COMMUNITY DEVELOPMENT AND JUSTICE STANDING COMMITTEE

AGENCY REVIEW HEARING — STATE CORONER

TRANSCRIPT OF EVIDENCE
TAKEN AT PERTH
WEDNESDAY, 12 OCTOBER 2016

Members

Ms M.M. Quirk (Chair)
Dr A.D. Buti (Deputy Chair)
Mr C.D. Hatton
Ms L. Mettam
Mr M.P. Murray

Hearing commenced at 10.06 am

Ms ROSALINDA FOGLIANI
State Coroner, examined:

The CHAIR: On behalf of the Community Development and Justice Standing Committee, I would like to thank you for your interest and appearance before us today. One of the functions of the committee is to review departments within its portfolio responsibilities, and from time to time the committee will conduct agency review hearings. The purpose of today's hearing is to discuss the operations of the court and some specific issues relating to your role as coroner. At this stage, I would like to introduce myself and the other members of the committee. Of course you know me, Margaret Quirk. On my right is Dr Tony Buti, member for Armadale; on my left is Ms Libby Mettam, member for Vasse; on her left is Mick Murray, member for Collie–Preston; and on his left is Chris Hatton, member for Balcatta. The committee is a committee of the Legislative Assembly of the Parliament of Western Australia. This hearing is a formal proceeding of the Parliament and therefore commands the same respect given to proceedings in the house itself. Even though the committee is not asking witnesses to provide evidence on oath or affirmation, it is important that you understand that any deliberate misleading of the committee may be regarded as a contempt of Parliament. This is a public hearing and Hansard will be making a transcript of the proceedings for the public record. If you refer to any documents during your evidence, it would assist Hansard if you could provide the full title for the record.

Before I proceed today, I need to confirm the following. Have you completed the "Details of Witness" form?

Ms Fogliani: Yes, I have.

The CHAIR: Do you understand the notes at the bottom of the form about giving evidence to a parliamentary committee?

Ms Fogliani: Yes, I do.

The CHAIR: Did you receive and read the information for witnesses briefing sheet?

Ms Fogliani: Yes, I have.

The CHAIR: This must be a strange position for you to be in. Do you have any questions in relation to being a witness at today's hearing?

Ms Fogliani: No, I do not. Thank you.

The CHAIR: Before we proceed with further questions, would you like to make an opening statement to this hearing?

Ms Fogliani: No. Thank you for the opportunity. I am here to answer questions, if I can.

The CHAIR: As you are aware, there are a few areas that we want to ask you about. The first might be in relation to administration of the court and resources. I note from your annual report that was tabled yesterday, in terms of backlog cases, page 3 states that of those 466 backlog cases, 323 where no further finalisations were possible as at 30 June were because the coroner was awaiting completion of the investigation. Can you let us know who has responsibility for doing that investigation or does it depend on the inquiry?

[10.10 am]

Ms Fogliani: It is a bit of both. It does depend on the inquiry, but, essentially, the 323 that I am talking about here are not inquest cases, so they are matters that would be going to administrative finding. The Coroner's Court operates as a court, but it also has the assistance of forensic

pathologists and the police, through the coronial investigation squad. Basically, some of those cases could not be finalised because either the forensic pathologist had not provided an opinion on cause of death. That means the police, in turn, cannot finalise their report to the coroner. That might be one reason. Another reason may be that it is still with the police awaiting completion of their investigation.

The CHAIR: Have you raised this issue with the commissioner if it is an issue with police?

Ms Fogliani: Yes, I have raised it.

The CHAIR: What sort of response did you get?

Ms Fogliani: It was a helpful response in that some further resources were allocated. I have raised it with the commissioner and the Chief Forensic Pathologist, because both areas need to be addressed. Then, for a period of time some additional resources were put into the coronial investigation squad in order to assist with the throughput of the reports to the coroner's office. Because I was expecting an additional throughput, I dealt with DOTAG and asked if I could have an acting coroner for a period of time. That was granted for a specific number of working days to deal with the anticipated increase in the throughput.

The CHAIR: From your answer it seems that that extra allocation of police resources was a temporary measure only?

Ms Fogliani: Correct.

The CHAIR: Are you now back in the position where you are again waiting a longer time for the reports to come from police?

Ms Fogliani: The reason the question is a bit complex in terms of trying to provide an answer is that we do not have a case management system. Whilst there are ways of identifying where cases are, at present it is not possible to track them. It is going to happen and you will see in the annual report it is on the way, but, at present, in terms of individual cases, I cannot put them into phases like it is still with the pathologist or still getting further investigation et cetera. I cannot put that all into a database and come out with an answer to say that some are over here and some are over there and this is where they are up to. At the moment, as I understand, yes, it was a temporary allocation of resources, now the reports have got to come through again.

The CHAIR: One of the other recalcitrants appears to be WorkSafe and that they are not getting reports through to you on time.

Ms Fogliani: That is a different issue with WorkSafe. That is not necessarily an issue with timeliness. WorkSafe have changed their practice, and they have dealt with me in relation to this. Essentially, historically, the coroner's office would get the WorkSafe investigation report. What is happening now is that public interest immunity attaches to that, and so the coroner does not get the investigators' reports.

The CHAIR: That is extraordinary.

Ms Fogliani: For me, I would prefer to be getting it, because, essentially, what it does is avoid reinventing the wheel. If we talk about WorkSafe, the issue is: do I wait for the WorkSafe investigation to finish, do I wait for that prosecution to finish, or do I not? I suppose there are two ways to look at it. You could say, "Yes, you should wait", but the law does not require me to wait. I deal with them on an individual basis and, obviously, we will familiarise ourselves with the charges to the extent that we need to; for example, is it a cause death charge or not? That might be something I take into account. We look at WorkSafe cases and we ask, "Can we finalise it in any event or is it appropriate to wait for the conclusion of the prosecution because it may materially affect how the coroner decides to complete it?"

The CHAIR: I think there are time limitations on when WorkSafe would bring a prosecution, as I understand.

Ms Fogliani: Correct—it is three years.

The CHAIR: Given your time frame at the moment and your workload, you would be probably commencing an inquest before WorkSafe had at least laid charges, if not the hearing?

Ms Fogliani: If it is going to inquest, it can also be finalised by administrative finding. Essentially, the instruction that I have given is that if it can be finalised, finalise it; if not, we will have to wait.

The CHAIR: From what you said about public interest immunity, it sounds like this is something that has only recently been asserted?

Ms Fogliani: As I understand it, it might have arisen shortly before my appointment or maybe some years before my appointment. Certainly, historically, the investigator's report was made available to the coroner's office.

The CHAIR: What is the rationale for the claim?

Ms Fogliani: It has been the subject of discussion. The rationale is that that becomes a report by the employee to the commissioner; it is an internal report.

Dr A.D. BUTI: Do you mean employer or employee?

Ms Fogliani: It is from the employee—so the investigator to his or her WorkSafe commissioner.

Dr A.D. BUTI: Amazing.

The CHAIR: I suppose, technically, the same could be said about police investigations. That is obviously something that needs to be addressed. Does that need legislative reform or does it need administrative reform?

Ms Fogliani: I have raised it in a legal forum. I think it is probably better that I speak in generalities. The issue is that it looks as if—possibly—my legislation might have to, by obvious intent, abrogate legal professional privilege, and that does not often happen. I think, essentially, in terms of raising it, I am satisfied that I have explored it as far as I can in terms of what the issues are. The fact of the matter is that we are still able to get the source evidence. So the witness statements and all those matters and exhibits still come to us and there is a process in place now in relation to obtaining those. What I am not getting is the investigator's report. I would rather have it. But if I am not getting it, we will keep going.

The CHAIR: I take it that the Attorney General is aware of this situation?

Ms Fogliani: That is a good point. The department is aware of that situation, but I do not know what representations have been made.

The CHAIR: To go back to the case management system, are you saying that there is money set aside for a case management system? What is the time frame on all of that?

Ms Fogliani: Essentially, what I have been advised is that it is on the way.

The CHAIR: The cheque is in the mail.

Ms Fogliani: It is a bit better than that, I hope. I am told that it is going to commence in the latter part of the next reporting year. We are close to, I suppose, the top of the list in terms of the next agency to get a case management system. It is certainly something that I would like to have, because, first of all, in terms of management, it would really optimise how I can do that. But also in terms of responding to queries and getting statistics and letting people know where matters are up to, it is invaluable there as well.

The CHAIR: If someone rings up and asks what is happening with a particular matter, does that mean somebody has to physically go and get the file and see where the hold-up is?

Ms Fogliani: Yes. At the moment, you can certainly make a very basic computer search, so you can see whether the file is open or closed or whether the coroner has made a finding or not. They are very specific things that you can see. If you want to find out whether it is in an investigation phase or what phase it is up to or who essentially has responsibility, whether it is allocated to a coroner or still with a counsel assisting or whether the principal registrar is looking at it or whether it has gone back to the police for further investigation or whether there is an outstanding request to the pathologists, or any of those sorts of things, you have to pick up a file and look at it.

[10.20 am]

The CHAIR: You are required or you are part of a national system that gives information to, I think it is a national coronial —

Ms Fogliani: Yes, it is NCIS—the National Coronial Information System.

The CHAIR: Again, does the lack of a case management system hamper you being able to give returns to that database?

Ms Fogliani: No, it does not, because once the cases are finalised, the officers in my office can enter the salient details, and then they become available to the NCIS. Also, I should add, certain other information on open cases is also made available, but it is very basic information.

The CHAIR: There seems to be ongoing discussion about the need for additional coroners and you gave evidence that you were given an acting coroner for —

Ms Fogliani: Twenty working days.

The CHAIR: Is there any light at the end of the tunnel in terms of getting additional coroners?

Ms Fogliani: That is a good question. I had not formally asked for another, if I could call it, permanent coroner or coroner on staff. There are a few things, I suppose. Obviously, in the ideal world, I think everybody would like more resources. I think I also have a realistic appreciation of what the possibilities are all-round. It would not be a matter of adding a coroner; you would also have to add a counsel assisting and a JSO. There would be a fair bit that we would have to do. Perhaps it might be the appropriate time. In terms of the Law Reform Commission's review, there are some recommendations in that review that I have highlighted to the department and to the Attorney that I think would really streamline the coronial process and probably shorten, but properly shorten, certain types of coronial investigations so that we could focus in a better way on the ones that require the focus. I am happy to talk to you about that.

The CHAIR: Just off hand, can you recall some of the key ones in that context?

Ms Fogliani: There are two recommendations— 55 and 56. Essentially, what recommendation 55 is doing is looking at different types of deaths and asking, "Is it necessary to do a full investigation?" In relation to recommendation 55, I have not suggested or recommended that it be adopted in its entirety because it would require amendment to the fundamental wording of section 25. But a variant of that I have recommended. Basically, what I am saying there is that I think there are cases where the coroner does not need to find all the circumstances attending the death if there is no public interest in doing that. Basically, if we are looking at the major findings, it is cause and manner of death—cause and then how. "How" is all of the circumstances attending the death. That is what results in the greater investigation. If you have a case where obviously the person was not held in care, there is no need for an inquest. It is not a mandated inquest; for example, with cases of elderly people who fall and die shortly thereafter and therefore the fall may be referrable to the death and it becomes a reportable death. What you then have is that the pathologist will obviously look at that and give an opinion. The pathologist's opinion may eventually be, "In my opinion the death was due to coronary artery arteriosclerosis", in which case the fall is not referrable to the death. Do we then need to look at all of the circumstances attending the death and have the police conduct an investigation if, in fact —

The CHAIR: If it is an underlying cause of being —

Ms Fogliani: Yes, and I suppose if I can put it in that broader sense, you have to look at is there a remaining coronial concern. Obviously, then I would have to have guidelines in relation to what types of matters. I have been asked if I would do that in relation to, say, suicides. I say no; suicides are very complex and the public interest would always, to my perspective, require that you look at all of the circumstances attending the death. But there are a range of cases where I think quite properly there would be a point, an early stage, with a well-focused coronial investigation, that there would be no further coronial concern. That would mean that essentially the police are not conducting those full investigations.

The other recommendation is recommendation 56. These are based, I should say, on Victorian legislation. We have had discussions with Victoria. At my level, at principal registrar level, I can see that they work. Somebody was asking me if there is a risk to the community. I would say no. We would be very careful with it in terms of when you are minimising coronial investigations because coronial concern is very important. The other one is that you can discontinue if the only reason that the death has been reported to you is that it is unexpected, because deaths are reported when they are unnatural, unexpected or arising from violence or injury et cetera. If the only reason that the death has come to the coroner is that it is unexpected, and the pathologist can essentially give a cause that is consistent with a natural cause—for example, coronary artery atherosclerosis or a range of other natural causes—plus one more step: that the pathologist himself or herself states to the coroner that in their opinion the death was due to natural causes. So this is taking the pathologist a step further. I have discussed it with the Chief Forensic Pathologist and he essentially thinks it is doable in that they could do that, so, essentially, what would the pathologist do? In addition to looking at that, you look at the body, you check that there are no injuries, you look at the circumstances. You might look at the medical records and, in terms of the pathologist, satisfy yourself that the pathologist can tell the coroner that, from their perspective, this is consistent with natural causes, in which case the coroner will say, "Do I need to take this further? Is there a remaining coronial concern?" In terms of these cases, they will all be looked at individually and very carefully. If these two, for example, that I have highlighted are implemented, essentially, I think then the processes can become more streamlined and more effective. I would then be saying that I would be reluctant to talk about increasing resources if in fact these matters might alleviate the issue.

If I can add that one other matter that I have asked for is essentially for WA to have a dedicated CT scanner for the pathologist. That would be in line with the Law Reform Commission's recommendations. I essentially recommended that you use the least invasive process in terms of conducting a post-mortem examination.

The CHAIR: So what happens now? Does the pathologist have to queue jump on live patients or something?

Ms Fogliani: If you need a CT scan, you need a CT scan, but essentially what is happening is that you do a full internal post-mortem examination. What I am saying is that you might be able to avoid that by conducting a CT scan. That would be, I think, an excellent thing all round. In terms of where that is up to, there is a business case currently, with input from the department, that was submitted to the Department of Health in relation to the acquisition of a dedicated CT scanner for the pathologists.

[10.30 am]

Dr A.D. BUTI: This is slightly different, but I refer to section 26A of the Coroners Act, which is about access to evidence. Of course, you know it, but just for the sake of Hansard, it reads —

> If the senior next of kin of a deceased person asks a coroner for access to evidence obtained for the purpose of investigating the death, the coroner is to give that person access to that evidence, unless the coroner believes it is not desirable or practicable to do so.

I want to refer to a particular case, which you probably will not recollect and you may have to take this on notice. It relates to the death of Dale Stephen Plaziuk in 2012 as a result of a gunshot wound to the head. No inquest was conducted. His mother has been trying to access the evidence that your office has, and I believe she was accompanied at one stage by the Commissioner for Victims of Crime, Ms Hoffman, who I am led to believe is supportive but I do not know that directly. The mother, Michelle, has been telling me that she has not received any reason why she is denied access to the evidence. There is no ongoing criminal investigation—that has been dealt with—so I am just wondering if you can, maybe—I am sure you cannot provide that today but —

Ms Fogliani: I think the better thing to do is for me to take that one on notice. I am aware of the name because it was drawn to my attention yesterday, but hearing from you at present that the mother feels she cannot get—are you saying any access to the evidence?

Dr A.D. BUTI: Well, yes. I do not think she has not spoken to you directly, but she has been to your office a number of times and made telephone calls, and she said that she is unable to access the documentation. She said particularly that she would like to have a look at anything, obviously, that your office has, but anything with regard to the forensics, ballistics, police statements or the statements of witnesses to the actual shooting. They are the specific things, but obviously she wants to look at anything that your office has and she is telling me that she has been unsuccessful with that.

Ms Fogliani: All right. So Mr Plaziuk's mother has attended the court but has not actually been able to see these documents. All right. I will take that on notice.

Dr A.D. BUTI: Thank you.

The CHAIR: Just in general on that, we also have an inquiry that police have been approached to release their material, just generally, and they have been told that they are unable to release any information because of a coronial direction to police. Although the family can access a coronial file, police are saying that they cannot release additional material because there is a direction from the coroner. Are you able to say what particular direction is in place that would prevent the police from releasing any information?

Ms Fogliani: I will have to look into that. I think that it may relate to FOI—whether the court is subject to freedom of information—and it may relate to essentially the fact that coronial information is seen as essentially the court's information, irrespective of whether it is sitting at the court or sitting somewhere else. I would rather provide a better response on that.

The CHAIR: So if it is an issue, it might be an issue with FOI rather than you having formally given a direction to police not to release information as a matter of course.

Ms Fogliani: Yes. I would have to check that; I really would have to check that.

Mr C.D. HATTON: With regard to getting things progressed in a timely fashion, and being seamless and streamlined—it goes back maybe to resourcing—do you have a level of frustration with certain departments? It seems that you rely upon a number of departments. Do you have a level of frustration and maybe you could highlight something with WorkSafe, when WorkSafe may take up to three years to get something back to you. It is a very broad question.

Ms Fogliani: It is a broad question. I have to say the working relations are very good.

Mr C.D. HATTON: I was going to mention the working relations, if you could highlight something there.

Ms Fogliani: The working relations with the pathologist and the toxicologists are very good. They are very responsive to our queries—call back, keep us advised. I find them extremely helpful not just in terms of their reports to the coroner—very detailed reports to the coroner; obviously, they come and give evidence—but also ad hoc queries and telephone calls. They are very helpful to my office. It is the same with the toxicologists. It also has to be said that a lot of this I think is also due to there are regular meetings, there are meetings at my level, there are meetings at the principal registrar level et cetera, so people are generally talking about cases. That then facilitates the flow of information and the flow of cooperation. The service that I get from the CIS, the coronial investigation squad, is very good. Essentially, if I look at what we have had to return to them for further investigation, over a period of time that has reduced and they get used to us and we get used to them. As far as I am concerned, the quality is good; it is very satisfactory. From my perspective, they are doing as much as they can.

Mr C.D. HATTON: WorkSafe?

Ms Fogliani: WorkSafe? The only issue I have is that I really would prefer to be getting the investigation report, if I could. I am not privy to all of the reasons as to why they feel they cannot give it to me, and there may well be valid reasons. Other than that, what we have then established is a process between my office and WorkSafe—between the coronial investigation squad officers within my office, dealing with them in relation to exercising the coroner's compulsion to obtain documents. They make them available, obviously as they should. They help us in terms of letting us know what is there, but it is limited to the source material now. I do not have a general frustration over the three years, because I do not feel myself obligated to wait. That is not causing me that sort of frustration. If I can turn to section 53, where the law asks me to wait, I am not to hold an inquest when a person has been charged with an offence where the cause of death is an issue. They are not all the WorkSafe charges in any event, so I guess it depends on what perspective you take. If you take the perspective that you cannot do anything until WorkSafe finishes, then obviously I think you would experience frustration. I do not take that perspective; we will go ahead, unless the law requires us to wait because of section 53.

The CHAIR: Quite often the inquests that you are dealing with are of great public interest, and organisations—for example, the Deaths in Custody Watch Committee or something—might want to access transcripts or exhibits before the coroner and they do not have necessarily a great amount of financial assets to pay for the page-by-page transcript or something. Is there any capacity for them to access or get copies of the transcript or other material without having to, such as in other jurisdictions, you can apply to the coroner and get copies of them as exhibits and transcripts?

Ms Fogliani: I think I might start there by saying that there are different provisions in other jurisdictions. For example, Victoria has got section 115. It is actually a section that I have recommended we adopt, if possible—something like that for WA. One of those provisions allows the coroner to provide information in the public interest, so it is there by statute. We do not have that. Bear in mind also that the transcript has got copyright in relation to it, so the coroner cannot copy it and hand it out either. The other issue that I have to take account of is: are you an interested person or not? Essentially, when the entity becomes an interested party, or an interested person as per section 44 and regulation 17, then they become a party to the proceedings and things then flow from that in relation to provision of transcript and access to the brief and access to the exhibits. In some instances, it could be that they are an interested party, but it could be that they are not. If they are not, then they are not really a party to that coronial inquest.

[10.40 am]

The CHAIR: So you might have a situation where, say, counsel acting for a family has the right to appear, but they are not given the right to cross-examine witnesses.

Ms Fogliani: Counsel for the family?

The CHAIR: Yes. Are there any situations in which that happens?

Ms Fogliani: It should not happen because under section 44(1), an interested person—if we look at regulation 17, a mother, father, children et cetera, family members are an interested person—may appear or be represented by their lawyer at an inquest and examine or cross-examine witnesses. They can do that, but then it is up to the coroner to decide on relevance so that is an issue. Whilst they are there, if we take that into section 44(4), the coroner can disallow a question on the relevance test, but they have the right to appear and be represented and examine and cross-examine.

The CHAIR: You mentioned amendments to the Coroners Act, the regulations and the court rules. I gather that that is in progress. What stage is that actually at?

Ms Fogliani: As I said, in the annual report, the briefing note had gone to the Attorney General. It has been approved and, as far as I understand, it is in the process of moving towards implementation. But I might not be the best person at this point to ask exactly where it is up to.

The CHAIR: If I was in your position and I got very frustrated that there are inadequacies in the legislation or what have you, what is the process? Do you go to the head of DOTAG and say, "Can you talk to the Attorney about this?" Do you have regular meetings with the Attorney? How is it that you are able to address these issues?

Ms Fogliani: Yes. Essentially, what I am able to do is discuss direct with the Attorney. For example, there are 113 recommendations arising from the Law Reform Commission report that are being considered. I am now saying that two of those, recommendations 55 and 56, could really assist the coronial process, assist with streamlining and I have asked that they be advanced. That is currently under consideration.

The CHAIR: But the 113 —

Ms Fogliani: The 113 are still in train.

The CHAIR: Yes, and they have been around since 2014 or before that—2012.

Ms Fogliani: Yes.

The CHAIR: There was a media report in March this year that indicated—I am just slightly changing topic—that you would be holding an inquest into suspected Indigenous suicides across the Kimberley and Pilbara. So, you would be reviewing a number of suspected suicides and were determining that you would be looking at them at one inquest. I wonder where that is at. That was in March this year.

Ms Fogliani: Yes. Where that is at is that the evidence is currently being gathered for me. People in my office are working in relation to it, and that includes counsel, the police officer, the medical advisers at critical stages given to me for review in order for me to give direction and instruction if I need to.

The CHAIR: Some time ago, this committee made a recommendation that there be, if you like, a bit of running a list that is publicly accessible of recommendations.

Ms Fogliani: Yes, I saw that—"In Safe Custody".

The CHAIR: If, for example, you have 15 cases over three years involving kids drowning in a swimming pool, there might be recommendations about fencing or council enforcing fence laws or other things. It seems to me that those inquests are kind of one-off and there is no reference to previous inquests where there might have been recommendations made but were never actioned. Is that an accurate assessment of —

Ms Fogliani: I think you raise a good point. It is a point I raised when I started in my office, because, essentially, how do we ensure that you are not making recommendation A, take a left-hand turn and the next coroner says take a right-hand turn; how do we deal with all of that? Bear in mind that every coroner is an independent judicial officer as well—very important. Essentially, what I did

was I dealt with the NCIS, dealt with the counsel, dealt with the coroners and gave the proper people access to the NCIS database and instructed the counsel, "Go into the database and if there are recommendations that have already been made on that topic, you now have the option to have a look at that." It does not mean that the coroner has to now follow it, but at least the coroner knows if he or she is going to make a different recommendation. At the end of the day, a recommendation is not enforceable and it cannot be appealed —

The CHAIR: That seems to be a bit of a furphy. As policymakers, once a problem becomes endemic, we want to do something about it. We do not necessarily know about isolated recommendations or inquests, so there seems to be an information gap between policymakers and the work that individual coroners do.

Ms Fogliani: Yes; I see what you are saying. Obviously, all the inquest findings are on the website and the ministerial responses are put on the website as well, so if you go to the Coroner's Court website, you will see which inquests have had recommendations and you can also see the webpage—the initial webpage—so you click on it and the summary will show you where there has been a recommendation. There is a link to the inquest finding and then there is a link to the ministerial response, so it is available there.

The CHAIR: That is relatively recent, I take it?

Ms Fogliani: The inquest findings, I believe, since 2013 and then after I started, the ministerial responses went onto the website.

The CHAIR: Okay. That is an improvement, I think.

Ms Fogliani: There is something I would like to say about that, though, because I understand where you are headed. Recommendation 83 of the Law Reform Commission, if it is to be done I think effectively, said that a prevention team should be established within the office of the State Coroner, and this is certainly something that I am in support of. It is clearly a longer-term thing, but what that prevention team will do is update and maintain the website; monitor and evaluate responses to and implementation of coronial recommendations; analyse coronial data to identify trends and opportunities for prevention activities; conduct research to support decision-making and recommendations of the coroner; consult with stakeholders in relation to proposed formulations for recommendations so that by the time the coroner is making them, all of that has happened and you can do so intelligently; and provide coronial information to assist prevention bodies. In order to do it effectively, my view is that recommendation 83 would need to be implemented. You can head down that way, and, like I have said, they are on the website now and they can certainly be gathered and analysed. There could be better ways, I think, of getting them or summarising them; that is one thing. The next thing, though, that I think you are interested in is: What is the progress? What has happened as a result of that?

[10.50 am]

The CHAIR: No; that is a different issue to me. That is a political issue.

Ms Fogliani: Yes, okay.

The CHAIR: It is just a question of knowing that we have a systemic or endemic problem. How many deaths in custody do there have to be before action is taken? It just does not seem to be the basic correlation of evidence. Those improvements to the website are one thing, but whether anyone takes the time and does something about it is another issue.

Ms Fogliani: In the annual report, I am required under section 27 to provide a specific report to the Attorney on the death of every person held in care. When I provide that specific report in the second half, I summarise, and obviously they are on the website. I also, in the report, summarise on how many occasions the coroner has made an adverse comment on the treatment, care and supervision. To a degree, it is gathered within this report. I am not saying we could not gather it in a better way,

and I can give that some more thought in terms of just gathering that information and maybe making it available in summary form so that everybody could see all of the recommendations and maybe all of these —

The CHAIR: Yes, just some key words or something.

Ms Fogliani: Yes, I will give that some thought.

The CHAIR: Now, the next area we want to talk about trespasses on a current case, so just let us know if you are uncomfortable about what we ask. Can I just clarify there was some indication in the public domain and the media that you have reserved your decision on the Ms Dhu inquest and that you anticipated that your decision would be next year. Is that correct or not?

Ms Fogliani: The first bit is. On the second bit, I do not know where the anticipation of my decision being next year has come from; I have no idea where that has come from.

The CHAIR: That is good. I am glad it is not next year. I also heard—it was not reported in the media—that there was a draft copy of your decision being circulated. Is that something that happens?

Ms Fogliani: I do not know how that has been —

The CHAIR: I would have thought that was an extraordinary thing, if it was.

Ms Fogliani: No, it should not be happening. Essentially, I think it is appropriate to explain coroners do not distribute drafts to the interested parties for comment or anything like that. One thing that we do is this: once a coroner has signed—so it has got to be your final—that will be distributed to, say, the family members, the interested parties, people at risk of adverse comment; the aim is seven days before it gets onto the website. That is to give a family member, for example, time to just reflect and read before they see it in a public area. But they are not drafts for comment.

The CHAIR: Okay; thank you. On that same matter, and I do not want obviously to trespass on the particular issues there, but one of the live issues was releasing the video footage there. Obviously, one of the criteria you would need to rely on is public interest and impact on family members; is that correct? What other criteria are live in these sorts of cases?

Ms Fogliani: I think it is better, in terms of the case concerning Ms Dhu, that I not discuss that specific detail.

The CHAIR: No; I am just using that as an example.

Ms Fogliani: But I am going to talk in generality, so this is not about that case, what I am saying. Generally speaking, this is the situation. Open justice is very important and transparency is very important. The court proceedings are done in public, unless the coroner has issued a nonpublication order—otherwise known as a suppression order under section 49. It is important not to conflate the concept of suppression with the concept of not giving somebody an exhibit to put into the public domain to assist with reporting. If an exhibit is, for example, not being given to the media to utilise, that is not a suppression if, for example, it has been dealt with in court. I think that is the first point. Generally speaking, what the coroner has to do is look at the legislation—we are a statutory court—and see what are the release provisions. The release provisions, for example, are far narrower than they are, for example, in that section that I had mentioned—section 115 of the Victorian legislation that I have recommended that we adopt. You need to look at that. From my perspective the coroners gather the information for a coronial purpose and therefore you need to think: what is your coronial purpose here? Another issue is: is it necessary to put a photo in the public domain in order to make the finding explicable or not? So there are a lot of considerations: the views of the family are a very important consideration as well; the dignity in death of the deceased person is a very important consideration. All of those matters have got to be considered. Now, to give you an example, maybe, of some findings where the coroner has used a photo, for example, to assist, they are on the website. With the deaths of Messrs Vincent and Nelson, the date is 4 August 2014. The coroner in the

finding put a photo of Redgate Beach to show certain aspects of it, so it has been used for that coronial purpose. Another example is the death of Mr Paul Clifton; that is also on the website, and the coroner was describing something and put a photo of the boat into that filing. That then becomes available on the website, so it has to be borne in mind that the material is gathered for a coronial purpose, so careful thought needs to be given to it. In relation to the matter currently before me, I need to very carefully consider all of the submissions that I have before me in order to reach my decision, so it would not be appropriate for me to go into more detail than that, other than, as I have said, to give you those indications of what the coroner needs to look at.

The CHAIR: From what you have said, if this material was created for coronial purposes —

Ms Fogliani: If it was created, yes.

The CHAIR: But is in existence.

Ms Fogliani: Yes.

The CHAIR: Say we have CCTV at the police station. Does the fact that an inquest is ongoing preclude police from releasing that footage in their own capacity?

Ms Fogliani: That is a good question. I would think it does. It is very difficult talking about specific cases but essentially it has been given to the coroner. Under a particular section of the legislation, it has been seized and provided to the coroner because the person seizing it is one of the coroner's investigators. All police officers are coronial investigators.

The CHAIR: So seized, not volunteered. Is that what you are telling me?

Ms Fogliani: It is very interesting. Possession has been taken of it under section 33(2a), for example, if that is one of the sections that is used. If a particular thing is seized, section 33(2a)(c) states —

> take possession of anything which the coroner's investigator reasonably believes is directly relevant to an investigation of the death.

Dr A.D. BUTI: But does it give you exclusive property rights? I am looking at that section. What if someone makes a copy, so they give you a copy of it? I cannot see anything in there that gives you the exclusive right to that property. If it came into existence not for a coronial purpose, which it did not —

Ms Fogliani: Then was provided to me for a coronial purpose.

Dr A.D. BUTI: Yes, but it was already in existence. It may be provided to you to assist you but I do not see anywhere in the legislation that that automatically excludes anyone else from being able to see it or gives you the right to exclude other people from seeing it. It is like a family photograph. If I take a family photograph, I make a copy and give it to you. What legislative right or moral right does it give you from excluding how I want to distribute that photo?

[11.00 am]

Ms Fogliani: I wonder whether the answer is this. If the coroner is about to conduct an inquest in relation to a matter and there is, let us say, a still image or CCTV video or whatever, essentially the coroner needs to question witnesses in relation to what happened. In some instances, it is desirable for people not to see it until they are questioned in order to answer honestly or give the best answer to the coroner. That, for example, is a case where you would not want the information disseminated in another domain whilst the inquest is ongoing. If the coroner is conducting the inquest, I think really the appropriate thing is to allow the coroner to finish that process because there are instances when the release of a portion of the evidence, because that is what it is, has a risk of obfuscating the issues or creating, I suppose, a different perspective. Because it is coronial, the coroner needs that opportunity, with respect, to actually incorporate that evidence into the finding on the cause and manner of death and put it into its proper context. On the other hand, if it were to be released,

obviously there can be debate and there can be discussion and it runs the risk of people prejudging it or focusing on certain aspects of it when the coroner has not had that opportunity to question the witnesses and see what people say about it.

The CHAIR: What happens in situations where the witnesses have already been questioned and it has been public? So you have effectively been describing what is in, say, for example, a video, in evidence, in public, subject to cross-examination. What then precludes the release after that time?

Ms Fogliani: That is a good question. From my perspective, what precludes the release is the coroner has not handed down the findings in relation to that matter, and that is only a part of the evidence. So, in order to have the evidence considered in its proper context, because it is a coronial matter, then if it is going to be released, it ought to be done in connection with the finding.

The CHAIR: This then goes back to the issue about delays in inquests coming on. For example, we have a situation where the family are really very perplexed about what has happened. They are not being given answers. From what you say, if there is access to material that they could have independently of the coronial process, you would not be a supporter of that because you say that —

Ms Fogliani: I think we are speaking at cross-purposes. I thought that you had meant "access" meaning in the public domain. In terms of a family member wanting to come in before an inquest to have a look at things, we do that, and we try to facilitate it as best we can.

The CHAIR: I was saying that initially, but if, for example, the family then having seen it says, "We believe this is of such high public interest that we want it released in the public domain", surely that is a relevant —

Ms Fogliani: Yes. I can see why you say that. But I think we are now getting to that point where I think it is probably appropriate that I not deal with that specific case because it is still under consideration.

The CHAIR: We still have not answered the question that if it is not effectively material that is created for a coronial inquest, on what basis can you preclude its release by the person who owns that material?

Ms Fogliani: Yes. Okay. So that would essentially be if I had a copy, and somewhere somebody else has got another copy, for example, and it relates to the inquest.

Dr A.D. BUTI: While you are thinking, I know that section 33(2a) talks about "take possession of anything". We know that possession is nine-tenths of the property at issue. You may have possession. But generally with photography, the owner is the person that takes that photograph.

Ms Fogliani: Yes.

Dr A.D. BUTI: So I still do not understand how it gives you that right to prevent the owner from distributing a copy. Say they gave you a copy and they still have the original, you cannot prevent them from releasing the original, can you?

Ms Fogliani: I would be very surprised if it happened.

The CHAIR: No. That is not the question.

Ms Fogliani: I know. I think I need to look at that because it has not happened in my experience that when the material is given to the coroner, then it is also released. It would concern me if the material was of such a quality that it is material to the—if the images or the exhibit is material to the issues in the inquest, it would concern me. But nobody has come to me to say, "Can I or can't I?" I have not said to anybody "you can or you can't". But my expectation would be that it would not be released until I deliver my findings. But if you were to ask me —

Dr A.D. BUTI: Can you legally prevent that?

Ms Fogliani: That is right. I would need to give some thought to that, yes.

The CHAIR: I am going to ask you about the Dhu case, but when there were some submissions made a week or so ago about the video, did you make any public statement as to whether you would be making your decision at the same time as the release of your overall findings?

Ms Fogliani: No, because that is something that I need to still work through; yes.

The CHAIR: Because from what you are saying today, it sounds like you had formed the view that you would have to release both at the same time.

Ms Fogliani: Yes. I think that that is the better option, but, like I said with the Dhu matter, I am working my way through those submissions, and that is obviously one of the things that I am looking at.

The CHAIR: All right. Anything else on that matter? The officers had some contact in terms of—I will just check. I might have some notes here.

Ms L. METTAM: We have received some suggested or recommended questions from a colleague, another member of Parliament, Nick Goiran, MLC, the member for South Metropolitan Region. It refers to the answer to Legislative Council question on notice 2946, which was provided on 13 May and which informed that there were 20 babies born alive after an abortion procedure between July 1999 and December 2014 and that none of the 20 was provided any treatment. The first question is: how many of these 20 deaths were reported to your office?

Ms Fogliani: I think I am going to need some further detail on that. Can you give me some more? Why is it said they were born alive?

Dr A.D. BUTI: The allegation or the statement by Hon Nick Goiran is that there was an abortion procedure, but post-abortion there were signs of life of the foetus.

Ms Fogliani: Do we know what signs of life?

Dr A.D. BUTI: Well, a sign of life; I presume it is a medical sign of life. So I suppose the heart is beating and not brain dead, I presume. I do not know the actual signs of life, but I presume that is what is meant. Basically, what he is saying is that there were 20 abortions where the baby was still alive post-abortion, and his argument is that in some cases there may have been abnormalities, but not necessarily life-threating abnormalities—so, some disability of some sort. He has an issue about abortion. But what his question here is: he says the Coroner's Court should be notified of these 20 deaths, if there were 20 deaths, and the Coroner's Court or the coroner's office should be doing a coronial inquest or at least investigating these suggestions of death after an abortion.

[11.10 am]

The CHAIR: In other words, it is a failed abortion. The baby is still alive and there is a medical decision that their condition has no hopeful prognosis—that decision is not reviewed in any way. So what he is saying is: is there a mechanism so that the coroner can at least look at the medical judgement that that child was not viable, and so they will let it die? It is not reviewable, effectively.

Ms Fogliani: Yes, all right. The reason I ask for the additional information on what born alive means to Mr Goiran is that there is some law around the whole issue of born alive, obviously. The High Court has held that pulseless electrical activity is a sign of life. So, essentially, in order for the coroner to have jurisdiction, there has to be a life. So if it is a stillborn child, that is obviously not happening there.

The CHAIR: No, we understand the issue there. The obvious one, I suspect, is Down syndrome, really.

Dr A.D. BUTI: Yes, that is one of the ones.

The CHAIR: So someone can survive with that condition and live, but a judgement is made for whatever reason that they will let the baby die.

Ms L. METTAM: No resuscitation undertaken—a deliberate decision not to resuscitate.

Ms Fogliani: In terms of, I suppose, timing, are we talking about periods of gestation greater than 20 or 26 weeks?

The CHAIR: Yes, so it is post-20 weeks.

Ms Fogliani: Post-20 weeks, and Mr Goiran is saying that there are details in relation to 20 such cases?

Ms L. METTAM: Fourteen incidences.

Ms Fogliani: Are there details available of —

Mr C.D. HATTON: I think he is identifying that there seems to be no mechanism in the diagnosis, whether it is accurate or not at that time.

Dr A.D. BUTI: Just reading from what he has provided, in a question he asked, he is saying that the parliamentary secretary representing the Minister for Health stated that 14 of the 20 abortion procedures resulted in the delivery of a live child.

Ms Fogliani: The Minister for Health stated that?

Dr A.D. BUTI: The parliamentary secretary representing the Minister for Health stated that 14 of the 20 abortion procedures resulted in the delivery of a live child at 20 weeks' gestation or later.

Ms Fogliani: But they did not explain whether the child —

Ms L. METTAM: I will give you the parliamentary question.

Ms Fogliani: Yes; thank you.

Dr A.D. BUTI: I suppose the question, coroner, is that whatever one's position on abortion, Hon Nick Goiran's suggestion is: are there children who are born alive after an unsuccessful abortion; and, if so, is your office, and are you, informed about this and have you done any investigations?

Ms Fogliani: All right. Because we are talking about historical matters, 1999 to 2014—certainly nothing has come up since I have been appointed—I think the better thing to do is to try to source some facts in relation to it.

The CHAIR: Either that or you concede that there is no current mechanism for your office reviewing those sorts of decisions.

Ms Fogliani: I think that the issue is as follows. If there has been a death and it arises from violence or injury or it is unexpected et cetera, that is essentially a reportable death.

Dr A.D. BUTI: That is what he said. This is what he states: the question for the coroner, however, is not the conditions under which the abortion should be legal, but whether the deaths of babies delivered with conditions compatible with life after abortion are in fact reportable. So, his fundamental question is: In these cases, if they did occur, are they reportable? Have they been reported to the coroner's office?

Ms Fogliani: I would have to look at that. So, yes, I will look at that.

The CHAIR: I think that is all on that matter.

To go back, a lot of inquests in Western Australia one way or another involve the Indigenous community. I am just wondering what training your staff do in terms of dealing with Indigenous clients or family members?

Ms Fogliani: Kooya Consultancy has provided the cultural competency training to the Coroner's Court. I met with Mr Collard and Ms Collard in order to just, I suppose, scope it, because I wanted training at different levels and to be referrable to different areas of the office. For example, the grief counsellors need a certain type of training and input; the coroners and counsel assisting need

a different type. So, essentially Kooya Consultancy provided the type of training that we needed in order to deal with different people's functions.

I also had, and I will have to actually get more precise details, the office manager give them copies of our brochures and some of the standard letters to ask them whether they can be improved on or whether there is something that would make them more culturally appropriate or whether they noticed anything about that documentation that might not be appropriate. My understanding is that they came back and the documents were fine, but I would have to check entirely on that. That has been the training for the court as a whole. I have then had my own training through Notre Dame University and the residential training at Fairbridge myself. That is also available to other coroners, as and when and if they have the time. There have not been any other takers at present, but hopefully in the future that will also be taken up.

The CHAIR: You are providing some information for us. Can I let you know that we have a policy of putting most material on the website, so if there is anything you do not want us to, please let us know.

When was that training that you have referred to done?

Ms Fogliani: Kooya Consultancy?

The CHAIR: Yes.

Ms Fogliani: I am not very good with time. It could have been a year ago; it might have been half a year ago. I think it would be better for me to just give you that.

The CHAIR: Maybe what the extent of it was, if it was one hour or three hours or whatever.

Ms Fogliani: So you would like some further details on that?

The CHAIR: Yes, I think so, thank you.

Ms Fogliani: Okay. It was a number of hours per section of the office.

The CHAIR: In terms of family members generally, you have mentioned counselling. In terms of your approach to family members who are witnesses, are there any protocols that you have observed there that you tend to try not to—I mean, if you are talking about relevance, is your examination only relevant to fairly narrow issues that advance the case?

Ms Fogliani: That is a good question. There are two types of evidence that the coroner will take from the family in this. One type is that the family member is offered the opportunity to tell the coroner about their loved one and talk about the history. Within that there may be matters that are referrable to the death. For example, very sadly, it could be that somebody's much-loved child did have a drug problem. So it is part of the person's opportunity to tell the coroner that, but it also informs the coroner of a relevant factor. Other family members will come in and just talk about their loved one and talk about the impact. So that is one thing.

[11.20 am]

The CHAIR: Just on that, and with respect, yes, families usually know that maybe their loved one—the deceased—is on drugs, but they will not know the extent of that problem, necessarily. They are usually the last ones to know.

Ms Fogliani: Sometimes they are, but sometimes somebody is very supportive of their child and helps them to very much try to get over the drug addiction. But that is one type. Another type may be where the family member is actually able to give evidence that relates to the circumstances attending the death, so I am talking about factual evidence, which is different from the other component.

The CHAIR: Yes.

Ms Fogliani: In those cases there are a number of things the office tries to do. Obviously, the counsel assisting will talk to family members. The coroner will take into account if a family member feels that it is just going to be too difficult to come into the witness box. He will take account of that, and maybe give them the opportunity to make a statement, particularly if he does not feel it is necessary that the family member be cross-examined either in relation to it. We try to deal with it on an individual level. On the other hand, there are some family members who, I think, feel better if they have had the opportunity to say something to the coroner, including how it has affected them. But also it gives them the opportunity to make a comment about how things may be improved from their perspective, to tell the coroner, "In my opinion a future death may be improved if this had not happened or if those systems were different." That is one way of doing it. They will have the discussion with the counsel obviously, and if the counsel has a concern and feels that the family member will find it very onerous or difficult, that will always be brought to the attention of the coroner, obviously; I would expect that. That was the counsel assisting. We then have the grief counsellors, and they are available. People have different reactions to whether they want to engage with a grief counsellor or not, but the possibility is there and that person can help them through. That includes, for example, if we know that in the course of the inquest some evidence is going to be shown that is confronting and distressing, the counsellor or psychologist will talk to the family member and might give them the opportunity, if it is appropriate, to see it in advance so that it is not shocking the first time you see it in court. We will also say to the family member, "On such and such a day we are likely to have this evidence; the coroner will tell you before the forensic pathologist comes in. You can leave the courtroom if it is going to be difficult for you, or you can stay." There is a court companion service that we call on as well. If the family member wishes to see, for example, the post-mortem examination report of the pathologist there are different ways of trying to facilitate that. The best way from our perspective—we do not put them into their possession, but they are very detailed reports and they can make for very distressing reading if it is your loved one—is to send them to a nominated GP, for example. We will just say, "You can see your GP, and he or she will talk about it but can't actually give you a copy." Another option that sometimes has happened is that they can come in and one of my medical advisers will sit with them and maybe try to talk it through. There may be instances where we feel the family member may be assisted by looking at an expert specialist report—for example, if there has been a concern about how an operation was performed. Then there is an expert report where the independent expert says, "It was within the appropriate parameters" et cetera, or sometimes they might come in and have a read of it et cetera. So, we try to engage in that way and offer a range of support so that the process is as helpful as it can be.

The CHAIR: Some inquests are of greater public interest than others. I wonder how much discretion you have of moving an inquest up the list, for example. As to the one into the firefighter who died near Albany about three years ago, I think, I think by the time it gets to your inquest it will have been three years since her death. How much capacity do you have to, maybe, bring that up the list? Because things like that tend to inform the authorities as to how to conduct firefighting activities in the future. Similarly, I think, with the Dhu matter again, that might activate the authorities to act differently about custodial arrangements. How much discretion do you have to, sort of, bump what I call the public interest matters up the waiting list?

Ms Fogliani: I have that discretion, and at the end of the day it is an inquest list I am familiar with and I look at it and review it on a regular basis as part of a range of my functions. One of the things, obviously, that I can do, and have discretion to do, is to prioritise a matter for reasons of public health and for reasons of safety. But I have to also bear in mind that every time I prioritise somebody, I deprioritise somebody else; I have to take care with that. Generally speaking, the process is that we try to do the older matters first. You cannot always do that because sometimes you have a more recent matter and the investigation has just been efficiently done, because witnesses were available, people signed up and the various other matters were addressed, and so

I am not going to hold that back if it is ready. So you are taking, also, that into account as well. I would say, look, the guiding principle is to deal with the older matters first; the families deserve that. If something needs to be prioritised for reasons of public health or safety, I can do that and have done that while recognising, of course, that somebody else has been deprioritised. It is inevitable. It would happen rarely. Sometimes it will also happen when it may be that it appears that a death that seems to be recent is the subject of an inquest and there would not seem to be a major public health issue or safety issue. That is most likely when the investigation was finalised—everything was available, the evidence became available quite quickly—and it was all done and it is ready to go.

The CHAIR: On that context, I am advised, for example, that I think the coroner from Kalgoorlie will be doing the inquest into the three deaths from the Esperance fires, so, because that is occurring, I have been advised that that is going to progress quicker than some of the cases that are currently on the list. Is that true, or is that where it has been moved forward because of the public interest?

Ms Fogliani: I need to look into that one actually, yes, so thank you for that. I will take that on notice.

The CHAIR: All right, and the final question I have—I do not know if anyone else has any—just to go back to the standing of public interest groups like the Deaths in Custody Watch Committee, they seem to not be fully able to participate in hearings at the moment. Do you think there is some need for some changes to the act, maybe? There has been a growth of these sorts of general interest groups—it might be environmental groups—or these sorts of groups. I wonder if that is a status of interest group that was not really contemplated when the legislation was drafted.

[11.30 am]

Ms Fogliani: If I look at regulation 17 in section 44, at the end of the day the coroner still has discretion, because regulation 17 is a non-exhaustive list. The coroner still has that discretion, and I have just referred to section 44(3) so the prescribed list of persons is not exhaustive. The issue then is, if there is a public interest advocacy group, the coroner needs to take into account whether it is desirable that that group also becomes an interested party. Once a person becomes an interested party, things flow from that, obviously, including section 44(1). They have the right to appear, examine and cross-examine, so the sort of thing you might take into account is: is the family already represented and adequately so? You have got to take care that you are not going to have a situation where you run the risk of issues being repeated and the inquest becoming a little bit too broad. There is a middle ground, if I can call it that, where there is recognition of the importance of what an advocacy group has to say, balanced with whether they should become an interested person. So, for example, in one of my matters I have spoken about, in relation to the Deaths in Custody Watch Committee, I said essentially my decision there is that they are not an interested party, but they can make submissions to me. They can have access to material and they can have a spot in the court where they can work and, I suppose, deal with matters.

The CHAIR: But not cross-examine witnesses?

Ms Fogliani: Correct. I think it was dealt with in the Law Reform Commission report, and I think essentially what the Law Reform Commission report alluded to was that middle ground that I have said, where essentially there is a recognition that a group has something important that they wish to put to the coroner. The coroner will look at it. So it is giving them the ability to make submissions, but not be an actual party to the inquest, where they examine and cross-examine witnesses.

The CHAIR: Thanks very much for your evidence today. A transcript of this hearing will be forwarded to you for the correction of minor errors. Any such corrections must be made and the transcript returned within 10 days of the date of the letter attached to the transcript. If the transcript is not returned within this period it will be deemed to be correct. New material cannot be added via

these corrections and the sense of your evidence cannot be altered. Should you wish to provide any additional information or elaborate on particular points, please include a supplementary submission for the committee's consideration when you return your corrected transcript of evidence. There are a number of matters you are following up for the committee.

Ms Fogliani: Yes, thank you very much.

Hearing concluded at 11.33 am