

**CORONERS AMENDMENT BILL 2017**

*Introduction and First Reading*

Bill introduced, on motion by **Mr J.R. Quigley (Attorney General)**, and read a first time.

Explanatory memorandum presented by the Attorney General.

*Second Reading*

**MR J.R. QUIGLEY (Butler — Attorney General)** [12.18 pm]: I move —

That the bill be now read a second time.

In 2012, the Western Australian Law Reform Commission completed its review of the Western Australian coronial jurisdiction and published its report, “Review of Coronial Practice in Western Australia”. The Coroners Amendment Bill 2017 will give legislative effect to recommendations 55 and 56 of that report.

The Law Reform Commission of Western Australia investigated and carried out extensive research and consultations, which identified a number of problems affecting the coronial system, including lengthy delays in completion of coronial cases. Delay frequently causes unnecessary hardship to the family of the deceased. The proposed amendments to the act will give effect to two measures that will reduce delays and remove the current unnecessary impost on the resources of the Office of the State Coroner and Western Australia Police.

The problems identified by the Law Reform Commission of Western Australia arise because the act presently imposes an obligation to investigate all deaths that are reported to the State Coroner. Deaths due to natural causes are non-contentious and do not come within the coronial jurisdiction; therefore, they are not required to be reported to the Office of the State Coroner. However, a large number of deaths due to natural causes are reported each year to the coronial jurisdiction. That is because the act imposes an obligation to report a death due to natural causes if there is any perception that the death was unexpected, unnatural or violent, or resulted, directly or indirectly, from injury. For example, the death of an elderly person following a fall in hospital may be reported to the coroner in case there is a causal connection between the death and the fall. Upon examination of that death, it may become apparent to the forensic pathologist that the cause of death was coronary artery atherosclerosis and that it was due to natural causes and not attributable to the fall. Currently, notwithstanding that it is open to the State Coroner to make a determination that the death was due to natural causes, the State Coroner, and, therefore, the officers of the coronial investigation squad of WA Police, are statutorily required to fully investigate the circumstances of the death, which will involve seizing medical records, obtaining reports, and taking statements from hospital staff, family and witnesses. The continuation of the investigation of a death from natural causes is a waste of limited resources, causes delays on important investigations, and is unnecessarily intrusive for the family of the deceased.

The proposed amendment will remove the obligation to investigate, or continue to investigate, in circumstances in which the death was due to natural causes and comes within the definition of a reportable death solely because it appears to have been unexpected. This recommendation was confined to deaths that occur from natural causes. The obligation to investigate remains in circumstances in which there is a duty to hold an inquest or the death occurred during an anaesthetic.

A related reform recommended by the Law Reform Commission of Western Australia to reduce delay will also assist to reduce the considerable backlog of matters resolved administratively—that is, without inquest. Presently, allied to the State Coroner’s obligation to investigate all reported deaths, the Coroners Act 1996 requires a coroner investigating a death to find, if possible, and to document, the identity of the deceased, the cause of death, how the death occurred, and the particulars needed to register the death under the Western Australian Births, Deaths and Marriages Registration Act 1998. In circumstances in which the reported death is determined to be due to natural causes, the practice of the State Coroner is to document the “cause of death” as, for example, coronary artery atherosclerosis, and to document how the death occurred as “by way of natural causes”.

An amendment that was recommended by the Law Reform Commission of Western Australia to ensure legislative clarity was that a more extensive description is not required in circumstances in which there is no duty to hold an inquest and the coroner determines that there is no public interest in making a more detailed finding as to how the death occurred. This recommendation was not confined to deaths that occur by way of natural causes.

The Law Reform Commission of Western Australia made many other recommendations, which are being considered. These two recommendations are deemed to be the most urgent and will serve to eliminate much delay and unnecessary impost on resources.

Pursuant to standing order 126(1), I advise that this bill is not a uniform legislation bill. It does not ratify or give effect to an intergovernmental or multilateral agreement to which the government of the state is a party. Nor does this bill, by reason of its subject matter, introduce a uniform scheme or uniform laws throughout the commonwealth.

I commend the bill to the house.

Debate adjourned, on motion by **Ms L. Mettam.**