30th June, 2002

The Honourable Jim McGinty  
BA Bjuris(Hons) LLB JP MLA  
Attorney General

Dear Minister

In accordance with Section 27 of the Coroners Act 1996 I hereby submit for your information and presentation to each House of Parliament the report of the Office of the State Coroner for the year ending 30 June, 2002.

The Coroners Act 1996 was proclaimed on 7 April, 1997 and this is the fifth annual report of a State Coroner pursuant to that Act.

Yours sincerely

Alastair Hope  
STATE CORONER
# Table of Contents

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>STATE CORONER’S OVERVIEW</td>
<td>4</td>
</tr>
<tr>
<td>INVOLVEMENT OF RELATIVES</td>
<td>6</td>
</tr>
<tr>
<td>COUNSELLING SERVICE</td>
<td>11</td>
</tr>
<tr>
<td>CORONIAL ETHICS COMMITTEE</td>
<td>12</td>
</tr>
<tr>
<td>COUNSEL TO ASSIST CORONERS</td>
<td>14</td>
</tr>
<tr>
<td>INQUESTS</td>
<td>15</td>
</tr>
<tr>
<td>Langley George Hancock</td>
<td>21</td>
</tr>
<tr>
<td>Bronzewing Mine Site</td>
<td>21</td>
</tr>
<tr>
<td>Shane Hamill, Troy Terrence Woodard &amp; Timothy Lee Bell</td>
<td>21</td>
</tr>
<tr>
<td>Benjamin James Pitt</td>
<td>24</td>
</tr>
<tr>
<td>Christian Laurence Jensen, Jessica-Lea Campbell Broad &amp; Hilary Rebecca Smith</td>
<td>25</td>
</tr>
<tr>
<td>Susan Ann Taylor</td>
<td>26</td>
</tr>
<tr>
<td>Kaori Adachi</td>
<td>29</td>
</tr>
<tr>
<td>Timothy Wayne Clothier</td>
<td>31</td>
</tr>
<tr>
<td>Kieran John O’Shaughnessy</td>
<td>32</td>
</tr>
<tr>
<td>Donnelle Kay Parkin</td>
<td>33</td>
</tr>
<tr>
<td>Kyle Umberto Di Silvio</td>
<td>36</td>
</tr>
<tr>
<td>Wahib Ali</td>
<td>38</td>
</tr>
<tr>
<td>Jennifer Ann Cruse</td>
<td>39</td>
</tr>
<tr>
<td>Daren Cheng Lim Tan</td>
<td>40</td>
</tr>
<tr>
<td>DEATHS IN CUSTODY</td>
<td>43</td>
</tr>
<tr>
<td>INQUESTS – PERSONS UNDER CARE OF A MEMBER OF THE POLICE SERVICE</td>
<td>43</td>
</tr>
<tr>
<td>Peter Anthony Brooks</td>
<td>43</td>
</tr>
<tr>
<td>Derek James Allen Moore</td>
<td>46</td>
</tr>
<tr>
<td>Cuong Thi Truong &amp; Thuong Thi Truong</td>
<td>47</td>
</tr>
<tr>
<td>INQUESTS – DEATHS IN CARE – MINISTRY OF JUSTICE</td>
<td>48</td>
</tr>
<tr>
<td>Reginald Cyril Fry</td>
<td>48</td>
</tr>
<tr>
<td>Phillip Lionel Joseph</td>
<td>50</td>
</tr>
<tr>
<td>Wayne John Coyne</td>
<td>52</td>
</tr>
<tr>
<td>Adam Timothy Garner</td>
<td>54</td>
</tr>
<tr>
<td>Francesco Fragomeni</td>
<td>55</td>
</tr>
<tr>
<td>Lesley William Wesley</td>
<td>57</td>
</tr>
<tr>
<td>Martin Raymond Coffee</td>
<td>58</td>
</tr>
<tr>
<td>Jason Paul Matthews</td>
<td>59</td>
</tr>
<tr>
<td>Frederick Ronald Riley (also known as Frederick Stephen Wilson)</td>
<td>60</td>
</tr>
<tr>
<td>Bradley James Savory</td>
<td>62</td>
</tr>
<tr>
<td>Scott Davidson</td>
<td>63</td>
</tr>
<tr>
<td>Kirk Graham Lawson</td>
<td>65</td>
</tr>
<tr>
<td>Simon Otero</td>
<td>67</td>
</tr>
<tr>
<td>Gerardus Theron</td>
<td>68</td>
</tr>
<tr>
<td>Steven Anthony Pridham</td>
<td>70</td>
</tr>
<tr>
<td>Alan McKenzie Craig</td>
<td>72</td>
</tr>
<tr>
<td>Bradley William Rapley</td>
<td>74</td>
</tr>
<tr>
<td>DEATHS REFERRED TO THE CORONERS COURT</td>
<td>80</td>
</tr>
</tbody>
</table>
On reviewing the statistics for the Coroner’s Court for the year ending 30 June, 2002 the most striking feature is a considerable decrease in the number of deaths resulting from non-traffic accidents.

In the year ended 30 June, 2001 there were 228 deaths by way of accident where motor vehicles were not involved, in the year ended 30 June, 2002 the number was reduced to 157, a difference of 71.

It would appear clear that this considerable reduction results from a dramatic reduction in the number of deaths as a result of heroin overdoses. That reduction is in the order of 90%.

The following information provided to me by the Organised Crime Investigation Section of the Western Australian Police Service indicates that the number of deaths attributed to suspected heroin overdoses has reduced from over 80 in 1999 and 2000 to 8 until the end of September, 2002.

This reduction is also reflected in the number of call-outs recorded by St John’s Ambulance Service which were similarly reduced as were the number of cases where naloxone was administered.

It would appear that the dramatic reduction in heroin overdose deaths has resulted from a reduction in the availability of heroin across the nation.

According to the Australian Bureau of Criminal Intelligence, this reduction in the availability of heroin has resulted in lower street level purity and increased prices.
It is possible that this reduction in the availability of heroin results, at least in part, from a dramatic decline in opium poppy cultivation in Afghanistan as a result of a decree issued by Taliban Authorities in September 1999. Whether or not this reduction in availability of heroin will continue is a matter of conjecture and it is clearly important from the perspective of our office that this issue be monitored closely in the hope that information may be forthcoming which would assist in permanent reduction in accidental death by way of heroin overdose.

**The Aboriginal Justice Council**

Advice was received during the year that the Government has disbanded the Aboriginal Justice Council.

The Attorney General has advised that Government has signed an agreement with ATSIC on behalf of Aboriginal Western Australians and in the Government’s view it is time to move forward by developing appropriate responses to Aboriginal Justice issues within this new framework.

While it is to be hoped that arrangements can be put in place to replace the various functions provided by the Aboriginal Justice Council, I take this opportunity to put on record the fact that over the years since my appointment the Council has assisted the Coroner’s Court in a number of different, but important, ways.

In particular, Mrs Glynis Sibosado, who passed away on 19 April, 2001, worked closely with the Coroner’s Court and made arrangements for visits to Aboriginal Communities to assist in addressing health issues. Mrs Sibosado also assisted on many occasions when problems arose, liaising with grieving Aboriginal families in respect of important issues following the death of loved ones.

It is to be hoped that in the absence of the Aboriginal Justice Council, other representative bodies will ensure that processes
are available to meet the needs of the Coroner’s Court in relation to the liaison function previously provided by the Aboriginal Justice Council.

**Involvement of Relatives**

The *Coroners Act 1996* involves relatives of deceased persons in the coronial process to a far greater extent than previously was the case.

The Act requires a Coroner to provide information to one of the deceased person’s next of kin about the coronial process in every case where the Coroner has jurisdiction to investigate the death.

In practice the information is contained in a brochure which is provided by a police officer who is also required to explain the brochure. A police officer is further required to record details about the provision of the information on a mortuary admission form which is viewed by the Coroner or a delegate prior to any decision being made about whether or not a post mortem should be conducted.

During the year 1 July 2001 - 30 June 2002 a total of 2,038 deaths were referred to the Coroners Court. In 358 cases a death certificate was issued at an early stage and the body was not taken to the mortuary. Of the remaining 1,676 cases, a total of 161 objections were made to the conducting of a post mortem examination. In 4 cases there was a referral to the Coroner after burial.

In the majority of cases the objection was accepted and no internal post mortem examination was conducted.

In a number of cases the objection was subsequently withdrawn, either immediately or when a Coroner had overruled the objection. In some cases it appears that while family members were at first concerned about a post mortem
examination, later the family members realised that it would be important to know the cause of death with reasonable certainty.

Where objections are made, every effort is taken to attempt to ascertain the extent to which a cause of death can be determined without an internal post mortem examination.

It is a rare case in which there are no external factors which would give some insight into a likely cause of death.

The following charts detail statistics relating to objections to post mortem examinations for the year. The cases where a death certificate was issued by a doctor and the body did not reach the mortuary have not been included.
Deaths Referred to the Coroners Court from 1 July 2001 - 31 December, 2002

<table>
<thead>
<tr>
<th></th>
<th>Jul</th>
<th>Aug</th>
<th>Sept</th>
<th>Oct</th>
<th>Nov</th>
<th>Dec</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Death Certificate issued although the body was admitted to the Mortuary</td>
<td>24</td>
<td>27</td>
<td>21</td>
<td>18</td>
<td>12</td>
<td>25</td>
<td>127</td>
</tr>
<tr>
<td>Immediate post mortem ordered (usually these are homicide cases)</td>
<td>3</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>8</td>
</tr>
<tr>
<td>No objection to post mortem</td>
<td>120</td>
<td>105</td>
<td>104</td>
<td>119</td>
<td>104</td>
<td>77</td>
<td>629</td>
</tr>
<tr>
<td>Objection received by the Coroners Court</td>
<td>18</td>
<td>11</td>
<td>17</td>
<td>14</td>
<td>12</td>
<td>13</td>
<td>85</td>
</tr>
<tr>
<td><strong>TOTAL NUMBER OF DEATHS</strong></td>
<td><strong>165</strong></td>
<td><strong>144</strong></td>
<td><strong>142</strong></td>
<td><strong>152</strong></td>
<td><strong>129</strong></td>
<td><strong>117</strong></td>
<td><strong>849</strong></td>
</tr>
</tbody>
</table>

Developments in Cases where an Objection was initially received

<table>
<thead>
<tr>
<th></th>
<th>Jul</th>
<th>Aug</th>
<th>Sept</th>
<th>Oct</th>
<th>Nov</th>
<th>Dec</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Objection withdrawn prior to a ruling being given by a Coroner</td>
<td>5</td>
<td>4</td>
<td>8</td>
<td>8</td>
<td>5</td>
<td>5</td>
<td>35</td>
</tr>
<tr>
<td>Objection accepted by a Coroner and no post mortem ordered</td>
<td>13</td>
<td>7</td>
<td>9</td>
<td>6</td>
<td>7</td>
<td>8</td>
<td>50</td>
</tr>
<tr>
<td>Objection over-ruled by a Coroner*</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>18</strong></td>
<td><strong>11</strong></td>
<td><strong>17</strong></td>
<td><strong>14</strong></td>
<td><strong>12</strong></td>
<td><strong>13</strong></td>
<td><strong>85</strong></td>
</tr>
</tbody>
</table>
Deaths Referred to the Coroners Court from 1 January 2002 - 30 June 2002

<table>
<thead>
<tr>
<th></th>
<th>Jan</th>
<th>Feb</th>
<th>Mar</th>
<th>Apr</th>
<th>May</th>
<th>Jun</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Death Certificate issued although the body was admitted to the Mortuary</td>
<td>13</td>
<td>18</td>
<td>28</td>
<td>26</td>
<td>23</td>
<td>22</td>
<td>130</td>
</tr>
<tr>
<td>Immediate post mortem ordered (usually these are homicide cases)</td>
<td>2</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>1</td>
<td>1</td>
<td>13</td>
</tr>
<tr>
<td>No objection to post mortem</td>
<td>86</td>
<td>107</td>
<td>95</td>
<td>85</td>
<td>126</td>
<td>109</td>
<td>608</td>
</tr>
<tr>
<td>Objection received by the Coroners Court</td>
<td>16</td>
<td>11</td>
<td>8</td>
<td>14</td>
<td>15</td>
<td>12</td>
<td>76</td>
</tr>
</tbody>
</table>

**TOTAL NUMBER OF DEATHS**  117  138  134  129  165  144  827

Developments in Cases where an Objection was initially received

<table>
<thead>
<tr>
<th></th>
<th>Jan</th>
<th>Feb</th>
<th>Mar</th>
<th>Apr</th>
<th>May</th>
<th>Jun</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Objection withdrawn prior to a ruling being given by a Coroner</td>
<td>7</td>
<td>2</td>
<td>2</td>
<td>6</td>
<td>4</td>
<td>5</td>
<td>26</td>
</tr>
<tr>
<td>Objection accepted by a Coroner and no post mortem ordered</td>
<td>9</td>
<td>9</td>
<td>5</td>
<td>8</td>
<td>11</td>
<td>7</td>
<td>49</td>
</tr>
<tr>
<td>Objection over-ruled by a Coroner</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
</tbody>
</table>

**TOTAL**  16  11  8  14  15  12  76
It can be seen from the above charts that of the total number of deaths referred to the Coroners Court there were relatively few objections to the conducting of post mortem examinations (approximately 7.7%).

In the majority of cases where an objection was received the decision which was ultimately made was in accordance with the wishes of the family. There were a total of 161 objections of which 61 were withdrawn prior to a ruling being given by a Coroner and 99 were accepted by a Coroner and no post mortem examinations were ordered. In only 1 case did a Coroner order that a post mortem examination should be conducted.

In the vast majority of cases relatives of deceased persons who died suddenly during the year appreciated the importance of a thorough examination of the circumstances of the deaths. In many cases the results of the post mortem examinations provided important information for family members who would otherwise have been left with many unanswered questions surrounding the deaths.
REFERRALS – CORONIAL COUNSELLING SERVICE

1 July, 2001 – 30 June, 2002

TOTAL NEW CONTACTS
(letters to Next of Kin or referral from clients, other agencies or police)

3,576

<table>
<thead>
<tr>
<th>Information</th>
<th>Objection</th>
<th>Coronial Procedure</th>
<th>Retention</th>
<th>File Viewing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Objection</td>
<td>390</td>
<td>2,008</td>
<td>171</td>
<td>176</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Counselling</th>
<th>Phone</th>
<th>Office</th>
<th>Home</th>
</tr>
</thead>
<tbody>
<tr>
<td>Phone</td>
<td>1,048</td>
<td>240</td>
<td>172</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Support</th>
<th>Scene Mortuary</th>
<th>Court</th>
</tr>
</thead>
<tbody>
<tr>
<td>Scene Mortuary</td>
<td>28</td>
<td>61</td>
</tr>
</tbody>
</table>
The Coronial Ethics Committee has undergone some changes in composition since the previous financial year, and hopes to add two further members in the new financial year to bring it in line with the suggested composition of Ethics Committees as detailed in the National Health and Medical Research Councils (NHMRC) Guidelines.

During the year, two of the founding members of the Committee resigned due to other commitments. Ms Lesley Maloney, Deputy Chairperson of the Committee, and Mr Jeffrey Trudgian, the layman member, were both active members of the Committee and played an important role in its establishment. The fact that the Committee has efficient procedures in place and has functioned successfully since the first meeting on 17 March 1998, is in no small measure due to their efforts.

The resignation of Mr Trudgian leaves the Committee without a layman member. The Committee is endeavoring to identify a new candidate for that position, who can be nominated as a replacement member to the State Coroner.

The Committee has been assisted in the past by a member of the Aboriginal Justice Council. A new Aboriginal Justice Council representative was nominated as a member of the Committee early this year. Unfortunately, the Government disbanded the Aboriginal Justice Council on 1 May 2002 and consequently, their representative is no longer available to participate on the Committee. The Committee is currently attempting to find a suitable replacement in order to support the State Coroner’s commitment to obtaining opinions from the broader community.

Sarah Linton, Counsel Assisting the State’s Coroners, replaced Zoe Windsor as Secretary for the Committee in May 2002. To perform this function, Ms Linton is now assisted by Ms Claire Brockett, who provides secretarial support. The Secretary is responsible for ensuring that committee members are equipped with necessary documents for meetings and for ensuring
that a projects register is maintained and monitored. This register is retained at the Coroner’s Office.

The members of the Committee are as follows:

**Associate Professor Jennet Harvey** - *Chairperson*
Department of Pathology, UWA

**Reverend Michaela Tiller** – *Deputy Chairperson*
Executive Officer of Uniting Care, Uniting Church

**Ms Sarah Linton** - *Secretary*
Lawyer, Coroner’s Office

**Ms Evelyn Vicker S.M.**
Deputy State Coroner

**Dr Gerard Cadden**
Forensic Pathologist, PathCentre

**Professor John Papadimitriou**
Department of Pathology, UWA

**Ms Jan Battley**
Executive Director, Holyoake

**Ms Pam McKenna**
Director, Palmerston

**Ms Martine Pitt**
Executive Director, Communicare

The Committee attempts to strike a balance between family concerns (including privacy, confidentiality and consent issues), and the possible benefits of research to the community at large. The Committee then makes recommendations to the State Coroner to assist him to decide whether to approve a project or to allow access to coronial records.
The Application Form, drafted by the Committee in 1999, for use by persons seeking access to coronial information or to tissue, has proved to be a very fair and efficient means of assessing possible research projects and has allowed the Committee to consider a number of such projects more quickly.

The Committee has addressed the following projects during the last financial year as indicated in the table below.

<table>
<thead>
<tr>
<th>Number of Projects Considered</th>
<th>Number of projects approved</th>
<th>Number of projects not approved</th>
</tr>
</thead>
<tbody>
<tr>
<td>22</td>
<td>19</td>
<td>3</td>
</tr>
</tbody>
</table>

The considerable efforts of the Ethics Committee during the year are very much appreciated by the Coroners Court, particularly when it is considered that the Committee works on a voluntary basis and all members fit Committee work into otherwise very busy schedules.

**Counsel to Assist Coroners**

In May, 2002 Ms Sarah Linton replaced Ms Zoe Windsor as counsel assisting pursuant to a secondment arrangement with the Office of the Director of Public Prosecution.

Ms Linton will continue to be seconded to the Coroner’s Court until the beginning of May 2003.

In addition the Police Service continues to provide assistance to the Coroner’s Court in the form of two police officers who act as officers assisting, namely Sergeant Peter Harbison and Sergeant Dominic Licastro. These officers bring a wealth of experience and relevant knowledge to the task.
In a number of more complex cases Mr Dominic Mulligan was retained as counsel assisting. Mr Mulligan was the first counsel assisting appointed at the Coroner’s Court in 1997-1998 and he now practices as a Barrister and Solicitor in private practice.

Ms Linton and Mr Mulligan have provided the Court with a very high level of processional assistance which is necessary for the conducting of complex and important Inquest hearings and their assistance is clearly necessary in cases where issues arise relating to police involvement.

**Inquests**

During the year Inquests were heard by the State Coroner, Mr Alastair Hope, the Deputy State Coroner, Ms Evelyn Vicker, Mr Steve Wilson, Carnarvon Regional Coroner and Mr Greg Cockram who assisted the Coroners Court.

A total of 43 Inquests were heard during the year with a total number of 132 sitting days.

The State Coroner heard 17 Inquests with a total of 71 sitting days. The Deputy State Coroner heard 22 Inquests with a total of 45 sittings days. The Carnarvon Regional Coroner heard 2 Inquests and sat at the Perth Coroners for a total of 10 sitting days. Mr Cockram also heard 2 matters and sat a total of 6 sitting days.

There were 17 Inquests heard which involved Prison Deaths In Custody and 2 deaths which had police involvement.

The State Coroner and Deputy State Coroner conducted a total of 7 Inquests in country regions.

A chart follows detailing the Inquests conducted during the year.
It would be noted that in the case of the 1,500 cases each year which are not Inquested, each of these cases is investigated and in every case Findings are made by a Coroner and a Record of Investigation into Death document is complete detailing the results of the investigations which have been conducted.

In Perth the majority of these cases are determined by the Deputy State Coroner while in the country regions they are determined by the Regional Coroner.
<table>
<thead>
<tr>
<th>NAME</th>
<th>DATE OF DEATH</th>
<th>DATE OF INQUEST</th>
<th>NUMBER OF SITTING DAYS</th>
<th>CORONER</th>
<th>COURT SITTING</th>
<th>FINDING COMMENTS OR RECOMMEND</th>
<th>DATE OF FINDING</th>
</tr>
</thead>
<tbody>
<tr>
<td>HANCOCK</td>
<td>13/6/00</td>
<td>12-13/6/00</td>
<td>30</td>
<td>STATE</td>
<td>CLC AXA FREMANTLE</td>
<td>Natural Causes</td>
<td>26/4/02</td>
</tr>
<tr>
<td></td>
<td>19/12/00</td>
<td>9/4-16/5/01</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>6/8/01-</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>FRY</td>
<td>2/11/99</td>
<td>3-4/7/01 + 13/7/01</td>
<td>3</td>
<td>DEPUTY</td>
<td>CLC</td>
<td>Natural Causes</td>
<td>13/7/01</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>JOSEPH</td>
<td>16-20/7/01</td>
<td>23/8/01</td>
<td>7</td>
<td>STATE</td>
<td>KARRATHA</td>
<td>Suicide</td>
<td>12/12/01</td>
</tr>
<tr>
<td></td>
<td>23/11/01</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SAUNDERS</td>
<td>8/3/00</td>
<td>17-19/7/01</td>
<td>3</td>
<td>DEPUTY</td>
<td>PERTH</td>
<td>Misadventure</td>
<td>27/7/01</td>
</tr>
<tr>
<td>DUFF</td>
<td>20/10/00</td>
<td>16/8/01</td>
<td>1</td>
<td>DEPUTY</td>
<td>PERTH</td>
<td>Accident</td>
<td>24/8/01</td>
</tr>
<tr>
<td>PITT</td>
<td>18/7/00</td>
<td>21/8/01 + 23/8/01 + 30/10/01</td>
<td>3</td>
<td>DEPUTY</td>
<td>PERTH</td>
<td>Accident</td>
<td>19/11/01</td>
</tr>
<tr>
<td>DI SILVO</td>
<td>11/12/00</td>
<td>28/8/01</td>
<td>1</td>
<td>DEPUTY</td>
<td>PERTH</td>
<td>Accident</td>
<td>7/9/01</td>
</tr>
<tr>
<td>COYNE</td>
<td>19/8/99</td>
<td>10-12/9/01</td>
<td>3</td>
<td>DEPUTY</td>
<td>CLC</td>
<td>Suicide</td>
<td>14/9/01</td>
</tr>
<tr>
<td>THOMAS</td>
<td>16/3/00</td>
<td>10-11/9/01</td>
<td>5</td>
<td>CARNARVON</td>
<td>PERTH</td>
<td></td>
<td></td>
</tr>
<tr>
<td>JENSON BROAD SMITH</td>
<td>8/7/00</td>
<td>9-10/10/01</td>
<td>2</td>
<td>STATE</td>
<td>PERTH</td>
<td>Accident</td>
<td>12/10/01</td>
</tr>
<tr>
<td>TAYLOR</td>
<td>12/2/99</td>
<td>22-30/10/01</td>
<td>8</td>
<td>STATE</td>
<td>PERTH</td>
<td>Suicide</td>
<td>21/11/01</td>
</tr>
<tr>
<td>TRUONG x 2</td>
<td>21/10/99</td>
<td>1/11/01</td>
<td>1</td>
<td>DEPUTY</td>
<td>PERTH</td>
<td>Unlawful Homicide</td>
<td>12/11/01</td>
</tr>
</tbody>
</table>
### INQUESTS FOR THE YEAR 1 JULY, 2001 - 30 JUNE, 2002

<table>
<thead>
<tr>
<th>NAME</th>
<th>DATE OF DEATH</th>
<th>DATE OF INQUEST</th>
<th>NUMBER OF SITTING DAYS</th>
<th>CORONER</th>
<th>COURT SITTING</th>
<th>FINDING COMMENTS OR RECOMMEND</th>
<th>DATE OF FINDING</th>
</tr>
</thead>
<tbody>
<tr>
<td>GARNER</td>
<td>6/1/00</td>
<td>5-6/11/01</td>
<td>2</td>
<td>DEPUTY</td>
<td>FREMANTLE</td>
<td>Suicide</td>
<td>19/11/01</td>
</tr>
<tr>
<td>FRAGOMENI</td>
<td>1/7/00</td>
<td>6/11/01</td>
<td>1</td>
<td>STATE</td>
<td>PERTH</td>
<td>Natural Causes</td>
<td>8/11/01</td>
</tr>
<tr>
<td>ADACHI</td>
<td>2/12/98</td>
<td>12-14/11/01</td>
<td>3</td>
<td>STATE</td>
<td>PERTH</td>
<td>Accident</td>
<td>20/11/01</td>
</tr>
<tr>
<td>BRIGGA</td>
<td>31/7/00</td>
<td>20/11/01</td>
<td>1</td>
<td>DEPUTY</td>
<td>PERTH</td>
<td>Accident</td>
<td>20/12/01</td>
</tr>
<tr>
<td>WESLEY</td>
<td>7/5/00</td>
<td>26-28/11/01</td>
<td>3</td>
<td>DEPUTY</td>
<td>FREMANTLE</td>
<td>Suicide</td>
<td>11/1/02</td>
</tr>
<tr>
<td>BROOKS</td>
<td>17/1/00</td>
<td>26-30/11/01</td>
<td>5</td>
<td>STATE</td>
<td>PERTH</td>
<td>Lawful Homicide</td>
<td>19/12/01</td>
</tr>
<tr>
<td>TAN</td>
<td>19/1/00</td>
<td>3/12/01</td>
<td>6</td>
<td>COCKRAM</td>
<td>PERTH</td>
<td>Accident</td>
<td>23/7/02</td>
</tr>
<tr>
<td>COFFEE</td>
<td>28/1/00</td>
<td>10/12/01</td>
<td>1</td>
<td>COCKRAM</td>
<td>PERTH</td>
<td>Suicide</td>
<td>19/12/01</td>
</tr>
<tr>
<td>MATTHEWS</td>
<td>22/5/00</td>
<td>15-16/1/02</td>
<td>2</td>
<td>DEPUTY</td>
<td>CLC</td>
<td>Natural Causes</td>
<td>1/2/02</td>
</tr>
<tr>
<td>WILSON</td>
<td>7/6/00</td>
<td>22/1/02</td>
<td>1</td>
<td>DEPUTY</td>
<td>CLC</td>
<td>Natural Causes</td>
<td>1/2/02</td>
</tr>
<tr>
<td>SAVORY</td>
<td>23/5/00</td>
<td>5-7/2/02</td>
<td>3</td>
<td>DEPUTY</td>
<td>ALBANY</td>
<td>Suicide</td>
<td>15/2/02</td>
</tr>
<tr>
<td>CLOTHIER</td>
<td>3/1/01</td>
<td>12-13/2/02</td>
<td>2</td>
<td>DEPUTY</td>
<td>PERTH</td>
<td>Accident</td>
<td>22/2/02</td>
</tr>
<tr>
<td>STUBBS</td>
<td>20/2/02</td>
<td>1</td>
<td>STATE</td>
<td>FREMANTLE</td>
<td>Wilful Murder</td>
<td>21/2/02</td>
<td></td>
</tr>
<tr>
<td>CRUSE</td>
<td>24/4/01</td>
<td>25-26/2/02</td>
<td>2</td>
<td>DEPUTY</td>
<td>PERTH</td>
<td>Accident</td>
<td>8/3/02</td>
</tr>
<tr>
<td>DAVIDSON</td>
<td>5/6/00</td>
<td>11-13/3/02</td>
<td>3</td>
<td>DEPUTY</td>
<td>CLC</td>
<td>Suicide</td>
<td>12/4/02</td>
</tr>
</tbody>
</table>
## INQUESTS FOR THE YEAR 1 JULY, 2001 - 30 JUNE, 2002

<table>
<thead>
<tr>
<th>NAME</th>
<th>DATE OF DEATH</th>
<th>DATE OF INQUEST</th>
<th>NUMBER OF SITTING DAYS</th>
<th>CORONER</th>
<th>COURT SITTING</th>
<th>FINDING COMMENTS OR RECOMMEND</th>
<th>DATE OF FINDING</th>
</tr>
</thead>
<tbody>
<tr>
<td>HEWETT, MACKAY, FINEBERG, WOODS, WOODS, CLARKSON, LUBERDA, MOSEDALE</td>
<td>4/9/00</td>
<td>13-16/3/02 17/5/02 17-19/7/02</td>
<td>8</td>
<td>STATE</td>
<td>AXA</td>
<td>Natural Causes</td>
<td>5/4/02</td>
</tr>
<tr>
<td>LAWSON</td>
<td>26/5/00</td>
<td>3-4/4/02</td>
<td>2</td>
<td>STATE</td>
<td>KALGOORLIE</td>
<td>Open Finding</td>
<td>26/4/02</td>
</tr>
<tr>
<td>OTERO</td>
<td>15/6/00</td>
<td>8-10/4/02</td>
<td>3</td>
<td>DEPUTY</td>
<td>CLC</td>
<td>Accident</td>
<td>26/4/02</td>
</tr>
<tr>
<td>MOORE</td>
<td>8/12/00</td>
<td>16-18/4/02</td>
<td>3</td>
<td>STATE</td>
<td>PERTH</td>
<td>Suicide</td>
<td>3/5/02</td>
</tr>
<tr>
<td>THERON</td>
<td>25/6/00</td>
<td>16/4/02</td>
<td>1</td>
<td>DEPUTY</td>
<td>CLC</td>
<td>Accident</td>
<td>10/5/02</td>
</tr>
<tr>
<td>PRIDHAM</td>
<td>11/2/01</td>
<td>29/4-1/5/02</td>
<td>2</td>
<td>STATE</td>
<td>ALBANY</td>
<td>Suicide</td>
<td>22/5/02</td>
</tr>
<tr>
<td>CRAIG</td>
<td>5/12/00</td>
<td>29/4-2/5/02</td>
<td>3</td>
<td>DEPUTY</td>
<td>CLC</td>
<td>Accident</td>
<td>17/5/02</td>
</tr>
<tr>
<td>CRIDDLE</td>
<td>3/9/00</td>
<td>13-1/5/02</td>
<td>5</td>
<td>WILSON</td>
<td>CLC</td>
<td>Accident</td>
<td>7/6/02</td>
</tr>
<tr>
<td>POOLE</td>
<td>14/4/00</td>
<td>14-16/5/02</td>
<td>3</td>
<td>DEPUTY</td>
<td>CLC</td>
<td>Accident</td>
<td>24/5/02</td>
</tr>
<tr>
<td>O'SHAUGHNESSY</td>
<td>21/7/01</td>
<td>20/5/02</td>
<td>1</td>
<td>STATE</td>
<td>PERTH</td>
<td>Accident</td>
<td>10/6/02</td>
</tr>
<tr>
<td>THOMPSON</td>
<td>25/8/99</td>
<td>28/5/02</td>
<td>1</td>
<td>STATE</td>
<td>GERALDTON</td>
<td>Misadventure</td>
<td>19/6/02</td>
</tr>
<tr>
<td>PARKIN</td>
<td>24/10/99</td>
<td>29-31/5/02</td>
<td>3</td>
<td>STATE</td>
<td>GERALDTON</td>
<td>Accident</td>
<td>11/6/02</td>
</tr>
<tr>
<td>SCANLAN</td>
<td>19/3/00</td>
<td>10-11/6/02</td>
<td>2</td>
<td>DEPUTY</td>
<td>COLLIE</td>
<td>Accident</td>
<td>11/6/02</td>
</tr>
<tr>
<td>HMAS WESTRALIA</td>
<td></td>
<td>14/6/02</td>
<td>1</td>
<td>STATE</td>
<td>AXA</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
INQUESTS FOR THE YEAR 1 JULY, 2001 - 30 JUNE, 2002

<table>
<thead>
<tr>
<th>NAME</th>
<th>DATE OF DEATH</th>
<th>DATE OF INQUEST</th>
<th>NUMBER OF SITTING DAYS</th>
<th>CORONER</th>
<th>COURT SITTING</th>
<th>FINDING COMMENTS OR RECOMMEND</th>
<th>DATE OF FINDING</th>
</tr>
</thead>
<tbody>
<tr>
<td>ALI</td>
<td>11/12/00</td>
<td>14-28/6/02</td>
<td>5</td>
<td>STATE</td>
<td>PERTH</td>
<td>Accident</td>
<td>12/7/02</td>
</tr>
<tr>
<td>RAPLEY</td>
<td>2/9/99</td>
<td>24-26/6/02</td>
<td>3</td>
<td>DEPUTY</td>
<td>CLC</td>
<td>Suicide</td>
<td>5/7/02</td>
</tr>
</tbody>
</table>

Mr Hope 17 Inquests 83 sitting days  
Ms Vicker heard 22 Inquests 48 sitting days  
Mr Wilson heard 2 Inquests 10 sitting day  
Mr Cockram heard 2 Inquests 6 sitting days

Total Inquests heard 43  
Number of Sitting Days 131

16 Prison Deaths In Custody Heard  
7 Country deaths heard by Metropolitan Coroners
**Langley George HANCOCK**

An Inquest was conducted into the circumstances of the death of Langley George Hancock by the State Coroner on 12 June, 2000, 19 December, 2000, 9 April – 16 May, 2001 and 6–31 August, 2001.

Langley George Hancock (the deceased) died on 27 March, 1992 at a guesthouse at 151 Wellington Street, Mosman Park.

At the time of his death the deceased was 82 years of age. He had suffered from serious heart disease and renal failure and required constant medical care and attention.

Following the receipt of a number of submissions on behalf of Mrs Rinehard and her family which contended that there was a substantial amount of “new evidence” available which suggested that the wife of the deceased may have deliberately caused his death, a decision was made that it was necessary for an Inquest to be held. The State Coroner took the view that such serious allegations could not be ignored and that there was no alternative, other than to have those allegations tested in open Court.

In reasons provided on 26 April, 2002 the State Coroner expressed the view that he did not accept that the death was a homicide, he accepted the Chief Forensic Pathologist’s evidence to the effect that the medical cause of death was Arteriosclerotic Cardiovascular Disease in a man with Chronic Renal Failure and found that the arose by way of Natural Causes.

**Bronzewing Mine Site**

**Shane HAMILL, Troy Terrence WOODARD & Timothy Lee BELL**

An Inquest was conducted into the deaths of Shane Hamill, Troy Terrence Woodard and Timothy Lee Bell at the Kalgoorlie Court on 18-28 June, 2001.
On the 26 June, 2000 all deceased men were working at the Bronzewing Gold Mine which is a gold mine located approximately 80 kilometres north east of the town of Leinster in the northern goldfields. The mine is owned by Normandy Yandal Operations Ltd. Underground mining operations were being carried out by the mining contractor, Bradrill Ltd under a contract arrangement with Normandy.

The mine initially consisted of 2 surface open pits which were mined to completion in the mid 1990's. These pits are known as the Discovery and Central Pits. On 26 June, 2000 the ore bodies below both pits were being mined by underground methods. At the time of the incident a stope, known as the Sliver Stope, was being filled.

At the time the stope was being filled with uncemented hydraulic fill which was pumped underground to the top of the Sliver Stope on level 9. It was then allowed to fall to the bottom of the void, gradually filling the stope.

The fill was to be held in place in the stope and out of the tunnels where the men were working by purpose built barricade walls.

At approximately 5:00pm on 26 June, 2000 the backfill barricade wall on the 12 level collapsed and a very large amount of fill material poured into the mine.

When the wall collapsed backfill material and water in a liquid state flowed through the mine engulfing the three men and causing their deaths.

All three men died as a consequence of inhalation of backfill material and water.

When the barricade wall collapsed a number of other men who were working in the mine were fortunate to have survived, there could have been more deaths.
It was the view of the State Coroner that the backfill material placed in the Sliver Stope had been inadequately drained and for that reason when the wall failed the backfill material and water flowed through the mine eventually leaving the stope itself almost empty.

The State Coroner commented that “it is clear that when a hydraulic fill system is being used, adequate drainage is of fundamental importance.”

The State Coroner also observed that the case had highlighted the fact that there appears to be limited knowledge in relation to strengths which can be expected of barricade walls saturated with water.

The State Coroner found that there was no seismic event or other such activity which contributed to the deaths, the backfill was placed and the walls were constructed by human activity and so the deaths resulted from human actions.

The State Coroner found that there were no suspicious circumstances and no person deliberately contributed in any way to the deaths.

The State Coroner found that the deaths arose by way of Accident although the verdict of Misadventure would be equally open.

Extensive Comments on Safety Issues were made by the State Coroner who highlighted 9 particular safety issues.

On the 9 August, 2001 Mr Jim Limerick, Director General of the Department of Mineral and Petroleum Resources, responded to the State Coroner’s principal recommendations.

Mr Limerick advised that the Department has taken steps to convey to industry the Coroner’s findings following the inquest.
The Department is also working on preparation of a comprehensive guide document dealing with all types of filling operations which it is hoped will be of use not only to the industry in WA, but to the mining community on a world-wide basis.

In addition the Department is working to improve training and information available to the industry in WA in relation to placement and retention of fill.

**Benjamin James PITT**

The Deputy State Coroner held an inquest into the death of Benjamin James Pitt (the deceased) on 21 & 23 August 2000 and 30 October, 2001 at the Coroners Court. The deceased was a 27-year-old veterinarian who died following a fall from the landing at the top of a stairwell outside a nightclub on the 3rd floor of a building in Subiaco.

An issue of concern was whether or not the balustrading on the stairwell and landing complied with building requirements, and whether or not legislation in the area of height of balustrades on landings and stairwells was adequate. There were two main sources of relevant legislation; the *Building Codes of Australia* and their precursors, and the *Health (Public Buildings) Regulations 1992*.

Recommendations were not made at the conclusion of the inquest because the Deputy State Coroner was unable to determine the exact cause of Benjamin Pitt’s fall. However, the issue of landing and stairwell balustrades was discussed in general terms from the aspect of expected usages of those areas. It was suggested in areas of special usage, for example nightclubs where patrons may be inebriated, it may be necessary to consider special conditions over and above mere compliance with legislation.
An Inquest was conducted into the deaths of Christian Laurence Jensen, Jessica-Lea Campbell Broad and Hilary Rebecca Smith by the State Coroner on the 9-10 October, 2001 at the Perth Coroners Court.

The State Coroner concluded that Christian Laurence Jensen, Jessica-Lea Campbell Broad and Hilary Rebecca Smith all died on 8 July, 2000 when the car in which they were travelling was struck by a train at the Yarramony Road Railway Crossing, Yarramony.

It was not clear why the occupants of the vehicle did not appear to have been alerted to the impending collision.

It was clear that the signage on the road did not warn motorists of the presence of the railway crossing as effectively as signage which had been installed after the tragedy.

The State Coroner found that the train was not well lit and that a number of past studies, including a USA Federal Railroads Administration Report, had concluded that headlights of the type on the locomotive in question provide a very narrow beam width and have a focus angle which does not provide an effective warning to motor vehicle drivers unless the motor vehicle is stopped near the crossing. These studies had been known to Westrail for at least five years before the crash.

The State Coroner found that the deaths arose by way of Accident.

The State Coroner made a number of comments on safety issues including the extent of the hazard posed by the train, the road markings and particularly the lighting of the train.

On the 12 December, 2001 Mr Paul Joyce, Policy Officer with the Office of the Minister for Planning and Infrastructure, wrote to the State Coroner advising that the Minister had accepted all of
the findings and that a report had been prepared with a view to improving safety at passively protected level crossings. The letter also advised of the appointment of an independent consultant retained to test the strobe light system and compare it with the crossing lights system favoured by the US Federal Rail Authority for locomotive visibility.

The report has also recommended consideration of changes in other areas such as improving signage, installing "rumble strips" at crossing approaches, clearance of vegetation to improve sight lines, slowing traffic at crossing approaches and driver education.

A further letter has subsequently been received by the State Coroner from Mr Joyce, dated 16 January, 2002 advising of a proposed trial to be conducted at the Yarramony Road level crossing over the period 24-25 January, 2002.

Unfortunately it would appear from correspondence from the families of the deceased that trains in WA still do not have lights illuminating them from a side-on view.

It would seem that Westnet does not accept that there should be any lights on the top of trains and so trains remain the most dangerous and poorly lit of all large vehicles which motorists may encounter at night.

Even if strobe lights are believed to be unsatisfactory for some reason, there would appear to be no good reason for failing to have some form of lighting illuminating the side of trains at night.

Susan Ann TAYLOR

An Inquest was conducted into the death of Susan Ann Taylor, a 15 year old Aboriginal female, by the State Coroner on 22-30 October, 2001. The deceased had been located hanging on 12 February, 1999.
On the 4 January, 1999 the deceased had made a complaint to Police at Midland Detectives Office in relation to an allegation of an indecent assault and a physical assault which she claimed had been perpetrated on her by her uncle.

This matter was never fully investigated by Police and due to her tragic death it was determined that there was insufficient evidence for any charge to be laid.

At the Inquest evidence was led from a number of persons relating to concerns as to sexual abuse taking place in the Lockridge Campsite area and nearby locations. A number of witnesses gave evidence of older white men providing paint or solvent in exchange for sexual favours.

The Inquest also heard evidence from two female persons about regular sexual abuse of young persons taking place at the Lockridge campsite itself.

The State Coroner made the following comment:

“This case has highlighted the fact that sexual abuse of young Aboriginal Persons throughout Western Australia is common.

It is also clear that only a very small proportion of those cases are reported to appropriate authorities.”

The State Coroner found that the deceased died of Ligature Compression of the Neck (Hanging) after being found hanging from a hose at a toilet/ablution block at the Lockridge Campsite.

The investigation conducted by police was not sufficiently thorough to determine with certainty the circumstances in which the deceased was found and whether there was any significant delay, for example, in attempting to resuscitate her.
In the light of the lack of evidence in respect of the discovery of the deceased, the state of her clothing and the possible involvement of others in her death an Open Finding was made.

The State Coroner made a number of recommendations including a recommendation that the Health Department retain statistics which would identify sexual abuse in cases where chlamydia and gonorrhoea notifications relate to genital infection. He stressed that these statistics should not be confused with statistics relating to other infections which may not be sexually transmitted.

It was also the State Coroner’s view that that in every case of a young person who has been infected by a sexually transmitted disease there should be mandatory reporting by medical practitioners and other health workers and statistics should be maintained as to the outcome of any investigations.

A letter was received from the Minister for Health dated 20 February, 2002 advising that the Communicable Disease Control Branch, which currently maintains a database of notifiable diseases including those transmitted sexually, planned to improve the usefulness of the data base by differentiating more clearly between genital and non-genital infections. The database would be further enhanced by legislation requiring laboratories as well as doctors to notify of any such diseases.

The Premier, Dr Gallop, told State Parliament on 28 November, 2001 that the Coroner’s Inquest had prompted the State Government to hold an inquiry into the way Government agencies and non-Government organizations deal with the incidence of child abuse in Aboriginal communities.

Dr Gallop said that he had been shocked and disturbed by the Coroner’s Report, which included allegations of physical and sexual abuse at the camp.

Subsequently an Inquiry, chaired by Ms Sue Gordon AM, has been conducted into the Response by Government Agencies to
Complaints of Family Violence and Child Abuse in Aboriginal Communities.

It is hoped that the conclusions and recommendations following this Inquiry will have far reaching benefits for Aboriginal communities in Western Australia.

**Kaori ADACHI**

An Inquest was conducted into the death of Kaori Adachi (the deceased) on 12-14 November, 2001 by the State Coroner at the Perth Coroners Court.

The deceased was a 23 year old Japanese female who had visited Australia for a working holiday from October 1997 until October 1998.

In April 1998 the deceased completed a diving course in Surfers Paradise in Queensland for which she received an Open Water Certificate.

The deceased travelled to Exmouth to meet with a friend who was employed by the Village Dive Shop in Exmouth as a dive instructor. She acted as an unpaid host for a group of Japanese tourists on their arrival at Exmouth on 29 November, 1998 and assisted a number of the group of tourists to fit diving equipment for a night dive on 1 December, 1998.

On 1 December, 1998 the sea surface conditions were relatively rough and the Japanese divers found conditions difficult. There was also a relatively strong current.

The deceased became separated from the other divers and could not be located during a subsequent search. Her body was eventually discovered by divers at 12:50pm on 2 December, 1998.

The deceased had suffered an injury to her head which was not adequately explained and the State Coroner found that it
appeared likely that the injury was caused either in a contact with her dive buddy or his diving equipment or that at some stage the dive vessel had struck her.

The State Coroner concluded that the death should never have occurred and expressed the view that the death was contributed to by a number of safety deficiencies in the dive which took place and the rescue steps which followed when it was discovered that the deceased was missing.

The State Coroner found that the death arose by way of Accident.

The State Coroner made comments in relation to deficiencies which he found in the police investigation. The State Coroner commented that the police investigation should operate independently of any WorkSafe investigations.

The State Coroner also concluded that there was an unacceptable delay from the time when it was discovered that the deceased had disappeared until a vessel was used to search for her. The State Coroner commented that professional diving operators should be required to have a rescue craft which could be deployed immediately to assist any recreational divers who experience difficulties in the water.

In this case adequate out of water supervision was not provided even though two groups were diving at the same time. The State Coroner recommended that out of water supervision should be provided by a person specifically allocated that task.

The State Coroner commented that this case highlighted the fact that overseas divers may be relatively inexperienced for dives which take place in unfamiliar waters in Australian conditions irrespective of their apparent PADI qualifications.

Following the Finding which was delivered on 20 November, 2001, the Minister for Consumer and Employment Protection, Mr John Kobelke MLA wrote to the State Coroner advising that on
8 December, 2001 the Minister for Sport and Recreation announced release of the Recreational Diving and Snorkelling Codes for Western Australia. Codes would be reviewed after twelve months.

The letter advised that it would be necessary for the industry to submit the code to the WorkSafe WA Commission for consideration, if approval is to be sought as a code of practice under Section 57 of the Occupational Safety and Health Act 1984.

The State Coroner responded to the Minister's letter dated 26 February, 2002 expressing his support for the positive action being taken to prevent a repetition of such a tragedy.

Timothy Wayne CLOTHIER

The Deputy State Coroner conducted an inquest into the death of Timothy Wayne Clothier (the deceased) on 12–13 February 2002 at the Perth Coroner’s Court.

The deceased was 17 years of age at the time of his death on 3 January 2001. He had been in possession of his probationary motor vehicle drivers licence for approximately 6 weeks.

On the night of his death he was driving his father’s vehicle south on Fiegerts Road towards the intersection with Pinjarra Road. The road was newly under construction and did not at the time of the accident have any warning signs indicating it terminated at Pinjarra Road. The road rules require a driver on a terminating road give way to traffic on a through road, and traffic on a gravel road give way to traffic on a sealed road.

It was likely Timothy Clothier had driven on Fiegerts Road in the preceding weeks at night-time, but it was unclear as to whether or not it had at that stage been sealed.

The inquest heard evidence about the system in place for signage of roadways falling under the province of the Main Roads...
Department and Local Councils. There was no requirement for a regulatory sign at that intersection, however, it is likely some form of hazard signage would have assisted a driver as inexperienced as Timothy in assessing appropriate driving to the road conditions. Due to the fact the intersection was still technically under construction the appropriate signage for the completed intersection had not yet been addressed.

The Deputy State Coroner was of the view an experienced driver would probably have obtained visual clues as to the approaching terminating road. It was entirely possible the lack of hazard or warning signs of a terminating road decreased the scope of visual clues for an inexperienced driver.

Timothy Clothier only appeared to appreciate the presence of a truck on Pinjarra Road when he had visibility of the truck itself as opposed to its headlight pre-path. At that stage it was too late for him to take appropriate evasive action. The vehicle he was driving was struck by the truck which had attempted evasive action. He died at the scene of the collision.

*Kieran John O'SHAUGHNESSY*

An Inquest was conducted by the State Coroner on 20 May, 2002 into the death of Kieran John O'Shaughnessy (the deceased) at the Perth Coroners Court.

The deceased was struck by a train approximately 200 metres North of the Joondalup Train Station in the early hours of the morning on Saturday 21 July, 2001.

The deceased was seen at the Joondalup Railway Station at about 1:40am; and was spoken to by a Railway Special Constable and a Security Officer. After satisfying themselves that the deceased was well, they continued to go about their duties after positioning a surveillance camera onto the deceased who then seemed to be asleep.
The deceased had left the platform at 2:20am. The last train passed through Joondalup at approximately 2:25am and shortly afterwards the security officers were advised that the train had hit the deceased in the Joondalup tunnel.

The State Coroner concluded that in the early hours of the morning of 21 July, 2001 the deceased, who was significantly affected by alcohol, walked in a northerly direction along a rail line into a tunnel. Although the train driver took immediate action on seeing the deceased he was not able to stop the train in time to avoid the collision.

The reason for the deceased walking in a northerly direction when his home was located in a southerly direction is not known and it would appear that he may have been confused as a result of the alcohol which he had consumed.

The State Coroner found that the death arose by way of Accident.

The State Coroner commented in relation to a number of deficiencies in the investigation and the current Police Orders relating to investigation of railway fatalities.

These issues have subsequently been addressed by the Police Service and the Operating Procedures have been amended to improve the quality of railway fatality investigation.

Donnelle Kay PARKIN

On 29-31 May, 2002 the State Coroner conducted an Inquest into the death of Donnelle Kay Parkin at the Geraldton Court House.

On 23 October, 1999 Nigel Kingsley Broadhead and Donnelle Kay Parkin (the deceased) visited a farm property named "Tarcoola", located on Erriary Road, West Binnu.
They had flown from Carnarvon and had arrived at the property at about 4:45pm.

On the next morning they left the property in a helicopter owned and being flown by Mr Nigel Broadhead at approximately 8:45am. Shortly afterwards the helicopter struck power lines while traveling at a significant horizontal speed and crashed. The deceased died at the scene and Mr Broadhead suffered injuries.

The State Coroner found at the time of the crash the helicopter was flying very low and at some speed.

The State Coroner found that the pilot had not demonstrated an adequate approach to safety issues and did not carry out proper checking procedures prior to flying close to the ground.

The State Coroner also found that the investigation into the circumstances of the crash was not conducted in a coherent and efficient manner because of poor interaction between the three investigative organizations involved and important evidence had been lost.

The State Coroner found that the cause or causes of the crash could not be determined with any confidence, although there was no evidence of any mechanical problems contributing to the crash.

The State Coroner found that the death arose by way of Misadventure.

The State Coroner made a number of Comments in his finding concerning safety issues which were raised at the Inquest hearing. In relation to a number of these issues, it was the view of CASA that they involved possible breaches of the Civil Aviation Act (1988) and Civil Aviation Regulations (1988).
In addition the State Coroner concluded that it was to the detriment of CASA that exhibits, such as a fuel sample, were destroyed by the ATSB without testing.

The State Coroner was provided with a copy of Memorandum of Understanding between the ATSB and CASA dated 29 June, 2001 which encourages a degree of co-operation.

Clause 6.6 of that document provides –

"As far as it is reasonably practicable, ATSB and CASA will endeavour to ensure that their investigations do not impede any investigations by the other organization. If either party considers an investigation is creating an unreasonable impediment they will raise the matter with the other party”.

The State Coroner found that the provisions of that Memorandum of Understanding provided little assistance in cases where exhibits are seized by the ATSB, after which they are effectively of no use to other investigative authorities pursuant to current legislation as interpreted by the ATSB.

The State Coroner recommended that consideration be given to reviewing the Air Navigation Act 1920 so that evidence obtained by the ATSB should not be lost to other organizations interested in death prevention.

The State Coroner also recommend that the provisions of the Air Navigation Act 1920 be reviewed with a view to ensuring that CASA and police investigating air crashes have reasonable access to exhibits obtained by the ATSB, particularly when those exhibits are no longer required by the ATSB.

The State Coroner also recommended that the definition of "Air Safety Record" should be reviewed so that internal reports and documentation prepared by the ATSB which relate to the examination of aircraft parts should not be secret, particularly in the event of a fatal crash.
The State Coroner recommended that the CASA medical questionnaire for pilots should be re-drafted to be more simple and explicit.

A letter received from Mr Mick Toller, Director CASA, advised the State Coroner of CASA's ongoing willingness to assist Coroners in their inquiries into aviation accidents. Mr Toller also advised the State Coroner that the current Memorandum of Understanding between CASA and the ATSB will be reviewed for time to time to improve co-operation between the two organisations.

The Minister for Transport and Regional Services, Mr Anderson, responded to the inquest report by letter dated 19 August 2002, advising that the Executive Director of the ATSB and the Deputy Director of CASA had met on 6 July and agreed that additional guidance should be provided to the relevant officers of both bodies, and that CASA is currently reviewing its medical questionnaire forms.

The Minister also advised that the Transport Safety Investigation Bill 2002 had been introduced in Parliament on 20 June, 2002 and that the Bill addresses treatment of evidential material.

Kyle Umberto Di SILVIO

The Deputy State Coroner held an inquest into the death of Kyle Umberto Di Silvio on 28 August 2001 in the Coroners Court.

Kyle Di Silvio was an 11-month old toddler who had only, within the last week or so, learned to walk. He was a visitor with his mother at a household in Kewdale which had a family pool which did not comply with safety standards policed by the Local Council. It did not comply with the requirement the pool area be protected from the house by ensuring all doors had self-closing mechanisms, and the windows restricted openings. At the time of the incident it was discovered there was a faulty self-closing
mechanism on a sliding door onto the pool area. In addition it was possible a side door of the house was left open.

The significance of supervision in this case arises from the fact Kyle was the only toddler in the household, and died at a time when there were 7 adults at the property. Kyle’s absence was not noted until one of the young adults of the household found his body in the pool. It could not conclusively be determined how Kyle exited the house and found his way into the pool.

Following the death of the child the Council experienced some difficulty in causing property owners to comply with safety requirements. The Council attempted a conciliatory approach due to concern for the loss the family had experienced.

The Deputy State Coroner commented that regulation in the area of pool fencing was not the most significant factor. She was of the view that the most significant factor is maintenance and supervision. Even if a regulation does impose standards there has to be action on the part of property owners to ensure maintenance keeps properties complaint.

Evidence was heard from the Royal Life Saving Society as to their educational program in conjunction with Local Council inspection of pools. The Royal Life Saving Society’s program is directed at:

- Constant adult supervision – followed by
- Adequate fencing barriers (complaint with Australian Standard 1926.1 and 1926.2) to prevent access to pools when not in use.
- Participation in water familiarisation and learn to swim classes. It is important that this does not act as a substitute for adult supervision.
- Learn resuscitation

The Deputy State Coroner emphasised that constant adult supervision means conscious adult supervision. This case clearly demonstrated that simply because adults are around does not
mean a child will be observed. Adults must consciously supervise children in the vicinity of water.

   This child died from the effects of Immersion at Princes Margaret Hospital on 11 December 2000.

Wahib ALI
   An Inquest was conducted death of Wahib Ali (the deceased) on 24-28 June, 2002 at Perth Coroners Court by the State Coroner.

   The deceased, a 10 year old boy, died at Princess Margaret Hospital on 11 December, 2000.

   The deceased was born on 6 April, 1990 in Pakistan. When the deceased was about 5 years old his family moved to Melbourne and then subsequently in 1997 the family moved to Perth.

   The deceased was a healthy boy who rarely suffered from illness and led a normal, happy childhood.

   The deceased had been taking part in a school excursion with his school, Boyare Primary School, at Bayswater Waves Aquatic Centre when he was found at the bottom of the diving pool at the Centre apparently unconscious.

   At the time when the deceased was located in the diving pool, there were no teachers or other adults associated with Boyare Primary School closely supervising the diving pool and resuscitation attempts were made by teachers from Beldridge Senior High School, whose pupils were also attending the Aquatic Centre, and also by lifeguards attached to the Aquatic Centre.

   It was the view of the State Coroner that as the deceased was a weak swimmer he should not have been permitted to swim in a diving pool without close adult supervision.
A post mortem examination was conducted on 13 December, 2000 by pathologist Dr G A Cadden, who concluded that the medical cause of death was Immersion.

The State Coroner found that the death arose by way of Accident.

The State Coroner made a number of recommendations including a recommendation that the Education Department review its approach to professional development with a view to ensuring that teachers who will be expected to plan and conduct school excursions, particularly aquatic excursions, receive training on the practical application of relevant procedures and guidelines.

The Minister for Education, Mr Alan Carpenter MLA, provided advice on 7 August 2002 that the Department of Education has closely examined the Finding and has identified six key areas to receive immediate attention.

*Jennifer Ann CRUSE*

The Deputy State Coroner held an inquest into the death of Jennifer Ann Cruse on 25-26 February 2002 at the Perth Coroners Court. The deceased was a 19 year old Security Officer who fell from a balcony on the 6th floor of the Central Law Courts during a private social function for security officers working within the complex.

The Deputy State Coroner considered the actions of the deceased to be unexpected, in that, while inebriated she attempted to perform a gymnastic feat on the balcony wall. She then fell to her death on the concrete rooftop below. The wall complied with legislation for the purposes of normal usage and was of a safe height for a person of the build of Ms Cruse.
The recommendations made in respect of this death were specific to the site in question but raised the issue of safe balustrade heights which may require elevating over and above mere compliance with legislation. In this case there was a recommendation that the height of the balustrade be elevated artificially by installation of a guardrail along the top to provide a grip in the case of a fall, and increase the height at which a person’s centre of gravity could cause problems.

_Daren Cheng Lim TAN_

An inquest was conducted into the death of Daren Cheng Lim Tan (the deceased) at the Perth Coroner’s Court on 3 December, 2001 and 27-31 May, 2002 by Acting Coroner, Mr Phillip Gregory Cockram SM.

The deceased was 23 years of age at the time of his death on 19 January, 2000.

The deceased had been an excellent student and had graduated from the University of Western Australia in 1998 with double degrees in Commerce and Engineering with honours.

The deceased, at the time of his death, was working for Western Power Corporation as a Graduate Electrical Engineer.

At the time of his death the deceased was accompanying a Mr Pike who was undertaking metre-reading duties in the Coolgardie area.

The two men arrived at the Coolgardie Substation situated in Ladyloch Road, Coolgardie at approximately 12:15pm. The substation and pumping station are both contained within a wire mesh fence topped with barbed wire.

Mr Pike read the electricity metre while the deceased assessed the maintenance requirements for the substation. There was a discussion about vegetation and the likely delay in its
removal from the enclosed area and Mr Pike used a key to open the gate of the wire mesh fence enclosure.

The deceased and Mr Pike were about to go and have lunch when the deceased received a large electric shock which caused him to become engulfed with fire.

The fire brigade and an ambulance were called and the deceased was conveyed to Kalgoorlie Regional Hospital. The deceased was then flown to Perth by the Royal Flying Doctor Service and admitted to the Burns Unit at Royal Perth Hospital where he was certified life extinct at 20:23hours.

Mr Cockram SM. concluded that the deceased died as the result of Thermal Injury in Association with Electrocution arising out of contact with, or sufficient proximity to, a live arcing-horn on a transformer HV blue phase connection bushing at a substation at Coolgardie. He concluded that the deceased received an electric shock of up to approximately 19000 volts AC and burns.

Mr Cockram SM. expressed a number of safety concerns:

(i) The substation should have complied with the relevant safety standard for clearances from ground to any exposed live equipment;

(ii) There should have been formal documentation of the fact that the relevant safety standard for the height of exposed live electrical equipment, had not been complied with;

(iii) Mr Pike should not have had access to a key enabling him to enter the substation without specific permission;

(iv) Employees of Western Power should have been advised of the fact that the minimum safety standards had not been complied with;

(v) There was a lack of adequate signage at the substation;
(vi) Mr Pike should have been provided with the replacement fire extinguisher while his allocated fire extinguisher was being recharged (had Mr Pike been equipped with a fire extinguisher on 19 January, 2000, the deceased may not have been so badly injured).

Mr Cockram SM. also expressed concerns in relation to the actions of Mr Pike as follows:

(i) Mr Pike did not advise the deceased that the transformer bushings were lower than required;
(ii) Mr Pike entered the substation without the appropriate authority through a permit;
(iii) Mr Pike entered the substation when he knew that one transformer was still energised, when the normal procedure was for the transformer to be de-energised;
(iv) Mr Pike should not have entered the substation without complying with the permit system;

Mr Pike should not have entered the substation without the appropriate safe clothing.
**Deaths In Custody**

An important function of the Coronal System is to ensure that deaths in custody are thoroughly examined. Section 22 of the *Coroners Act 1996* provides that an Inquest must be held into all deaths in custody.

Pursuant to section 27 of the *Coroners Act 1996* the State Coroner is required to provide a specific report on the death of each person held in care. The following contains reports on Inquests held during the year into deaths in care together with charts detailing the position of all deaths in care during the year.

**Inquests – Persons Under Care of a Member of the Police Service**

The definition of a “person held in care” includes the case of a person under, or escaping from, the control, care or custody of a member of the Police Service. Section 22(1)(b) of the Act provides that a Coroner who has jurisdiction to investigate a death must hold an Inquest if it appears that the death was caused, or contributed to, by any action by a member of the Police Service.

In this context there were three relevant Inquests, the following is a summary of the Inquest Findings.

**Peter Anthony BROOKS**

On the 26-31 November, 2001 the State Coroner conducted an Inquest into the death of Peter Anthony Brooks at the Perth Coroners Court.

On 17 January, 2000 Peter Anthony Brooks (the deceased) was shot in an incident involving police at Canning Highway, Como near Hobbs Avenue.
The deceased first came to the notice of the police in April 1985 when he was charged with illegal use of a motor vehicle in Fairfield, New South Wales.

From that time up until the time of his death the deceased appeared before a number of Courts on a series of charges including charges as serious as sexual assault and armed robbery.

The deceased also had a long history of drug abuse.

On 15 September, 1994 while the deceased was an inmate at Long Bay Gaol he was attacked by other inmates and received multiple, life threatening stab wounds to his chest, face and right eye.

The deceased was released from Long Bay Gaol in 1995 but on 13 August, 1996 he was arrested and charged with 8 counts relating to armed robbery offences, found guilty and imprisoned for 3 years.

The deceased was released from prison on 3 September, 1999 on parole, his parole period was due to expire on 12 August, 2001.

The deceased travelled from Sydney to Perth in December 1999 and shortly after his arrival in Perth commenced to consume heroin on a regular basis.

In order to fund his heroin habit the deceased became involved in a mobile telephone scam and a number of serious armed robbery offences.

Between 18 December, 1999 and 17 January, 2000 a series of armed robberies were committed throughout the metropolitan area of Perth. The response of the Police Service involved setting up a task force consisting of staff from Perth and Fremantle Tactical Investigation Groups.
During the course of the investigation the deceased was identified as being the main person of interest in a respect of a total of 15 armed robbery offences.

On 17 January the deceased robbed a pizza store in Bentley after which he drove away in a Sigma vehicle which was followed by police.

The deceased turned into a Caltex Service Station at 264 Canning Highway, Como where police attempted to apprehend him.

As police officers reached the front and rear passenger windows of the Sigma vehicle, the deceased reversed away at speed.

Two shots were fired at the engine area of the vehicle in an attempt to stop the vehicle without success.

As the deceased drove out onto the Canning Highway a Detective White was hanging onto the inside of a window. The deceased then lifted a knife which he had used in the robbery and raised it in a stabbing motion directed at Detective White.

At that stage Detective White was also aware that he was in danger of being struck against a lamp-post.

Detective White then discharged his firearm, inflicting the fatal wound to the deceased.

The State Coroner found that the shooting took place in self-defence and that the death arose by way of Lawful Homicide.
Derek James Allen MOORE

On the 16-18 April, 2002 the State Coroner held an Inquest into the death of Derek James Allen Moore (the deceased) at the Perth Coroners Court.

At approximately 5:00pm on Friday 8 December, 2000 the deceased was riding a Kawasaki 1000cc motor cycle north on the Kwinana Freeway.

The deceased was seen travelling at an excessive speed and was followed by Senior Constable Royston Sheppard of the Traffic Operations Group who was on duty on a marked police motorcycle.

The deceased travelled north on the Freeway followed by Senior Constable Sheppard and at the area of the off-ramp to the Leach Highway the deceased, without warning, travelled from the right lane for northbound Freeway traffic, across the Freeway and onto the off-ramp lane.

The deceased lost control of his motorcycle on the off-ramp lane and he collided with steel posts holding a large directional sign. His motorcycle continued for a further 17 metres into scrub before bursting into flames.

The deceased died as a result of multiple injuries resulting from the crash.

Evidence given by a number of witnesses described the motorcycle driven by the deceased overtaking other vehicles on the centre dotted line and coming very close to the vehicles which were being overtaken at great speed.

The State Coroner found that it was appropriate for Senior Constable Sheppard to follow and to attempt to intercept the deceased.
The deceased died as a result of injuries suffered in the crash.

The State Coroner found that the death arose by way of Accident.

**Cuong Thi TRUONG and Thuong Thi TRUONG**

The Deputy State Coroner held an Inquest into the deaths of Cuong Thi Truong and Thuong Thi Truong on 1 November, 2001.

Thuong Thi Truong was 28 years of age at the time of her death and was the driver of a motor vehicle traveling in a westerly direction on Beach Road, Balga. Cuong Thi Truong was her sister and was also in the vehicle with the driver’s baby daughter. On approach to the Hainsworth Avenue intersection Thuong Thi Truong turned right into the gap in the median strip where she slowed and stopped her vehicle prior to turning right across the eastbound carriageway of Beach Road intending to travel into Hainsworth Avenue. As she traveled across the eastbound lanes of Beach Road her vehicle was struck by a motor vehicle traveling at speed in an easterly direction on Beach Road.

Thuong Thi Truong died on 21 October, 1999 at Royal Perth Hospital whilst Cuong Thi Truong died at the scene of the accident. The baby girl was un-injured. Both died as a result of injuries received in the motor vehicle collision.

The vehicle which struck the sisters’ vehicle was being pursued by an off-duty policeman in an unauthorized pursuit.

The driver of the vehicle which struck the vehicle in which the sisters were driving was convicted in respect of their deaths while in a separate trial the off-duty policeman was acquitted. In view of the other Court’s determinations in respect of the driver of the vehicle which struck the sisters’ vehicle, the Deputy State Coroner was bound to bring a finding of Unlawful Homicide.
During the year 17 Inquests were conducted into the deaths of persons who died while in the custody of the Department of Justice.

It is not proposed to detail the Findings in relation to each of these Inquests in this report as in each case the Record of Investigation into the Death is publicly available, but a brief summary is as follows.

Reginald Cyril Fry

On 3 & 4 July 2001 the Deputy State Coroner conducted an inquest into the death of Reginald Cyril Fry at the Central Law Courts.

Reginald Fry (the deceased) was 59 years of age at the time of his death and had a long history of Severe Liver and Cardiac Disease. He had a long history of exposure to the prison system and the authorities were aware of his health difficulties. His last period of incarceration commenced on 10 March 1997 when he was received into Casuarina Prison. He was transferred to CW Campbell Remand Centre in April 1997, and sentenced later in the year to a period of imprisonment of 5 years. He was sent to Albany Regional Prison and returned to Casuarina Prison on 10 April 1998 for medication reasons. He was transferred from Casuarina Prison to Wooroloo Prison Farm on 2 February 1999.

The deceased’s medical problems fell into three major categories being his liver and hepatitis C, cardiac problems and chronic airway limitation. He was provided with consultant care and review external to the prison system. By July 1999 it was clear he required heart surgery which could not be performed due to his severe liver problems.

Due to his deteriorating health with respect to his airway limitation it became difficult to provide the deceased with the level
of medical care necessary at Wooraloo Prison Farm which does not have a dedicated medical facility. He was transferred to Casuarina Prison, which does have an infirmary, pending transfer to Canning Vale Prison.

Ultimately, he was considered fit for transfer to Canning Vale Prison which appears to have distressed him. He was assessed on the morning of 26 October 1999 as fit for transfer to Canning Vale Prison and was transferred.

During his transfer he was noted to appear unwell and on arrival at Canning Vale Prison he was assessed. The assessing hospital officer was familiar with the deceased, and did not consider his presentation unusual for his medical problems. The deceased commenced to refuse medication and the hospital officers made special efforts to intervene with his medication. Particular note was taken of him over-night on 26 – 27 October 1999. During the morning of 27 October 1999 the deceased deteriorated rapidly and was transfer to Fremantle Hospital. He remained in Fremantle Hospital until he died on 2 November 1999.

The post mortem concluded the cause of death was Liver Failure Consequent upon Hepatitis C induced Cirrhosis. Dr Margolius informed the court the findings at post mortem were consistent with the presentation of the deceased having good days and bad days. The symptoms noted from time to time were entirely consistent with his illness. Dr Margolius confirmed the final deterioration of the deceased could be very rapid and alter within the space of a few hours. She was of the view he had been under appropriate consultant review and his treatment was adequate in all the circumstances.

Overall, it would seem the deceased did receive adequate medical care although there was some difficulty for the deceased in managing the different aspects of his various illnesses as a whole in the options available in the prison system.
Phillip Lionel JOSEPH

The State Coroner conducted an Inquest into the death of Phillip Lionel Joseph (the deceased) on 16-20 July, 2001 at the Karratha Courthouse and on 23 August, 2001 at Central Law Courts and then on 23 November, 2001 at the Perth Coroner’s Court.

On 6 January, 2000 (the deceased) was a remand prisoner at Roebourne Regional Prison housed in cell 3.9.

At approximately 6:00pm the deceased was located in the cell hanging from bars in the cell. A green T-shirt was around his neck and that had been tied to the wire grill next to the door in the cell.

The State Coroner concluded that on 6 January, 2000 the deceased was being punished by being placed in a multi-purpose cell at Roebourne Regional Prison.

The deceased at the time was being punished for refusing to take part in a video record of interview relating to his alleged possession of home brew alcohol. The decision to place the deceased in the multi-purpose cell was made by Assistant Superintendent John Williamson but he had been misinformed as to the state of agitation of the deceased by Senior Officer Woods.

The deceased had not been told how long he was to be placed in the multi-purpose (Punishment) cell or when and by whom his placement might be reviewed.

At approximately 5:00pm the deceased activated the cell call alarm in his cell on three occasions.

No checks were made to determine whether the deceased was distressed, whether he was suffering from an asthma attack or what his condition was.
On the third occasion when the deceased activated his cell call alarm, a “time out” button was pressed which effectively suppressed the alarm for a period of 60 minutes.

While alone in his cell, after having unsuccessfully attempted to raise an alarm using his cell call button, the deceased placed his T-shirt around a grill in the cell and took his own life.

While it appears in this case that the deceased took his own life, in the absence of any evidence as to why he was activating the cell alarm and the fact that he was then placed in a situation where he had no form of communicating with prison staff or fellow inmates as to his predicament, the State Coroner found that it was not possible to determine what led to the deceased taking his own life. The State Coroner did find, however, that the problems which the deceased faced at that time were exacerbated by his treatment by the prison officers concerned and that treatment contributed to his death.

The State Coroner found that the death arose by way of Suicide.

The State Coroner made recommendations that immediately after a death in custody a report should be prepared by each prison officer with involvement at about the time of death. The reports should be on a form designed for that purpose containing instructions requiring the officer to address issues relating to the deceased before death which may have had a bearing on the death.

The report should be prepared in circumstances where the preparation is monitored by an independent officer and then the report should be forwarded to that officer or another independent officer.

A Department of Justice report dated 3 September, 2002 advised that two prison officers had resigned and Mr Woods, the acting Senior Officer, was dismissed effective on 28 May, 2002.
The report also addressed in detail a number of issues raised at the Inquest.

Following the Inquest, therefore, it is clear that the Department has taken strong and timely action to address the situation.

Wayne John COYNE

On 10 & 12 September 2001 the Deputy State Coroner conducted an inquest into the death of Wayne John Coyne (the deceased) at the Central Law Courts.

The deceased was 24 years of age at the time of his death and had spent substantial periods of his life in institutions. He suffered a closed head injury in December 1994 as a result of a high-speed car chase and psychiatrists believed that resulted in Organic Brain Damage. While in prison or hospital he had numerous self-harm, self-mutilation and suicide attempts from which he had always been successfully resuscitated. His final diagnoses in August 1999 were Psychosis and Cluster B Personality Disorder.

His self-harming behaviour was of concern to both prison authorities and medical authorities in that he often influenced other persons in his vicinity to self-harm. He was described as lonely, often bored, and very impulsive. He was known to manipulate his placements. He was transferred from Graylands Hospital to Casuarina Prison on the afternoon of 16 August 1999 and placed in the infirmary. He did not like a “safe” placement and wished to be placed in accommodation that would facilitate his transfer to Albany Regional Prison. He was advised that to enable transfer to Albany he had to show some level of self-responsibility. He was placed in the IOU under special arrangements.
On the morning of 19 August 1999 the deceased appeared happy and communicative. While he was in the shower his cell had been checked for any indication of self-harm preparation. None was found. The prison officers commencing the lunchtime issue attended the prisoner’s cell just after 11:30am and could not locate him. They found him in his exercise yard suspended by his neck with sheeting from his bed. His legs were out in front of him and his buttocks approximately 30cms off the ground. There was immediate resuscitation.

Dr Patchett of the Frankland Centre at Graylands Hospital considered the deceased suffered from four areas of difficulty. He had anti-social personality disorders, organ brain damage, psychotic interludes and poly-substance abuse. He was a difficult management problem for the authorities due to his erratic behaviour. There is a real possibility due to his institutionalised life he did not fully appreciate his self-harm behaviour could actually kill him. There was some tension between the prison authorities and the medical authorities as to his appropriate placement. At the time of his death the mental health specialist from Casuarina Prison was at Graylands Hospital negotiating his return to that facility.

The death of the deceased highlighted the difficulty for authorities in dealing with offenders with behavioural and anti-social personality disorders. The tension between therapeutic and safe environments is exacerbated by incarceration. The difficulty for inmates with behavioural problems and organic brain dysfunction remains one of resources. The prisoners are considered management problems rather than health problems.

The Deputy State Coroner expressed a concern incarceration is a likely experience with personality/behavioural disorders and that skilled medical and health personnel are necessary to assist management of these persons. The adequate provision of these personnel is a resource issue.
Adam Timothy GARNER

On 5 & 6 November 2001 the Deputy State Coroner conducted an inquest into the death of Adam Timothy Garner (the deceased) at the Central Law Courts.

The death of the deceased at 18 ½ years of age by Ligature Compression of the Neck was considered by the Deputy State Coroner to highlight a particularly vulnerable time for persons in the criminal justice system. It is becoming apparent there are a number of identifiable risk factors for suicide which needed to be objectively assessed as well as any subjective presentation. In this case the deceased was 18 ½ years of age, he was a remandee, it was his first time in an adult prison system, he was a heavy drug user experiencing detoxification and withdrawal at the time of his admission, he believed he did not have the support of his family, he had a history of ADHD, he was concerned about having contracted Hepatitis C and the length of his likely sentence, he had made comments to other prisoners about considering suicide on the “outside”, he was concerned as to other peoples’ opinion of him, and he had made some comments of concern to other prisoners.

He suicided within 24 hours of admission to the adult system before the transfer of his medical files or adequate orientation.

The Deputy State Coroner expressed a concern all prisoners are “at risk” in real terms on incarceration, and it is only those that are “at risk” of acute suicidal ideation that the assessments are equipped to detect. There was a comment young and new admittees should receive adequate orientation and counselling prior to extensive contact with mainstream and its possible negative influence on requests for assistance from non-prisoners.

The Department of Justice response to the comments of the Deputy State Coroner indicated there were implemented improvements in:-
the transfer of information about remandees from the juvenile to adult system;
- the assessment program for new admissions to prison taking into account the differences between “at risk” terminology in the prison system; and
- the orientation of new admittees.

Francesco FRAGOMENI

The State Coroner conducted an Inquest into the death of Francesco Fragomeni (the deceased) at the Perth Coroner’s Court on the 6 November, 2001.

The deceased, an 84 year old male, died on 1 July, 2000 at Murdoch Community Hospice, Murdoch.

The deceased was subsequently examined by a medical practitioner and medical director of the Murdoch Community Hospice, Dr David Thorne, who declared life extinct in the presence of family members at 12:10pm.

At the time of his death the deceased was a sentenced prisoner and as such was a “person held in care” as defined in the Coroners Act 1996. An Inquest into the circumstances of the death was, therefore, mandatory.

On 9 November, 1998 the deceased caused the death of his wife of some 49 years at their residence in Forrestfield.

On 20 December, 1999 the deceased was sentenced in the Supreme Court for the murder of his wife. In his sentencing remarks the sentencing Judge was of the view that the attack was a “sustained and violent one which constituted a bad case of murder”.

The sentencing Judge noted that the deceased had been born in Calabria, Italy, on 17 October, 1915, so at the time of his sentence was 84 years of age. The deceased had no convictions
for any other criminal offences and suffered from a combination of illnesses.

The deceased was housed in Casuarina Prison from 1999 until he was transferred to the Hospice in June 2000.

The death was expected and family members had previously been consulted by Dr Thorne at the Hospice and they had agreed that the goals of care at that stage were comfort and a dignified death.

The State Coroner was satisfied that the deceased received adequate treatment during his period of detention and that whenever it was necessary for him to see a specialist, arrangements were put in place for him to attend at Sir Charles Gairdner Hospital for that purpose.

The State Coroner found that the death arose by way of Natural Causes.

The State Coroner made recommendations that guidelines be prepared which would assist Medical Officers, Prison Superintendents and others in contact with prisoners whose medical health is deteriorating to such an extent that they cannot pose any danger to society and are going to die in custody by providing advice as to the steps which would be required to arrange for the release on parole of such prisoners and the factors which would be taken into account in determining whether such a release would be considered appropriate in a particular case.

The guidelines should also address generally all action to be taken by prison authorities in communicating with relatives, providing suitable accommodation for the prisoner etc. in cases when for medical reasons a death in custody will be inevitable.
Lesley William WESLEY

The Deputy State Coroner conducted an inquest into the death of Lesley William Wesley (the deceased) at the Fremantle Law Courts on 26 – 28 November 2001.

The deceased was 32 years of age at the time of his death by hanging on 7 May 2000. He was of the Wungi tribe from the Warburton/Kalgoorlie areas and had been diagnosed as a chronic paranoid schizophrenic and diabetic in addition to suffering chronic alcohol abuse. He had many admissions to Graylands Hospital, was generally non-compliant with his medication and had an extensive imprisonment history.

The prison most suited to his medical needs was Casuarina Prison Complex which was probably the most removed from his preferred environment.

At the time of his death he was on remand following a fitness to plead application. It is apparent he was a complicated management issue both as a genuine result of auditory hallucinations and as a way of manipulating the system in his favour.

At the time of the deceased’s death there was a high muster in Unit 5 which would have reduced staff capacity to deal with individual problems. There was no evidence the deceased had difficulty in obtaining individual attention when he so desired. He had proved himself adapted at obtaining specific attention when he wished despite the acknowledged over-crowding. While it is accepted the general conditions of over-crowding in an hostile environment apply to all those incarcerated and working in the system, these could not be tied specifically to this death. It was clear the death was unexpected at the time it occurred and there appeared to be no discernible pre-warnings. The Deputy State Coroner made the general comment that it was to be hoped the current lower muster levels would not lower the availability of health service staff.
Martin Raymond COFFEE

On 10 December, 2001 an Inquest was held into the circumstances of the death of Martin Raymond Coffee (the deceased) by Acting Coroner, Mr Phillip Gregory Cockram SM.

The deceased had been sentenced on 16 October, 2000 to a term of imprisonment following convictions for driving a vehicle whilst legally disentitled to hold a driver’s licence and breach of bail. The deceased had been transferred to Wooroloo Prison where he had been assessed. He advised he was suffering from paranoia because of amphetamine use and had further suffered depression for three years as a result of the death of his son.

On 20 October, 2000 the deceased applied to be released on home detention and a Home Detention Order was made with a release date of 27 December, 2000.

At the Inquest an issue was raised as to whether or not the deceased was a “person held in care” for the purposes of Section 25(3) of the Coroner’s Act 1996. Mr Cockram SM did not make a specific finding in relation to that issue but determined that it was appropriate for him to make comment about the supervision, treatment and care of the deceased.

Mr Cockram SM concluded that there was no evidence that the deceased was ill-treated by any person and, on the contrary, all those involved with his Home Detention went to great lengths to support and encourage him.

Mr Cockram SM concluded that the quality of supervision, treatment and care of the deceased was, on balance, adequate.

Mr Cockram SM did, however, raise concerns as to the provision of information to the Home Detention sponsors in this case who were of the view that if they had known more about the deceased’s state of mind while he was imprisoned they may not have agreed to sponsor the deceased’s Home Detention or may have managed his Home Detention differently.
While issues of confidentiality arose in relation to the provision of information, in the Coroner’s view, at the stage when Home Detention was being considered and the views of the people living in the proposed residence were being sought, in order to provide informed views they should have been provided with relevant information.

By letter dated 2 August, 2002 the Acting General Manager, Community Justice Services, Department of Justice, advised that the concern regarding the provision of relevant information to Home Detention sponsors had been referred to the Community Justice Services, Professional Practice Standards Committee.

Jason Paul MATTHEWS

On 15 & 16 January 2002 the Deputy State Coroner conducted an inquest into the death of Jason Paul Matthews (the deceased) at the Central Law Courts.

The deceased was 30 years of age and a sentenced prisoner at Casuarina Prison Complex at the time of his death on 22 May 2000. He had a known medical history of Hypertension that was treated both in the community and in prison.

The deceased had been brought up in a Caucasian environment although he had an Aboriginal birth mother he had not, at the time of his death, met. He was trained and qualified as an electrician but became involved in illicit substance use in his mid twenties. The deceased collapsed while at work in the vegetable preparation area of the Industrial Workshop on 22 May 2000. He was immediately assisted by fellow prisoners. At the time it was thought his death was drug related but post mortem results indicated his death was as a result of natural causes being Coronary Artery Thrombosis in association with Arteriosclerosis.

Due to the initial concern the death may be drug related it was difficult to determine whether or not the deceased had suffered any symptoms prior to his collapse.
Dr Margolius, the Forensic Pathologist who conducted the autopsy, was of the view the deceased could have been symptomless prior to the event, however, there were indications he had old and recent scarring to the heart muscle. If the deceased was aware of these cardiac events it would appear he did not inform anybody of any symptoms at any time.

The adopted family of the deceased were positive about the medical care received by the deceased while in custody. Both his adopted mother and sister are qualified nurses and commented they believed his health care was better in custody than in the general community in view of his known substance abuse.

The deceased’s known Hypertension was monitored while he was in custody and medicated. He was also advised on life style measures to assist with heart disease prevention.

The Deputy State Coroner concluded the deceased’s medical care while in custody was appropriate in all the circumstances.

Frederick Ronald RILEY (also known as Frederick Stephen WILSON)

On 22 January 2002 the Deputy State Coroner conducted an inquest into the death of Frederick Ronald Riley (also known as Frederick Stephen Wilson) (the deceased) at the Central Law Courts.

The deceased was 48 years of age at the time of his death when he suffered a Ruptured Berry Aneurysm. He had spent a considerable amount of his adult life in custody and at the time of his death was serving an aggregate term of 19 years for a variety of offences of violence and dishonesty.

Earlier in his prison history there were attempts by management to improve his behaviour problems. These had been largely unsuccessful.
He was considered a difficult prisoner by both prison management and other prisoners alike. All who had contact with him immediately prior to his death considered his behaviour to be normal for him. He made no complaints about ill health.

On the day of his death the deceased had played cards with fellow prisoners and become fairly argumentative at one stage. All prisoners indicated this was normal and he later apologised for his behaviour. During the lunchtime lockdown on 4 June 2000 he made no calls for assistance by use of either his cell call alarm or by calling out. His neighbouring prisoner heard noises from his cell but nothing he considered to be unusual. When unlocked he was found on the floor of his cell by prison officers, vomiting. They immediately called for medical assistance. When the hospital officer arrived the deceased was still coherent and able to communicate. He became unconscious on his transfer to the infirmary. He was thereafter transferred to Fremantle Hospital, then Royal Perth Hospital.

It became apparent he had suffered a Ruptured Berry Aneurysm of significant proportions. The resulting bleed into his brain had caused the vomiting, and left sided weakness, progressing until he became unconscious. He never recovered from the incident despite appropriate medical intervention.

The Forensic Pathologist advised the court there may be a catastrophic haemorrhage resulting in death without warning. There may be prior symptoms of headache but these alone are not generally enough to alert medical personnel to the problem. The deceased had been treated appropriately from the time of collapse.

There was an issue raised by next-of-kin about a delay in notification of the transfer of the deceased to a hospital. The difficulty appeared to result from the deceased’s failure to maintain his next-of-kin details. Since the incident, next-of-kin forms have been distributed around the system to allow those prisoners wishing to update their next-of-kin information to do so.
Bradley James SAVORY

The Deputy State Coroner held an inquest into the death of Bradley James Savory (the deceased) on 5 – 7 February 2002 at the Albany Court House.

The deceased was 27 years of age at the time of his suicide. He was a resident in the Self Care Unit of Albany Regional Prison. He was a long-term prisoner and generally considered by prison management and other prisoners as to be a model prisoner.

It became apparent during the course of the investigation into his death that there were activities at the Albany Regional Prison not disclosed by the documentation. Witnesses were called for the inquest who had not been prepared to make full police statements. It transpired there was a significant gambling habit in the prison generally, and specifically involving the deceased.

Details of the gambling activity were explored to enable prison authorities to understand the mechanisms for payment of debts. These tended to occur externally to the prison. It was acknowledged problems of the nature experienced by the prisoner could not be identified by prison authorities without external assistance from families or friends prepared to disclose abnormal requests.

It was clear the deceased had become financially disadvantaged as a result of his gambling. It was not the Deputy State Coroner’s view his suicide by hanging was as a result of fear of reprisals for unpaid debts, rather it was considered the deceased’s inability to control his gambling reflected his general dissatisfaction with his ability to control his life thereby leading to his suicide.

The inquest indicated the extent of gambling in Albany Regional Prison was greater than originally suspected by prison management. Gambling is prohibited in prison but the techniques developed in Albany Prison made it virtually impossible to detect under normal circumstances. In this case
due to the deceased’s financial difficulties there was a defuse trail that did disclose the activities. As a result of the death of the deceased additional procedures have been implemented in prison management for the receipt of funds into prisoners’ accounts. There was no indication to prison authorities of the deceased’s difficulties. Those experienced by his family were not communicated to the appropriate authorities until after his death.

Scott DAVIDSON

On 11–13 March 2002 at the Central Law Courts the Deputy State Coroner conducted an inquest into the death of Scott Davidson (the deceased).

The deceased was 26 years of age and had been recently sentenced for the attempted murder of his father and a serious attack on his mother. He was located in the Casuarina Prison Complex.

The deceased was a heroin addict at the time he attacked his parents. When first received into CW Campbell Remand Centre he informed the authorities he intended to “neck himself” at the first opportunity and was placed under medical observations at Casuarina Prison.

The deceased was referred by the Midland Court of Petty Sessions to Graylands Hospital for assessment and was there diagnosed as being a paranoid schizophrenic. There were significant issues as to his criminal responsibility at the time of his offence, although he appeared to know what he had done and what he had done was wrong. There was no doubt in the treating psychiatrist’s view the deceased was, and had been, extremely unwell.

The deceased was returned to the prison system on 14 March 2000, and required ongoing psychiatric assessment and medication. He was sentenced for his offences on 2 June 2000 and while expecting a long custodial term seems to have
nevertheless been un-nerved by the process. The sentencing Judge asked for the deceased be psychiatrically assessed as soon as possible on his return to custody. There is no provision for this type of recommendation on the warrant of commitment and the sentencing transcript is not received by prison authorities until some weeks after the event.

There followed an unfortunate series of events with the deceased being exposed to other prisoners self-harming and talking of self-harm. He was assessed by a psychologist between incidents, but not after the final incident. Overall the Deputy State Coroner did not believe the managing staff were as alert to the deceased’s mental status as they should have been. The deceased was “doubled up” with another inmate who was known to manipulate the system by use of erratic behavioural techniques to obtain additional medication. There was conversation by way of jest as to ways to manipulate placement within the prison system which would assist with medication. It was clear there was no malicious intent towards the deceased with any of the incidents.

The deceased suicided overnight by hanging. It was clear from the evidence there had been one, and possibly two, cell checks with the deceased in position. He was not noticed until his cellmate woke and discovered him.

There was discussion at the inquest of the difficulty of obtaining enough visibility into the cells during night checks to enable prison officers to adequately perform their duties.

While the Deputy State Coroner felt there was no involvement by a third party in the death of the deceased, she was concerned that risk factors in his presentation were not properly appreciated. Recommendations were made in the following areas:

(i) Warrants of commitments should have provision for recommendations to be made by the sentencing Judicial Officer as to appropriate medical review of prisoners after sentencing.
(ii) Prisoners who have been in remand be returned to familiar surroundings immediately after a sentence of imprisonment until the effect of their sentence has been assessed.

(iii) A prisoner’s medical file be transferred in a timely (12hrs) fashion when a prisoner moves prison or is readmitted to the prison system after a period of absence.

(iv) Until a prisoner’s medical file has been reviewed by an appropriately skilled medical officer, a prisoner newly sentenced for a significant period of time be afforded special observation. ie, Senior Unit Officers consciously afford those prisoners special regard.

(v) Prisoners with a known psychiatric illness or personality disorder be appropriately assessed as soon as possible after an incident that is an obvious stressor.

(vi) There be ongoing education of prison officers to keep them alert to indicators for self-harm and prevent desensitisation to the environment of incarceration.

---

*Kirk Graham LAWSON*

On 3-4 April, 2002 the State Coroner conducted an Inquest into the death of Kirk Graham Lawson (the deceased) at the Kalgoorlie Court House.

The deceased was a tribal aboriginal person who was born on 20 April, 1975 at the Warburton Ranges Aboriginal Community. His parents are respected members of the community and he had three brothers and three sisters.

The deceased had been received at Eastern Goldfields Regional Prison on 23 November, 1999 having been sentenced for 18 months imprisonment for offences of Stealing a Motor Vehicle and Reckless Driving.

The earliest eligibility date for release of the deceased was 22 May, 2000.
On 24 March, 2000 the deceased received a further 82 days imprisonment for default relating to outstanding fines. His earliest eligibility date was amended to 12 August, 2000.

The deceased had a history of suffering from epileptic fits, his first recorded fit in prison was on 27 March, 1994. The second was on 24 June, 1994 when he had been taken to the Kalgoorlie Regional Hospital.

Although recognized as having suffered fits previously, the deceased was not prescribed further medication during his later periods of imprisonment and did not make any further complaints of suffering from seizures.

The deceased also advised that he suffered from asthma and medical records indicated that he had previously been identified as having Hepatitis B.

On 26 May, 2000 at the 4:50pm parade it was noted that the deceased was not present and he was located by a prison officer in his cell. At the time it appeared that he was suffering from a fit and an ambulance was called for.

A post mortem examination was conducted on 30 May, 2000 by Dr G A Cadden, Forensic Pathologist, State Mortuary, Perth.

Autopsy findings indicated that the deceased suffered from a congenital structural abnormality of the brain which would explain the epileptic fit.

At the conclusion of his examination Dr Cadden formed the opinion that the cause of death was Epilepsy in Association with Cerebral Cortical Dysplasia.

The State Coroner found that the death arose by way of Natural Causes.
The State Coroner recommended that the Department of Justice review training requirements relating to prison officers to ensure that officers are aware of –

- The location of air viva or oxy viva devices;
- The correct use of air viva devices and where appropriate oxy viva devices;
- The appropriate action to be taken with fitting prisoners pending arrival of an ambulance.

The State Coroner further recommended that the Department of Justice review the provision and location of oxy viva and air viva devices in all prisons in Western Australia with a view to ensuring that in each prison such equipment is readily available to suitably trained officers.

**Simon OTERO**

On 8–10 April 2002 the Deputy State Coroner conducted an inquest into the death of Simon Otero (the deceased) at Central Law Courts.

The deceased was a young new admittee with no prior history of incarceration.

The circumstances of the death tended to indicate that the deceased may have been using a suicide attempt in an effort to persuade his parents they should provide surety for him. He caused his death by hanging overnight prior to a bail hearing the following morning.

The deceased, when being orientated to the system, recognised a friend and was placed in a single cell, at his request, in the same unit as his friend. He appears to have been welcomed by his friend and other prisoners but did indicate he was angry with his parents because he believed they were trying to scare him. His friend did not believe the deceased was “at risk” because he was concerned about the recent pregnancy of his
girlfriend. There was an exchange of shoe laces at some stage between the deceased and his friend, with his friend being quite adamant he would not have provided the deceased with additional shoe laces if he thought he would used them to self-harm. The death of the deceased came as a great surprise to his friend.

The deceased was located at the 10:35pm cell check on 15 June 2000 by prison officers. CPR was commenced immediately but to no avail.

The main issues of concern in respect of this death was not the provision of shoe laces and razor blades per se, but the number of such items readily to hand to a new, young and vulnerable admittee.

**Geradus THERON**

On 16 April 2002 at Central Law Courts the Deputy State Coroner conducted an inquest into the death of Gerardus Theron (the deceased).

The deceased was 39 years of age and was in the CW Campbell Remand Centre as a remand prisoner at the time he suicided by hanging on 25 June 2000.

The history with respect to the deceased was one where the Deputy State Coroner was of the view it was likely he would suicide at some stage due to the enormity of his offence. He had effectively killed his wife in the presence of his children. While the deceased did not acknowledge to the prison authorities that his youngest son had seen the act in question, he did acknowledge it to a fellow prisoner who was very sympathetic to the deceased’s circumstances.

Full knowledge of the circumstances of the deceased’s offence may have resulted in closer supervision of the deceased, but his emotional state and the possibility of post traumatic stress disorder were noted at the time of his original admission to
prison. He was assessed at Graylands Hospital where it was believed he had been stabilised and was making plans for the future. He was diagnosed as suffering from a depressive disorder, reactive to his increasing realisation of the reality of his situation, and the impact the offence had on his life and on his children.

Overall, those concerned with his management at Canning Vale Remand Centre believed the deceased improved considerably in his emotional status. He disliked being placed in a safe-cell and it was decided continued placement in a restrictive environment would not be beneficial. He was placed in a unit for vulnerable prisoners with careful observation. It was stated it was likely he would remain at considerable risk for sometime. He was “doubled up” as a precaution although he preferred a single cell. His assessment was changed from “moderate risk” to “low risk” on 12 June 2000.

The deceased was moved from the wing for vulnerable prisoners to a mainstream wing at a time when he obtained employment and indicated he was feeling positive with his life. It was noted he was generally depressed, but this was expected in all the circumstances relating to his incarceration. Within those circumstances he appeared to be progressing well.

On the morning of Sunday 25 June 2000, immediately after his moving to a mainstream wing, the deceased was found after lunchtime lockdown by a friend from his previous wing. He located the deceased hanging from a rack on the left of the cell in a crouched position with his feet on the ground, but not his bottom. That prisoner ran to obtain assistance and resuscitation efforts commenced. Unfortunately the deceased was not resuscitated and a suicide note was found indicating his wishes in respect of his funeral.

The Deputy State Coroner was of the view that the deceased was at all times a significant suicide risk. It was perceived there may be some difficulty in balancing the necessary confidentiality aspect of a prisoner’s medical situation and keeping prison staff informed as to the facts relevant to a prisoner’s offence.
The Deputy State Coroner was concerned that a proper balance should be maintained between objective analysis and subjective assessment by competent skilled health professionals in the prison system properly informed of relevant facts. However, she did not believe any amount of management could have removed the reality of the deceased’s perception of the circumstances of his offence and realistically reduced his suicide risk. She felt it was appropriate he be managed by attempting to achieve a positive framework for his continuing life, while accepting it was always to be a matter of choice as to whether he lived or not. The current prison structure is such that a prisoner cannot be maintained in an environment that gives him no choices at all without being destructive of his future therapeutic progress.

**Steven Anthony PRIDHAM**

On 30 April – 1 May, 2002 at Albany Court House the State Coroner conducted an inquest into the death of Steven Anthony Pridham (the deceased).

The deceased was a 31 year old male prisoner at the Walpole Work Camp when on 10 February, 2001 he and another prisoner were swimming at the "Blue Holes" Beach near Nornalup in Western Australia. The deceased experienced difficulties while swimming and was unable to return to shore.

On 22 June, 2000 the deceased was sentenced to a total of 4 years imprisonment on 4 counts of armed robbery and 4 counts of stealing a motor vehicle. The deceased was transferred from Canning Vale Prison to Pardelup Prison Farm on 10 October, 2000.

On 1 February, 2001 the deceased was transferred from the Pardelup Prison Farm to Walpole Work Camp. The Work Camp had a maximum of 8 prisoners attached to it at any time. Prisoners at the Work Camp perform work each day of the week
but are permitted recreational time. Recreational activities are decided upon by the prison officer attached to the Work Camp.

On Saturday 10 February, 2001 at approximately 2:00pm a prison officer with the prisoners, apart from one prisoner who remained at the Camp, left the Work Camp to go swimming.

The deceased drowned while swimming at Blue Holes Beach near Walpole.

The beach is notorious for rips and currents and a sign warning of the danger of swimming at the location was situated near the entrance of the beach at a particularly well chosen point.

The deceased was caught in a rip and although he was able to reach a sand bar on a number of occasions he was repeatedly swept off the sand bar and away from the beach.

The State Coroner found that in spite of courageous rescue attempts, particularly by prisoner Obelgoenner, the deceased could not be returned to the shore until too late.

The State Coroner found that a CALM officer, Christopher Goodsell, demonstrated considerable courage by entering dangerous waters with his surf board to bring the deceased back to shore.

The State Coroner found that the death arose by way of Accident.

The State Coroner commented that this case had highlighted the fact that individual prison officers may not be skilled at identifying suitable locations for recreational pursuits and that prisoners may have very different life skills and competencies and recreational activities should be selected to accommodate the lowest rather than the highest level of skills of those who are to participate.
The State Coroner found that the response of the Department of Justice to the tragedy had been comprehensive and appropriate.

*Alan McKenzie CRAIG*

The Deputy State Coroner conducted an inquest into the death of Alan McKenzie Craig (the deceased) at the Central Law Courts on 29 – 30 April 2002.

The deceased was 25 years of age at the time of his death and was housed at Casuarina Prison Complex as a sentenced prisoner. He had been diagnosed as suffering from an anti-social personality disorder, social phobia, polysubstance abuse and benzodiazepine dependency.

The deceased appeared at all times to have been a management problem for medical staff in the prison system. He was seen as highly manipulative and at times aggressive with respect to medical professionals. He was prepared to intimidate those he did not perceive as meeting his needs, but was not generally seen as a self-harm or suicide risk.

The deceased was assessed by a psychologist on 31 October 2000 and remained from then onward on the “At Risk Management System” at varying risk levels depending on his presentation. He was a difficult management problem due to his benzodiazepine addiction which tended to motivate his manipulative behaviour. He was offered extensive medical input which was varied through the offices of different psychiatrists and medical personnel in an attempt to obtain his compliance.

Eventually in late November Dr Patchett from Graylands Hospital manage to establish rapport with the deceased and attempt a medication management plan that would appropriately treat his social phobia which Dr Patchett believed to be the underlying cause of his difficulties.
The management plan was explained to the deceased who appeared to understand it, and he was supported by the mental health nurse specialist who was available to talk with the deceased on a regular basis.

Thereafter, the deceased was generally compliant with his new medication plan although he still challenged medical staff with whom he was not comfortable as to his medication. He gave other prisoners the impression he was being deprived intentionally of appropriate medication.

On the morning of 5 December 2000 his cellmate reported the deceased as behaving normally until the cellmate was about to go to work when the deceased said “I feel a loop coming on”. The cellmate told the court he did not believe this was anything other than the deceased’s usual erratic behaviour. Other prisoners noted the deceased seemed to be in a good frame of mind. Nothing particularly untoward was noted about the deceased’s behaviour during the course of the morning. There was no indication there was a problem during the lunchtime lock-down.

At unlock the cells were unlocked, and prisoners sighted, if present. It is common ground the deceased was not seen at unlock although it is reasonably clear he was in fact hanging at that stage.

Sometime later the cellmate returned from work and located the deceased hanging by a white sheet from the inner rail of the wardrobe and suspended over the door to support the deceased’s weight.

The cellmate hurried to get assistance and other prisoners cut down the deceased and commenced resuscitation. It was unsuccessful.

The deceased left a note in his cell making it clear he intended to take his life. There was no complaint about his
management and it appears he simply made a decision he wished to end his life.

Dr Patchett was of the view the medical attention received by the deceased while in custody was at a higher level than he would have received in the general community. He was assessed and reviewed frequently and received considerable attention with respect to his known difficulties.

As a result of the missing of the deceased at the lunchtime unlock the Deputy State Coroner made the following recommendations with respect to supervision, treatment and care of prisoners allowing for the fact prisons have a high population of “at risk” persons.

(i) the informal musters checks and unlocks during the day ensure there are consistent prisoner counts in each area.

(ii) The officer in the control room at the time of an emergency immediately commence a running sheet utilising the same timepiece. At the conclusion of an emergency when writing incident reports there be a time check between all time pieces utilised in the emergency.

(iii) Prisoners be offered training in resuscitation and refresher training if desired.

Bradley William RAPLEY

The Deputy State Coroner conducted an inquest into the death of Bradley William Rapley (the deceased) at the Central Law Courts on 24-26 June 2002.

Bradley Rapley was 22 years of age at the time of his death and was a sentenced prisoner in Casuarina Prison Complex having previously escaped from Karnet Prison Farm.

The death occurred on 2 September 1999 but due to reasons beyond the control of the Coroners Court the inquest was not held
until June 2002. By the time of the inquest many of the problems relating to care and management of prisoners in Casuarina Prison during 1999 had been addressed.

Following riots in Casuarina Prison in 1998 the prison environment was subjected to a “lockdown regime” until the physical security of the facility could be improved. It is now common ground a lockdown regime caused psychological difficulties in terms of management for both the inmates and the prison officers.

In addition the deceased had a history of depression in the prison setting, and on a prior incarceration had suffered a sexual assault for which he received counselling.

The deceased was transferred on 25 August 1999 from the Orientation Unit to a mainstream unit with his fellow escapee in a “double up” situation. It was agreed they were “doing time extremely hard”.

The deceased had a non-contact visit with his girlfriend that afternoon and it is common ground there had been some difficulties in their relationship in the preceding months. His girlfriend had knowledge of previous self-harm attempts in the community but believed by the end of her visit he would not do anything to endanger himself.

The deceased had missed his medication due to the visit. His cellmate believed his visit had gone well and after a brief discussion went to sleep. The cellmate awoke sometime later to find the deceased lying on the cell floor with a plastic bag secured with a towel and fragments from a blanket over his head. He activated the cell call alarm to call for assistance. There was a delay in response. Once he had obtained a response he removed the bag from the deceased’s head and attempted to arouse him.

The recovery team arrived at the cell and attempted to resuscitate the deceased. The medical officers also arrived and there was resuscitation for 14 minutes before a response was
achieved. The deceased was transferred to Fremantle Hospital where he remained in an unconscious state until he died on 2 September 1999.

At post mortem the cause of death was found to be Hypoxic Ischaemic Encephalopathy resulting from the restriction of oxygenated blood to the brain.

The Deputy State Coroner was of the view that on objective criteria the deceased was at risk of suicide.

Many of the problems faced by the deceased in relation to his response to the lockdown regime and his personality disorders will hopefully have been resolved by progress in the prison system since that date.

The deceased should not have had ongoing access to a plastic bag although it is believed he adapted it for his purpose on this occasion. Currently bags are perforated but it is accepted that even these can be adapted for self-harm purposes.

Overall the policy of attempting to make prison life as “normal as possible” is to be supported, however, there is an issue as to how “normal” prison life can ever be.

The issue with the delay in the response to the cell call alarm has now been addressed by the implementation of an override system.

There was also an issue with the notification of the deceased’s next-of-kin by inappropriate means. In hindsight prison management acknowledge the notification could have been better handled but at the time those concerned were hopeful for a positive outcome in view of the fact he had apparently been successfully resuscitated.
The following chart details the position in respect of all cases of deaths in care since January 1999 where the deceased was either in prison custody or there was police involvement.

<table>
<thead>
<tr>
<th>Date of Death</th>
<th>Date of Inquest</th>
<th>Name of Deceased</th>
<th>Police/Prison Custody</th>
<th>Place of Death</th>
<th>Medical Cause of Death</th>
<th>Finding</th>
</tr>
</thead>
<tbody>
<tr>
<td>3/3/99</td>
<td>4-8/10/99</td>
<td>ACKERMAN Norman Frank</td>
<td>Prison</td>
<td>Cottage Hospice via Wooroloo</td>
<td>Suffocal Carcanomia with widespread medistatic disease</td>
<td>Natural Causes</td>
</tr>
<tr>
<td>11/3/99</td>
<td>6/10/00</td>
<td>ROWLAND Dwayne</td>
<td>Prison</td>
<td>ShentonPark Hospice via Canning Vale</td>
<td>AIDS</td>
<td>Natural Causes</td>
</tr>
<tr>
<td>12/3/99</td>
<td>6-8/2/01</td>
<td>MALONE James Gerard</td>
<td>Prison</td>
<td>Canning Vale</td>
<td>Ligature Compression of the Neck</td>
<td>Suicide</td>
</tr>
<tr>
<td>30/6/99</td>
<td>28-30/6/00</td>
<td>BRUMBY Stanley (a)</td>
<td>Police</td>
<td>Derby Lockup</td>
<td>Ligature Compression of the Neck</td>
<td>Suicide</td>
</tr>
<tr>
<td>19/7/99</td>
<td>27-30/11/00</td>
<td>LAYFIELD Kenneth Ronald</td>
<td>Prison</td>
<td>Casuarina Prison</td>
<td>Suffocation – plastic bag</td>
<td>Suicide</td>
</tr>
<tr>
<td>23/8/99</td>
<td>10-13/9/01</td>
<td>COYNE Wayne John (a)</td>
<td>Prison</td>
<td>Casuarina Prison</td>
<td>Ligature Compression of the Neck</td>
<td>Suicide</td>
</tr>
<tr>
<td>2/9/99</td>
<td>24-26/6/02</td>
<td>RAPLEY Bradley William</td>
<td>Casuarina Prison</td>
<td>Fremantle Hospital</td>
<td>Suffocation – plastic bag</td>
<td>Suicide</td>
</tr>
<tr>
<td>14/9/99</td>
<td>11-15/12/00</td>
<td>GIBSON Willy</td>
<td>Police</td>
<td>Warburton Lockup</td>
<td>Ligature Compression of the Neck (Hanging)</td>
<td>Suicide</td>
</tr>
<tr>
<td>2/11/99</td>
<td>3-4/7/01</td>
<td>FRY Reginal Cyril</td>
<td>CanningVale Prison</td>
<td>Fremantle Hospital</td>
<td>Liver Failure consequent upon Hepititis “C”</td>
<td>Natural Causes</td>
</tr>
<tr>
<td></td>
<td>23-27/10/00</td>
<td>WEBER Janek</td>
<td>Police</td>
<td>Port Hedland</td>
<td>Police Shooting</td>
<td>Self-defence</td>
</tr>
<tr>
<td></td>
<td>27/11/99</td>
<td>WOODS Gerald Trevor</td>
<td>Prison</td>
<td>CW Campbell Remand Centre</td>
<td>Coronary Arterthrombosis superimposed on severe coronary arteriosclerosis</td>
<td>Natural Causes Recommendations</td>
</tr>
<tr>
<td>Date of Death</td>
<td>Date of Inquest</td>
<td>Name of Deceased</td>
<td>Police/Prison Custody</td>
<td>Place of Death</td>
<td>Medical Cause of Death</td>
<td>Finding</td>
</tr>
<tr>
<td>---------------</td>
<td>-----------------</td>
<td>---------------------------</td>
<td>-----------------------</td>
<td>----------------</td>
<td>------------------------------------------------------------</td>
<td>-------------</td>
</tr>
<tr>
<td>6/1/00</td>
<td>5-9/11/01</td>
<td>GARNER Adam Timothy</td>
<td>Prison</td>
<td>Canning Vale</td>
<td>Ligature Compression of the Neck (Hanging)</td>
<td>Suicide</td>
</tr>
<tr>
<td>6/1/00</td>
<td>16-20/7/01</td>
<td>JOSEPH Phillip</td>
<td>Prison</td>
<td>Roebourne Prison</td>
<td>Ligature Compression of the Neck (Hanging)</td>
<td>Suicide</td>
</tr>
<tr>
<td>17/1/00</td>
<td>26-30/11/01</td>
<td>BROOKS Peter Anthony</td>
<td>Police</td>
<td>Como</td>
<td>Gun Shot Wound to Chest</td>
<td>Lawful Homicide</td>
</tr>
<tr>
<td>7/5/00</td>
<td>26-30/11/01</td>
<td>WESLEY Leslie</td>
<td>Prison</td>
<td>Casuarina</td>
<td>Ligature Compression of the Neck (Hanging)</td>
<td>Suicide</td>
</tr>
<tr>
<td>22/5/00</td>
<td>15-16/5/00</td>
<td>MATTHEWS Jason Paul</td>
<td>Prison</td>
<td>Casuarina</td>
<td>Coronary Arterythrombosis</td>
<td>Natural Causes</td>
</tr>
<tr>
<td>23/5/00</td>
<td>5-7/2/02</td>
<td>SAVORY Bradley</td>
<td>Prison</td>
<td>Albany Prison</td>
<td>Ligature Compression of the Neck</td>
<td>Suicide</td>
</tr>
<tr>
<td>26/5/00</td>
<td>3-4/4/02</td>
<td>LAWSON Kirk</td>
<td>Prison</td>
<td>Kalgoorlie Prison</td>
<td>Epilepsy in Association with Cerebral Cortical Dysplasia</td>
<td>Natural Causes</td>
</tr>
<tr>
<td>4/6/00</td>
<td>11-15/3/02</td>
<td>DAVIDSON Scott</td>
<td>Prison</td>
<td>Casuarina</td>
<td>Ligature Compression of the Neck (Hanging)</td>
<td>Suicide</td>
</tr>
<tr>
<td>7/6/00</td>
<td>22/1/02</td>
<td>RILEY (aka) WILSON Frederick Ronald</td>
<td>Prison</td>
<td>Casuarina</td>
<td>Brain Hemorrhage</td>
<td>Natural Causes</td>
</tr>
<tr>
<td>16/6/00</td>
<td>8/4/02</td>
<td>OTERO Simon</td>
<td>Prison</td>
<td>Canning Vale</td>
<td>Ligature Compression of the Neck (Hanging)</td>
<td>Open Finding</td>
</tr>
<tr>
<td>25/6/00</td>
<td>16-18/4/02</td>
<td>THERON Gerhardus</td>
<td>Prison</td>
<td>Canning Vale</td>
<td>Ligature Compression of the Neck (Hanging)</td>
<td>Suicide</td>
</tr>
<tr>
<td>1/7/00</td>
<td>6/11/02</td>
<td>FRAGOMENI Francesco</td>
<td>Prison</td>
<td>Casuarina/Murdoch Hospice</td>
<td>Prostate Cancer</td>
<td>Natural Causes</td>
</tr>
<tr>
<td>5/12/00</td>
<td>29/4-2/5/02</td>
<td>CRAIG Alan McKenzie</td>
<td>Prison</td>
<td>Casuarina</td>
<td>Ligature Compression of the Neck (Hanging)</td>
<td>Suicide</td>
</tr>
<tr>
<td>8/12/00</td>
<td></td>
<td>MOORE Christopher Peter</td>
<td>Prison</td>
<td>Wooroloo Prison</td>
<td>Heroin</td>
<td></td>
</tr>
<tr>
<td>9/12/00</td>
<td>19-22/8/02</td>
<td>UGLE Mark Amelo (a)</td>
<td>Police</td>
<td>East Perth Lock-up</td>
<td>Heart Attack</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Adj sine die families request</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Date of Death</td>
<td>Date of Inquest</td>
<td>Name of Deceased</td>
<td>Police/Prison Custody</td>
<td>Place of Death</td>
<td>Medical Cause of Death</td>
<td>Finding</td>
</tr>
<tr>
<td>---------------</td>
<td>-----------------</td>
<td>-----------------------------</td>
<td>------------------------</td>
<td>----------------</td>
<td>---------------------------------</td>
<td>----------</td>
</tr>
<tr>
<td>28/12/00</td>
<td>6-8/8/02</td>
<td>AUSTIN Alan Edward</td>
<td>Prison</td>
<td>Casuarina</td>
<td>Natural Causes</td>
<td></td>
</tr>
<tr>
<td>11/2/01</td>
<td>30/4-1/5/02</td>
<td>PRIDHAM Steven Anthony</td>
<td>Prison</td>
<td>Pardalup Prison Farm</td>
<td>Immersion</td>
<td></td>
</tr>
<tr>
<td>13/3/01</td>
<td></td>
<td>SLATER Evan Charles</td>
<td>Prison</td>
<td>Hakea Prison</td>
<td>Ligature Compression of the Neck</td>
<td></td>
</tr>
<tr>
<td>4/4/01</td>
<td>10-12/9/02</td>
<td>YAPPO Mervyn</td>
<td>Prison</td>
<td>Hakea Prison</td>
<td>Liver and Kidney Failure</td>
<td></td>
</tr>
<tr>
<td>22/5/01</td>
<td>4-6/9/02</td>
<td>BECKETT Richard John</td>
<td>Prison</td>
<td>Karnet Prison</td>
<td>Ligature Compression of the Neck</td>
<td></td>
</tr>
<tr>
<td>18/6/01</td>
<td></td>
<td>RILEY Tyron</td>
<td>Prison</td>
<td>Casuarina Prison</td>
<td>Ligature Compression of the Neck</td>
<td></td>
</tr>
<tr>
<td>20/8/01</td>
<td></td>
<td>JOHNSON Parata Peter</td>
<td>Prison</td>
<td>Casuarina Prison</td>
<td>Ligature Compression of the Neck (Hanging)</td>
<td></td>
</tr>
<tr>
<td>27/8/01</td>
<td></td>
<td>QUARTERMAIN Natasha Leanne</td>
<td>Prison</td>
<td>Bandyup Women’s Prison</td>
<td>Ligature Compression of the Neck (Hanging)</td>
<td></td>
</tr>
<tr>
<td>19/9/01</td>
<td></td>
<td>HOLCROFT Gary John William</td>
<td>Prison</td>
<td>Casuarina Prison</td>
<td>Ligature Compression of the Neck (Hanging)</td>
<td></td>
</tr>
<tr>
<td>9/10/01</td>
<td></td>
<td>TANADI Pangky</td>
<td>Prison</td>
<td>Albany Prison</td>
<td>Collapsed</td>
<td></td>
</tr>
<tr>
<td>22/12/01</td>
<td></td>
<td>BOYLE James Hughes</td>
<td>Prison</td>
<td>Casuarina</td>
<td>Aspiration Pneumonia &amp; Meningitis</td>
<td></td>
</tr>
<tr>
<td>17/2/02</td>
<td></td>
<td>VAUGHAN Michael Roy</td>
<td>Prison</td>
<td>Hakea Prison, Canningvale</td>
<td>Natural Causes</td>
<td></td>
</tr>
<tr>
<td>8/3/02</td>
<td></td>
<td>HATCHER Marie</td>
<td>Prison</td>
<td>Bandyup Women’s Prison</td>
<td>Ligature Compression of the Neck (Hanging)</td>
<td></td>
</tr>
<tr>
<td>18/3/02</td>
<td></td>
<td>CASSIDY Michael Patrick</td>
<td>Prison</td>
<td>Fremantle Hospital</td>
<td>Emphysema/Cancer</td>
<td></td>
</tr>
<tr>
<td>9/5/02</td>
<td></td>
<td>WAYMAN Donald James</td>
<td>Prison</td>
<td>Casuarina Prison</td>
<td>Asphyxiation – Plastic Bag</td>
<td></td>
</tr>
<tr>
<td>17/5/02</td>
<td></td>
<td>QUARTERMAINE Kevin Gregory</td>
<td>Prison</td>
<td>Fremantle Hospital</td>
<td>Natural Causes</td>
<td></td>
</tr>
</tbody>
</table>
Deaths Referred to the Coroners Court
1 July 2001 – 30 June 2002

A total of 2,038 deaths were referred to the coronial system during the year.

Of these deaths, in 615 cases death certificates were ultimately issued by doctors. In many cases there were initial problems experienced in locating a treating doctor or a treating doctor had initial reservations about signing a certificate which were ultimately resolved.

In the Perth area there were 1,020 Coroner’s cases and in the country regions there were 403 Coroner’s cases.

Coroner’s cases are ‘reportable deaths’ as defined in section 3 of the Coroners Act 1996. In every Coroner’s case the body is in the possession of the Coroner until released for burial or cremation. In all Coroner’s cases an investigation takes place and either on the basis of that investigation or following an Inquest subsequent to the investigation, a Coroner completes Findings as to the identity of the deceased, how the death occurred and the cause of death.

Statistics relating to the manner and cause of deaths referred to the Coroner for investigation are detailed below. In a number of cases a Finding by a Coroner had not been made at the time of compilation of the statistics, but an apparent manner and cause of death has been provisionally determined from the circumstances in which the body was found and from other information available.
### Deaths referred to a Coroner for investigation for the Metropolitan area

#### 1 July, 2001 - 30 June, 2002

<table>
<thead>
<tr>
<th>Category</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Natural</td>
<td>520</td>
</tr>
<tr>
<td>Suicides</td>
<td>214</td>
</tr>
<tr>
<td>Accidents</td>
<td>122</td>
</tr>
<tr>
<td>Traffic</td>
<td>90</td>
</tr>
<tr>
<td>Homicide</td>
<td>25</td>
</tr>
<tr>
<td>Open</td>
<td>20</td>
</tr>
<tr>
<td>Misadventure</td>
<td>0</td>
</tr>
<tr>
<td>Inconclusive</td>
<td>23</td>
</tr>
<tr>
<td>Combined Natural Causes/Accident</td>
<td>1</td>
</tr>
<tr>
<td>No Jurisdiction</td>
<td>1</td>
</tr>
<tr>
<td>Subsequent referral to Coroner</td>
<td>4</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>1,020</strong></td>
</tr>
</tbody>
</table>

### Deaths referred to a Coroner for investigation for the Country area

#### 1 July, 2001 - 30 June, 2002

<table>
<thead>
<tr>
<th>Category</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Natural</td>
<td>180</td>
</tr>
<tr>
<td>Suicides</td>
<td>69</td>
</tr>
<tr>
<td>Accidents</td>
<td>35</td>
</tr>
<tr>
<td>Traffic</td>
<td>87</td>
</tr>
<tr>
<td>Homicide</td>
<td>10</td>
</tr>
<tr>
<td>Open</td>
<td>5</td>
</tr>
<tr>
<td>Inconclusive</td>
<td>16</td>
</tr>
<tr>
<td>Misadventure</td>
<td>1</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>403</strong></td>
</tr>
</tbody>
</table>