Government of **Western Australia**
Department of **Justice**
Strategic Reform

Statutory Review of the *Coroners Act 1996* (WA)

Final Report

July 2021

Contents

1 Executive summary 3
2 Findings and Recommendations 4
2.1 Recommendations 4
2.2 Findings 4
3 The *Coroners Act 1996* (WA) 6
3.1 About the Act 6
3.2 The objects of the Act 6
4 Scope of the Review 7
4.1 The Review provisions of the Act 7
4.2 Terms of reference 7
4.3 Consideration of section 22(1)(d) 7
4.4 Methodology 7
5 Background 8
5.1 Overview of the Act 8
5.2 Previous reviews of the Act 11
6 Implementation of LRCWA legislative recommendations 12
6.1 The Legislative Project amending the *Coroners Act 1996* (WA) 12
6.2 The *Coroners Amendment Act 2018* (WA) 13
7 Implementation of LRCWA non-legislative recommendations 15
7.1 Coronial guidelines and information provided to the coroner – improving consistency in coronial investigations 15
7.2 Delegation of powers 17
7.3 Principal Registrar position 18
7.4 Conduct of post mortem examinations 19
7.5 Reforms to support the role and rights of families in the coronial process 20
7.6 Death prevention role 24
8 Attainment of the objects of the Act 26
9 The Attorney General's power to direct under section 22(1)(d) 27
9.1 The narrow scope of section 22(1)(d) 27
Appendix A – List of LRCWA recommendations being progressed through the Legislative Project to amend the *Coroners Act 1996* (WA) 29

1 Executive summary

- The *Coroners Act 1996* (WA) (**the Act**) commenced on 7 April 1997 implementing a new coordinated coronial system in Western Australia.
- Section 57 requires the Attorney General to carry out a statutory review of the Act, as soon as practicable after the expiration of five years from the commencement of the Act and every five years thereafter.
- The Department of Justice (**the Department**) has undertaken this review (**the Review**) on behalf of the Attorney General.
- The Law Reform Commission of Western Australia (**LRCWA**) published the *Review of Coronial Practice in Western Australia, Final Report, Project 100* (**the LRCWA Report**) in January 2012. The LRCWA Report contained 113 recommendations comprising 236 initiatives/actions.[1]
- While reforms addressing the recommendations of the LRCWA Report have been implemented, there are significant further reforms to the Act, and to the policies and practices of the Coroner's Court, in progress. Several recommendations also extend to different agencies with responsibilities for delivering coronial services in Western Australia.
- As a result, the Department did not undertake a comprehensive review of the administration, effectiveness and operation of the Act and Coroner's Court at this time. It was considered more appropriate to undertake a comprehensive review including the implementation of the LRCWA recommendations, as part of the next recurrent review of the Act.
- The Review considers that, overall, the objects of the Act as per the Second Reading Speech have been attained.[2]
- However, as stated in Recommendation 4, the next recurrent review of the Act will be able to properly assess the statutory objectives of the Act, which are included in the tranche of legislative amendments that are in progress.
- Prior to finalisation of the Review, the Office of the Attorney General requested that consideration be given to whether section 22(1) of the Act ought to be amended to avoid confusion about its operation. That consideration is included under the Review.

[1] Law Reform Commission of Western Australia, *Review of Coronial Practice in Western Australia, Final Report - Project 100* (January 2012) (*'LRCWA Final Report'*).
[2] Western Australia, *Parliamentary Debates*, Legislative Assembly, 22 June 1995, 5702 (Cheryl Edwardes, Attorney General) ('*Second Reading Speech'*).

2 Findings and Recommendations

2.1 Recommendations

Recommendation 1 (p 17)
At the next recurrent review of the Act, consider the impact of guidelines on coronial practice and operations.

Recommendation 2 (p 20)
At the next recurrent review of the Act, consider the impact of the Coroner's Court's practice and the introduction of the CT scanner on meeting the principles governing the conduct of post mortems, which will be enshrined in the Act.

Recommendation 3 (p 23)
As guides and forms are developed for families, consideration should be given to publishing this information on the website in accessible formats and in multiple languages.

Recommendation 4 (p 26)
At the next recurrent review of the Act, a full assessment of the Act be conducted against the objects of the Act as implemented through the Legislative Project. [3]

Recommendation 5 (p 28)
The Attorney General's power to direct a coroner to hold an inquest under section 22(1)(d) be repealed. The repeal of the power should be progressed as part of the existing suite of proposed amendments to the Act being progressed through the Legislative Project.

2.2 Findings

Finding 1 (p 13)
The Review finds that the amendments to the Act overseen by the Legislative Project, if progressed, will implement the majority of the LRCWA recommendations for legislative reform.

Finding 2 (p 15)
The Review finds that the amendments made to the Act through the *Coroners Amendment Act 2018* (WA), and the supporting triage system to facilitate the earlier finalisations of certain coronial cases, have made a positive impact on addressing the concerns expressed in the LRCWA Report on delays in finalising cases.

Finding 3 (p 17)
The Review finds that, with one exception, guidelines for coronial practice remain to be drafted or updated, but it is appropriate to delay implementation of LRCWA recommendations in relation to coronial guidelines until the Legislative Project is complete.

[3] See page 12 for an explanation of the term "Legislative Project".

Finding 4 (p 18)
The Review finds LRCWA recommendation 12 was not supported in the Strategic Review or by stakeholders. In practice, the State Coroner delegates few powers, and issues relating to delegations may be better addressed through guidelines.

Finding 5 (p 19)
The Review finds that full implementation of LRCWA recommendation 11 is contingent on completion of the Legislative Project, but the administrative creation of the Principal Registrar position has allowed the State Coroner to delegate certain functions, which is providing coroners with extra time to focus on more complex aspects of their casework.

Finding 6 (p 20)
The Review finds that full implementation of LRCWA recommendations 101 and 102 is contingent on an amendment to the Act. However, the introduction of a new process in the Coroner's Court has increased the number of non-invasive examinations in line with LRCWA recommendation 102. It is too early to determine the impact of the introduction of the CT scanner on increasing the number of non-invasive examinations.

Finding 7 (p 23)
The Review finds that work is ongoing to support and inform families throughout the coronial process in line with a number of LRCWA recommendations but the Department will need to continue to explore options to improve the provision of culturally appropriate coronial counselling services to regional areas.

Finding 8 (p 25)
The Review finds that full implementation of LRCWA recommendations in relation to the Coroner's death prevention role is contingent on amendments to the Act. However, the State Coroner is meeting the requirement outlined in LRCWA recommendation 87(3) through changes to practice.

Finding 9 (p 28)
The Review finds that the power under section 22(1)(d) has never been relied upon to direct an inquest and its repeal would avoid uncertainty and confusion for persons who are seeking an inquest.

3 The *Coroners Act 1996* (WA)

3.1 About the Act

The Act replaced the *Coroners Act 1920* (WA), establishing the Coroner's Court of Western Australia (**the Coroner's Court**) and implementing a new, coordinated coronial system in the State. The Act also incorporated the recommendations arising from the Royal Commission into Aboriginal Deaths in Custody (**RCIADIC**) as they related to the coronial process. In the 1995 Second Reading Speech for the Bill, the then Attorney General stated:

> The new legislation will establish a coronial system that is responsive to the needs of the Western Australian community. The coronial system will ensure that prompt and thorough investigations are carried out on reportable deaths; that the families and friends of the deceased receive sympathetic and helpful assistance by the participants within the system; and uniform practices are delivered across the State.[4]

3.2 The objects of the Act

The objects of the Act are not explicitly stated in the legislation. For the purpose of determining the terms of reference for this Review, the objects were adopted from the Second Reading Speech. The objects of the Act as stated in the Second Reading Speech are to:

- move the operation of the coronial system into the twenty first century with the creation of a coordinated state wide coronial system;
- recognise the stress and trauma experienced by relatives and friends of a loved one who has died suddenly, and involve them in the decision making process;
- respond to community concern about aspects of the coronial process by banning the use of human tissue for purposes other than investigation of death, without written consent of the deceased in his or her lifetime or, in the event that such wishes are not known, the written consent of the senior next of kin;
- provide for the establishment of a widely representative ethics committee to oversee the research process;
- shift the onus for assisting relatives and friends onto the system instead of the individual by establishing a coronial counselling service to assist people in understanding the process;
- incorporate the recommendations of the RCIADIC insofar as they relate to the coronial process; and
- provide for an initial and independent review after 12 months and a complete report to Parliament after five years[5], to ensure that community needs continue to be met.

[4] *Second Reading Speech* above n 2, 5707.
[5] Section 57 of the Act makes provision for a review every five years, in addition to the undertaking given in the *Second Reading Speech* for a review after 12 months.

4 Scope of the Review

4.1 The Review provisions of the Act

In accordance with section 57 of the Act, the Attorney General is required to carry out a review of the operation of the Act as soon as practicable after every fifth anniversary of its commencement. Section 57 requires that the Review consider and have regard to:

a) the attainment of the objects of the Act;
b) the administration of the Act;
c) the effectiveness of the operation of the Coroner's Court; and
d) such other matters as appear to be relevant to the operation and effectiveness of the Act.

4.2 Terms of reference

It will be more appropriate to undertake a thorough review (including any recommendations implemented following the LRCWA Report) as a part of the next recurrent review of the Act. The review plan for a limited evaluation was endorsed by the Department's Evaluation and Review Steering Committee before being submitted to the Attorney General. In line with the review plan, the Review is to consider the Act in terms of:

a) the LRCWA recommendations which have been implemented by the Government; and
b) whether the Act has attained the objects as set out in the Second Reading Speech (listed above).

The LRCWA Report contained 113 recommendations, a large proportion of which are in various stages of implementation, and it is not yet possible to determine their success or otherwise.

4.3 Consideration of section 22(1)(d)

On 2 June 2021, the Office of the Attorney General requested that consideration be given to whether section 22(1) of the Act ought to be amended to avoid confusion about its operation. The query was specifically raised in the context of the Attorney General's power under section 22(1)(d) to direct that there be an inquest. That consideration is set out under section 9.

4.4 Methodology

4.4.1 Literature review

The Department conducted a literature review to revisit the Act and previous statutory reviews.

4.4.2 Stakeholder consultation

The Review was managed by the Department under the guidance of a Project Reference Group. In addition to those members of the Project Reference Group, the draft report was circulated to the State Coroner, Principal Registrar and the WA Police Force Sergeant within the Coroner's Court for comment prior to collation of the final report.

4.4.3 Final report

Having considered the findings from the literature review and the responses of the aforementioned stakeholders, the Department prepared this final report, including findings and recommendations, for the Attorney General.

5 Background

5.1 Overview of the Act

5.1.1 Coroners and the Coroner's Court

Section 5 creates the Coroner's Court of Western Australia as a court of record with exclusive jurisdiction to hold all inquests under the Act. Section 16 provides that the State Coroner is to ensure that a counselling service is attached to the Coroner's Court.

The State Coroner is appointed under section 6 of the Act and has broad functions under section 8. The State Coroner is assisted by the Deputy State Coroner (section 7), coroners (section 11), coroner's registrars (section 12) and coroner's investigators (section 14). Every magistrate is contemporaneously a coroner under section 11(1) and every member of the Western Australia Police Force (**WAPF**) is contemporaneously a coroner's investigator under section 14(2).

5.1.2 Reporting of deaths

Section 17 of the Act requires a person to report a death that is or may be a reportable death to a coroner or a member of the WAPF. A reportable death is defined under section 3 of the Act and includes a Western Australian death:

- that appears to have been unexpected, unnatural or violent or to have resulted, directly or indirectly, from injury;
- that occurs during an anaesthetic;
- that occurs as a result of an anaesthetic and is not due to natural causes;
- of a person who immediately before death was a person held in care;
- that appears to have been caused or contributed to while the person was held in care;
- that appears to have been caused or contributed to by any action of a member of the WAPF; or
- that occurs in Western Australia where the cause of death has not been certified under section 44 of the *Births, Deaths and Marriages Registration Act 1998*.

5.1.3 Investigation of deaths

Section 19(1) establishes the jurisdiction of the coroner to investigate a death if it appears that the death is or may be a reportable death. Where a person is missing and the State Coroner has reasonable cause to suspect that the person has died and that the death was a reportable death, section 23(1) enables the State Coroner to direct the investigation of the suspected death.

The State Coroner has the power to, with the prior approval of the Chief Magistrate, provide a coroner with directions about investigations into deaths generally and the manner in which they are to be conducted (section 21(1)). The State Coroner also has the power to provide a coroner with directions about an investigation into a particular death (section 21(2)). The State Coroner must also issue guidelines with respect to the principles, practices and procedures of the State coronial system (section 58(1)).

Pursuant to section 30, if a reportable death occurs and the body is in Western Australia, then the body is under the control of the coroner investigating the death until a certificate is issued under section 29(1). Once jurisdiction is assumed, section 20 requires the State Coroner to provide comprehensive information concerning the coronial process to any of the deceased person's next of kin according to section 37(5). This information must be in writing in a language and form likely to be understood by the person receiving the information.

Under section 34(1) a coroner may direct a pathologist or a doctor to perform a post mortem examination on a body if a coroner reasonably believes that it is necessary for an investigation of a death; e.g. to establish the cause of death pursuant to section 25(1)(c). Section 34 also outlines the circumstances under which tissue may be removed from the body of the deceased during post mortem examinations.

A coroner will usually wait 24 hours from the provision of the information to next of kin before directing a post mortem examination, unless the coroner believes a post mortem examination must be performed immediately.[6] This allows an opportunity for the senior next of kin to object to the examination under section 37.

Any person may request a coroner who has jurisdiction to investigate a death to direct a post mortem examination be performed (section 36). The senior next of kin of a deceased may elect to have an independent doctor present at the post mortem examination (section 35).

Section 33 outlines the powers of entry, inspection and seizure for coroners and coroner's investigators. Section 32 provides for a coroner or coroner's investigator to restrict access to an area where a death has occurred. In practice, it is usually WAPF who exercise these powers for the purpose of establishing first whether there are any elements of criminality in relation to the death.[7] Other agencies with statutory authority to investigate deaths in particular circumstances include WorkSafe, Resources Safety, Energy Safety, the Office of the Chief Psychiatrist, the Ombudsman and the Australian

[6] Department of Treasury (WA), *Coronial Investigations 90 day Mapping and Reform Project Series Report No. 4* (March 2018) 24 ('*Reform Series Report*').
[7] Ibid.

Transport Safety Bureau. Sometimes these investigations occur concurrently with the WAPF investigation.

5.1.4 Inquests into deaths

Under section 22(1), a coroner who has jurisdiction to investigate a death must hold an inquest into a death if:

- the deceased was immediately before death a person held in care;
- it appears that the death was caused, or contributed to, by any action of a member of WAPF;
- it appears that the death was caused, or contributed to, while the deceased was a person held in care;
- the Attorney General so directs;
- the State Coroner so directs; or
- the death occurred in prescribed circumstances (none are presently prescribed).

Under section 22(2), a coroner who has jurisdiction to investigate a death may also hold an inquest "if the coroner believes it is desirable".

Those coronial cases that are not the subject of public inquest are dealt with "on the papers" and are the subject of administrative findings. In approximately 97 percent of cases, an investigation is finalised by way of administrative finding.

Under section 28, the coroner investigating a death must notify the Registrar of Births, Deaths and Marriages as soon as possible of the particulars (if any) needed to register the death, including the identity of the deceased, date, place and cause of death.

5.1.5 Recommendations and findings

Section 25(1) requires the coroner investigating a death to find if possible:

- the identity of the deceased;
- how death occurred;
- the cause of death; and
- the particulars needed to register the death under the *Births, Deaths and Marriages Registration Act 1998* (WA).

However, in the circumstances set out in section 25(1A), a coroner is not under a duty to make a detailed finding as to how the death occurred.

A coroner may comment on any matter connected with the death, including public health or safety, or the administration of justice (section 25(2)). Where the death is of a person held in care, a coroner must comment on the quality of supervision, treatment and care of the person while in that care (section 25(3)).

According to section 25(5) a coroner must not frame a finding or comment in such a way as to appear to determine any question of civil liability or to suggest that any person is guilty of any offence. However, a coroner may refer any matter to the

Commissioner of Police or the Director of Public Prosecutions if an offence is believed to have been committed (section 27(5)).

Under section 27(3) the State Coroner may make recommendations to the Attorney General on any matter connected with the death and must provide written notice to the agency of any recommendations relating to a death of a person held in care relevant to the operation of that agency (section 27(4)).

The State Coroner must also report to the Attorney General annually on the deaths that have been investigated in each year, including a specific report on the death of each person held in care (section 27(1)). The Attorney General is to cause the report to be laid before each House of Parliament within 12 sitting days of such House after its receipt by him or her (section 27(2)).

5.2 Previous reviews of the Act

The Act commenced on 7 April 1997. The then Attorney General agreed to conduct "an independent review twelve months after this Act is proclaimed".[8] Further, the Attorney General committed "to carry out a review of the operations and effectiveness of the Act and the Coroner's Court" after five years. This latter commitment is reflected in section 57 of the Act.

The first legislative review of the Act was completed in May 1999 by the then State Coroner of South Australia, Wayne Chivell (**the Chivell Review**). The Chivell Review recommended a number of legislative improvements based on extensive stakeholder interviews and analysis of various documents associated with the creation, implementation and management of the Coroner's Court. Further, the Chivell Review considered the extent the legislation reflected the recommendations of the RCIADIC, concluding that the Act, when coupled with the State Coroner's guidelines, had comprehensively implemented the recommendations of RCIADIC.[9]

Many of the Chivell Review's recommendations for legislative reform were implemented by the *Coroners Amendment Act 2003* (WA). Other recommendations were implemented by introducing procedures and guidelines for deaths in custody.[10]

A second legislative review was completed in August 2008 by the then State Coroner of Queensland, Michael Barnes (**the Barnes Review**). The Barnes Review made a number of recommendations on the structure of the Coroner's Court, its resourcing and staffing levels, as well as the objects of the Act. Mandatory responses to coronial recommendations were also proposed, consistent with the recommendations of the RCIADIC.

In parallel, the LRCWA was engaged in 2008 to complete a comprehensive review of the coronial system, including consideration of the recommendations made in the Barnes Review. The then Attorney General asked the LRCWA to consider:

[8] *Second Reading Speech* above n 2, 5707.
[9] Wayne Chivell, *Report on Review of the Coroners Act 1996 (WA)* (May 1999) 1 ('*Chivell Review*').
[10] The Law Reform Commission of Western Australia, *Review of Coronial Practice in Western Australia*, Background Paper - Project 100 (September 2010) 10 ('*LRCWA Background Paper*').

(a) any areas where the *Coroners Act 1996* (WA) can be improved;
(b) any desirable changes to jurisdiction, practices and procedures of the coroner and the office that would better serve the needs of the community;
(c) any improvements to be made in the provision of support for the families, friends and others associated with a deceased person who is the subject of a coronial inquiry including, but not limited to, issues regarding autopsies; cultural and spiritual beliefs and practices; and counselling services;
(d) the provision of investigative, forensic and other services in support of the coronial function; and
(e) any other related matter.

The LRCWA released a Background Paper in September 2010, a Discussion Paper in June 2011 and the LRCWA Report in January 2012 on its *Review of Coronial Practice in Western Australia*. Together these documents represent the most comprehensive examination of the Western Australian coronial system since the Act came into effect.

Key concerns identified by the LRCWA include: problems with delay in delivering coronial findings; lack of communication and cooperation between the Coroner's Court and other key stakeholders delivering coronial services; lack of information, guidance and training to regional magistrates, registrars, contractors and investigators and a lack of supporting information systems capability. The LRCWA Report contained 113 recommendations for reform comprising 236 initiatives/actions.

Following recommendation 5 of the LRCWA Report, the *Strategic Review of the Office of the State Coroner of the Coroner's Court* was undertaken by AOT Consulting in May 2012 (**the Strategic Review**). The Strategic Review proposed 27 recommendations, comprising 74 strategic initiatives/actions in total.

At the same time, AOT Consulting was commissioned to complete the third statutory review of the Act in accordance with section 57, producing the Final Report *Section 57 Review – Coroners Act 1996* in December 2012 (**the AOT Statutory Review**).[11] The AOT Statutory Review largely supported the findings and recommendations of the LRCWA Report and the Strategic Review;[12] however, it did recommend that consideration be given to rewriting the Act or restructuring it to better align with coronial processes (recommendations 1 and 2).

6 Implementation of LRCWA legislative recommendations

6.1 The Legislative Project progressing the amendments to the *Coroners Act 1996* (WA)

Following the conclusion of the last statutory review in December 2012, the Department, formerly the Department of the Attorney General (**DotAG**), commenced a legislative project to oversee the process to amend the Act and its regulations in accordance with the agreed LRCWA recommendations (**the Legislative Project**). Supported by a reference committee and a focus group, the Legislative Project also

[11] AOT Consulting Pty Ltd, *Section 57 Review of the Coroners Act 1996* (December 2012) 3 ('*Section 57 Review*').
[12] Ibid 5.

considered some legislative changes identified by the State Coroner that were not addressed by the LRCWA Report.[13]

LRCWA recommendations 55 and 56 were implemented as a matter of priority, resulting in amendments to the Act in 2018. Further legislative amendments remain in the drafting process. A list of the LRCWA recommendations being progressed through the Legislative Project to amend the Act is contained in **Appendix A**.

Finding 1
The Review finds that the amendments to the Act overseen by the Legislative Project, if progressed, will implement the majority of recommendations for legislative reform made in the LRCWA Report.

6.2 The *Coroners Amendment Act 2018* (WA)

LRCWA Report Recommendation 55
Non-narrative findings

1. That the Coroners Act contain a section modelled on s 67 of the *Coroners Act 2008* (Vic) enabling a coroner to make an administrative finding consisting of the identity of the deceased, the manner and cause of death, and the particulars required to register the death (that is, excluding the narrative of circumstances attending the death).

LRCWA Report Recommendation 56
Power of coroner to discontinue investigation in certain cases

1. That a provision modelled on s 17 of the *Coroners Act 2008* (Vic) be inserted into the Coroners Act to provide that in cases where a forensic pathologist has examined the body of a deceased and has expressed an opinion that the death was consistent with natural causes and the coroner determines that, other than the fact that the death of the person was unexpected, the death is not a reportable death, a coroner may discontinue the coronial investigation into the death and report the particulars required to register the death to the Registrar of Births, Deaths and Marriages.
2. That a coroner may not discontinue a coronial investigation in cases where the deceased was a person held in custody or where the death was during or following and causally connected to a medical procedure.
3. That the power to discontinue a coronial investigation into a death in the circumstances described above may be delegated by the State Coroner to the Principal Registrar.

A key issue identified by the LRCWA concerned the apparent delays in finalising coronial investigations. The impacts of delay within the coronial system were noted as:

- difficulties faced by next of kin trying to achieve timely closure in relation to a death;
- delays in finalising the deceased estate and associated financial matters; and
- delays in coronial findings and the implementation of recommendations to prevent future deaths in Western Australia.

[13] Office of the State Coroner (WA) Annual Report 2012-13, 30 ('*OSC Annual Report 2012-13*').

Although inadequate resourcing has often been identified as a leading cause of delay, the LRCWA found a number of contributory factors leading to delay and made several proposals for reform to both the Act and coronial processes.

Two amendments to the Act were progressed as a matter of priority in order to improve the efficient provision and finalisation of coronial investigations. The *Coroners Amendment Act 2018* (WA) came into effect on 22 September 2018, implementing recommendations 55 and 56 of the LRCWA Report (now reflected in sections 19A and 25(1A) of the Act). The reforms aimed to reduce the number of longer term investigations by removing a coroner's obligation to:

- continue to investigate a death by natural causes in circumstances where the death was reported because it was unexpected, subject to particular exceptions; and
- provide a detailed narrative on the circumstances of the death if there is no duty to hold an inquest under the Act and the coroner determines there is no public interest served in doing so.

Following these legislative amendments, the Coroner's Court has implemented a new triage system, "to fast track certain types of coronial cases to provide earlier responses for families". [14] The new triage system commenced in December 2018 in the metropolitan area, and was extended to regional areas in March 2019. It resulted in 88 findings completed under section 19A and 51 findings completed under section 25(1A) of the Act, up to 30 June 2019.[15]

Further, additional resources have been put towards addressing the concentrated referral by police of a number of long-term missing persons cases, by the appointment of a fifth, part-time coroner for one year, ending in June 2020. The accumulated backlog of cases will continue to be addressed by the four full time coroners, the most recent of whom was appointed in July 2019 for a term of five years.[16]

At the end of the 2018/19 financial year, the Coroner's Court had a backlog of 458 cases, but 338 of those were cases where no further finalisations were possible because the coroner was awaiting completion of investigations by external entities.

In 2018, the State Coroner commenced an inquiry into the origins of the backlog, which is now being carried out with the assistance of the Principal Registrar and Office Manager. Information is currently being collated to assist the State Coroner to ascertain whether those aforementioned backlog cases cannot be finalised by the Coroner's Court by reason of:

- the need to await the pathologist's opinion on the cause of death; and/or

[14] Office of the State Coroner (WA) Annual Report 2018-19, 26 ('*OSC Annual Report 2018-19*').
[15] Ibid 4.
[16] Government of Western Australia, 'New appointment to help reduce backlog in Coroner's Court' (Media Release, 19 June 2019). <https://www.mediastatements.wa.gov.au/Pages/McGowan/2019/06/New-appointment-to-help-reduce-backlog-in-Coroners-Court.aspx>.

- the need to await the completion of the investigation by police, and their report to a coroner.

Finding 2
The Review finds that the amendments made to the Act through the *Coroners Amendment Act 2018 (WA),* and the supporting triage system to facilitate the earlier finalisations of certain coronial cases, have made a positive impact on addressing the concerns expressed in the LRCWA Report on delays in finalising cases.

7 Implementation of LRCWA non-legislative recommendations

While the majority of the LRCWA recommendations relate to legislative reform, there were proposals aimed at reforming the practices and policies of the Coroner's Court as well as other agencies involved in the delivery of coronial services in Western Australia. A number of these non-legislative recommendations relate to the operation of provisions in the Act or require the Act to be amended prior to implementation.

In this context, the following subsections discuss the LRCWA non-legislative recommendations that have been addressed to date.

7.1 Coronial guidelines and information provided to the coroner – improving consistency in coronial investigations

LRCWA Recommendation 97
State Coroners Guidelines: Review, update and publish

1. That, in addition to issuing guidelines about the specific matters addressed in recommendations throughout this Final Report, the State Coroner review and update all existing guidelines and consider guidelines that should be made to discharge the obligation under s 58(1) of the Coroners Act.
2. That, at the earliest opportunity, all State Coroner's guidelines be publicly available for download from the Coroner's Court website.

Section 58(1) of the Act provides that the State Coroner must issue guidelines with respect to the principles, practices and procedures of the State coronial system. In the LRCWA Discussion Paper, it was proposed that all existing guidelines should be reviewed, updated and published at the earliest opportunity.[17]

The LRCWA Report made several recommendations aimed at achieving consistency in the coronial investigations of reportable deaths, including the quality of information provided to coroners. These included:

- the adoption of the National Police Form (recommendation 28);
- revised guidelines to WAPF (recommendation 27);

[17] Law Reform Commission of Western Australia, *Review of Coronial Practice in Western Australia*, *Discussion Paper - Project No.100* (June 2011) Proposal 94 ('*LRCWA Discussion Paper*').

- training of coroners and coroner's registrars (recommendation 13);
- informing medical practitioners of relevant changes to the Coroners Act (recommendation 20); and
- review of the 'Death in Hospital' form (recommendation 23).

The LRCWA noted the benefits of Western Australia adopting the National Police Form which is currently used in several Australian coronial jurisdictions. Benefits include:

- a greater capacity to electronically track trends to inform death prevention strategies;
- elimination of several paper forms required to be completed;
- improvement in the information about the circumstances of a death to assist in coronial investigations; and
- standardisation of death investigations across Western Australia.[18]

Both the Coroner's Court and WAPF have indicated support in principle for the adoption of the National Police Form, though there are differing views on whether the form should serve as the basis of the WAPF report to the Coroner's Court for the purpose of a reportable death determination.[19] Ultimately, the adoption of a standardised reporting system will most likely require the successful implementation of the Integrated Courts Management System within the Coroner's Court and WAPF.

Ten of the LRCWA recommendations related to developing coronial guidelines. The LRCWA noted the guidelines issued for WAPF were "outdated, limited and in need of review."[20] The State Coroner has advised that processes have improved since the publication of the LRCWA Report.[21] The revised guidelines to the WAPF will be implemented as the Act is amended and the subsequent reforms to coronial practice take place.[22] By way of example, the guidelines concerning preliminary investigations are subject to change with the introduction of a dedicated CT scanner within the State Mortuary.[23]

[18] Ibid 83.
[19] AOT Consulting Pty Ltd, *Strategic Review of the Office of the State Coroner* (November 2012), 58 (*'Strategic Review'*)
[20] LRCWA Discussion Paper above n 17, 67-8.
[21] *Reform Series Report* above n 6, 83.
[22] Ibid.
[23] Ibid.

In 2014, the State Coroner issued the *Guide to Writing Administrative Findings* to assist regional coroners and coroner's delegates and improve consistency of investigations.[24] However, the large number of proposed amendments to the Act will impact significantly on the operations of the State coronial system. Accordingly, the State Coroner will commence a project to draft guidelines once the Legislative Project is complete.

Finding 3
The Review finds that, with one exception, guidelines for coronial practice remain to be drafted or updated, but it is appropriate to delay implementation of LRCWA recommendations in relation to coronial guidelines until the Legislative Project is complete.

Recommendation 1
At the next recurrent review of the Act, consider the impact of guidelines on coronial practice and operations.

LRCWA Report – Recommendation 12
Delegation from the State Coroner to coroners' registrars

1. That the State Coroner may, in writing, delegate to a coroner's registrar any function or power of a coroner other than the functions or powers listed in subsection (2).
2. The following functions or powers of the State Coroner or a coroner cannot be delegated to a coroner's registrar (other than the Principal Registrar):
   (a) the power of delegation in subsection (1);
   (b) directing a forensic pathologist or medical practitioner to perform an internal post mortem examination;
   (c) ordering an exhumation;
   (d) releasing a body;
   (e) ordering an inquest;
   (f) making final determinations on any application under this Act;
   (g) making findings or reviewing findings;
   (h) making practice directions;
   (i) authorising the restriction of access to an area; and
   (j) performing such other functions as are prescribed by regulation.

7.2 Delegation of powers

Section 10 of the Act permits the State Coroner to "delegate to a coroner's registrar any power or duty of a coroner other than a prescribed power or duty or this power of delegation". During LRCWA's consultations, stakeholders expressed concerns regarding the extent of coronial power being delegated to coroners' registrars such as directions to conduct post mortem examinations and the drafting of coronial findings.[25]

The LRCWA considered the power of delegation under section 10 to be too wide, recommending that the Act be amended to restrict the State Coroner from delegating

[24] Ibid 81.
[25] *LRCWA Final Report* above n 1, 14.

core coronial functions to a coroner's registrar (other than the Principal Registrar) (recommendation 12).[26]

In practice, the only powers delegated to coroners' registrars in the regions are: directing a forensic pathologist or medical practitioner to perform an internal post mortem examination and releasing a body. The State Coroner has expressed the view that these delegations are necessary to ensure that decisions regarding deaths occurring regionally are dealt with by local courts which are better placed to deal with families, doctors and service providers.[27] The Strategic Review considered that the practical issues pertaining to delegations may be better addressed through coronial guidelines.[28] The position taken in the Strategic Review was supported by the stakeholders.

Finding 4
The Review finds LRCWA recommendation 12 was not supported in the Strategic Review or by stakeholders. In practice, the State Coroner delegates few powers, and issues relating to delegations may be better addressed through guidelines.

7.3 Principal Registrar position

LRCWA Report – Recommendation 11
Principal Registrar

1. That the position of Principal Registrar of the Coroner's Court of Western Australia be established.
2. That the Principal Registrar be a suitably qualified person who is eligible to be appointed to the Magistrates Court of Western Australia.
3. That the Principal Registrar have such powers and functions as are prescribed under the Coroners Act or delegated in writing by the State Coroner.
4. That a decision of the Principal Registrar be capable of review by the State Coroner on its merits.

The LRCWA also recommended that the quasi-judicial position of Principal Registrar be established to allow for the State Coroner to delegate more routine matters to this position and therefore provide the coroners with more time to conduct investigations (recommendation 11). An amendment to the Act to create the Principal Registrar role is included in the tranche of amendments that have progressed to drafting.

In the meantime, the position of Principal Registrar has been created administratively, with delegated functions from the State Coroner including functions to authorise and sign non-narrative natural cause administrative findings, to authorise coroners' investigators to enter a specified place and take possession of things, and to approve external post mortem examinations when recommended by a forensic pathologist.[29]

[26] *LRCWA Final Report* above n 1, 22.
[27] *Section 57 Review* above n 11, 34.
[28] *Strategic Review* above n 19, 34.
[29] *OSC Annual Report 2018-19* above n 14, 25. Note that in the case of the incumbent, it awaits his appointment as a registrar.

It is expected the Principal Registrar will be delegated more critical coronial functions when the position is confirmed legislatively. The State Coroner has reported that the "ongoing and timely execution" of the Principal Registrar's duties has allowed the coroners to focus on more complex aspects of their casework.[30]

Finding 5
The Review finds that full implementation of LRCWA recommendation 11 is contingent on completion of the Legislative Project, but the administrative creation of the Principal Registrar position has allowed the State Coroner to delegate certain functions, which is providing coroners with extra time to focus on more complex aspects of their casework.

LRCWA Recommendation 102
Principles governing conduct of post mortem examinations

That the following principles governing the conduct of a post mortem examination be inserted into the Coroners Act:

1. When a post mortem examination or other examination or test is conducted on the remains of a deceased person, regard is to be had to the dignity of the deceased person.
2. If more than one procedure is available to a person conducting a post mortem examination to establish the cause and manner of a deceased person's death, the person conducting the examination should use the least invasive procedures that are available and appropriate in the circumstances.
3. Without limiting subsection 2, examples of procedures that are less invasive than a full post mortem examination of the remains of the deceased person include (but are not limited to) the following:
    a. an external examination of the remains,
    b. a radiological examination of the remains,
    c. blood and tissue sampling,
    d. a partial post mortem examination.

7.4 Conduct of post mortem examinations

The LRCWA made recommendations to provide the State Coroner with the power to order external or preliminary post mortem examinations (recommendation 101) and to insert principles governing the conduct of a post mortem examination into the Act which includes the use of the least invasive procedure available (recommendation 102). The proposed amendments to the Act include provisions to implement LRCWA recommendations 101 and 102.

At the time the LRCWA's Report was published, Western Australia had a very high autopsy rate with an estimated 95 percent of coronial cases being subject to full internal post mortem examination.[31] The LRCWA observed the impact this high autopsy rate had on available resources. Further, it was thought to be an imposition on the cultural and religious beliefs of some Western Australians.[32] Accordingly, in

[30] Ibid.
[31] *LRCWA Final Report* above n 1, 126.
[32] Ibid.

2018 while the legislative amendments progressed, the State Coroner introduced a new process to encourage the use of the least invasive procedures to conduct post mortem examinations. After a successful trial period, this has since become a part of the Coroner's Court's practice in both metropolitan and regional areas.[33]

The process involves the forensic pathologist recommending to the coroner, where appropriate, that an opinion regarding the cause of death can be formed without the need to undertake a full post mortem examination. In each instance the senior next of kin are consulted, and the coroner makes a decision as to whether to approve the forensic pathologist's recommendation. During the 2018/19 financial year this process has resulted in 273 non-invasive post mortem examinations, compared to 261 for 2017/18, and compared to 227 in 2016/17.[34]

The installation of a CT scanner in the State Mortuary in July 2019 further fulfils recommendation 102 by reducing the use of invasive internal examinations.[35] The CT scanner will expand the range of cases that may be more efficaciously progressed under the above process, improving the quality of coronial services delivered to the Western Australian community.[36]

Finding 6
The Review finds that full implementation of LRCWA recommendations 101 and 102 is contingent on an amendment to the Act. However, the introduction of a new process in the Coroner's Court has increased the number of non-invasive examinations in line with LRCWA recommendation 102. It is too early to determine the impact of the introduction of the CT scanner on increasing the number of non-invasive examinations.

Recommendation 2
At the next recurrent review of the Act, consider the impact of the Coroner's Court's practice and the introduction of the CT scanner on meeting the principles governing the conduct of post mortems, which will be enshrined in the Act.

7.5 Reforms to support the role and rights of families in the coronial process

In its Discussion Paper, the LRCWA noted that one of the driving principles behind the introduction of the Act was the need for greater communication between the Coroner's Court and the deceased's family. The LRCWA examined the role of the family in the coronial process, focusing on how families can access coronial information and support and how the process can better cater for the culturally and linguistically diverse Western Australian community.[37]

The LRCWA Report made a number of recommendations concerned with the rights and roles of families in the coronial process including:

[33] *OSC Annual Report 2018-19* above n 14, 20.
[34] Ibid 4.
[35] Ibid 7.
[36] Ibid.
[37] *LRCWA Final Report* above n 1, 111.

- provision of coronial counselling and liaison to Aboriginal people (recommendation 90);
- community awareness education and training (recommendation 91);
- expanding available translations of important coronial information (recommendation 92);
- improving the coronial information service (recommendation 94); and
- improving the Coroner's Court website (recommendation 96).

7.5.1 Case management – communicating with families

A survey conducted by the LRCWA revealed that 74.5 percent of respondents "did not feel adequately informed about the progress of the deceased's case at various stages of the coronial process".[38] The LRCWA recommended "that the Office of the State Coroner investigate ways to provide families with regular updates about the progress of the deceased's case through the coronial process and accessible information about each stage of the coronial process, including the provision of a secure online service that is able to be accessed by senior next of kin of a deceased, and other family members at the coroner's discretion" (recommendation 94).

During consultations, the Coroner's Court acknowledged it would like to have the ability to contact families more frequently, but this was not possible due to staffing issues.[39]

Since the LRCWA's Report was published, the Coroner's Court has taken steps to improve communications with senior next of kin and families at various stages of the coronial process. In response to the LRCWA's recommendation 94, the State Coroner requested that ICMS implement the portal for families. The processes of the Coroner's Court are still manually driven; however, the introduction of ICMS will provide capacity for the automation of some of these practices when matters reach key milestones.

7.5.2 Counselling services

The LRCWA noted "particular concern that the coronial counselling service was not being effectively offered to people located regionally in Western Australia".[40]

Significantly, the LRCWA observed that the free telephone service to the coronial counsellors in Perth did not adequately meet the needs of Aboriginal people, particularly those in remote communities with limited access to telephones.[41] At the time of the LRCWA review, Coroner's Court counsellors were utilising Aboriginal health workers to initiate contact between the Coronial Counselling Service and Aboriginal families to achieve better outcomes.[42] The LRCWA therefore proposed that the Coroner's Court make arrangements with relevant agencies based regionally to provide coronial counselling and information liaison services to Aboriginal people. Further, it was recommended that the staff within the Coroner's Court receive cultural

[38] *LRCWA Discussion Paper* above n 17, 190.
[39] Ibid 191.
[40] *LRCWA Background Paper* above n 10*,* 55.
[41] *LRCWA Discussion Paper* above n 17, 183.
[42] *LRCWA Final Report* above n 1, 114.

awareness training to assist in the delivery of culturally appropriate services (recommendation 90).

The Strategic Review considered this issue further, concluding that the Coroner's Court is "inadequately resourced to provide an equitable counselling service across the state".[43]

The Coroner's Court, and the Department of Justice more generally, have taken steps to improve counselling services to regional areas, particularly in relation to Aboriginal communities. Cultural competency training has been implemented within the Coroner's Court[44] and informal arrangements have been put in place between the Coronial Counselling Service and regional onsite counselling services with a specific focus on culturally relevant counselling for Aboriginal communities.[45]

In 2017, the Department of Justice employed an Indigenous Manager Aboriginal Advisory Services, who improved the capacity of the Coroner's Court to liaise with Aboriginal communities in the Kimberley region.[46] The Aboriginal Mediation Service within the Department of Justice also provides conflict resolution services, including burial disputes in coronial matters.[47]

Although steps have been taken to address the disparity in the provision of counselling services to regional Western Australia, it is evident that reforms in this area will be ongoing and the Department will need to continue to explore options to improve the provision of culturally appropriate coronial counselling services to regional areas.

7.5.3 Access to information

The LRCWA made several recommendations relating to the provision of coronial information to relatives of the deceased. Some have been partially implemented (recommendations 96 and 97) and others were regarded as too resource intensive (recommendations 93 and 94) or impractical due to confidentiality issues (recommendation 95). As previously noted, some of the LRCWA recommendations cannot be implemented until the Act is amended.

7.5.3.1 Translation of coronial information to common languages

In response to the LRCWA Discussion Paper, the Coroner's Court translated the brochure *When a Person Dies Suddenly* into five common written languages in Western Australia: Farsi, Arabic, Chinese, Vietnamese and Italian, which have been published on the Coroner's Court website (**the website**). The brochure was also reviewed by the Aboriginal consultants who conducted the cultural competency training within the Coroner's Court.

In the LRCWA Report it was proposed that the Coroner's Court expand the range of languages provided on its website to include communities of newly settled migrants.[48] Further, the LRCWA recommended that the Coroner's Court provide links to the

[43] *Section 57 Review* above n 11, 36.
[44] *Reform Series Report* above n 6, 86.
[45] Ibid 90.
[46] Ibid 88.
[47] Ibid.
[48] *LRCWA Final Report* above n 1, Recommendation 92.1.

brochure in the relevant language (as opposed to English) (recommendation 92). To date, this recommendation has not been implemented. As educational material is updated to reflect the upcoming legislative amendments, consideration should be given to reviewing the common languages, sourcing translations and publishing this information on the website.

7.5.3.2 Coroner's Court website

The LRCWA reported a number of deficiencies with the website, primarily concerning the lack of online material to guide and inform people who may come into contact with the coronial system. The LRCWA recommended that the website should provide, at a minimum: information sheets; copies of the State Coroner's guidelines and public forms (for example, an application form for an inquest as per recommendation 65); the hearings list; coronial comments, findings and recommendations; responses to coronial recommendations; and links to community support organisations.[49]

The website has improved since the release of the LRCWA Report and provides a greater range of information including a dedicated webpage for legal practitioners and call over listings. Links to community counselling support, coronial guidelines and forms have yet to become available. As guidelines and forms are developed or updated to reflect the upcoming legislative amendments, consideration should be given to publishing this information on the website as per LRCWA recommendation 97.

Finding 7
The Review finds that work is ongoing to support and inform families throughout the coronial process in line with a number of LRCWA recommendations but the Department will need to continue to explore options to improve the provision of culturally appropriate coronial counselling services to regional areas.

Recommendation 3
As guides and forms are developed for families, consideration should be given to publishing this information on the website in accessible formats and in multiple languages.

[49] Ibid, Recommendation 97.

7.6 Death prevention role

LRCWA Recommendation 87
Mandatory response to coronial recommendations

1. That a public statutory authority or public entity the subject of a coronial recommendation must, within 21 days of receiving the recommendation, acknowledge receipt of the recommendation in writing to the State Coroner.
2. That a public statutory authority or public entity the subject of a coronial recommendation must within three months of receiving the recommendation or such other time as agreed between the public statutory authority or public entity and the State Coroner, provide a written response to the State Coroner specifying a statement of action (if any) that has, is or will be taken in relation to the recommendation made by the coroner.
3. That, unless otherwise ordered by the State Coroner, as soon as reasonably practicable upon receipt of the written response from a public statutory authority or public entity, the State Coroner must publish the response on the internet and provide a copy of the response to any person who has advised the Principal Registrar that they have an interest in the subject of the recommendations.
4. That the state government give consideration to whether private entities performing public functions be subject to the same mandatory response requirement as public statutory authorities and public entities.

Section 27(3) of the Act provides that the State Coroner may make recommendations to the Attorney General on any matter connected with a death which a coroner investigated. The LRCWA Report recommended that the legislative power to make recommendations be expanded to all coroners.[50] This recommendation is incorporated in the proposed legislative amendments to the Act. Other LRCWA recommendations in relation to the coronial death prevention role are being pursued through changes to coronial practice and procedure.

One of the primary functions of the coroner is to prevent deaths through recommendations and findings. Although a coroner has the power to make recommendations, there is currently no legislative requirement for an agency subject to a recommendation to provide a response.

The LRCWA noted that public agencies in Western Australia typically demonstrated a "high rate of responsiveness" to coronial recommendations, with specific reference to the Department of Health, WAPF and the former Department of Corrective Services (now part of the Department of Justice).[51] However, the issue of responsiveness to coronial recommendations generally has been the subject of consideration by the Council of Attorneys-General since 2009, highlighting the level of concern about the rate of response and implementation of such recommendations. It is also the subject of one of the few RCIADIC recommendations that is yet to be implemented in Western Australia.[52]

The LRCWA received "overwhelming support" for its proposal that public entities subject to a coronial recommendation must provide a written response to the State Coroner within three months of receiving the recommendation specifying a statement

[50] *LRCWA Final Report* above n 1, 103.
[51] Ibid 105.
[52] Deloitte, *Review of the Implementation of the Recommendations of the Royal Commission into Aboriginal Deaths in Custody* (August 2018) 39.

of action.[53] There were limited submissions received regarding whether this should be extended to private entities, therefore the LRCWA recommended that this issue be considered further by the State Government (recommendation 87).

In 2014, the State Coroner adopted recommendation 96 of the LRCWA in publishing findings and recommendations on the website, in addition to the submission of an annual report to the Attorney General. The State Coroner supports the introduction of legislative or policy options mandating responses to coronial recommendations, consistent with recommendation 87.[54]

The only issue that remains is the capacity of the State Coroner to catalogue and monitor the implementation of recommendations. In 2013, the Community Development and Justice Standing Committee recognised the need for ongoing monitoring of the implementation of coronial recommendations. The Committee found, for example, separate inquests "quite often" produce similar recommendations and a central record was necessary to avoid repeating "mistakes of the past".[55] Further, there is no transparency to the community as to the status of what is being done in response to recommendations and the progress being made.[56]

The Strategic Review recommended that coronial recommendations and responses be catalogued within an electronic case management system, to allow a record to be searched for research and monitoring purposes.[57] It also recommended that responses from agencies be published on the website.[58]

The State Coroner has advised that Ministerial responses to recommendations are currently published on the website and further advice is being sought regarding the search functionality on responses to recommendations for website visitors.

Further, the State Coroner maintains a central catalogue of all Ministerial responses to recommendations, and counsel/coroners have approved access to the National Coronial Information System database, that keeps a searchable record of all coronial recommendations.

Finding 8
The Review finds that full implementation of LRCWA recommendations in relation to the Coroner's death prevention role is contingent on amendments to the Act. However, the State Coroner is meeting the requirement outlined in LRCWA recommendation 87(3) through changes to practice.

[53] *LRCWA Final Report* above n 1, 106.
[54] *OSC Annual Report 2012-13* above n 13.
[55] Community Development and Justice Standing Committee, Parliament of Western Australia, *In Safe Custody, Inquiry into Custodial Arrangements in Police Lock-ups*, No. 2 (November 2013).
[56] *Section 57 Review* above n 11, 69.
[57] *Strategic Review* above n 19, 223.
[58] Ibid, Recommendation 17.

8 Attainment of the objects of the Act

Both the Barnes Review and the LRCWA Report identified that the objects of the Act are not expressly stated within the legislation and consequently made recommendations to insert an objects clause within the Act to more clearly define the role of the coroner and the objectives of the coronial process.[59] Proposal 1 of the LRCWA Discussion Paper set out a proposed objects clause for the Act.[60] The proposal received overwhelming support and formed Recommendation 1 of the LRCWA Report.[61] The provision to insert an objects clause in the Act is included in the tranche of legislative amendments that remain in the drafting process.

While the terms of reference for this Review specified the objects as set out in the Second Reading Speech, the Barnes Review and the AOT Consulting Reviews used different methods to identify the objects of the Act. The Barnes Review had regard to the Second Reading Speech, the substantive provisions of the Act and the role of coroners.[62] The Strategic Review mapped the coronial processes using the criteria derived from the proposed objects of the Act as recommended in the LRCWA Report and assessed attainment using criteria derived from the objects proposed by the LRCWA Report and Barnes Review.[63]

Section 57 of the Act requires that the Review consider and have regard to the attainment of the objects of the Act. However, as previously stated, there are no objects prescribed within the Act. Rather than conduct a full assessment against the objects as set out in the Second Reading Speech, the Review considers it appropriate to delay consideration until the objects are prescribed in legislation, as is anticipated through the Legislative Project. Future recurrent reviews will have the benefit of consistent objects.

Recommendation 4
At the next recurrent review of the Act, a full assessment of the Act be conducted against the objects of the Act as implemented through the Legislative Project.

[59] Michael Barnes, *Review of the Coroners Act 1996 (WA)* (August 2008) 30 (‘*Barnes Review*’); *LRCWA Final Report* above n 1, recommendation 1.
[60] *LRCWA Discussion Paper* above n 17, 13.
[61] *LRCWA Final Report* above n 1, 9.
[62] *Barnes Review* above n 59, 30.
[63] *Section 57 Review* above n 11, 6.

9 The Attorney General's power to direct under section 22(1)(d)

Section 22(1)(d) of the Act provides that a coroner who has jurisdiction to investigate a death must hold an inquest if "the Attorney General so directs".

On 27 October 2020, the Hon John Quigley MLA, Attorney General, issued a media statement entitled "Legal advice clarifies position regarding direction to hold inquests".[64] That media statement notes the following:

- The Attorney General sought the Solicitor General's advice on the proper construction of the section 22(1)(d) power.
- Despite section 22(1)(d) appearing "simply to grant an Attorney General power to direct an inquest", the effect of the legal advice received was that once a coroner decides not to hold an inquest, "the executive does not have the power to overrule that decision and direct that an inquest be held".
- The power in the Act is not intended to be used to overrule a coroner's decision not to hold an inquest.
- The power should only be used in exceptional circumstances where a coroner has not yet decided on whether an inquest should be held, where there is an obvious and immediate public interest in an investigation.
- The Attorney General could, for example, direct an investigation into all coronavirus deaths in a particular aged care facility, without waiting for the Coroner to determine whether each death should be investigated.
- Persons may apply to the Supreme Court of Western Australia to challenge any refusal of a coroner to hold an inquest (see section 24 of the Act). Further, the existing seven-day period to commence proceedings in the Supreme Court would be extended to 30 days as part of forthcoming legislative reforms.

9.1 The narrow scope of section 22(1)(d)

Given the legal position stated above, the Attorney General's power under section 22(1)(d) is of very limited application. Where an inquest is discretionary (that is, where a coroner *may* hold an inquest, but is not *required* to hold one) the Attorney General's power would be available between the date of death until such time the coroner determines whether or not to hold an inquest.

Presumably persons who are aware of and understand this legal position and who want an inquest, will petition the Attorney General during this time. However, this is the very same period where the matter is under consideration by the coroner. The creation of this parallel process is problematic and undesirable. Prior to a coroner deciding whether to hold an inquest, the coroner will necessarily be compiling and reviewing information regarding the death. A coroner will have the appropriate information and expertise to determine whether an inquest is desirable. In contrast, the Attorney General does not have any particular statutory functions to investigate deaths (including to obtain reports or require post-mortem examinations), and therefore would be required to make decisions based on very little material.

[64] <https://www.mediastatements.wa.gov.au/Pages/McGowan/2020/10/Legal-advice-clarifies-position-regarding-direction-to-hold-inquests.aspx>

It is important to also note the significant workload of the Coroner's Court. 2,573 deaths were reported to the Coroner's Court in the 2019-20 financial year.[65] In the same period, only 100 investigations were finalised by inquest. Of those 100 inquests, 13% comprised investigations where the inquest was discretionary (as opposed to mandatory). There were 2,637 administrative findings (that is, findings without an inquest) during the same period. Therefore, with only a small proportion of cases ever proceeding to inquest, it would seem undesirable from a resource allocation perspective for the Attorney General to have such a significant role in determining how many inquests the Coroner's Court should conduct.

In light of the above considerations, it would seem justifiable and appropriate for an Attorney General to decline to consider whether to hold an inquest while the matter is under consideration by a coroner. However, it is acknowledged that such a decision is likely to cause further distress to the person who has requested an inquest.

It was acknowledged in the media statement that the text of section 22(1)(d) appears to simply give the Attorney General power to direct that there be an inquest (without regard to whether a coroner has declined to hold an inquest). It is likely that this text may lead to confusion for persons who do not appreciate that the Attorney General's power is limited in the manner described above. Those persons may therefore choose to await the coroner's decision prior to petitioning the Attorney General. However, once the coroner refuses to hold an inquest, the recourse is to the Supreme Court, not the Attorney General. This, again, is likely to result in further distress.

While there may be circumstances where an inquest should be directed prior to the coroner fully investigating the circumstances of the case (such as where there has been a natural disaster resulting in a mass loss of life), it is noted that the State Coroner has the power under section 22(1)(e) to direct that there be an inquest. The review considers that it would be more appropriate for the State Coroner, rather than the Attorney General, to direct that there be an inquest in these circumstances.

Finally, the Review is not aware of any instance where a Western Australian Attorney General has directed that there be an inquest under section 22(1)(d). This suggests that either persons never ask the Attorney General to exercise the power (which, based on the media statement, does not seem to be the case) or no Attorney General has ever considered it appropriate to exercise the power.

Finding 9
The Review finds that the power under section 22(1)(d) has never been relied upon to direct an inquest and its repeal would avoid uncertainty and confusion for persons who are seeking an inquest.

Recommendation 5
The Attorney General's power to direct a coroner to hold an inquest under section 22(1)(d) be repealed. The repeal of the power should be progressed as part of the existing suite of proposed amendments to the Act being progressed through the Legislative Project.

[65] Office of the State Coroner for Western Australia *Annual Report 2019-2020*. <https://www.coronerscourt.wa.gov.au/_files/Annual_Report_2019_2020.pdf.

Appendix A – List of LRCWA recommendations being progressed through the Legislative Project to amend the *Coroners Act 1996* (WA)

It is noted that the suite of reforms being implemented by the Legislative Project are still in development. The information set out below is current as at the time the Review was completed.

LRCWA Report Rec No	LRCWA Report Recommendation	Section of the Act	Classification
1	**Objects of the Coroners Act**	New section under Part 1	Overview
10	**Oath of Office**	New section under Part 2	Coronial jurisdiction
11	**Principal Registrar**	New section under Part 2	Coronial jurisdiction
12	**Delegation from the State Coroner to coroners' registrars**	Section 10	Coronial jurisdiction
15	**Increase penalties for failure to report a death**	Section 17	Death reporting
16	**Obligation to report a suspected death**	Section 17	Death reporting
17	**Removal of specific categories of anaesthesia-related deaths**	Section 3	Death reporting
18	**Reportability of healthcare-related deaths**	New section under Part 1 & section 17	Death reporting
21	**Authorisation to issue a cause of death certificate**	New section under Part 4	Death reporting
29	**Restriction of access to area**	Section 32	Death investigation
30	**Penalty for obstructing a coroner or coroner's investigator**	Section 33	Death investigation
31	**Regulations for dealing with items seized by coroner's investigators**	Section 33	Death investigation
32	**Coroner may require medical practitioner to report**	Section 18 Section 33 Section 46 Section 47	Death investigation

LRCWA Report Rec No	LRCWA Report Recommendation	Section of the Act	Classification
33	**Power to request documents or prepared statements**	Section 18 Section 23	Death investigation
35	**Penalty for failure to provide information to a coroner**	Section 18	Death investigation
37	**Information sharing and confidentiality**	Section 18 Section 49 Section 53	Death investigation
47	**Assistance to and from coroners in other jurisdictions**	Section 31	Death investigation
48	**Statement of referral in record of investigation**	Section 25	Coronial findings and inquests
49	**Coroner's discretionary comment function**	New section under Part 4	Coronial findings and inquests
50	**Re-opening of investigation or inquest on coroner's initiative**	New section under Part 5	Coronial findings and inquests
51	**Application to coroner to re-open investigation or inquest**	New section under Part 5	Coronial findings and inquests
53	**Superior court review of coroner's findings**	New section under Part 5	Coronial findings and inquests
54	**Power to correct errors in records of investigation**	New section under Part 4	Coronial findings and inquests
57	**Two categories: persons held in custody and persons held in care**	Section 3	Coronial findings and inquests
58	**Definition of 'person held in custody'**	Section 3	Coronial findings and inquests
59	**Definition of 'person held in care'**	Section 3	Coronial findings and inquests
62	**Removal of standard of proof for suspected deaths**	Section 23	Coronial findings and inquests
63	**Guidance for coroners when an inquest should be held**	New section under Part 4	Coronial findings and inquests

LRCWA Report Rec No	LRCWA Report Recommendation	Section of the Act	Classification
66	**Superior court review of coroner's decision to refuse inquest**	Section 24	Coronial findings and inquests
68	**Interested persons**	Section 44	Coronial findings and inquests
69	**Inquest brief to be provided by Coroners Court**	New section under Part 5	Coronial findings and inquests
70	**Inquest brief in electronic form**	Amendment to section 6 *Courts and Tribunals (Electronic Processes Facilitation) Act 2013*	Coronial findings and inquests
71	**Pre-inquest hearings**	New section under Part 5	Coronial findings and inquests
72	**Notification and publication of pre-inquest and inquest hearing dates**	Section 25	Coronial findings and inquests
79	**Interruption of an inquest**	Section 51	Coronial findings and inquests
80	**Power to exclude from inquest**	Section 45	Coronial findings and inquests
81	**Restriction of publication**	Section 49	Coronial findings and inquests
84	**Coroner's power to make recommendations**	New section under Part 4	Coroner's prevention role
86	**Notification of coroner's recommendations**	New section under Part 4	Coroner's prevention role
87	**Mandatory response to coronial recommendations**	New section under Part 4	Coroner's prevention role
101	**Coroner may order external or preliminary post mortem**	New section under Part 4	Family support
102	**Principles governing conduct of post mortem examinations**	New section under Part 4	Family support

LRCWA Report Rec No	LRCWA Report Recommendation	Section of the Act	Classification
103	**Factors that coroners must consider in ordering an internal post mortem examination**	New section under Part 4	Family support
104	**Objection may only be made to internal post mortem examination**	Section 37	Family support
110	**Release of body by a coroner**	New section under Part 4	Family support
111	**Application for release of body by a coroner**	New section under Part 4	Family support
112	**Supreme Court review of Coroner's decision to release a body**	New section under Part 4	Family support