on what you are measuring it from: from the time that the crime is being committed to the time that they get before a jury or a magistrate, or are you talking about the time that it is actually filed in the court—say an indictment is filed in the court—to the time that a hearing date is allocated? So there are all sorts of fuzzy figures in it and I am not criticising, but am simply pointing out that it is not a very precise measure as to what time to trial is.

Hon LJILJANNA RAVLICH: But it is one used by the government as a performance indicator. So I did not put it there and —

Hon MICHAEL MISCHIN: No, no, certainly. But what do you mean by time to trial—from the time the offence is committed to the time when it is disposed of?

Hon LJILJANNA RAVLICH: I do not know. Most people would think it was the time that they made the application to the time of the actual hearing. That is what I would have thought. That is a layperson's interpretation. But if you are saying it is nonsensical to have that as a performance indicator, perhaps —

Hon MICHAEL MISCHIN: I am not saying that. I am just saying that it is like comparing apples with oranges sometimes unless you are looking at the same criteria, because tribunals and courts and police investigations and coronial investigations and coronial inquests would be working on different triggering mechanisms.

Hon LJILJANNA RAVLICH: And I do not have a problem with that. If that results in some difficulty in terms of comparison, perhaps we should look at another indicator that is more reflective and there is greater truth in the indicator than currently exists, but —

Mr Hope: I think that is a very good point that you make. I think one of the things that I hope would come out of the review that will be conducted in the near future is that there would be some identification of sensible performance indicators. At present, the time they are talking about is the time of death to the time of inquest. And you mentioned the time when people write in asking for cases. Well, we quite often get people writing and asking for an inquest one or two or three years after the death. People often cannot come to terms with their grief quickly and we often get letters a long time after the death. I mean, that could be part of a performance indicator. In respect of what we do and the types of issues that we address, we were talking before about the recommendations and so on. If you take for example someone who goes jogging and falls over and passes away and there is no medical information immediately available to explain their death, that will become a coroner's case. In that case—when you are looking at the positive outcomes that there may be—we would conduct a toxicology analysis that might for example reveal a particular susceptibility to a type of drug. It might reveal problems in respect of the drug. It might reveal problems in respect of

a combination of drugs. So toxicology could enhance our knowledge generally to the good of society. The autopsy conducted might reveal a genetic problem. We get quite a few cases like that each year where an autopsy in respect of someone who has died in apparently relatively innocuous circumstances reveals some sort of genetic issue that has considerable impact for the family. We ensure that a doctor explains that to the family. And the rest of the family members may be tested to determine if they have the same genetic predisposition to disease. So there are important ramifications for the community generally in knowing what has happened.

Hon MICHAEL MISCHIN: Or indeed as to why that person was prescribed the drug in the first place, which might lead the coroner to a totally different line of inquiry.

Mr Hope: Yes.

Hon PHILIP GARDINER: Thank you for that explanation, Mr Hope; and, yes, parliamentary secretary, the confidence that society needs to have in why our citizens die is taken as a given for me, I am afraid. I was more interested in the kinds of remarks Mr Hope just made about what improvement we can make so we can reduce it. It just comes back to the direct costing, which is really, for the confidence, a matter of how many coronial people you have to help you.

Mr Hope: Yes.

Hon PHILIP GARDINER: And that is what I guess amazed me when I saw the record that we have.

Mr Hope: It is particularly disappointing for me in the sense that we are already paying for the forensic pathology, which is a very expensive part of the budget; we are already paying for toxicology in all these cases; we are already paying for the body removal and all those sorts of things—it is disappointing to me that we then do not pay that extra little bit to make sure it is all pulled together properly at the end.

Hon LJILJANNA RAVLICH: Just a follow-on from that: I have just picked up something from the Law Reform Commission. It says that there have been significant technological advances in the past 15 years in respect of the use of imaging technologies in post-mortem examinations and that Western Australia needs to be brought into the twenty-first century with legislative encouragement to utilise available technologies so that the least invasive procedures that are available and appropriate in the circumstances are used. Now they sort of paint a picture of us being out-of-touch dinosaurs and not going about it very efficiently. What is your comment in respect of that?

Mr Hope: In 1996 we were leaders in the coronial area, and we have just slipped downhill ever since. Compared to states like Queensland, we are considerably behind, but hopefully with this additional funding and the results of the outcome of the review that will be conducted, we will be able to pick up. The point that you make is again a very good one because that is one of the issues that we want to be addressing and that we need to address in the future. There is increasing pressure to move away from autopsies in every case. I mean, the idea of cutting open a body every single time is something that a lot of people find abhorrent for a start, for cultural and various other reasons. And with improved imaging, there is definitely an opportunity to move away from the autopsy. Part of that will require more direct input from the coroner's point of view. And this is one of the reasons that I am suggesting that improved funding is important. It is very difficult to have directive input in all of these cases as they are going if there are only two people looking after 2 000 matters. Obviously, if we are going to have direct input and say, "Look, in this case the imaging is satisfactory we don't want an autopsy", you have to specifically address each case individually. So there needs to be more directive input, and not just at the beginning and the ends as I was describing earlier. Forensic pathologists have been liaising with the radiology section at Sir Charles Gairdner Hospital and they are very supportive of our move towards more imaging. CT scans and so on are very expensive to run, but there now seems to be a lot of support from Health as well for our pathologists using radiology more often. I mean, this is something that we needed to move into and

that is why I want us to be in a reasonable position so we can go forward. There will be all sorts of issues because radiologists are not trained to identify issues relevant to death because they see only live patients. So there is a plan for some radiologists to undergo training in pathology to upskill them in that regard. In the United Kingdom the move has been the other way: to upskill forensic pathologists in radiology—it is cheaper apart from anything else. But there definitely needs to be an interaction between the two disciplines and that will involve the resolution of some very complex issues.

Hon LJILJANNA RAVLICH: Coroner, once again, you are saying it comes down to money. It is not a cultural problem in the organisation; it is fundamentally an issue with funding.

Mr Hope: No; we are definitely supportive of moving towards a change in that respect. We are fortunate in this state that our forensic pathologists are some of the more open forensic pathologists in the whole of Australia. In fact, we probably have some of the best forensic pathologists in Australia. I mean, there are some very good things happening, and our forensic pathologists are one of them.

Hon LJILJANNA RAVLICH: Madam chair, I just want to go back to the annual report.

The CHAIR: Which year?

Hon LJILJANNA RAVLICH: I refer to 2010–11. Once again, focusing on the work of the office, there has been an increase in the number of deaths that you are dealing with—2 743, which represents an increase of 163 over the previous financial year. Also, there has been a significant increase in the number of reportable deaths from 1 860 to 1 994. Are you concerned with the increase in the number of reportable deaths?

Mr Hope: The number of deaths that has been reported—well, I am expecting that the number of deaths reported would increase year by year. But in fact I still suspect that there is a considerable number of non-reported reportable deaths—that is, considerable underreporting of deaths—and that, if we were in fact better able to monitor what is happening in the hospitals, we would get more reportable deaths than appear here. At the moment, I am not looking for extra work, but one of the things I tried to do some years ago was to have a better monitoring system of some of the deaths going by way of death certificate in hospitals. Where they have been adverse events, it is clear that we are not picking up all those cases, so our figures are actually below the true number of reportable deaths.

The CHAIR: The onus is on the hospital and doctors at the hospital to fulfil their requirement there, so is the inference that that is not necessarily being met?

Mr Hope: Well, it is definitely what is not happening as well as it should. It is part—there are all sorts of complicating factors there. I mean, one of the factors is that people often pass away and there may have been an adverse event. The person may be in hospital for some time. They pass away at night and there is a totally different group of medical practitioners on duty, and those people do the processes and fill out the documents without necessarily being clear about the adverse event that occurred earlier—or certainly not alert to it. What I wanted to have in place was a form that would be filled out with every death in hospital—a form with tick boxes. The doctor has to tick a box yes or no and if there are any yesses that would be a coroner's case. That would force people to address the issue. But the Department of Health was not prepared to mandate that at the time.

Hon LJILJANNA RAVLICH: I think in fact that the Law Reform Commission had also suggested that the penalty for not reporting a death be increased to $12 000 as opposed to the current penalty of only $1 000 so as to, you know, make sure that people do the right thing. Clearly it has been identified as an issue.

Mr Hope: Yes. And the other reason is that because the fine is so low, the police are not interested in prosecuting anybody. We had a couple of cases. In one case the doctor put down on the death

certificate that the cause of death was poisoning. I mean, obviously, that is a coroner's case. It is not a natural cause death. And they did not even prosecute that doctor.

Hon LJILJANNA RAVLICH: They did not prosecute even that doctor?

Mr Hope: No; they did not prosecute.

Hon PHILIP GARDINER: That is the problem. Fines do not mean a lot unless you have something else really working to support the case coming up.

Hon LJILJANNA RAVLICH: Coroner, in—it must have been—March 2011, you attended a mental health forum at which you said in relation to the issue of suicide that the time for political politeness and political correctness and beating around the bush over suicide was long past, and that there were 290 verdicts of suicide made in WA that year. I asked a parliamentary question in relation to suicide figures based on the national coronial information system and relating to the coronial jurisdictional regions. The figure for 2010 was 295. Now a day or so later, the figure that you used in your speech was reduced from 290, and the figure of 260 became the figure that was being used in the media. I am wondering how we can get some better certainty wrapped around the information in relation to suicide data. As I understand, the state has a requirement to pass that information on to the national body, which takes that information from all the states and does what it does with it. But it seems that when asking in Parliament for information in relation to suicide figures that it is almost impossible to get a set of figures that makes any sense.

[3.30 pm]

Mr Hope: Well, ironically, our figures are probably about as good as they are anywhere in the world. This is one of the reasons I want to get rid of the backlog of cases that would be determined without an inquest, because if we can get rid of that backlog, it will significantly reduce the time. Deciding whether or not a case is a suicide can often be a very difficult task. Very few people leave suicide notes. Say there has been an overdose of medications that has resulted in death, we have to really scrutinise the evidence to conclude whether or not it is a suicide, or it could be an accidental overdose of medications, or we just cannot determine one way or the other. There are a lot of cases that fall into one category or the other. What tends to happen is that the first entry into the computer is made by a clerk who is just looking at the mortuary admission form, which is the information that police have when they arrive at the scene. The reasonably reliable information is the coroner's finding, ultimately, but we are just seeing here that we have 327 cases over 12 months old, and quite a lot of those cases are suicides, and we have not come up with a final determination yet. Once we can get rid of the backlogs, then we will get the decisions more promptly and then we will get reasonably confident figures about suicide, but there is always a bit of a judgement call on these sorts of cases, because it is so difficult to determine with confidence whether a death is a suicide or not. That is one of the other things I will be working with the other coroners on to try to improve our consistency between ourselves as to what we would call a suicide and what we would say is an open finding. Having said that, at least we actually do it, whereas in South Australia the coroners do not actually make a finding of suicide, so their suicide statistics are wholly based on the police appraisal, and their figures are more rubbery than ours.

Hon LJILJANNA RAVLICH: I know you have the backlog, given that so many cases are older; 845 are older than one year, from memory. They will naturally feed into the previous couple of years' statistics, depending on how old they are; I am not saying that they are all going to be suicide cases, but it may well be that five per cent or 10 per cent of those 845 cases could be suicides, and they will alter those figures. I am wondering whether you could give us a figure for 2010, and an up-to-date figure for 2011? The best figure I have, based on information from the Attorney General's office as at May 2011 is for people over the age of 25 years in 2010; there were 254, and under 25 years of age, it was 41, which gives a total of 295. I am just trying to compare that with the road toll, which was somewhere around 180-odd.

Mr Hope: Yes, the road toll every year has been less than the suicide toll, but as I said, with the backlog, as we deal with those cases, there will be more confident determinations coming through. If we have a backlog of cases that are over 12 months old, that means that for the last 12 months, you could not have a great deal of confidence in our suicide stats.

Hon LJILJANNA RAVLICH: I am wondering whether, if you take a question on notice, if you could provide the committee with that information?

Mr Hope: What information would you like?

Hon LJILJANNA RAVLICH: I would want the data—you will have to take this on notice—from the — It is the same question as question 3814, which was on suicide figures.

The CHAIR: Coroner, just to let you know, we will provide this.

Hon LJILJANNA RAVLICH: We will provide this in writing to you; you do not have to write this down. What we want to do is to get an up-to-date set of figures that we can basically work with that is an advance on where we were, I guess, 12 months ago.

Mr Hope: Okay. As I said, until we get completed files, I do not have great confidence in the numbers.

Hon LJILJANNA RAVLICH: Well, they will continue to change, but it is hardly likely that they will go backwards.

Mr Hope: No, they can, because it could be thought that death was by way of suicide and we might decide, ultimately, to make an open finding. That happens quite often, so the number could go down.

Hon LJILJANNA RAVLICH: But in terms of the information that has been provided to date, when we ask for suicide figures, surely you would not be providing figures that have not been determined one way or another, or you would not include in those figures verdicts of open findings?

Mr Hope: We are not including open findings, but what we are doing is giving you, as it were, a best guesstimate in respect of the cases that we have not done a determination for yet. Until we actually finalise the case, we cannot say with any great confidence that that was a suicide. When I analyse these suicide files—and I have read thousands of them now—some of them are obviously quite harrowing, but you analyse what the person's mood was, their background, whether there have been past suicide attempts. There is a whole raft of information that needs to be looked at. Sometimes you have to chase the police back up to find out if there were empty blister packs found near where the body was, if they have not reported that; that sort of information, to try to put together a picture that will give you a confident determination. As I said, in so few of the cases is there a suicide note or a positive, clear indication that the person was going to suicide.

Hon LJILJANNA RAVLICH: So when I ask the Attorney General to provide a breakdown of people over the age of 25 who died by way of suicide in each of the regional health districts from 2008 onwards, and he provides me with a firm set of figures, are you telling me that these are rubbery?

Mr Hope: Well, firstly, they are always a bit rubbery, but I think we make more effort than just about anyone in the world to make our figures reliable, and our figures are reliable at the time when the determinations are completed. In respect of the ones that are not complete, as I mentioned before, we have 376 police investigations more than 12 months old, so I would not place a great deal of confidence in all the cases where we have not even got a file.

Hon LJILJANNA RAVLICH: Let me put it to you this way: given that you cannot place confidence in the data, if I look at just that answer, it shows me that—these are rubbery—in 2008, Bunbury had 11 suicides; 2009, 14; 2010, 20; and 2011, 17. That is a lot of suicides in that regional jurisdiction. One might say that, as the coroner, you would then ask yourself what is going on down

there. You are saying that the figures are rubbery, whereas, certainly if I were in your position, I would be asking: what is going on down there? Shall we go and have a look at what is going on and what is causing this abnormality?

Mr Hope: One of the things we asked the NCIS to do is to provide us with a software capability to pick up—as it were, automatically—on clusters of suicides and other similar problems, and that is one of the things I would like to see in place when we get a much more improved IT system. Otherwise we are pretty much reliant on the local people in Bunbury; the local coroner might ring us up. Local people write letters to us, and we get a lot of letters from people advising us of problems like this. Ideally, the best way to do it is to have a software system that just picks it up, and that would pick it up based on — The figures may be rubbery, but they are clear enough to indicate that there is a potential problem there, and start pulling the files and seeing where they are actually at. That is what we did with the Kimberley cases; we had a letter from KALACC raising these concerns. We went and pulled out the files physically and had a look at them.

Hon LJILJANNA RAVLICH: Has anyone pulled out the files on Bunbury, just out of interest?

Mr Hope: I am not sure, but we are certainly monitoring suicide rates in country regions on a regular basis.

Hon LJILJANNA RAVLICH: Mr Hope, I wonder whether you could provide the committee with an update on what has happened in relation to these cases in Bunbury, and whether your office has actually done any analysis of what appears to me to be clusters? They are not just there; there is another cluster in Geraldton and it appears that there is another one in Albany. I am hearing about the south west informally from lots of people—about the real problems in the south west.

Mr Hope: Part of the complication there is the fact that our current system is based on the regions, so that the actual findings in respect of Bunbury are done by the Bunbury magistrates or Bunbury coroners. The magistrates there are acting part time as coroners and are actually finalising the cases and reviewing them. Kelvin Fisher is magistrate in Bunbury; I have great confidence in Kelvin.

Hon LJILJANNA RAVLICH: Well, can you get a report from Kelvin as to what he might think is —

Mr Hope: We would have those stats in our office now; I mean, the stats would come through to us, so I can give you those statistics, subject to the riders I have given you. We are trying as hard as we can to find out whether a suicide is actually a suicide, as against the United Kingdom; because they have these very short inquests into sudden deaths like suicides, there is huge family pressure to find that they are not suicides, so their suicide rates are grossly understated. We make a real effort to try to call it a suicide, even if the family might be upset by that.

Hon LJILJANNA RAVLICH: Mind you, there would be some cultures within a multicultural society, even in our community, that would not want a picture of suicide to emerge as a cause of death. I do not know how you deal with that, but I would imagine that our suicide figures may also be a bit undercooked for the same reason.

Mr Hope: There is definitely a lot of pressure in some cases to not make a finding of suicide. I quite often get statements from parents and so on saying that they do not believe that this was a suicide and that the person was happy beforehand, and all that sort of thing. Quite often people are concerned that a finding of suicide places some sort of blame on them; that they should have done more to prevent it from happening. It is a very difficult area. One interesting little blip that we picked up in the statistics was immediately after Bond's wife died, that week I think we had 14 suicides straightaway. I do not know whether it was publicity that was sympathetic to the deceased that encouraged people who were in two minds about taking their own lives, but I have not seen a blip as high as that previously with suicides.

Hon LJILJANNA RAVLICH: From our point of view, we have to get to a point where we have integrity in the data, because it so informs in terms of treatment, demand for services and a whole range of things.

Mr Hope: That is true of all of our figures; it is the same thing with co-sleeping and so on. It is very important that the people who are doing research into co-sleeping to know how many deaths are associated with co-sleeping. That is the sort of data that we obtain that is important for the community.

The CHAIR: I just have a question. We have talked a fair bit about the backlog and the resourcing issue. How do we compare with other states? We have talked about technology, and we are behind in that regard, but is this a problem common to all coroners' offices, or is this something that is worse in WA?

Mr Hope: Well, it varies. It is difficult to do a comparison state by state, because we are so differently funded and we have quite different budgets, so for some people counsel assisting comes out of the coroner's budget, for some of them it comes out of DPP's budget. We have talked about body removals and things like that; Queensland has been upgraded in respect of its resourcing since the Patel case. It tends to be that some sort of disaster prompts a reaction and better funding. Victoria is much better funded in respect of some aspects; my impression is that New South Wales may be keeping up to date with its cases and not having the backlog issues that we have, but in a lot of other ways it is a long way behind us. It is very difficult to make a meaningful comparison. Northern Territory seems to be reasonably well funded; Australian Capital Territory is completely different. In South Australia, they take a different approach. As I said to Hon Ljiljanna Ravlich, in South Australia they are not addressing the issue of suicides, and they are not making administrative findings in a lot of cases. So they are not providing a lot of the information that we provide. But, having said that, they are completing matters more promptly. So it is a very inconsistent picture across Australia.

[3.45 pm]

The CHAIR: So we are not comparing apples with apples, as it were?

Mr Hope: No. New Zealand changed their coronial system recently and injected a huge amount of money and a considerable number of coroners. I am not expecting a system similar to that one, and I do not think that that is an ideal system. But they are definitely hugely more resourced than we are. Queensland is better resourced. But New South Wales has practices that have been there from 20 years ago, 30 years ago.

Hon LJILJANNA RAVLICH: You may be in for a big surprise when you come back from leave!

Mr Hope: I am hopeful that we will be chugging along quite nicely by then.

The CHAIR: In terms of the complaints about the speed of resolution, do those complaints come to your office? Do you have a lot of those?

Mr Hope: Quite a few. I am surprised we do not have a lot more. If it was me, I would be complaining.

Hon LJILJANNA RAVLICH: Absolutely.

The CHAIR: I guess there is a phenomenon where if some people complain and nothing happens, it gets to a point where they stop thinking it is going to make a difference so they kind of just give up.

Mr Hope: A surprising number of people in the community are actually sympathetic to our position and understand where we are coming from. I try to be as honest as I can. If someone writes to me, I just write back and tell them what I think has happened; and if it is our fault, I tell them it is our fault.

Hon PHILIP GARDINER: That is why they are sympathetic!

Mr Hope: Yes.

The CHAIR: My understanding from reading the annual report is that at least half of the cases that are outstanding are because you are waiting on police work or other work. Is it obvious that that therefore means that more resourcing needs to be applied to those other areas as well—it is not just what is within your own control in your budget, is it?

Mr Hope: Yes. The backlog has been moving up and down the chain of production, as it were. Really, this is the first time the backlog has actually hit the coroner's office in the last few years. Previous to that, it was just dribbling through to us and we were keeping in control of things. But lately it has been us that have not been able to complete the cases. Previously with our office, it was no counsel assisting, and then problems with the office finalising cases and getting additional staff in the office, and office staff completing their work better. But police need to have plans in place to address their backlog, and I am confident that for some short period of time at least in the foreseeable future that will be addressed.

The CHAIR: I am not sure that you have addressed this, but in terms of the resources that you are anticipating, do you have a best estimate of when the backlog will be brought under control?

Mr Hope: In respect of the non-inquested cases, I would like to get that under control. As I say, there are 327 cases. I would like to get that down to a manageable number, 10 or whatever it is.

Hon MICHAEL MISCHIN: How long does it take to do each case?

Mr Hope: It varies in how long it takes to do a case. But we could get those out of the way in a matter of months. In respect of the inquested cases, we are talking about years of backlog, so even with the additional funding, with two additional coroners, if we can run two people full time, I am not expecting that that backlog will be eliminated in the next 12 months or anything like that. The backlog is still going to be very substantial

The CHAIR: It might be a matter of years rather than months?

Mr Hope: Well, there is going be some review of our office, and there may be some additional resourcing coming out of that. So that may impact on that backlog. Also, with some of our cases, some of them, frankly, are getting so old that the reason for inquesting them in the first place has diminished. So with some of the really old ones, we probably will eventually not inquest them.

Hon LIZ BEHJAT: Can you give us an example of a case—like, why has it been there for so long, and what is it, and why has it now diminished?

Mr Hope: There might be a case where somebody wrote to me and they considered that there were some recommendations that a coroner could make for death prevention purposes and so on, and I thought that was an appropriate reason to have an inquest, and then I have allocated it to counsel assisting. In a lot of these cases, there may be a lot of information that is not on the file—if the police file just focuses on the immediate circumstances around the death—and because we have not had counsel assisting, we have not been able to prepare that case and it has just been sitting there on the backlog, as it were, resting, and the issues may have been relevant two years ago, but in another two years, things will have changed. It may have been an issue to do with practices in health, but the whole hospital could be changed by the time we actually get around to inquesting it. So that case would fall out of the list.

Hon PHILIP GARDINER: What is the oldest case that you have on your list?

Mr Hope: Just to say those cases that are the oldest is not really that meaningful. Do you mean the oldest case that has not been resolved? It all depends on when you are counting and what you are talking about. We have got missing person cases that may relate to years and years and years ago,

and the case is subject to prosecutions where we have been waiting for various prosecutions to be completed. So there are a number of factors that can result in the delays.

Hon PHILIP GARDINER: So undiscovered missing persons, they are not in your numbers, though, are they?

Mr Hope: I do not know whether they are, but they should be.

Hon PHILIP GARDINER: The girl who went missing four or five or six years ago, is that a number in your statistics?

Mr Hope: I am not sure whether it is, but it should be.

Hon PHILIP GARDINER: It should be?

Mr Hope: In respect of missing people, suspected dead, we can make a determination that the person is actually dead, once we have an inquest. But we do not presently have in place an effective system of picking up all those cases unless people raise them with us. I think that is the Hayley Dodd case that you might be thinking about.

Hon PHILIP GARDINER: Yes.

Mr Hope: In that one, the mother has raised the case with us, and we have been monitoring it from time to time, but the police keep telling us that they are conducting further lines of investigation. So that is the reason that we have not inquested that to establish that she is dead.

Hon LJILJANNA RAVLICH: Have you ever had a case where you established that somebody was deceased and they turned out not to be?

Mr Hope: I have not personally, but that has happened.

Hon LJILJANNA RAVLICH: In Western Australia?

Mr Hope: Not in Western Australia, but there was quite a spate of them in the United Kingdom a while ago, where people allegedly went missing. In fact, the suggestion was that they had suicided. They would leave their clothes, go to the beach, wander off, and then 10 years later they would turn up.

Hon MICHAEL MISCHIN: There has been at least one case that I know of where it was found to be a suicide—I think it was well before your time, in about 1985—and it turned out later to be a homicide. A bloke and a woman came into a house to use the phone and ended up killing the occupant by drowning her. So sometimes these things change.

Mr Hope: There have been quite a few cases that have been believed to be suicides and that have turned out to be homicides, and sometimes they have been picked up by the forensic pathologist, and sometimes they have been picked up by us and the forensic pathologists and the police.

Hon MICHAEL MISCHIN: Theoretically I suppose the Corryn Rayney case would be one that is in the backlog in as much as the trial has not concluded yet.

Mr Hope: That is right.

Hon LIZ BEHJAT: I want to ask you to do a bit of crystal ball gazing. With the expected level of funding that you are going to receive in this forthcoming budget, and the way that you will be able to utilise that—where it seems that you will be given pretty much free reign as to how you want to allocate those funds—if we were to call you back in 12 months' time for a further hearing, do you think you will be painting a much rosier picture for us and you will be feeling a lot more comfortable about the levels that you have in your office?

Mr Hope: Yes, I am hugely confident. I would be very, very, very disappointed if that was not the case.

Hon LIZ BEHJAT: That is very good to know.

Hon LJILJANNA RAVLICH: Is this commonwealth money that you are getting?

Mr Hope: No. This is state funding.

Hon MICHAEL MISCHIN: I can reveal the figures if anyone is interested.

Hon LIZ BEHJAT: We shall sit with our fingers crossed and our breath bated!

Mr Hope: It is certainly enough to get the ball rolling and to deal with the backlog of admin findings and to start getting a really sensible system for planning. One of our problems with inquests is because of the fact that there are only two of us, and as I mentioned before, if one person was ill or something, things would fall away, because we tended to have spates where things were going madly ahead with the inquests, and spates where they were falling being, and spates where we were dealing with all the administrative files. So what we want to do is have a proper planned progress, with cases listed well in advance, and copies of statements provided to all the parties well in advance—that is one of the things that the Law Reform Commission has raised —

Hon LIZ BEHJAT: And no more disasters at Christmas Island!

Mr Hope: That would be helpful.

The CHAIR: Parliamentary secretary, did you indicate that you might have some figures?

Hon MICHAEL MISCHIN: Yes. I am happy to say what they are.

The CHAIR: Fantastic.

Hon MICHAEL MISCHIN: Just to put it in context, in 2009–10, as a result of the representations from the coroner, the sum of $822 000 was allocated for that financial year; and in 2010–11, the sum allocated was $641 000.

Hon KEN TRAVERS: Was this the total budget or additional?

Hon MICHAEL MISCHIN: This was additional funding. For the 2011–12, period, the sum allocated was $660 000; and for 2012–13, the sum allocated was $680 000. As I understand it, that is non-recurrent provisional funding based on the problems that the office has been experiencing and continues to experience. But although it has gone through the EERC, and the budget process has not been completed, the coroner has been assured that he will have, for the 2011–12 financial year—the one that we are currently in—an additional $509 000, and a further $1 015 million for the 2012–13 financial year, in addition to the figures that I have already mentioned. That, as I understand it, will provide for two counsel assisting, a court officer to assist in administrative requirements for inquests —

The CHAIR: Parliamentary secretary, I think you might just want to check with —

Hon MICHAEL MISCHIN: Sorry—for two coroners, and two counsel assisting. I will say that again. I am looking at the wrong one. It is two additional coroners, one principal registrar, and four administrative support staff. The other funding that I mentioned in past years was for the two counsel assisting; a court officer to assist in administrative requirements; a senior counsellor, bringing the number to three; a receptionist to assist in the administration; and funding for a medical practitioner to provide advice to the coroner from time to time. So the new funding that has been allowed will give us two extra coroners, one principal registrar to run the registry, and four administrative support staff; and the coroner has been assured that that will happen and that he can go and start advertising for staff.

Mr Hope: Can I just clarify those figures slightly? Certainly as I understand it, this is new money. So this is a new $500 000 for the rest of this year, and a new $1 million for next year. So that is going to provide us with the two coroners, support staff, et cetera. That is a huge benefit. To be accurate in respect of the past funding, there was a $200 000 one-off payment in 2009. In respect of the $600 000 that was provided in three different years, about $350 000 of that was new money in the sense that we were previously receiving non-recurrent funding in respect of some of those items.

I can tell you what the additional funding was for. It was funding for six staff, one of whom was a receptionist. Prior to that, we did not actually have a proper receptionist. We were using a trainee. We have about 20 000 calls a year. So there was a receptionist. We also got a senior counsellor, so our counselling service went from two to three. Prior to that, our counselling service had practically broken down completely.

The funding for the medical adviser was happening already. We were already funding a medical adviser but this regularised that and included a proper budget item for the medical adviser. In respect of counsel assisting, the $600 000 relates to—we were already previously getting non-recurrent funding for one counsel assisting, so we got additional funding for another counsel assisting and a court support officer. In new money, as compared with the previous government, over those three years, although there is reference to $1.8 million over the three years, there actually is about $350 000 in new money for three years. In addition to that, we are now actually getting $500 000 and $1 million. This is real money, and it is a huge difference.

[4.00 pm]

Hon MICHAEL MISCHIN: That is subject to the strategic review, I should add, which is flowing on from the Law Reform Commission's recommendations. Hopefully the strategic review will be completed in the last quarter of this financial year with a view to being able to plan for the following budget process after 2013. This is really provisional non-recurrent funding in terms of being able to tide the coroner's office over until the strategic review is finished and a proper budget assessment can be made.

Hon KEN TRAVERS: Will the additional coroners you are appointing only be temporary?

Mr Hope: Yes.

Hon KEN TRAVERS: So you are saying, parliamentary secretary —

Hon MICHAEL MISCHIN: By that stage we should have the strategic review completed in time for —

Hon KEN TRAVERS: And that will be the basis for a permanent ongoing increase in recurrent funding?

Hon MICHAEL MISCHIN: Yes.

Mr Hope: It is anticipated that prior to the funding being expended in the end of the financial year 2013, the review will be complete and recurrent positions can be appointed.

Hon PHILIP GARDINER: When was the last review into your funding?

Hon MICHAEL MISCHIN: There are supposed to be statutory reviews every five years under section 57 of the Coroners Act. The office came into being on 7 April 1997, so a statutory review should have been initiated by the then Attorney General in 2002 and another one in 2007, but neither of them took place. There is one due after 7 April this year, which should be the third statutory review but it will be in fact the first statutory review. The Attorney General is currently considering a recommendation from the department that that statutory review form part of the strategic review as well so that it can be dealt with as a job lot.

Hon KEN TRAVERS: I am intrigued by the impact of having acting coroners, as opposed to permanent appointments.

Mr Hope: Obviously I would prefer it if they were made permanent appointments because that would make it a lot easier to appoint someone, but it is a heck of a lot better than having nobody. We can appoint people and I am reasonably confident that we will retain two very competent people to do the work for the next 15 months or so. I am very confident that we will fill those positions with competent coroners who will address the backlog. I can tell you, they will be addressing it. There is no issue about that.

Hon KEN TRAVERS: Do not apply unless you enjoy hard work!

Mr Hope: I tell you what, I think I am fairly forthright in my opinions about that.

Hon KEN TRAVERS: In terms of the recommendations that you make as a result of an inquest, do you ever do follow-ups to see whether they are taken up? Whose responsibility is that? When you have made them, apart from issuing your formal inquest document with the recommendations in it, what then happens to them?

Mr Hope: When we make the recommendations, we generally send out a letter to each of the people to whom we have made the recommendation advising them that we would like a response, usually within three months, and when they do provide a response our plan, generally, is to put them in the annual report. That has, to an extent, fallen away for the work issues that we discussed earlier. Basically, it is only my secretary and I who do all this. One of the things we need to do is get a proper and sensible website up. When we get a proper and sensible website, our recommendations and responses to the recommendations can all go onto the website. Hopefully the responses will be in the annual reports, which you will get every year, and they will be on the website.

Hon KEN TRAVERS: Until that occurs, is there any way anyone can find out what the response to a recommendation was?

Mr Hope: Probably not really.

Hon KEN TRAVERS: Short of ringing your office and asking, from the sounds of it?

Mr Hope: No, they cannot.

Hon KEN TRAVERS: They cannot even do that?

Mr Hope: They cannot. One of the recommendations that we would make is that the website should be upgraded. I think the Law Reform Commission referred to that at one stage. A proper website would enable all of these sorts of things to be available to the community.

Hon KEN TRAVERS: I am glad to hear that because you see the recommendations but then it is hard to follow what happens.

Mr Hope: We try to promote our recommendations to everyone who needs to respond to them and make sure that they have copies, but as far as following through with the results of the recommendations, we are not really publicising that and we do not have the ability to do that except on a web page.

Hon LJILJANNA RAVLICH: I have one last question about the suicide data. The 2010–11 annual report outlines a loss of funding relating to the collection of suicide data arising from a change in approach to the funding by the Ministerial Council for Suicide Prevention. I wonder whether you could first of all inform the committee of the funding change.

Mr Hope: This is not something directly to do with my office but it has to do with a change. Mental Health was outsourcing the acquisition of data to the Telethon Institute. They changed to that to—sorry, the name of the organisation escapes me at the moment, but I can easily provide it to you. Anyway, there was a change in the organisation that was outsourced to acquire the data. You talked earlier about the quality of our data. Previously, the Telethon Institute retained a person who came into our office and read the current files. That was something that came before and was approved by our ethics committee, which is made up of good people in society who contribute their time freely. Someone physically came into our office and checked our suicide files. They used to refer to it as the Coroner's Court database and it was actually maintained by the Telethon Institute. Telethon Institute staff went through the files in advance of them being completed, but that fell away under the new funding arrangement.

Hon LJILJANNA RAVLICH: And now somebody else is doing it. It is not the Telethon Institute and you do not really know who it is.

Mr Hope: I do, but I have forgotten the exact name.

Hon LJILJANNA RAVLICH: Alright; we can get that. It seems that there are two sets of data: the data that you collect and the Mental Health Commission is collecting another set of data.

Mr Hope: The Telethon Institute was getting, as it were, an advance picture of what our data was likely to reveal in a better format, which was an excellent function that it performed. Because of the change in the funding arrangement there was outsourcing to a different organisation. I do not think that organisation built into its tender the resourcing that would be required to send someone around to our office just to check all these files. There was a further delay in accessing the data because it took them about six or seven months to make a proper application to the ethics committee before the ethics committee gave approval for the organisation to access the public data it was looking at.

The CHAIR: Page 15 of the annual report 2010–11 states —

> Eventually an application was received from a new group of researchers, the Sellenger Centre for Research in Law, Justice and Social Change, School of Law and Justice, Edith Cowan University, to access this essential data.

Is that the new organisation?

Mr Hope: Yes.

Hon LJILJANNA RAVLICH: Why can it come in as a private organisation—if it is a private organisation—to take data that has been funded by the public purse?

Mr Hope: It was creating it for the Ministerial Council for Suicide Prevention. It was being funded by government but it was an outsourced organisation. Anyone who wants to access our data has to make a proper application to our ethics committee, and it has very strict criteria that must be satisfied. The organisation must explain exactly how it will manage the data and what use it will make of it. Our ethics commit actually follows through with that and checks that the data is being properly used. The Telethon Institute came up with a proposal and viewed the files in our office—it did not take them away—and provided us with access to the results of its inquiry so we could be confident that everything was adequately de-identified.

Hon LJILJANNA RAVLICH: Thank you.

Hon LIZ BEHJAT: Parliamentary secretary, just so you do not lose any sleep over this issue tonight, I have done some calculations while I have been sitting here. You might be pleased to know that in 2010 after your department received the report, there were 10 sitting days as to when it was tabled, and in 2011 it was three sitting days, which is well within the 12 sitting days. I knew you would be worried about that!

Hon MICHAEL MISCHIN: Thank you, I can rest easy tonight!

The CHAIR: Picking up on the ethics committee, I noted in the annual report that there was a note that the ethics committee requires a substantial secretarial support that comes from the state coroner's office. Will this additional resourcing address that issue as well?

Mr Hope: It will not have anything to do with that issue. We now have three counsel assisting. That is probably not quite enough, considering that they have to do that sort of task as well. However, having said that, because the coroners were tied up for a number of months last year, counsel assisting are now quite a few months ahead of us in their preparation of cases. By the end of the financial year 2013, maybe we will have caught up with them, but they are that much ahead of us in their preparation of cases because they have something like 40 cases prepared for inquests. We have to inquest those plus the ones they will be preparing in the meantime. Counsel assisting does a lot of work for the ethics committee.

The CHAIR: So in a way that will catch up, as it were.

Mr Hope: Hopefully by the time the review that Mr Mischin is talking about takes places that situation can be addressed. Until then, I am not seeing it as a potential problem because we are so far behind them that we will be starting to catch up in that time.

The CHAIR: If members do not have additional questions, I have a closing statement. I do not think we had any additional questions, did we?

Hon LJILJANNA RAVLICH: There was one.

The CHAIR: The committee will forward that additional question to you via the minister in writing in the next couple of days, together with a transcript of the evidence, which includes any questions taken on notice. It is either a question on notice or an additional question; there is one more to come. If members have any unasked questions, please submit them to the committee clerk at the close of this hearing. Responses to these questions will be requested within 10 working days of receipt of the question. Should you be unable to meet this due date, please advise the committee in writing as soon as possible before the due date. The advice is to include specific reasons why the due date cannot be met. On behalf of the committee, I thank you very much for your attendance this afternoon.

Hearing concluded at 4.13 pm

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