Section 57 Review

Coroners Act 1996

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Document Number
ATG-018-008-005 FINAL V1.0

12 December 2012

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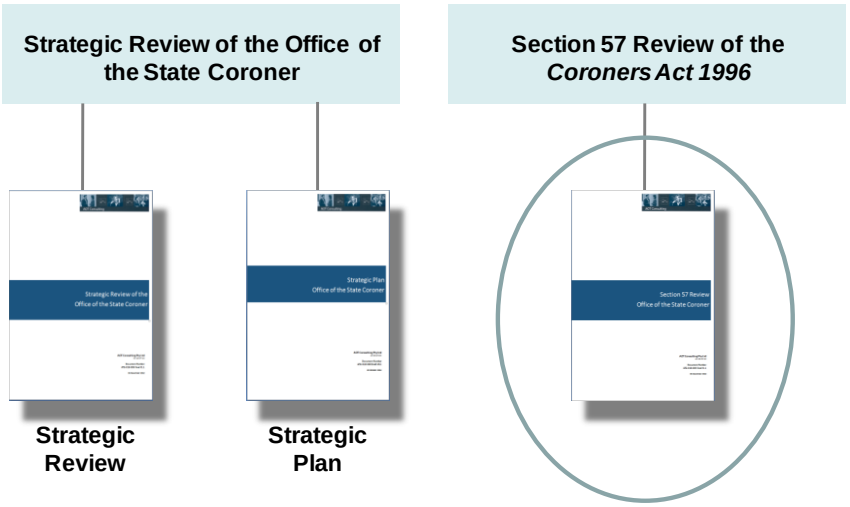
1 S.57 Review of the *Coroners Act 1996*

1.1 Introduction

This document sets out the Section 57 Review of the *Coroners Act 1996* ('s.57 Review'), which has been developed immediately after a Strategic Review of the Office of the State Coroner ('Strategic Review') in accordance with the requirements of the Department of the Attorney General (DotAG). The Strategic Review responded to Recommendation 5 of the Law Reform Commission of Western Australia's Project 100 - Review of Coronial Practice in Western Australia[1] ('LRCWA Review').

This document is one of three reports developed for the Strategic Review of the Office of the State Coroner and the Section 57 Review ('s.57 Review') of the *Coroners Act 1996*.

Figure 1-1: Strategic Review of the Office of the State Coroner



As illustrated in Figure 1-1, the Strategic Review and Strategic Plan are separated into two discrete documents and the s.57 Review is a standalone report.

In accordance with *Coroners Act 1996,* under s.57, the Attorney General is required to carry out a review of the operations of the Act after every fifth anniversary of its commencement. Section 57 requires that a 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 court; and

d) Other matters as appear to be relevant to the operation and effectiveness of the Act.

This s.57 Review is aided by the LRCWA Review, which made 113 recommendations, 66 of which were identified as being directly relevant for consideration to the s.57 Review. This s.57 Review is also aided by LRCWA Review of which 77 of the LRCWA recommendations were either directly relevant, partially relevant or commented on in regard to the Strategic Review and therefore have varying degrees of relevancy to the s.57 Review, particularly those pertaining to effectiveness and efficiency. The Strategic Review made a further 27 recommendations.

[1] Law Reform Commission of Western Australia, 2012, Review of Coronial Practice in Western Australia, Government of Western Australia, Perth

1.2 Summary of key points

The Attainment of the Objects of the Act

The Barnes Review in 2008, and more recently the LRCWA Review identified that the objects of the Act are not explicitly stated. Both reviews proposed an objects statement be included in the Act.

Taking into consideration what is set out in the Act, the findings from the LRCWA Review and the Strategic Review that followed, the current level of attainment is assessed as being partially conducive to meeting the objects of the Act.

The Administration of the Act

It follows that if an assessment pertaining to achieving the proposed objects of the Act is partially conducive, then the administration of the Act is unlikely to be assessed differently.

The basis of this statement is discussed in detail throughout the LRCWA Review and the Strategic Review that followed, both of which took a critical look at the coronial practice in Western Australia and the supporting strategic and operational framework.

The LRCWA Review proposed 113 recommendations comprising 236 initiatives / actions.

The Strategic Review proposed 27 recommendations, comprising 74 strategic initiatives/actions in total.

Identifying 310 strategic initiatives/actions that are recommended improvements in the administration of the Act, in effect supports the view that the current administration is partially conducive to achieving this.

The Effectiveness of the Operation of the Court

The interpretation of “the operation of the court” in the context of s.57 (1) (c) is taken to mean the Office of the State Coroner in this section. The Strategic Review identified:

- The hearts and minds of people are committed to coronial work and some work long hours.
- The coronial system is broader than the OSC and requires a different approach to inter-agency governance and OSC management.
- Reportable deaths are complex and not well understood outside of the OSC – complexity is increasing.
- The system is vulnerable to breaking down as it relies too much on tacit knowledge and individual ways of working.
- Current operations appear to have organically evolved and need overhauling.
- The OSC, WA Police CIU and PathWest are running to capacity.
- There are risks in potential loss of continuity of skills, knowledge, experience – the OSC has the highest leave liabilities in the whole of DotAG and can ill afford extinguishing the leave.
- Coronial services to regional Western Australia is inequitable as identified by the LRCWA Review and the counselling service in particular needs increased capacity.
- There are three distinctly different models in operation for Registry, Inquests (case management) and Counselling.

- Information systems that support coronial processes for registry, counselling services and case management are not adequate to support the OSC.
- Information management and control issues put the prevention of death role at risk.
- Some LRCWA Review recommendations will result in an increase in deaths being reported.
- Existing performance indicators are not adequate for monitoring and managing performance.
- Systemic issues the LRCWA referred to are mainly to do with:
    - Resource capacity coupled with ineffective and inefficient use of resources;
    - Process management and case management controls;
    - Quality control and quality management;
    - Lack of supporting information systems capability;
    - The need for improved education and training;
    - Management team fragmented looking across to whole of the OSC; and
    - Many seemingly inconsequential issues equal the sum of the parts of a broader issue.

Overall, the coronial system is unlikely to be sustainable if the current model continues and is vulnerable to the issues identified by the LRCWA Review and the Strategic Review persisting unless change is effected.

Other matters as appear to be relevant to the operation and effectiveness of the Act

This section of the s.57 Review discusses specific points identified when undertaking the review in the context to the Act and also draws upon LRCWA Review and the Strategic Plan.

It considers:

- 29 LRCWA Review recommendations that appear to be generally agreed to, which can go forward to be considered further by Parliamentary Counsel as part of the proposed Legislative Project. Given this quantum of proposed legislative change, the s.57 Review recommends that consideration be given to rewriting the *Coroners Act 1996.*
- The structure of the Act and recommends consideration to restructuring the *Coroners Act 1996* to be better aligned to the coronial processes.
- The Administration of the Act in the context of clearly distinguishing between the principal judicial officer of the Coroners Court and the administrative responsibility of DotAG.
- The State Coroner's and Deputy State Coroner's views pertaining to legislative change that are in addition to the LRCWA Review.
- The Prevention of Death Role and the distinction to be made in preventing and informing on the prevention of death.
- The LRCWA Review and Strategic Review's different, yet complementary views on addressing the requirements for regional Western Australia.
- A summary of the Strategic Review and Strategic Plan's proposed changes;
- Concluding statements pertaining to the s.57 Review; and
- A summary of recommendations.

2 Section 57 Review

2.1 This Review

Whilst this s.57 Review responds to Section 57 of the Act, it is dissimilar to the previous review undertaken by Mr Michael Barnes, State Coroner, Queensland ('The Barnes Review') in 2008 and is likely to be dissimilar to the next s.57 Review that is undertaken.

This s.57 Review is undertaken at a unique moment in time in close proximity to publishing the LRCWA Review and also the Strategic Review that closely followed commencing in May 2012. The LRCWA Review commenced in 2008 and was published in 2012, representing an extensive assessment. These two reviews therefore represent an unprecedented detailed examination of the coronial system in Western Australia since the *Coroners Act 1996 (WA)* came into effect.

This s.57 Review has been designed to be cognisant of the LRCWA Review and the Strategic Review, both of which made several recommendations. The LRCWA Review set out 113 recommendations and the Strategic Review made a further 27 recommendations. Combined, the two reviews represent comprehensive bodies of work, both in the assessments and also in the implementations.

When commencing this s.57 Review, a view was formed that there would be marginal benefit re-examining the same areas as the two reviews given that due consideration has already been given to most aspects of the coronial system in detail.

Whilst the LRCWA explored various aspects of the coronial system thereby unearthing many points for consideration, which benefitted the Strategic Review, the LRCWA recommendations also complicated the Strategic Review to some degree. Where there was consensus amongst the LRCWA, DotAG, the State Coroner and Deputy State Coroner on several of the recommendations, the Strategic Review considered the implementation of such recommendations in amongst its findings. That is, with all parties agreeing in principle, the question on the focus was how to implement rather than if, though it was agreed that should the Strategic Review form a different view it was within the scope to raise this and augment or counter as the case may be[2].

Conversely, where there was not the same level of consensus with some of the recommendations, particularly the question of addressing the requirements for regional Western Australia, the Strategic Review further considered the merits of these in consideration to its findings. That is, the implementation could not be considered by the Strategic Review without further examining the rationale for such recommendations. The Strategic Review was also mindful that the intent was not to validate the LRCWA recommendations. Rather, the approach was to complement the work of the LRCWA and build onto this in order to maintain alignment where possible.

The approach taken with this s.57 Review is to consider the *Coroners Act 1996 (WA)* in the perspectives of the LRCWA Review, the Strategic Review and the views expressed by the State Coroner and Deputy State Coroner in response to the LRCWA Review. Whilst the views of the State Coroner and Deputy State Coroner have previously been conveyed to the LRCWA Review amongst other stakeholders consulted, their views as practitioners of coronial processes provide a firsthand perspective and are therefore referenced to bring a practitioner's perspective to the s.57 Review.

This s.57 Review will not capture everything and nor should it as the detail can be found elsewhere. It attempts to draw upon key points from the different perspectives in order to consider the attainment of the Act, the administration of the Act, the effectiveness of the operation of the court; and other matters as appear to be relevant to the operation and effectiveness of the Act.

[2] During an early briefing it was pointed out that the Strategic Review would need to be mindful that due consideration had already been given where there was already consensus amongst the LRCWA, DotAG, the State Coroner and Deputy State Coroner.

2.2 The attainment of the objects of the Act

The Barnes Review in 2008 and more recent LRCWA Review identified that the objects of the Act are not explicitly stated. Without the benefit of the LRCWA Review and the Strategic Review that followed, the absence of an objects clause would leave the question of attainment to giving consideration to the sections of the Act and deriving from that an overall view accordingly.

For this particular s.57 Review, the LRCWA Review and the Strategic Review provide an unparalleled baseline to form a view on the attainment of the objects of the Act. Both reviews and to some degree the former Barnes Review are the primary derivatives used therefore to consider the question of attainment. There is a further dimension, which is consideration to the Act itself in its current form and this has been explored further in Section 3 of this report. Section 3 continues the theme of considering the perspectives of the LRCWA Review and the Strategic Review.

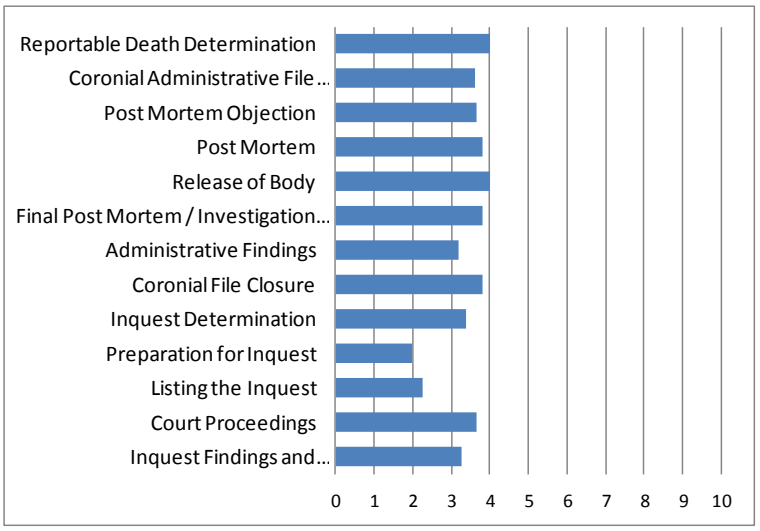
Many of the issues identified by Barnes Review in 2008 continue today, which are further elaborated upon and added to by the LRCWA Review. Both of these two reviews recommended inclusion of an objects clause and whilst the two proposals are subtly different they are not materially different and can serve as a basis to make an informed view in regard to the attainment of the Act. The Strategic Review also assessed the coronial processes from three perspectives – effectiveness, efficiency and a qualitative assessment. The qualitative assessment criteria undertaken for the Strategic Review were derived from the proposed objects of the *Coroners Act 1996 (WA)* as recommended by the LRCWA Review and as amended in consultation with the Department of the Attorney General and the Office of the State Coroner[3].

When considering the question of attainment this s.57 Review has been mindful that attainment could be considered from a compliance perspective. However, attainment is not a binary issue as evidenced by the LRCWA Review and the Strategic Review that followed. The reviews considered many points that are qualitative, reflecting varying degrees of attainment.

Given that reportable deaths are reported, investigated and inquested, it would be unreasonable to state that the objects of the Act are categorically not being attained. However, it is the extent to which they are being attained that the LRCWA Review and the Strategic Review have examined.

Taking into consideration the extensive review undertaken by the LRCWA, which identified 113 recommendations comprising 236 initiatives / actions, it brings into question the extent to which the attainment of the objects of the Act is being achieved. The Strategic Review mapped the coronial processes and using the criteria derived from the proposed objects of the *Coroners Act 1996 (WA)* and assessed the current level of attainment to be partially conducive to meeting the proposed objects as illustrated in Figure 1-1[4] [5].

Figure 2-1: Assessment against the proposed objects of the Act



[3] As explained further in Section 3, the proposed insertion of an objects section into the Act is generally agreed to by stakeholders consulted with the exception of explicitly making provision for coronial regions.

[4] The assessment used a rating system whereby 0 is not conducive; 3 marginally, 4 partially, 5 reasonably, 7 conducive and 9 is highly conducive.

[5] It should be noted there is a degree of subjectivity in the assessment even though the framework is structured.

2.3 The administration of the Act

It follows that if an assessment pertaining to achieving the proposed objects of the Act is partially conducive, then the administration of the Act is unlikely to be assessed differently.

Many of the issues highlighted in the 2008 Barnes Review appear to persist and are consistent with those identified in the LRCWA Review and the Strategic Review. Rather than encapsulate the key points from the LRCWA Review the following extract from the forward section[6] serves to succinctly present key points pertaining to the administration of the Act and the coronial system as a whole.

"The Final Report contains 113 recommendations for reform. While the majority of recommendations address much-needed legislative reform or clarification, there are a number of recommendations that invite reform to practices and policies, both of the Office of the State Coroner and of other agencies with peripheral involvement in the delivery of coronial services in Western Australia.

Western Australia has the second oldest Coroners Act in Australia. Reviews and recommendations for reform in the late 1980s to early 1990s resulted in the passing of the current Coroners Act in 1996. The Coroners Act has allowed for the development of a coronial system which has served Western Australia well. In particular, the State Corner, Alistair Hope, and the Deputy State Corner, Evelyn Vickers, have been instrumental in establishing a system to strengthen the prevention role of the coroner. However, in undertaking this reference it was clear that significant reforms were warranted. Significant delays to coronial findings in recent years have considerably added to the distress of families in a time of grief. This Report maps out a principled approach to reform of the coronial jurisdiction to address the concerns communicated by members of the public and by those closely involved in delivering coronial services in Western Australia. The Commission's recommendations will bring the Coroners Act into line with recent reforms in comparable jurisdictions in Australia while taking into account the special circumstances of Western Australia, in particular its geographic and demographic realities.

Although the number of deaths being dealt with by coroners has not radically risen (1526 in 2000 to 1827 in 2009), demands placed upon the coronial system have changed since the passage of the Coroners Act. Public expectations of coroners appear to be higher. People expect the coroner to play a greater role in the prevention of future deaths in similar circumstances and the recommended reforms in this report bring that role into greater focus in Western Australia.

People are also demanding greater transparency of the coronial process and greater accountability of the Coroners Court. There is an urgent need to promote public confidence in the coronial system. The Commission has made a number of recommendations to improve transparency of the coronial process. The Commission has also recommended that the next State Coroner be drawn from the District Court of Western Australia to increase accountability and to place the Coroners Court firmly within the judicial hierarchy of Western Australia.

The Commission found that the public as well as people involved in the delivery of coronial services lack knowledge of the system and this may add pressure to the system by placing unrealistic expectations upon it. There is a need for greater attention to public awareness and training for those involved either intimately or peripherally in the coronial system.

Significantly, the Commission found that regional Western Australians did not have equality of access to coronial services with problems including no coronial counselling services in the regions, uneven quality of coronial investigations, and significant concerns regarding the inadequate training of regional coroners and registrars. The Commission has recommended that coronial regions be established and serviced by dedicated regional coroners.

[6] Law Reform Commission of Western Australia, 2012, Review of Coronial Practice in Western Australia, Government of Western Australia, Perth, p.v-vi

The Commission has also made recommendations to improve practices within the Office of the State Coroner. The Commission has recommended that a position of Principal Registrar be created. While there has been an increase in staff by over 50% since 2009 there has been no evaluation of inefficient internal administrative processes or any strategic plans made for the future. The Commission has recommended that there be an urgent independent strategic review of the Office of the State Coroner.

There have also been significant technological advances in the past 15 years in respect of the use of imaging technologies in post mortem examinations. Western Australia needs to be brought into the 21st century with legislative encouragement to utilise available technologies so that the least invasive procedures that are available and appropriate in the circumstances are used."

Recommendation 5 of the LRCWA Review provided the platform to examine administrative systems and processes further and framed the terms of reference for the Strategic Review.

"**Recommendation 5 Strategic review of the Office of the State Coroner**

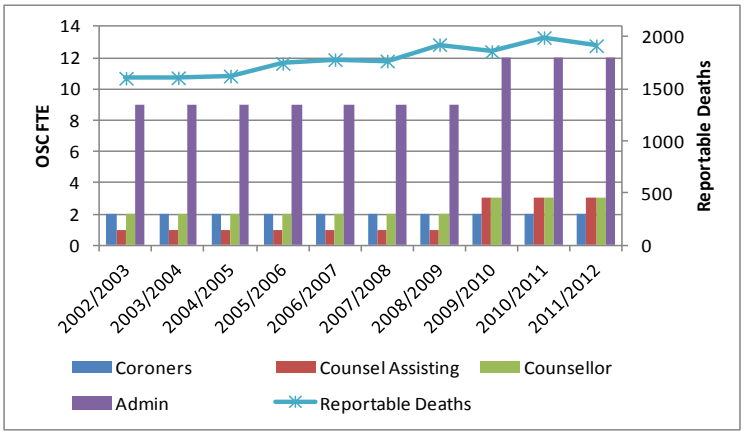
That a strategic review of the Office of the State Coroner be conducted by a suitably qualified independent person or persons at the earliest opportunity. The review should include, but not be limited to:

1. an evaluation of administrative systems and processes;
2. an evaluation of infrastructure and human resourcing needs;
3. a review of the functions and supervision of administrative staff within the Office of the State Coroner;
4. a review of the office's risk management plans;
5. consideration of the implementation of administrative, policy and procedural recommendations of the Law Reform Commission of Western Australia; and
6. the development of a strategic plan for the efficient and effective delivery of coronial services.

Consultations with relevant stakeholders including the Registry of Births Deaths and Marriages, PathWest, Western Australia Police, the Department of Health, regional Coroners and registries may also be required to inform the evaluation of administrative procedures that affect or involve those entities."[7]

The remainder of this section draws upon the key points from the Strategic Review rather than the LRCWA Review though it is evident from both reviews there the Act can be more effectively and efficiently administered.

Figure 2-2: OSC FTE to Reportable Deaths



The OSC is heavily reliant on a key coronial and administrative personnel that are hard working and are clearly committed to the work of the OSC. They often work long hours and have in the past deferred taking leave. Agility is a word that underpins their disposition towards dealing with the multitude of manner and causes of death they encounter on a day by day basis. Determining the manner and cause of death is central to the OSC's work and

[7] Law Reform Commission of Western Australia, 2012, Review of Coronial Practice in Western Australia, Government of Western Australia, Perth, p.17

over the years a wealth of tacit knowledge has accrued and is vested in these key coronial and administrative personnel.

The OSC's growth and development has been organic, starting with a small team of less than 10 staff when the legislation was first enacted on 1996 to an office that now employs 23 staff plus 4 coroners including temporary positions[8]. Figure 2-2 illustrates the number of coronial staff in relation to the number of reportable deaths for the last ten years. Additional staff was funded in financial year (FY) 2009/2010.

Organic growth appears to be a root cause of the operating issues the Strategic Review and the LRCWA identified. The design and development of business processes and supporting systems appears to have been without the benefit of designing a system from the top-down. Whilst this is not unusual for many organisations, it is also not conducive to the overall effectiveness and efficiency of operations. During its early days the closest reference point it had when starting out was the operations of other jurisdictions in other states and more locally the experience of Magistrates Court, which is subtlety yet distinctly different to the workings of the Coroner's Court. Systems and processes appear to have grown organically with the office and key personnel developing their own ways of working and individual methods that make up the sum of the parts. As one of the senior personnel expressed on the first walk through of the office, it's chaotic but the system works. And work it does but only because key personnel have continued to work hard and make it work.

Key personnel have fashioned ways of working that manage the processes from determining a reportable death through to its conclusions. Unfortunately a system that is held together by key personnel is susceptible to breaking down and as demand has increased over the years this is what appears to have occurred, though in a slow, elusive and creeping normalcy way that eventually caught up with the OSC when a series of situation factors allowed a backlog of cases to build up. In short, increased demand over the years has put pressure on the system to the point that it is no longer sustainable. Creeping normalcy is an apt phrase that reflects that the operational system appears to have gradually been deteriorating without it being noticed holistically. The impression formed is that the increase in reportable deaths over the years has served to distract attention from the health of the system other than an awareness that opportunities for improvement existed. Individual initiatives appear to have battled to gain traction or lost ground due to lack of support or competing objectives.

There is no one single issue. Rather, there are a lot of issues ranging from minor things that can be fixed through to some that are of greater concern.

Tracking the status of cases and their associated files is as much an art as a science and many staff interviewed commented on the mysterious ways that files or their contents were moved without notice. File tracking in particular is an issue.

The use of systems such as MUNCCI[9] is little more than a filing system and sadly untapped as a resource that could help support business processes even though it is limited in its capability to support case management.

The quality of data is a key concern and given it is the foundation for the provision of research at a state and national level towards informing on the prevention of death its accuracy is questionable. Inconsistencies in describing the cause of death were found and there are issues with dates and blank fields, which brings into question the accuracy of the data and may explain why the quarterly report on suicides requires so much effort to compile when it should just be a push of a button.

[8] The 23 staff counted, excluding Coroners, was at the time of undertaking the baseline assessment of the current environment.

[9] MUNCCI is the local instance of the National Coroners Information System (NCIS), derived from the Monash University National Centre for Coronial Information (MUNCCI).

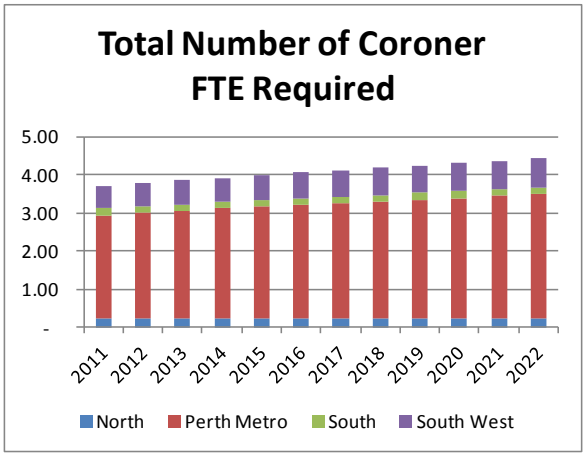
Growth has also put pressure on internal ways of working to the point that there is a degree of friction that exists as a result of individual ways of working that invariably runs against other ways of working. There is variable harmony in the coordination of activities even though some aspects operate mechanically as though on auto pilot.

The system works, though only just and is in need of an overhaul. Lack of resource has been cited as the root cause of the issues which is the general view held within the OSC and externally, which is understandable given the backlog that has accrued and to some degree this is the case but the ineffectiveness and inefficiency of the system and use of resources are more at the heart of the root cause. Quality control in particular causes much rework and in one sample of work examined there was an error rate of 100%, often being discarded by the coroner reviewing the work who considered rewriting the findings more efficient than reworking them. The use of resources is also ineffective, particularly highly paid personnel standing at photocopies for several hours or doing other administrative work that could be handled more cost effectively by support staff.

Restructuring to provide support resources alone would not alleviate some of the inefficiencies such as managing the volume of paper based records that are required for inquests. It is surprising to find such a dependency on paper-based systems in an environment that deals with the quantum of documents the OSC does, especially as many of these documents are received or exist in a digital format. Staff spend days standing at photocopiers, which in turn accelerates the wear and tear on the equipment, unnecessarily expends money on vast quantities of paper, and reduces the ability to be agile when late information arrives close to or on the day of an inquest which needs to be distributed to interested parties and legal counsel representing parties. The legal profession was an early adopter of digital technologies and most if not all of the agencies the OSC exchanges information with have established systems and can readily operate digitally. Apart from the issues of non-repudiation and lack of traceability, the inefficiencies of fax are long understood and it is particularly questionable when some fax communications are sent to the same people that are emailed. There's also the impression of ineffective operations to external parties which was one of the areas considered by the Strategic Review. The OSC's predominately paper-based administration of the current process will increasingly be the weakest link in amongst more advanced technology based ways of working.

Overall, the assessment process undertaken for the Strategic Review suggests that the OSC is partially conducive to operating effectively and efficiently, which substantiates many of the LRCWA claims in its review. Throwing more resources at the problem will not resolve the issues identified and may serve to exacerbate the problems by more resources exercising inefficient and ineffective ways of working. However, it is clear that the OSC requires additional capacity, though organised in a way that is designed to enable improved effectiveness and efficiency.

Figure 2-3: Projected Required Coroners



Based upon the analysis of the reportable death projections up to 2022, the Strategic Review formed a view that four permanent coroners are required, which also takes into consideration the proposed changes to the regional model.

It is acknowledged that the State Coroner and Deputy State Coroner will be disappointed by this view given they hold firm views that the OSC needs five coroners. The proposed changes however should introduce effectiveness and efficiency gains to reduce the burden. Nonetheless, the projection still identified that four permanent coroners are required.

2.4 The effectiveness of the operation of the court

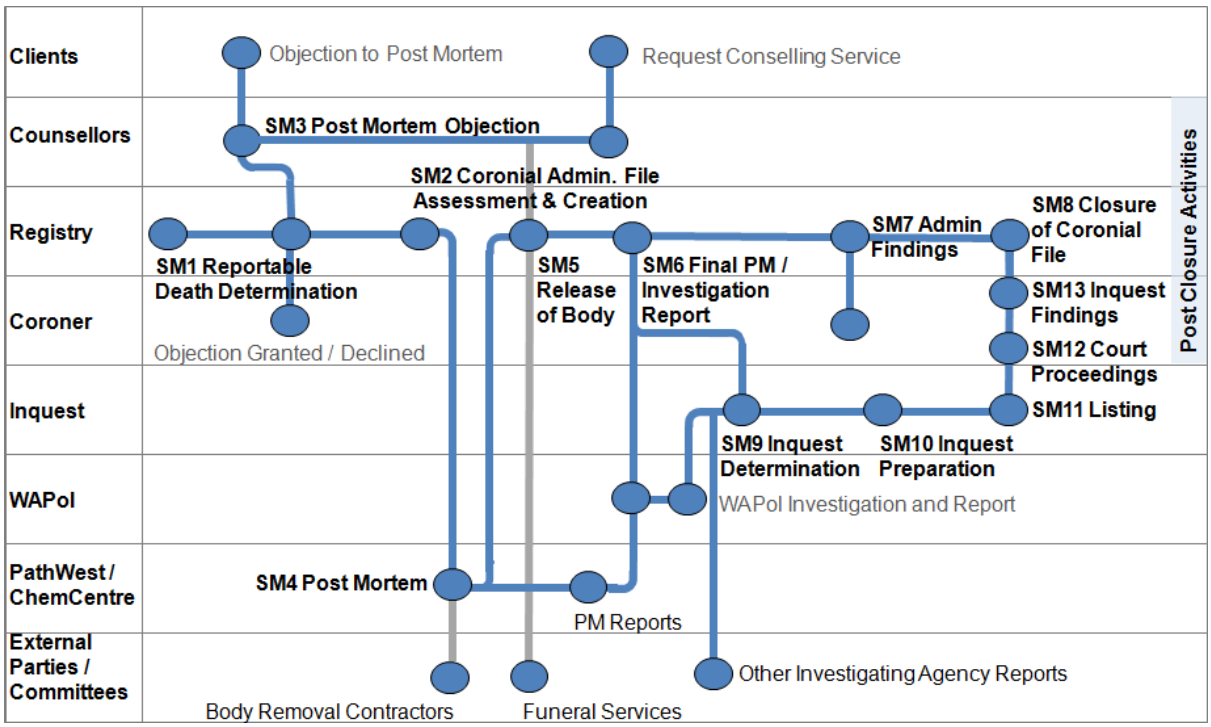
The interpretation of "the operation of the court" in the context of s.57 (1) (c) is taken to mean the Office of the State Coroner in this section. During the initiation of the Strategic Review project, the scope of the review was discussed with representatives from DotAG and it was agreed that the Strategic Review would not take into consideration the effectiveness and efficiency of the actual proceedings in court because the scope was focussed specifically on the OSC as opposed to the Coroner's Court. It was also acknowledged that the pattern of each individual inquest would vary and whilst the actual court proceedings could be considered the pinnacle of coronial processes, it is also concise when compared to other processes.

The Strategic Review also acknowledged that the LRCWA Review discussed in sections of its report matters pertaining to court proceedings, judicial practice, protocols and procedures and the LRCWA or the like would be the appropriate body to consider matters pertaining to court proceedings. The Strategic Review therefore considered some aspects pertaining to process, though did not extend to judicial practice, protocols and procedures of the Coroner's Court itself. The supporting processes leading up to and following an inquest however were considered as the effectiveness and efficiency of these supporting processes materially affect the effectiveness and efficiency of the Coroner's Court itself. It is worthy of noting that courts proceedings are efficient from the perspective of the cycle time taken to commence and conclude an inquest in court. According to the inquest statistics from the Annual Reports 2001-2012, 68.42% to 73.70% of all inquests take 1 to 3 days sitting days for each inquest to complete.

Figure 2-4 presents a high level summarisation of the coronial processes model that was mapped (SM1 through to SM13[10]).

This high level view should not be considered all inclusive as it was only developed to depict the process flows in the context of the key parties involved.

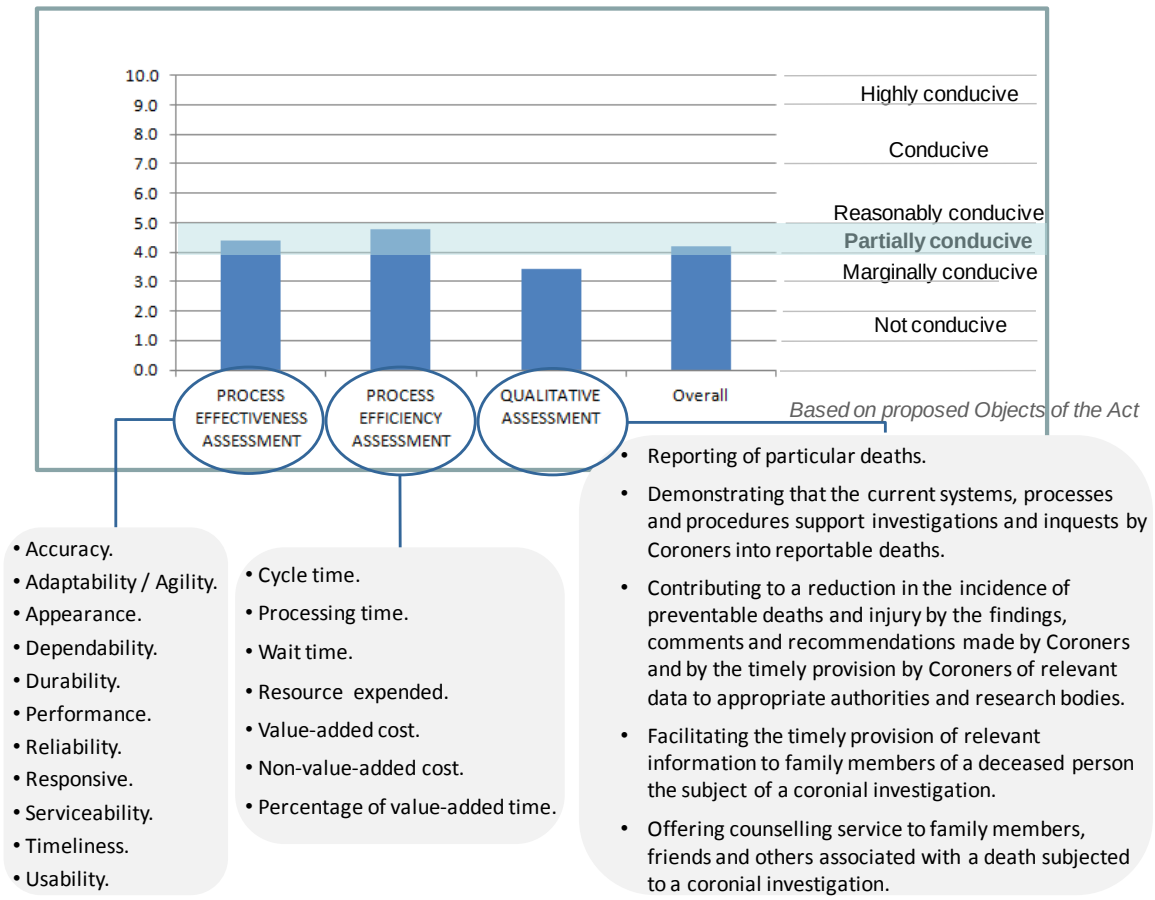
Figure 2-4: High Level Process Model



[10] SM1 – SM13 were coded for the Strategic Review and have no particular relevance in coding other than to reflect a series of processes that move through the coronial system.

Figure 2-4 presents a summary of the assessment.

Figure 2-5: Overall Assessment



The overall assessment suggests that the OSC is partially conducive to meeting the assessment criteria for process effectiveness, process efficiency, and the qualitative assessment.

As outlined, the assessment is based upon a 0-9 system that assesses the conduciveness of the process to criteria. The criteria was based upon a three dimensional model using metrics for effectiveness and efficiency, derived in part from the business process improvement metrics developed by Harrington[11]. The third dimension as discussed previously is based upon a derivative of the proposed objects of the Act.

It should be noted that Figure 2-5 presents a summary of the averages and therefore does highlight processes that are more effective and efficient than others. The process metrics and criteria are shown in the pull-down sections underneath the graph.

The thirteen core business processes starting with reportable death determination were identified and mapped with key stakeholders from the OSC. Overall, 714 process steps were identified during the process mapping excluding decision making steps. Each of the 13 processes were then assessed against the 23 elements listed in Figure 2-5, thereby providing 299 elements considered in total. A further assessment of post closure and management activities was also assessed though not to the same extent. Some elements (39) were not assessable or the Strategic Review considered it inappropriate for assessment such as court proceedings in the Coroner's Court for the reasons discussed. The remaining 260 elements formed the basis of the assessment.

[11] Harrington H. James, 1991, Business Process Improvement, McGraw-Hill, USA, p.74 (the definition has been adapted for the purpose of this Review).

Figure 2-6 and 2-7 illustrate the effectiveness and efficiency assessments for each of the coronial processes. Table 2-1 sets out the system that was applied for each assessment area.

Figure 2-6: Overall Assessment of Effectiveness

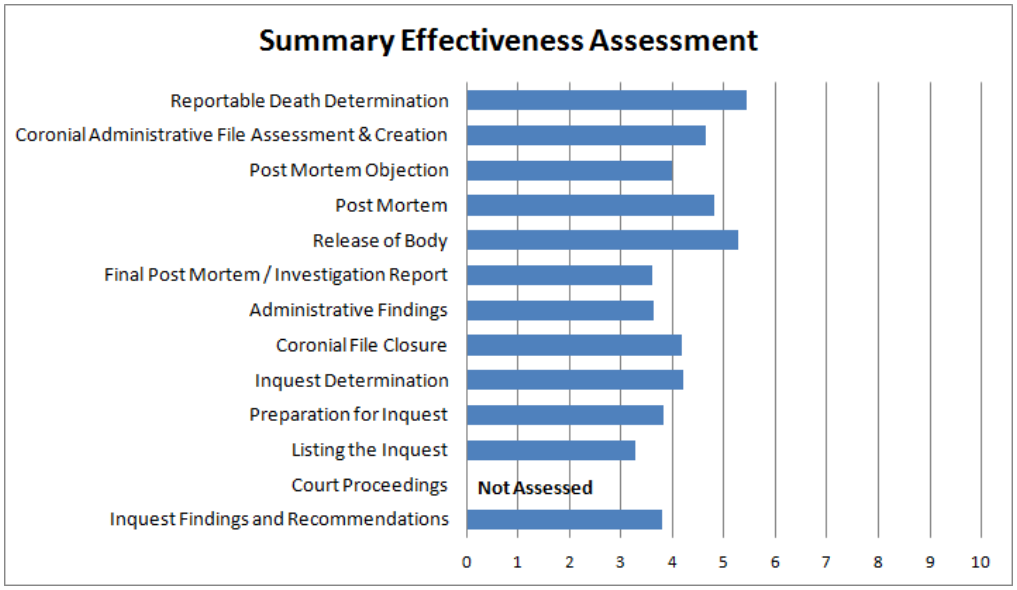


Figure 2-7: Overall Assessment of Efficiency

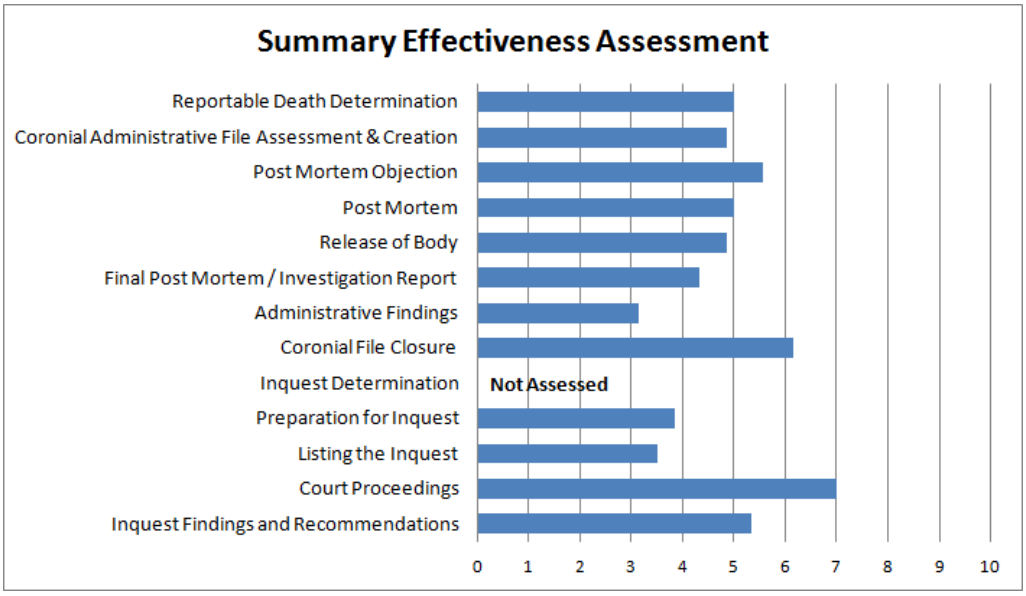


Table 2-1: Qualitative Assessment Areas

Assessment	Description
0	The assessment area does not meet the assessment criterion.
1 or 2	This assessment area is not conducive to meeting the assessment criterion.
3	This assessment area is marginally conducive to meeting the assessment criterion.
4	This assessment area is partially conducive to meeting the assessment criterion.
5	This assessment area is reasonably conducive to meeting the assessment criterion.
6 or 7	This assessment area is conducive to meeting the assessment criterion.
8 or 9	The assessment area is highly conducive to meeting the assessment criterion.

In conclusion, some of the key points identified by the Strategic Review are:

- The hearts and minds of people are committed to coronial work and some work long hours.
- The coronial system is broader than the OSC and requires a different approach to inter-agency governance and OSC management.
- Reportable deaths are complex and not well understood outside of the OSC – complexity is increasing.
- The system is vulnerable to breaking down as it relies too much on tacit knowledge and individual ways of working.
- Current operations appear to have organically evolved and need overhauling.
- The OSC, WA Police CIU and PathWest are running to capacity.
- There are risks in potential loss of continuity of skills, knowledge, experience – the OSC has the highest leave liabilities in the whole of DotAG and can ill afford extinguishing the leave.
- Coronial services to regional Western Australia is inequitable as identified by the LRCWA Review and the counselling service in particular needs increased capacity.
- There are three distinctly different models in operation for Registry, Inquests (case management) and Counselling.
- Information systems that support coronial processes for registry, counselling services and case management are not adequate to support the OSC.
- Information management and control issues put the prevention of death role at risk.
- Some LRCWA Review recommendations will result in an increase in deaths being reported.
- Existing performance indicators are not adequate for monitoring and managing performance.
- Systemic issues the LRCWA referred to are mainly to do with:
  - Resource capacity coupled with ineffective and inefficient use of resources;
  - Process management and case management controls;
  - Quality control and quality management;
  - Lack of supporting information systems capability;
  - The need for improved education and training;
  - Management team fragmented looking across to whole of the OSC; and
  - Many seemingly inconsequential issues equal the sum of the parts of a broader issue.

Overall, the coronial system is unlikely to be sustainable if the current model continues and is vulnerable to the issues identified by the LRCWA Review and the Strategic Review persisting unless change is effected.

2.5 Such other matters as appear relevant

This section discusses specific points identified when undertaking the s.57 Review in the context to the Act. This s.57 Review is mindful of the wealth of material set out in the LRCWA Review and does not aim to replicate it here as the document is a publically available document and can be considered in conjunction with this report. The alignment with the LRCWA Review recommendations is however considered in Section 3 of this report, which sets out the recommendations in the context of each section of the Act.

In the context of the Strategic Review however, there are some key areas that are reiterated from the summary of the report as they form the basis of the Strategic Plan that was developed as a separate product to the Strategic Review. The Strategic Plan embraces the key points emanating from both the LRCWA Review and the Strategic Plan.

2.5.1 s.57 Review Recommendations pertaining to the Act

The LRCWA Review recommended a series of legislative changes, some of which are agreed by key stakeholders in principle and some that require further consultation with the coroners in relation to an agreed direction. Table 2-2 lists the 29 LRCWA Review recommendations that appear to be generally agreed to, which can go forward to be considered further by Parliamentary Counsel as part of the proposed Legislative Project.

Table 2-2 LRCWA Recommendations Affecting the Act that appear to be generally agreed

Section of Act (other sections may be affected)	LRCWA Review Rec No	LRCWA Review Recommendation
New – Part 1 or Part 2	1	Objects of the Coroners Act
Section 11	2	No ex officio Coroners
Section 17	15	Increase penalties for failure to report a death
Section 17	16	Obligation to report a suspected death
Section 3	17	Removal of specific categories of anaesthesia-related deaths
Section 32	29	Restriction of access to area
Section 33	30	Penalty for obstructing a Coroner or Coroner's investigator
Section 31	47	Assistance to and from Coroners in other jurisdictions
Section 25	48	Statement of referral in record of investigation
Section 25	49	Coroner's discretionary comment function
Section 25	53	Superior court review of Coroner's findings
Sections 25 and 26	54	Power to correct errors in records of investigation
Section 25	55	Non-narrative findings
Section 25	57	Two categories: persons held in custody and persons held in care

Section of Act (other sections may be affected)	LRCWA Review Rec No	LRCWA Review Recommendation
Section 25	58	Definition of 'person held in custody'
Section 25	59	Definition of 'person held in care'
Section 25	62	Removal of standard of proof for suspected deaths
Section 25	66	Superior court review of Coroner's decision to refuse inquest
Section 42	68	Interested persons
Section 48	70	Inquest brief in electronic form
Section 25	71	Pre-inquest hearings
Section 25	77	Use of concurrent expert evidence at inquest
Section 51	79	Interruption of an inquest
Section 45	80	Power to exclude from inquest
Section 49	81	Restriction of publication
Section 34	101	Coroner may order external or preliminary post mortem
Sections 29, 30 and 34	110	Release of body by a Coroner
Sections 29, 30 and 34	111	Application for release of body by a Coroner
Sections 29, 30 and 34	112	Supreme Court review of Coroner's decision to release a body

In addition, there are several other LRCWA Review recommendations which after further consultation, may also lead to changes in the Act.

Implementing these changes could result in the Act becoming cumbersome to interpret and administer and consideration should be given to rewriting the Act rather than integrating the proposed changes into the existing Act. A rewrite would also facilitate taking into consideration the overall findings from the LRCWA Review and the Strategic Review.

Recommendation 1: It is recommended that consideration be given to rewriting the *Coroners Act 1996.*

2.5.2 s.57 Review Structure of the Act

Whilst it is acknowledged why Acts are structured a certain way, it is clear that the coronial process follows a reasonably sequential set of processes, including by not limited to:

- Reportable Death Determination;
- Coronial Administrative File Assessment and Creation;
- Post Mortem Objection;
- Post Mortem;

- Release of Body;
- Final Post Mortem / Investigation Report;
- Administrative Findings;
- Coronial File Closure;
- Inquest Determination;
- Preparation for Inquest;
- Listing the Inquest;
- Court Proceedings; and
- Post Closure Activities.

The current Act steps in and out of these processes dealing with various aspects pertaining to the Act. Consideration should be given to restructuring the Act if it is considered rewriting the Act is beneficial rather than integrating the proposed changes into the existing Act.

Recommendation 2: It is recommended that consideration be given to restructuring the *Coroners Act 1996* to be better aligned to the coronial processes.

2.5.3 s.57 Administration of the Act

The *Acts with Administering Portfolios and Public Sector Agencies* states that the Attorney General has responsibility for the *Coroners Act 1996 (WA)* while the agency principally assisting is the Department of the Attorney General.

The assignment of Ministerial responsibility is assumed to be the prerogative of the Cabinet and as such, decisions affecting governance at a Ministerial level is at the discretion of the Premier and Cabinet.

The Act however does not appear to clearly distinguish between the principal judicial officer of the Coroners Court and the administrative responsibility other than s.8(a) where it states the functions of the State Coroner are to ensure that a State coronial system is administered and operates efficiently.

Taking into consideration the LRCWA Review and the Strategic Review there is clearly an administrative burden to administering and operating the coronial system efficiently, much of which falls to the Department of the Attorney General Court and Tribunal Services to facilitate through the provision of resources, systems and the like. Whilst the Strategic Review has made recommendations to provide greater support for the broader coronial system by introducing an overarching governance framework and strengthening the governance structure within the OSC so that the system of management can be shared, yet managed as a collective, the Act itself does not make such a distinction in regard to the administration of the Act.

Recommendation 3: It is recommended that consideration be given by Parliamentary Counsel to further define the administrative responsibilities of the *Coroners Act 1996* as part of the proposed Legislative Project.

2.5.4 State Coroner's and Deputy State Coroner's views pertaining to legislative change

The State Coroner and Deputy State Coroner expressed views pertaining to the mechanisms for effecting change and noted there are other mechanisms to legislative change. This section provides an extract of a communication provided by the State Coroner, though as outlined in Section 3, the State Coroner and Deputy State Coroner expressed several views pertaining to the LRCWA Review, which should be taken into consideration.

For this particular section, the State Coroner conveyed –

For the Coroners' Court there are a number of different mechanisms which could be used to effect change, these include:

- Amendments to the *Coroners Act 1996*;
- The drafting of new regulations or amendment to the Coroners Regulations 1997;
- The provision for Rules of Court and the power to publish Practice Directions in relation to how court procedures should be followed; and
- Guidelines.

In addition a number of changes can be effected by taking simple, practical steps which do not require any of the above.

The views expressed suggest that a number of the recommendations suggesting legislative change could be better effected by new regulations, court rules, practice directions or guidelines.

The State Coroner also identified required legislative changes that were not addressed by the LRCWA Review.

Directions by the State Coroner
Section 21 of the Act provides that "with the prior approval of the Chief Magistrate of the Magistrate's Court the State Coroner may give to a coroner directions about investigations ... "

The portion of this provision which refers to the Chief Magistrate should be deleted as the Chief Magistrate has no interest in directions about investigations into deaths. This aspect of the provision was presumably inserted at a time when the expectation was that the only coroners, apart from the State Coroner, would be magistrates.

The Definition of Post Mortem Examination
Section 3 of the Act defines post mortem examination in the following terms:

“post mortem examination means an examination of the body of a person who has died, for the purpose of investigating the death:”;

On its face this definition is inadequate and in the context of the sections of the Act which deal with post mortem examinations, it is confusing and unhelpful. Sections 34 and 36 deal with objections to "post mortem examinations" and applications for "post mortem examinations" in terms which clearly suggest that what is intended is internal post mortem examinations.

In addition, it is clear that there must be some post mortem examination of the body of a person who has died, at least externally, in every case. It is obvious that it is necessary to look for knife wounds, bullet holes or other injuries etc and that this will take place before any issues arise in relation to whether or not an internal examination is required.

Warrant of Apprehension Where a Witness Fails to Appear
Form 11 in the Coroners Regulations 1997, which purports to provide for warrants to be used when a witness fails to appear (Section 46(4)), is deficient in that the last paragraph commencing, "I DIRECT ... " is not supported by the Act and provides for an unenforceable undertaking.

This type of form could best be provided for in Rules of Court.

Position of Medical Adviser
The position of Medical Adviser is an important one within the Coroner's Court and in my view should be a statutory position with statutory protections under the Act.

Recommendation 4: The views expressed by the State Coroner and Deputy State Coroner should be taken into consideration by Parliamentary Counsel as part of the proposed Legislative Project.

2.5.5 The Prevention of Death Role

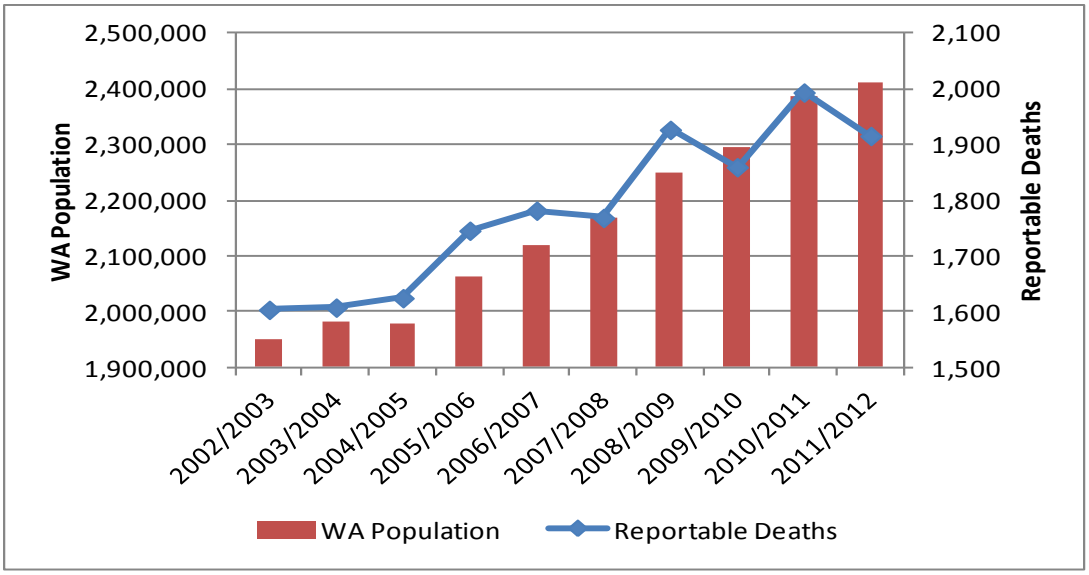
The prevention of death role was a key theme of the LRCWA Review and also during the consultation process for the Strategic Review. Throughout the Strategic Review this was referred to as "informing on the prevention of death" as the view was formed that the OSC cannot directly prevent death, only inform on preventing death though findings, recommendations and statistical trend analysis.

Whilst this is a subtle distinction, legislative change pertaining to the prevention of death role should take into consideration the extent to which the OSC can reasonably prevent death.

2.5.6 The LRCWA Review, Strategic Review and Coronial Regions

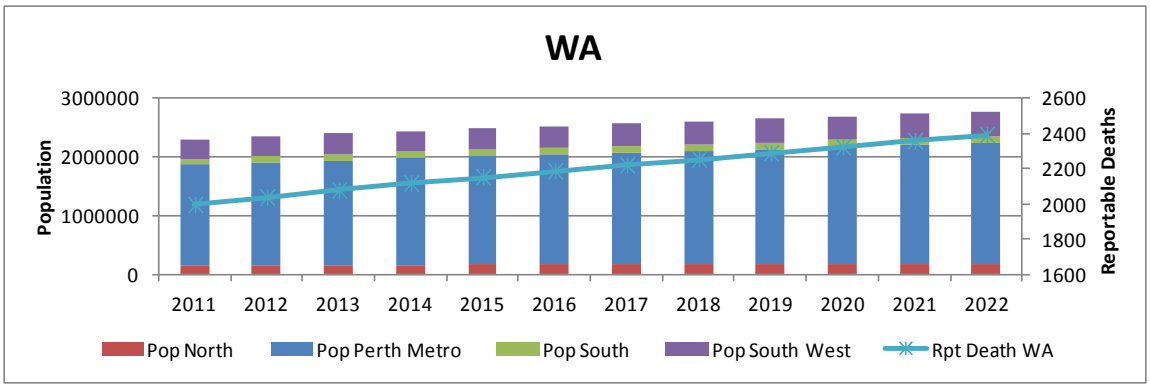
The Strategic Review considered in detail the rationale and issues the LRCWA Review set out in its report and the proposed model to address the inequity of regional support and concurred with the views expressed with exception of the model itself. The Strategic Review analysed the historical data using a combination of data from NCIS[12] and the ABS[13] to forecast the future trends likely to occur across the state. The analysis looked backward ten years to FY2002/2003 in Figure 2-8 and forward ten years to 2022 in Figure 2-9.

Figure 2-8: Historical Growth of Reportable Deaths



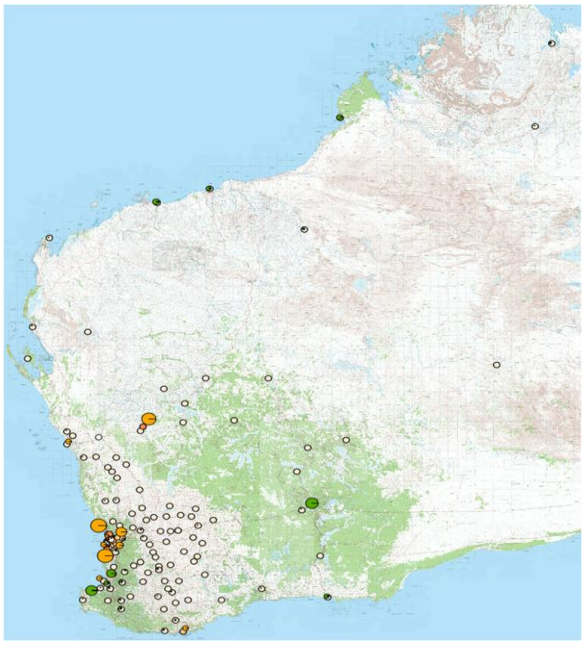
[12] NCIS - National Coronial Information System.
[13] ABS - Australian Bureau of Statistics.

Figure 2-9: Projected Growth of Reportable Deaths



As illustrated in Figure 2-9, the number of reportable deaths is not projected to grow substantially over the next 10 years and on a region by region level would not sustain permanent coronial resources being located in regional offices. The results clearly show it will be some years before the case to establish permanent coronial resources in regional Western Australia can be substantiated. One option considered was to establish a regional capability in the South West but even then it will be some years before the quantum of reportable deaths in the region would justify permanent resources.

Figure 2-10: Projected Reportable Deaths



The historical analysis also identified that most inquests are already held in the region where a reportable death has occurred. The estimated budgetary impact of moving to a Decentralised Model (Option 2), assuming all the existing regional magistrate court personnel would continue to be paid in addition to the new regional coronial personnel would be approximately $785,000 per annum, comprised of a $904,000 reduction in Perth Metropolitan Area personnel costs, $1.627 million additional cost for regional personnel, and $62,000 for rent and outgoings for regional offices[14]. It should be noted that it is likely that resources would be underutilised.

Setting aside there is insufficient reportable deaths to mount a case for permanent resources being deployed regionally; a key concern with the regionalisation model is the OSC clearly needs to focus its activities on improving its operational model, internal processes, procedures, systems and the like before embarking on a distributed regional model.

The absence of an information system alone that is capable of serving the regions would add more pressure to what is already a disconnected arrangement. The OSC needs its operating model to be working like a well-oiled engine before extending it to the regions and there is much to do before it will be in such a position. This Strategic Review recommended a model that moves some of the work back to the OSC during the period of reform such as drafting Administrative Findings to ensure that quality and consistency of findings improve, especially as it varies most in the regions.

[14] These costs were estimated to facilitate a comparison of costs and to determine the likely order of magnitude between the two options. There are several assumptions applied and the modelling did not extend to the depth of examination as a business case would. Operational Expense and Direct Service Expense for example are based upon the current expenditure are is likely to increased in a regional model.

Regional Counselling Services

However, it is also clear that the inequity of regional support needs to be addressed, particularly in the support for families. The current practice of regional Magistrate Court staff providing counselling services should be changed to using local counselling services that are trained and skilled in supporting families. The Strategic Review recommended extending the current DotAG network of Not-for-Profit (NFP) organisations to provide local counselling services.

There would still need to be a local presence however to remain with the regional Magistrate Court staff, though this would be reduced to activities such as liaising with local WA Police, liaising with families and the coronial counselling and liaison services, and arranging for body transport. In addition to maintaining a local presence, retaining some regional activities will be beneficial and facilitate transitioning back some of the processes such as Administrative Findings once defined processes, guidelines, training materials and supporting information systems are available. This therefore provides a degree of risk mitigation should undertaking these activities in the OSC prove problematic.

Should an unprecedented growth in the population occur in the South West, the Department can consider trialling a South West hub for two years. The OSC operating model should be working well and by this time are able to be extended to this region if deemed appropriate.

2.5.7 Strategic Review and Strategic Plan Proposed Changes

Throughout the Strategic Review it became increasingly evident that the State Coroner, Deputy State Coroner and key personnel were disappointed that events over the past years have eroded its position as a leader in coronial systems. A vision that the Office aspires to is **to be a leader in contemporary coronial systems**[15].

Also evident throughout the Strategic Review was a consistent view expressed by stakeholders in different ways that underpins the mission of the Office, which is in two parts. The first part is **to be the advocate for the deceased, and determine the truth and facts**. The pursuit of the truth and the facts was evident from the beginning of the process when WA Police or other investigating agencies first investigate a death through to the end when findings are handed down and recommendations are made. The second part is **to inform on the prevention of death**. This part of a mission statement underpins assertive views expressed in regard to the Office's raison d'être. It brings meaning to the reason for being if the outcomes from inquests contribute towards preventing death in the future by informing others by way of recommendations.

The strategic outcomes should be to **promote public confidence and equity of access throughout Western Australia** and to **provide for the timely resolution of coronial cases**.

Introduction to Proposed Key Changes

To achieve the vision that the OSC be a leader in contemporary coronial systems, to be the advocate for the deceased and determine the truth and facts, and to inform on the prevention of death, the Strategic Review proposed a future state model that fully integrates the OSC into a broader coronial system. The key changes go beyond complementing each other; they are inherently dependent on each other. The recommendations have not been designed to be selectively implemented and should be viewed as an integrated package. Whilst the changes can be implemented in stages, all changes must be implemented in order to achieve the maximum benefits for the future state model.

The recommendations are focused around the following areas, which forms a summary of the Strategic Review.

[15] The vision, mission and outcomes statements are those that the Strategic Review identified for the Strategic Plan and are not endorsed at this stage.

1. Service Delivery Model

With the exception of delivering services to regional Western Australia, the proposed service delivery model does not materially change, primarily because the services are modelled to align with the *Coroners Act 1996.* The key difference in the service delivery model is the way in which the services are delivered that needs to change. The service delivery model has been designed however to recognise the three distinct areas of the coronial processes – Registry, Inquests and Counselling. The operational models for each of these areas are distinctly different. Registry processes a large quantity of reportable deaths and has an operational characteristic to it. Inquests are like projects, with each case being the equivalent to a project in its own right that represents a portfolio of approximately 155 projects (cases) including 130 backlogged based upon current volumes. Case management should therefore be subject to controls such as time, budget, scope, quality, risks and benefits (in the case of discretionary inquests). Counselling is predicated on relationship management and community services principles, which again is distinctly different to the other two areas.

2. Governance and the Broader Coronial System

The coronial system is broader than the OSC and extends across several agencies, some of which are intrinsically part of the end-to-end process and some that are affected by the process. It is evident that some parts of the broader coronial system are running to capacity for the core agencies with the OSC, Coronial Investigation Unit (CIU) at WA Police and PathWest all running to capacity for various reasons. Whilst the Strategic Review did not quantify the number of resources occupied in the coronial system the sum of the parts in terms of FTEs would clearly outweigh the OSC.

It is difficult for the OSC to orchestrate the broader coronial system at an operational level due to the way the system of government is structured.

The system as a whole needs a governance framework that can foster and coordinate collaboration, continual improvement and innovation across the broader coronial system. In particular, to better coordinate with individual policies, priorities and budget plans, none of which may align to facilitate continual improvement or innovation of the broader coronial system.

The Strategic Review recommended the creation of a Western Australia Coronial System Governance Group (WACSGG) to work on cross-agency initiatives.

Two other governance-based initiatives were recommended, the first being a revised Office of the State Coroner Management Team and second being the Coronial System Reform Program Governance group that will provide oversight for the change management program required.

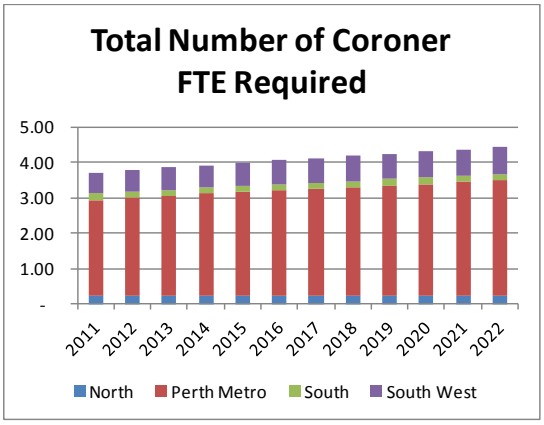
3. Enhanced Semi-Centralised Model

The preferred option is predicated on a semi-centralised model, though enhanced to address the issues indentified by the LRCWA together with this Strategic Review's effectiveness, efficiency and qualitative assessment as well as the views expressed during the stakeholder consultation process.

4. Revised Organisational Structure

A revised structure is proposed. In addition to four permanent Coroners, the revised structure also takes into consideration LRCWA Recommendation 11 to introduce a Principal Registrar, though the Strategic Review's recommendation modifies the scope of this role from a quasi-judicial officer, to a role similar in concept to a 'General Manager.' New roles introduced include Business Systems Analyst, Quality and Education Officer, Business Services

Figure 2-11: Projected Required Coroners



Coordinator, Senior Findings Clerk, and two Paralegals; as well as an additional Counsellor and dedicated counselling administrative assistant. The Strategic Review also confirmed the requirements for a Listings Coordinator and Senior Counsellor but re-aligned the responsibilities of the roles. Some Level 2 general positions will no longer be required.

5. Quality Management

Many of the issues the LRCWA referred to in its review can to be attributed to a large degree to quality management and quality control, or the OSC's lack thereof. There are three components of quality management. First, *quality control* mechanisms must be implemented into the core business processes. Second, *measurement, analysis and improvement* framework must be implemented to track occurrences of quality issues. And third *management responsibility* must be present as demonstrated by *management commitment* from the outset and *management review*, particularly where re-occurring quality issues are escalated to the OSC Management Team to achieve *product realisation*. To implement and monitor improvements in quality, a new position of Quality and Education Officer has been proposed.

The key focus will be on implementing capabilities that will yield the most improvements and to ensure they are embedded into the core day-to-day business processes. The infallibility of people is why quality review processes and procedures are essential. In the case of the OSC, the quality of the information is critically important and information such as date of death, wrong place of death, spelling mistakes, and wrong date of signing the finding are all things that could be detected if appropriate quality review processes are in place and quality reviewers are trained and have check lists (criteria).

6. Gated Processes to Manage Workflow and Quality

The Strategic Review proposed a gated process that is designed to address the majority of reportable deaths much earlier in the process. The progression of processing reportable deaths in effect goes through a series of gates which should have their own in-process and end of process quality checks built in.

To complement the gated process, the in-house CIU Officers are required to focus their attention on the Daily Assessment Team, on being an available source of coronial investigational expertise for all metropolitan and regional police officers (including Major Crime, Major Traffic, Specialist Crime and Internal Affairs), and on tracking the investigation process, with other investigative bodies, in the regions and in inquest cases.

There are several improvements proposed including the introduction of the National P98 Form, the introduction of a Daily Assessment Team, revised Death in Hospital Form, formal directions and so on as further set out in the Strategic Review.

7. Communications and Information Access

Communications and Information Access were two key areas of concern highlighted during the consultation process and also in the LRCWA Review. The Strategic Review has recommended improvements in these areas, especially the provision of adequate notification and the variable protocol of keeping officers in other agencies informed of summons during the listing process.

8. Revised Performance Indicators

The Strategic Review has recommended a series of revised targets once the new or enhanced capabilities have been delivered through the proposed Reform Program. These targets should be introduced at such time new capabilities are operational. However, some should be introduced immediately, such as the performance indicators for natural Administrative Findings and Inquest Listings.

Implementing the revised performance indicators would in effect make the current “time to trial” KPI redundant as the proposed performance indicators would provide improved controls, which are more granular.

Following a period of operation, the opportunity exists to further review the performance indicators to an extended level of granularity after determining cycle time patterns for different types of reportable deaths, which vary in their complexity.

9. Promoting Open and Transparent Accountability

The Strategic Review has made recommendations that support the LRCWA recommendations pertaining to the publication of Findings, Recommendations and Responses. This will address the LRCWA recommendation but will also bring into alignment the OSC with other jurisdictions.

In addition, the Strategic Review recommended the OSC publishes its performance targets and openly demonstrate the basis for sequencing inquests and also the situation factors for elevating certain cases. The OSC should also publish its performance targets and ‘dash board’ to demonstrate to the community its effectiveness and efficiency once the Reform Program has been implemented.

10. Information Systems

A key issue identified is the lack of supporting information systems, which is constraining the effectiveness and efficiency of the OSC.

The Strategic Review has proposed a 3-Stage approach to improving information systems, starting with minor improvements with MUNCCI / NCIS and then moving to the implementation of the Queensland Coronial Case Management System (CCMS). The Strategic Review noted that based upon other reviews, designing and developing an equivalent system to the CCMS would require an investment in the vicinity of $1.5-$2 million plus ongoing support charges. The equivalent cost to undertake the analysis and customisation for the Queensland CCMS is estimated to be one L6 FTE at $114,000 per annum to be funded in DotAG Courts Technology Group (CTG).

MUNCCI has provision to link files and the Queensland CCMS appears to have similar features, though the need for improved document and records management however extends beyond the integration with a case management system. The Strategic Review recommended improving the current TRIM system to (a) include integration with the CCMS as and when this work is done and (b) move to digitally based document and records management to replace a highly ineffective and inefficient paper-based system of working. The key focus will be on implementing capabilities that will yield the most improvements, such as e-briefs as recommended by the LRCWA.

11. Information Management and Analysis, and Informing on the Prevention of Death

The Strategic Review has made a series of recommendations pertaining to quality of the data and ability to better utilise the data for the identifying trends in manner and causes of death. During the review of the MUNCCI / NCIS database extract, a number of data errors and inconsistencies were identified. Some of these issues will mainly affect case management related data, such as dates that events occur, though as noted by the Strategic Review, critical dates such as the Date of Death appears to be referenced incorrectly (though it is uncertain if these dates are derived from incorrect dates in MUNCCI / NCIS). However, some of the issues relate to the coding of the manner or cause of death.

The introduction of a new Business Analyst position is critically important to support the OSC informing on the prevention of death. In particular, the Strategic Review has recommended a data integrity project to review and correct the quality issues and increase the confidence in the integrity among other activities.

12. Training Systems and Guidelines

It is evident from the LRCWA Review and during the consultative process that there is much need for guidelines and training. The Strategic Review has recommended an approach to developing education and training programs, predominately focusing on e-learning and leveraging Court and Tribunal Services Techniworks Learning Management System (eLMS). As with other initiatives, the key focus will be on implementing capabilities that will yield the most improvements. This initiative is closely linked to improving quality management and is intended to incorporate newly created guidelines into e-leaning modules using inexpensive software to adapt the content. Over time, the OSC will build up a comprehensive suite of coronial training modules.

In addition, the Strategic Review recommends the OSC host an annual Western Australian Coroners Conference to promote knowledge sharing across the coronial system and using the product of presentations as content for future e-learning.

13. Contract Management and Sourcing Strategy

The Strategic Review recognises the challenges that the OSC has with managing its body removal contracts and its arrangement with the ChemCentre and PathWest. Whilst this has not been examined in detail, the Strategic Review has recommended developing a sourcing strategy for body removal contracts and suggested a possible minor improvement for the ChemCentre, whilst acknowledging there will be ongoing negotiations at an operational level.

14. Management of Risk

The Strategic Review has recommended that risk identification, assessment and management are focused at the OSC level of operations given there is much attention on the OSC by government and the media. In addition, risk management should be integrated into the day to day operations of the OSC so that risks can be proactively monitored by the management team using a Red, Amber, and Green system.

15. Change Management

It is important to note that without exception stakeholders consulted were all committed in their own way to the improvement of the coronial system as a whole. However, the Strategic Review formed a view that change will not come easy to the OSC because there are ingrained practices and beliefs that will not readily embrace change. This is understandable, particularly for those that have been there since the early days and have been instrumental in developing and evolving the systems from the beginning. This is not a criticism as opposed to recognising there has not been the time to step back and consider the system as a whole. Whilst some change initiatives have been progressed they have not made a material difference to counter the inefficient and ineffective ways of working. It takes time to make change and equally important it takes a willing cohort to work as a collective.

Integral to the Reform Program is the temporary position or contract for a Change Manager.

Recommendation 5: It is recommended that the recommendations of the Strategic Review are implemented.

2.6 Conclusion

It is acknowledged that the recommendations of the Strategic Review and the LRCWA Review represents a body of work, which is why the Strategic Review proposed a Reform Program to provide the required governance, program management and controls. Whilst the Reform Program appears to be a sizable body of work it needs to be kept into perspective that it does not need to be onerous if approached from the perspective of implementing the proposed initiatives on a staged approach as discussed for quality management, education and information systems. The Reform Program should embrace a mantra of investing effort in the areas that will yield the most benefits.

It is also acknowledged the OSC has now undergone two reviews which has been a drain on resources and the implementation of the Reform Program will continue to consume resources, which needs to be kept in mind.

The recommendations emanating from the Strategic Review are predicated on implementing initiatives based on where the OSC needs to be in the future but the backlog has clearly been and will continue to be a disruptive phenomenon in the operational running of the OSC. It was also disruptive to some extent for the Strategic Review itself because the backlog creates an environment that is not typical of normal operating conditions, which is compounded by the OSC implementing refinements to business processes and practices in parallel.

It is evident that the OSC is making headway through the backlog now that Administrative Findings for natural caused deaths appears to have caught up and the target line for non naturals is closing.

The Strategic Review's concern is with the current backlog of inquests which is now understood to be approximately 155 inclusive of 130 on the backlog list. A portfolio of 155 cases (projects) is a formidable quantum to work through for any practice the size of the OSC, particularly because of the need to undertake the equivalent of investigations through the hunt and gather process[16]. The OSC will remain to be busy for at least the next two years whilst it implements the Reform Program and continues to work through the backlog of cases.

The Strategic Review's recommendations are designed to address effectiveness and efficiency issues as discussed throughout the report and the LRCWA Review. Whilst the Reform Program requires a concerted effort, the estimated cost is not significant because the proposed model is predicated largely on restructuring and implementing improvements. The proposed model requires investment, particularly the first year to fund implementing new and enhanced capabilities and partly to increase capacity, though the recurrent increase is not considered significant compared to the existing budget. Whilst the Strategic Review is not a business case, a separate budget estimate has been prepared to provide an input to the DotAG financial and budgetary management process.

The primary objective behind the Strategic Review's recommendations is to improve the timely resolution of coronial cases by reducing the end-to-end cycle times, processing times, wait times and improving the effective use of resources amongst other benefits. The proposed increase and reconfiguration of resources together with the proposed recommendations are designed to achieve this objective, but the success is equally dependant on the will and commitment of the OSC, Court and Tribunal Services and the Department of the Attorney General.

The success is also dependent on the proposed recommendations of the Strategic Review and the LRCWA Review being funded, which at the time of this s.57 Review presents a challenge given the drive by the Department of Treasury to reduce budgets.

The challenge before government will be to decide if the priority falls in favour of limiting the capacity of the OSC or in favour of the public interest to determine the truth and facts of reportable deaths; to inform on the prevention of death; and be a leader in contemporary coronial systems demonstrated in part by the timely resolution of coronial cases.

In conclusion, four years have passed since the last s.57 Review and problems highlighted by the Barnes Review still persist. Whilst the LRCWA Review has examined in detail issues and opportunities looking forward its review and the subsequent Strategic Review has in effect placed the OSC on hold in regard to making step changes in coronial practices while it has waited for the outcomes. The reviews are now complete, culminating in a series of recommendations and a comprehensive plan to move forward. The remaining pivotal factor that will prevent the recommendations being implemented and effecting change in accordance with the proposed strategic plan will be funding.

[16] Hunt and Gather" is a colloquial phrase use by Counsel Assisting to reflect the investigative characteristics of the work.

2.7 Section 57 Review Summary of Recommendations

As outlined, this s.57 Review builds onto the 113 LRCWA Review recommendations, to which 66 were identified as being directly relevant for consideration to the s.57 Review.

The Strategic Review made a further 27 recommendations.

Whilst the following recommendations appear brief, they are (a) additional recommendations identified specifically emanating from the s.57 Review and (b) need to be considered in the context of the aforementioned recommendations. Recommendation 5 in particular, encapsulates the 27 recommendations made by the Strategic Review of which many relate to the 113 LRCWA Review recommendations.

Recommendation 1: It is recommended that consideration be given to rewriting the *Coroners Act 1996.*

Recommendation 2: It is recommended that consideration be given to restructuring the *Coroners Act 1996* to be better aligned to the coronial processes.

Recommendation 3: It is recommended that consideration be given by Parliamentary Counsel to further define the administrative responsibilities of the *Coroners Act 1996* as part of the proposed Legislative Project.

Recommendation 4: The views expressed by the State Coroner and Deputy State Coroner should be taken into consideration by Parliamentary Counsel as part of the proposed Legislative Project.

Recommendation 5: It is recommended that the recommendations of the Strategic Review are implemented.

3 The *Coroners Act 1996* in perspective

This section of the report steps through the *Coroners Act 1996 (WA)*, commenting on the LRCWA Review recommendations in the context to the associated sections of the Act.

Where there appears to be general consensus on the LRCWA Review Recommendations, the associated recommendations are listed accordingly. Similarly, some of the recommendations require further consultation with the coroners in relation to an agreed direction. Whilst many of these may still generally be supported, views expressed by stakeholders suggest they may be better addressed through Regulations, Rules of Court and Guidelines as opposed to amending the Act.

The section also comments on sections of the Act in the context of the Strategic Review. The points highlighted in this section are not all inclusive and whilst they have been selectively chosen in the context of the sections of the Act, there will invariably be further relevance that can be found in the LRCWA Review's report and the Strategic Review's report.

It should also be noted that whilst the views of the State Coroner and Deputy State Coroner previously conveyed to the LRCWA Review are referenced on occasions in this section to provide a firsthand practitioner's perspective, they were conveyed to the LRCWA Review during its review and the views expressed may have changed slightly with the passage of time.

3.1 Objects of the Act

Both the Barnes Review[17] in 2008 and LRCWA Review in 2012 made recommendations pertaining to the introduction of an objects clause into the Act. There are many credible sources that can be found supporting these recommendations to include an objects clause. One example is the Australian Law Reform Commission publication[18] pertaining to the *Privacy Act*, which noted -

"An objects clause is a provision—often located at the beginning of a piece of legislation—that outlines the underlying purposes of the legislation and can be used to resolve uncertainty and ambiguity. Objects clauses have been described as a 'modern day variant on the use of a preamble to indicate the intended purpose of legislation'[19]. The Office of Parliamentary Counsel, which is responsible for drafting Australian Government legislation, has noted that:

Some objects provisions give a general understanding of the purpose of the legislation … Other objects provisions set out general aims or principles that help the reader to interpret the detailed provisions of the legislation[20]."

As discussed in Section 2.5.6, the Strategic Review considered in detail the rationale and issues the LRCWA Review set out in its report and the proposed model to address the inequity of regional support and concurred with the views expressed with exception of the model itself. An alternative, yet complementary model was proposed though it does not materially change the scope of coronial services, primarily because the services are modelled to align with the *Coroners Act 1996*. That is, the services remain aligned to the proposed objects of the Act with the exception of the reference to the LRCWA's inclusion for "coronial regions", which for the reasons explained in Section 2.5.6 is not considered viable to servicing the objects.

The proposed objects provide both the framework for the legislation and the service delivery model.

Recommendation 1[21] Objects of the Coroners Act

[17] Barnes, Michael, 2008, Review of the *Coroners Act 1996 (WA)*, Government of Western Australia, p.4

[18] Australia Law Reform Commission, For Your Information: Australian Privacy Law and Practice (ALRC Report 108) /5, the Privacy Act: Name, Structure and Objects, Australia Government.

[19] D Pearce and R Geddes, Statutory Interpretation in Australia (6th ed, 2006), p.154

[20] Office of Parliamentary Counsel, Working with the Office of Parliamentary Counsel: A Guide for Clients (3rd ed, 2008)

That the Coroners Act feature a section which articulates the following primary objects of the

Act:

(a) to require the reporting of particular deaths;

(b) to establish the procedures for investigations and inquests by Coroners into reportable deaths;

~~(c) to establish a coordinated coronial system for Western Australia with defined coronial regions and dedicated Coroners including a State Coroner as head of jurisdiction;~~

(d) to contribute to a reduction in the incidence of preventable deaths and injury by the findings, comments and recommendations made by Coroners and by the timely provision by Coroners of relevant data to appropriate authorities and research bodies;

(e) to facilitate the timely provision of relevant information to family members of a deceased person the subject of a coronial investigation; and

(f) to offer a counselling service to family members, friends and others associated with a death the subject of a coronial investigation.

In addition, the State Coroner made the point that in any event, it is not appropriate to have a reference to 'coronial regions' in an objects clause. The other 'objects' referred to in the suggested provision all relate to outcomes, whereas this reference is to a mechanism for producing an outcome.[22]

The Barnes Review proposed -

"The objects of this Act are to—

(a) establish the position of the State Coroner;

(b) require the reporting of particular deaths;

(c) establish procedures for investigations, including by holding inquests, by coroners into reportable deaths;

(d) assist families of deceased persons obtain information about the cause and circumstances of reportable deaths;

(e) reassure the public that reportable deaths are appropriately investigated; and

(f) encourage coroners at inquests to make recommendations on matters connected with deaths investigated concerning:-
public health and safety;

the administration of justice;

ways to prevent death occurring in similar circumstances."

Whilst the LRCWA formed its views subsequent to the Barnes Review, the intent of both proposals appears similar.

With the exception of the LRCWA 1(c), the State Coroner, Deputy State Coroner and DotAG concur in principle with the LRCWA recommendation with the exception of LRCWA 1(c), though the State Coroner and Deputy State Coroner also noted points relevant to the drafting of an objects clause.

Given the extent of examination to this matter that has gone before and key stakeholders appear to be in general agreement, there appears to be no reason to further delay including an objects clause into the Act.

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[21] Law Reform Commission of Western Australia, 2012, Review of Coronial Practice in Western Australia, Government of Western Australia, Perth, p.10 (Note, amended to strike out (c) on the basis of the removing the reference to regions in the objects clause).

[22] Hope Alistair, 30 August 2012, Review of Coronial Practice in Western Australia: Final Report of the Law Reform Commission of Western Australia January 2012 Response by State Coroner, p.4

DotAG has made preparations for a Legislative Project, which will comprise resources from DotAG, the OSC and Parliamentary Counsel to start working on the inclusion of an objects clause.

3.2 s.5 Establishment of court

Whilst the S.57 Review acknowledges the purpose of Section 5 is to make legislative provision for the Coroner's Court to be established and is included in the Act for completeness, there are some practical matters worthy of comment. The sustainability of establishing the Coroner's Court also depends on the ability to make provision for the continuity of the Coroner's Court.

The Strategic Review made a series of recommendations to improve effectiveness and efficiency as discussed in Section 2. A consequence of implementing a combination of the LRCWA Review's recommendations and the Strategic Review's recommendations will be a revised organisational structure and improved processes. These will have the combined effect of increasing the capacity of the Inquest Team in conducting inquests. However, there is a limitation in the number of inquests that can be listed by the physical bottleneck of only having one dedicated courtroom for Coroner's Court. Whilst it is acknowledged the issue may be a procedural booking issue to access other courts, there is also the physical difference in a Coroner's Court having sufficient capacity to accommodate multiple interested parties at the same time.

With an additional courtroom, it would be possible to potentially run 90-100 inquests per annum.

Given the mandatory inquests represent 1-1.5% of reportable deaths, the maximum number of mandatory inquests in a year would be 30. If only 10-20 discretionary inquests are conducted each year, that would equate to approximately 40-50 new inquests per annum. As at 30 September 2012, the total number of inquest cases stood at 153 with 132 being backlog (older than 12 months). Depending on how aggressively the Inquests are prepared and listed, the backlog could be cleared in 2.5 years, which may lessen the demand on the Coroner's Court around 2015. However, whilst the OSC progresses through the backlog another factor will emerge that places more demand on the Coroner's Court, which is the introduction of new legislation to increase penalties for failure to report a death. Some of the recommended legislative changes could give rise to an additional 600 hospital deaths being reported as coronial cases per year.

It is clear that an additional dedicated courtroom is required to facilitate improved effectiveness and efficiency of the coronial process.

For regional Western Australia, given regional inquests are held locally and generally last no more than five days, with the majority less than three, the preparation, court proceedings, findings and recommendations can be serviced centrally as long as the existing network of Magistrates Courts can continue to provide a local support for some of the services.

It should be noted that the majority of regional inquests are currently managed centrally. Therefore, other than providing a reasonable time for listing inquests, there should be adequate time to schedule regional inquests accordingly.

3.3 s.6 State Coroner

The LRCWA Recommendation 6[23] proposed –

Recommendation 6 Status and tenure of the State Coroner

1. That the State Coroner of Western Australia be a judge of the District Court appointed by the Governor upon the recommendation of the Attorney General made after consultation with the Chief Judge of the District Court.

[23] Law Reform Commission of Western Australia, 2012, Review of Coronial Practice in Western Australia, Government of Western Australia, Perth, p.19.

2. That the State Coroner be appointed for a term not exceeding five years and is eligible for reappointment.
3. That service in the office of State Coroner be taken for all purposes to be service in the office of a judge of the District Court of Western Australia.

It was agreed with DotAG that the matter of status and tenure is a policy decision for Government and for the purposes of the Strategic Review would not be considered further, particularly as the matter had been examined by the LRCWA. The LRCWA recommendation is therefore a matter for the Attorney General to consider.

However, the Strategic Review commented from two perspectives pertaining to Recommendation 6(2). First, in support of the view the State Coroner expressed that "the appointment should be for life as with other judicial appointments", a period of tenure could be disruptive and rely on tacit knowledge being captured as explicit knowledge. That is, there would be greater need for documented processes, procedures and guidelines and in particular, supporting information systems to supplement the tacit knowledge of the State Coroner to some degree. Business continuity could be vulnerable towards the end period of tenure if a change of State Coroner occurred. However, the Strategic Review identified that documented processes, procedures and guidelines, and in particular supporting information systems or the lack thereof, are intrinsically linked to the issues experienced in the Office of the State Coroner. Therefore, these need to be addressed regardless of tenure.

The concerns expressed by the State Coroner and the Deputy State Coroner reflect the issues with the steep learning curve to transition to coronial work as evidenced by the views expressed by one of the temporary coroners during the Strategic Review and the stark contrast in operation to other jurisdictions such as the magistrates court. The motivation for not supporting limited tenure appears to be risk mitigation to maintain the depth of skills, knowledge, expertise and experience in coronial processes.

Conversely, limited tenure brings with it the potential for new ways of working and a deepening of knowledge in the coronial system over time. Irrespective of a period of tenure, handing over the reins will occur at some stage. Limited tenure therefore focuses the attention on business continuity and sustainability on the basis that the State Coroner of the day must perform their duties cognisant that a successor will take over. The Strategic Review concluded that it is rare for positions not to be subject to tenure.

3.4 s.7 Deputy State Coroner

The same view expressed for Section 6 applies to this Section.

However, the Strategic Review further identified that the State Coroner's role will be heavily consumed for a period of two years whilst being intrinsically involved in the transformational change that is required to undertake a Reform Program of the Office of the State Coroner. With the State Coroner's anticipated occupation with other duties, the Deputy State Coroner will need to lead the direction of the Inquests, including the continuous improvements to be identified, developed and implemented in the Inquest process with the assistance of the Listing Coordinator, Senior Counsel Assisting and the proposed new position of Quality and Education Officer.

In recognising that the OSC makes coronial recommendations affecting the same agencies it needs to foster collaboration with to improve the system as a whole. An important role for the Deputy State Coroner will be to enable the OSC to maintain separation between making coronial recommendations and following-up on progress whilst the collaborative arm of the OSC fosters continual improvement and innovation across the broader coronial system.

The elevation in duty should be reflected in the increase in remuneration equivalent to the Deputy Chief Magistrate.

In regard to s.7(3) -

Where the State Coroner is absent from duty or the office of State Coroner is vacant, the Deputy State Coroner may act in the office of State Coroner and when so acting has all the functions of the State Coroner.

Rather than "may act", the Act should be amended to state "shall act" for the avoidance of doubt.

3.5 s.8 Functions of the State Coroner

The functions of the State Coroner are —

(a) to ensure that a State coronial system is administered and operates efficiently;

(b) to oversee and coordinate coronial services;

(c) to ensure that all reportable deaths reported to a coroner are investigated;

(d) to ensure that an inquest is held whenever there is a duty to do so under this Act or whenever it is desirable that an inquest be held;

(e) to issue guidelines in accordance with this Act;

(f) such other functions as are conferred or imposed on the State Coroner under this Act.

As discussed in Section 2, the Strategic Review formed a view that overall, the current system is partially conducive to operating efficiently. The LRCWA also expressed views in its review pertaining to effectiveness and efficiency of the system.

In the context of the functions of the State Coroner, the ability to oversee and coordinate coronial services is limited to some degree given that the coronial system is broader than the OSC. That is, the coronial system extends across several agencies, some of which are intrinsically part of the end-to-end process and some that are affected by the process. It is difficult for the OSC and therefore the State Coroner to orchestrate the broader coronial system at an operational level due to the way the system of government is structured. There are understandably no provisions to enforce coronial recommendations which also limit the State Coroner's function in the context to the prevention of death.

Orchestration of the broader coronial system requires something more than the legislative functions of the State Coroner and the Strategic Review therefore recommended the creation of a Western Australia Coronial System Governance Group (WACSGG) to work on cross-agency initiatives.

Ensuring reportable deaths reported to a Coroner are investigated is limited to some degree by the issues identified in the LRCWA Review. By way of example, the Barnes Review and the LRCWA Review both identified the issue with hospital deaths being reported and the Strategic Review was advised by the OSC that it has been approximated by the OSC that additional 600 hospital deaths should be reported as coronial cases per year. The LRCWA Review's Recommendation 18 also made specific recommendations pertaining to the reportability of healthcare-related deaths. Whilst s.8(c) is to ensure that all reportable deaths reported to a Coroner are investigated, the question the LRCWA Review gave rise to is the extent to which reportable deaths are reported in the first instance.

In regards to s.8 (e), ten of the LRCWA Review recommendations were related to guidelines that needed to be developed, which suggests that issuing guidelines in accordance with this Act needs to be progressed further. It will be beneficial to update the guidelines in a way that facilitates the creation of training modules as set out in the Strategic Review's proposed Reform Program.

The scope of s.8 focuses on key functions leaving it to s.8 (f) to address "such other functions as are conferred or imposed on the State Coroner under this Act". Key functions as outlined in the proposed objects clause should be more prominent, especially informing on the prevention of death and also provision of counselling services. The Legislative Project should therefore consider aligning

s.8 to be more relevant to the proposed objects clause and the LRCWA Review findings. The proposed LRCWA Review recommendations therefore, are likely to give rise to broadening the functions of the State Coroner, particularly in relation to the proposed objects of the Act.

Overall, the Attorney General can be reasonably confident that attainment of s.8 is being achieved, though there is much work that needs to be done for Western Australia to be a leader in contemporary coronial systems.

3.6 s.9 Oath of office

Recommendation 10 of the LRCWA Review proposed -

Recommendation 10 Oath of Office

1. That a person appointed as coroner or acting coroner under the Coroners Act must, before commencing to act as a coroner, take before a judge of the Supreme Court an oath or affirmation of office.
2. That the prescribed form of the oath or affirmation of office for a coroner be specific to the duties as coroner and be developed in consultation with the State Coroner.

The State Coroner expressed a view that this is a not controversial and should be addressed by Parliamentary Counsel as part of the proposed Legislative Project. There appears to be no reason to delay amending Section 9 of the Act accordingly.

3.7 s.10 Delegation

Recommendation 12 of the LRCWA Review proposed 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 the proposed subsection (2). The State Coroner expressed a view that most of the identified functions or powers which is recommended should not be delegated and have never been delegated.

The LRCWA's proposed exclusions[24] to functions or powers were:

(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.

The Strategic Review proposed a revised organisation structure to improve effectiveness and efficiency. As part of the revised structure, delegation would be extended to the Coroner's registrars in Perth for (b) directing a forensic pathologist or medical practitioner to perform an internal post

[24] Law Reform Commission of Western Australia, 2012, Review of Coronial Practice in Western Australia, Government of Western Australia, Perth, p.23.

mortem examination and (d) releasing a body. The varying degrees of skills, knowledge, expertise and experience in regional Western Australia as identified by the LRCWA Review with Coroner's registrars exercising these powers would no longer be relevant because the Strategic Review proposed these functions be centralised. These functions would therefore be undertaken by experienced personnel based in the OSC.

The State Coroner expressed a view that he does not agree with 2(b) while country magistrates are still working as coroners. The matter is considered to a transitional issue pending the recommendations of the Strategic Review being implemented. That is, country magistrates would no longer be required to undertake some of these delegated responsibilities following the proposed restructure.

The extent to which exclusions need to be explicitly stated in the Act should be considered by the Legislative Project, particularly LRCWA Review Recommendation 12(b), 12(d), 12(h), and 12 (i) whilst also taking into consideration the recommendations of the Strategic Review, some of which rely on delegated authority. Consideration should be given to practical issues pertaining to delegations, which may be better addressed through OSC policy.

3.8 s.11 Coroners

Recommendation 2 of the LRCWA Review proposed that magistrates should no longer hold automatic contemporaneous ex officio appointments as coroners. This view is supported in principle by the State Coroner who expressed a view that coronial work is becoming increasingly specialised and throughout Australia the move is away from use of coroners who are not appointed as such.

The State Coroner has no involvement in the appointment of magistrates and has reservations about such appointments. The Strategic Review identified that outside of the OSC, a view held by some stakeholders is that Magistrates' Court and the Coroner's Court are similar, though in practice they are distinctly different, particularly because of the need to undertake the equivalent of investigations through what the OSC refers to as the hunt and gather process[25]. Reportable deaths are a complex matter and it is clear from the consultation process that temporary coroners, even with their wealth of skills, knowledge, expertise and experience, acknowledge there is a steep learning curve. The NCIS[26] Data Dictionary provides a good indication of the complexities. As an example, one area in summary comprises 84 Mechanisms of Injury, which further expands to 276 sub-mechanisms. There is also the distinction between the adversarial and inquisitorial systems of law. Whilst Magistrates' Court and the Coroner's Court appear similar in many respects, they are quite different.

Whilst there was no doubt a practical need at one point in time for magistrates to be contemporaneous appointed as ex officio coroners by virtue of their office, this appears to be increasingly less relevant in contemporary coronial systems and there appears to be little support to maintain s.11(1) accordingly as proposed by the LRCWA Review.

Further, section 11(2) of the Act would enable such appointments to take place should the need arise.

The Strategic Review recommended several reforms, which would also reduce the dependency on regionally based magistrates to be contemporaneous appointed as ex officio coroners.

[25] Hunt and Gather" is a colloquial phrase use by Counsel Assisting to reflect the investigative characteristics of the work.
[26] NCIS - National Coronial Information System

3.9 s.12-14 Coroner's registrars, functions and appointment

A key reform advocated by the LRCWA Review in its Recommendation 11 was the introduction of a Principal Registrar, which was considered further by the subsequent Strategic Review. Contrary to the LRCWA Review, the Strategic Review did not view the role of Principal Registrar as a quasi-judicial officer, but the 'General Manager' of the OSC. The Principal Registrar would play a key role in coordinating the broader coronial system and liaising with key 'partner' agencies. Whilst this is similar to the LRCWA Review's proposed role, the Principal Registrar would undertake this within the formal structure of the proposed Western Australian Coronial System Governance Group.

The primary function of the Principal Registrar would be to assist the State Coroner in managing the coronial system as a whole. The day-to-day function of the office would be the responsibility of the Office Manager while the interaction of the OSC with other stakeholders and 'partner' agencies would be the responsibility of the Principal Registrar. The Strategic Review recommended the remuneration be at the Public Service Agreement (PSA) Special Calling Level 5 or equivalent for the Principal Registrar. The LRCWA Review suggested that the Principal Registrar would have such powers as prescribed by the *Coroners Act 1996* or delegated by the State Coroner which, in addition to the powers currently delegated to registrars. The Strategic Review proposed that these functions would be better aligned to other roles in the revised organisational structure and processes.

Sections 12-14 of the Act should therefore be reviewed and amended as required to align to the recommendations of the Strategic Review as augmented from the recommendations of the LRCWA Review accordingly as part of the proposed Legislative Project for consideration by Parliamentary Counsel .

As outlined, the Strategic Review's recommendations have not been designed to be selectively implemented and should be viewed as an integrated package. Whilst the changes can be implemented in stages, all changes must be implemented in order to achieve the maximum benefits for the future state model. The proposed Legislative Project must be cognisant that a critical success factor is to ensure the appropriate alignment of Sections 12-14 of the Act to proposed Reform Program as an integrated program. Consideration to the recommendations of the Strategic Review, some of which rely on delegated authority, should be given by the Legislative Project.

3.10 s.15 Affidavits

The LRCWA recommendation 78[27] proposed –

Recommendation 78 Status and tenure of the State Coroner

Use of affidavits at an inquest

1. That the section in the Coroners Act dealing with affidavits (currently s 15) expressly provide for the acceptance and use of affidavits at inquest.
2. That the Coroners Regulations be amended to provide a form for affidavits relating to a coronial investigation and sworn before a coroner's registrar or coroner's investigator pursuant to the Coroners Act.

The proposed amendment of s.15 was contested by the State Coroner and Deputy State Coroner. The Department of the Attorney General advised that Court and Tribunal Services will take carriage of this recommendation and advised this need not be taken into consideration for the s.57 Review.

The point is therefore noted for completeness.

[27] Law Reform Commission of Western Australia, 2012, Review of Coronial Practice in Western Australia, Government of Western Australia, Perth, p.19.

3.11 s.16 Counselling

The LRCWA Review dedicated a chapter on [28] –

"the role, rights and support of families in the coronial process including provision of information and counselling, cultural issues, and the rights and concerns of families in respect of post mortem examinations and release of bodies. Recommendations in this chapter [7] include improvements to training, education and information provided within the coronial system, to related service providers and to the public at large. Recommendations are also made about improving the access of families to information about progress of a deceased's case and about their rights in the coronial process. Finally, the Commission makes a number of recommendations about post mortem examinations including recommendations to enable external post mortem examinations in all cases; to legislate factors that coroners must consider when ordering an internal post mortem examination; to govern objections to post mortem examination; and to govern the release of a body by a coroner".

Chapter 7[29] of the LRCWA Review presented compelling arguments to improve the role and support of the family in the coronial process.

The Strategic Review considered the provision of counselling services further and concluded that the OSC is inadequately resourced to provide an equitable counselling service across the state. The current resources alone have limited capacity to service the Perth Metropolitan Area and the LRCWA Review in particular highlighted the inequity of servicing regional Western Australia.

The State Coroner and Deputy State Coroner expressed views that it is not accepted any stigma attaches to the word "counselling" or that "a stigma is not avoided by pandering to it". However, it is not entirely for that reason alone that the Strategic Review suggested amending the name of the service, it is also in recognition that much of the service is liaison.

Implementing the recommendations of the Strategic Review and the LRCWA Review presents an opportunity to emphasise elevating the service by extending its reach to regional areas and also providing increased capacity to assist with the liaison of post mortem objections.

The provision of counselling services is another dimension to case management, though there is more emphasis on relationship management and tracking that the OSC has provided services to the satisfaction of the families. One measure that provides a good indication of serviceability is customer satisfaction and whilst it is acknowledged that the death of a family member is a difficult period, it is also one that families are likely to comment on in regard to the level of satisfaction of the overall service provided by the OSC.

The Strategic Review proposed an alternative to the LRCWA Review's Recommendation 89 to naming the counselling service and proposed the "Coronial Counselling and Liaison Services" (and renaming accordingly). The Strategic Review recommended the Coronial Counselling and Liaison Services is extended by (a) increasing its capacity in the OSC and (b) extending its network through the existing Court Counselling and Support Services, Court and Tribunal Services network of Not-for-Profit (NFP) Organisations.

The need for improved Coronial Counselling and Liaison Services through increased capacity in Perth plus establishing a network of NFP organisations in the regions that can assist families locally was also considered by the Strategic Review as part of its options assessment for servicing regional Western Australia and also in the proposed service delivery model.

[28] Law Reform Commission of Western Australia, 2012, Review of Coronial Practice in Western Australia, Government of Western Australia, Perth, p5, p.103-138

[29] Law Reform Commission of Western Australia, 2012, Review of Coronial Practice in Western Australia, Government of Western Australia, Perth, p.109

The Strategic Review also identified that counselling services fall away as the coronial process moves forward, typically at the point that a reportable death determination to inquest begins, which is primarily due to the case being taken over by the inquest team. Whilst there appears to be well intentioned arguments for Counsel Assisting controlling the interactions with families, the continued interaction by counsellors would be preferable, particularly given they are skilled in the provision of counselling services. However, transitioning the relationship management to the counsellors is difficult due to the lack of supporting information systems throughout the OSC. Without supporting information systems counsellors cannot easily determine the status of a case without seeking advice from Counsel Assisting, which would be disruptive. However, the absence of readily available information is not the sole impediment. Counsel Assisting are also concerned about the risk of inadvertent disclosure of information unless they are in full control. The Strategic Review advocated that counselling services should be intrinsically involved throughout the coronial process and at such time supporting information systems are available, for the counselling service to maintain the relationship throughout the coronial process.

Another point that resonates through the LRCWA Review and the Strategic Review is the need for improved education and training, particularly to ensure the quality and consistency of service is maintained throughout the state. The Strategic Review proposed a contemporary approach to developing training material and leveraging existing information and the content that will be created through the new and improved guidelines. The Strategic Review drew upon the experience of innovative approaches utilised by Legal Aid Western Australia's Train-N-Track program implemented under the Commonwealth Regional Innovations Program for Legal Services (RIPLS).

The provision for counselling services is a key requirement in its own right to a sufficient degree that it should not be left embedded in other sections of the Act. The brevity of Section 16 affords the OSC a degree of latitude in its interpretation of counselling services. The scope of the counselling services however should be further defined through a mechanism such as a customer service charter that provides guiding principles to the provision of such services.

3.12 s.17 Obligations to report a death

Recommendation 15 of the LRCWA Review recommended increasing the penalties for failure to report a death and there appears to be no opposition to increase penalties, which occurs elsewhere in the LRCWA Review to -

"bring the penalties in the Coroners Act into line with the relationship between fines and terms of imprisonment under s 41 of the *Sentencing Act 1995 (WA)* and some of the more common penalty provisions under the *Criminal Code*, the Commission has decided to amend its recommendation to increase the penalty to a fine of $12,000 or 12 months' imprisonment." [30]

If the recommendations for stricter penalties in not reporting a death are implemented as outlined in the LRCWA recommendations, the potential result would be a large influx in telephone calls to Coroner's Delegates. The durability of the current process would be susceptible to degradation with the current capacity. The broader coronial system as a whole is also susceptible to degradation, which relies as much on the capacity of WA Police and other agencies as it does the OSC. The broader coronial system in effect operates as an ecosystem and it is evident that the OSC's effort to reduce the backlog of cases is now putting pressure on the CIU to move through its investigations.

Making changes such as implementing the recommendations of the LRCWA Review for stricter penalties or other initiatives that have far reaching implications beyond the OSC is not conducive to the effectiveness of durable and consistent processes unless adequate resources can respond to

[30] Law Reform Commission of Western Australia, 2012, Review of Coronial Practice in Western Australia, Government of Western Australia, Perth, p.30

increased demand. The service delivery model identified by the Strategic Review is designed to address the need for increased resources, improved processes and supporting information systems.

Recognising that seemingly straight-forward initiatives such as increasing the penalties for failure to report a death has far reaching implication and is one of many reasons why the Strategic Review recommended the creation of the Western Australia Coronial System Governance Group to provide oversight across the broader coronial system and to progress continual improvement and innovation. Increasing the penalties for failure to report a death will affect more agencies than the OSC and warrants a collaborative approach to ensure all agencies affected ready themselves for the introduction of such changes in legislation.

3.13 s.19 Jurisdiction of coroner to investigate a death

Section 19 was considered at length in the LRCWA Review and there appears to be general acknowledgment of the points raised by the LRCWA, though the State Coroner and Deputy State Coroner expressed views that jurisdiction relating to stillbirths is a complex legal matter which merits proper consideration.

The Strategic Review did not consider the LRCWA Review recommendation 14 as it did not appear to have an impact on the effectiveness and efficiency of the OSC. The matter serves to illustrate however the increasing complexity of the coronial system.

3.14 s.20 Information to be provided to next of kin

With the exception of s.20 (1)(a) this section of the Act primarily refers to other sections of the Act, including, though not referred to s.20 (1) (j) that a counselling service is available. The specific subsections are discussed in relation to these sections elsewhere in this report accordingly.

From the broader perspective of access to coronial information the LRCWA Review and Strategic Review considered the issue of information being provided and made recommendations accordingly.

Specifically, LRCWA -

Recommendation 82 Publication of inquest findings, comments and recommendations

Recommendation 92 Expand available translations of important coronial information

Recommendation 93 Use of interpreters

Recommendation 94 Coronial information service

Recommendation 95 Release of post mortem examination report

Recommendation 96 Coroners court website

The Strategic Review supported these recommendations noting that the OSC needs to adopt a more contemporary and open philosophy to making information available and whilst points on privacy were well made by stakeholders consulted, this has not prevented other jurisdictions publishing findings and making relevant information available including inquest findings.

The Strategic Review noted there are also techniques available to manage disclosure of confidential information, though it is acknowledged this would require managing and would take time. Intrinsic to the proposed restructure of the OSC is the introduction of new positions including a Business Systems Analyst, Quality and Education Officer and Business Services Coordinator to provide support to contribute to, amongst other things, content management for the purpose of making information more available and more easily accessible.

The point about emphasising a more contemporary philosophy is in recognition that society is changing in terms of information being readily available. One benefit of the OSC being less advanced than many organisations in this regard is the opportunity to align developments to contemporary

approaches. Also discussed in the Strategic Review is the recognition that techniques such as small video vignettes are becoming more common place via the increasing penetration of mobile technologies and use of social media to access information.

The Strategic Review also identified that one of the key issues affecting effectiveness and efficiency is the lack of supporting information systems for case management, records management and the like. Such supporting systems provide the foundation to manage the relationships of those affected by the coronial system and extends beyond case management. The website in effect provides the front-end, though is only part of the information management and supporting systems required.

As discussed in Section 2, the Strategic Review has proposed a 3-Stage approach to improving information systems, starting with minor improvements with MUNCCI / NCIS and then moving to the implementation of the Queensland Coronial Case Management System (CCMS).

Apart from aiding the provision of information to be provided to next of kin, the proposed strategy to improve information systems is critically important to informing on the prevention of death as with out, the analysis of trends in deaths is limited.

As highlighted in the LRCWA Review, it was noted that ‘‘people from more than 200 different countries live, work and study in Western Australia, speaking as many as 270 languages and identifying with more than 100 religious faiths“[31]. Recommendation 92 to expand available translations of important coronial information has since been progressed by the OSC. The brochure has been translated into five other languages – Arabic, Chinese, Farsi, Italian and Vietnamese. According to the Australian Bureau of Statistics, the most common languages spoken at home for recent immigrants are, in descending order: Mandarin, Punjabi, Hindi, Arabic, Cantonese, Korean, Tagalog (from the Philippines), Vietnamese and Nepali. This would suggest that the current translations are not sufficient. Because of the limited languages, the police often secure the assistance of family members to translate the information. The police also have interpreting services at their disposal if required. This issues pertaining to the needs of multiculturalism is discussed at length in the LRCWA Review section on catering for a culturally and linguistically diverse community[32] and it appears that the OSC still has more work to do in addressing multiculturalism.

The Australian Funeral Services Association commented that the current brochure is too small and often gets lost amongst all the paperwork that is given to the family. As well, they frequently have to explain the coronial processes to the family as not enough information is provided to them. The Strategic Review also noted that referring to the website as a source of information was not adequate as it was not easy to navigate without assisting learning tools such as frequently answered questions (FAQs); the font was small and hard to read against the background; and the information was vague and only provided in English. In contrast, the Queensland Coroner’s Court website provides more comprehensive information and may serve as a model framework.

The Strategic Review also identified that the depth and breadth of the Inquest Findings and Recommendations is a subjective issue and views will vary on this particular point, though its length is proportionate to the value-added cost and non-value-added cost of preparing findings. The question of what is appropriate is difficult to gauge, but given that Western Australia appears to produce the largest reports of all jurisdictions, it gives rise to the question if value-added cost is appropriate or if adopting a more succinct approach could be a better use of resources.

The Strategic Review did not extend to surveying families and without canvassing users of the reports, it is difficult to gauge if the depth and breadth of the Inquest Findings and Recommendations is considered appropriate. However, access to information is also facilitated by

[31] Law Reform Commission of Western Australia, 2012, Review of Coronial Practice in Western Australia, Government of Western Australia, Perth, p.112.

[32] Law Reform Commission of Western Australia, 2012, Review of Coronial Practice in Western Australia, Government of Western Australia, Perth, p.112-116.

easily understandable content. In its preparation, the Coroners should consider that the reader of the Inquest Finding may not be as familiar with the coronial system or as highly-educated as the Coroners, and the reader may only be interested in the summary of concluding facts and not how the process of deduction (i.e. Registry of Births, Deaths and Marriages). To assist in communicating the important facts of the Inquest Finding, New South Wales, Northern Territory, Queensland and Victoria have included a summary page(s) at the beginning of the Inquest Finding in a table-like format. The Strategic Review recommended a compilation of the summary pages of the four states to be adopted into the Inquest Finding template.

3.15 s.21 Directions by State Coroner

The intent and inclusion of Section 21 is acknowledged to ensure the State Coroner has the requisite powers to direct. Whilst the Strategic Review did not consider Section 21 specifically, it did make observations pertaining to the direction about investigations into deaths generally and the manner in which they are to be conducted.

In particular, the examination of the process for inquest determination gave rise to considering the directional process. During the consultation process, the timeliness of determining to hold an inquest was discussed to clarify if timeliness could disrupt the chronological order of holding inquests. The State Coroner highlighted the point that sometimes it is timely to prioritise cases. For example, deaths that are product related and the Coroner forms a view it is important to expedite findings and inquest a case to raise awareness of a potentially dangerous products. Deaths that are related to seasonal trends such as those that are fire related whereby the Coroner wants to expedite findings before the bush fire season is another reason to escalate a case.

It was also noted by some stakeholders consulted that they formed a perception that high profile cases tend to take priority, and whilst this has not been substantiated, it is noted because the view was expressed on more than one occasion. On the basis that perception can be viewed as reality by some, it gives rise to thinking there would be a benefit in adopting a more transparent process in determining to hold an inquest and the timeliness of such an inquest.

Whilst the backlog of cases accrued should not have a material impact on determining to hold discretionary inquests, it is not unreasonable to assume that the capacity of the OSC could factor into the decision making, especially if the material available is borderline in raising doubts concerning the cause or circumstances of the death.

Whilst the points for consideration to determine when it is “desirable” to hold an inquest is discussed in the recent paper on inquest hearings[33], the decision making process is not as clear. It is understood that a recent initiative is a regular meeting with the State Coroner, Counsel Assisting and Listings Manager and one of the agenda items is the allocation of inquest files (and timing of).

Within the OSC the decision to inquest however appears to rest primarily with the State Coroner who may seek views from other Coroners, Counsel Assisting, investigating agencies, other professional bodies and individuals. Consideration could be given to a collegial approach such as a weekly conference including the State Coroner, Deputy State Coroner, Coroners, Counsel Assisting, the Principal Registrar and the Office Manager (the attendance by the Principal Registrar and Office Manager would also enable caseload and capacity to be taken into consideration amongst other things).

Unlike mandatory inquests, the decision to hold discretionary inquests may come after the police investigation is completed, after the administrative findings is drafted, or even after the coronial case is closed. Thus, more often than not backtracking occurs causing duplication of work effort.

[33] Office of the State Coroner Western Australia, 2012, Inquest Hearings in Western Australia, Government of Western Australia, Perth, p.23

More timely determination to hold discretionary inquests may reduce the need to resurrect dated records and locate witnesses that have moved on.

The backlog of cases affects the timeliness of investigations and inquests, though this should improve as the OSC moves through the backlog. It nonetheless impinges on the effectiveness of the process, though even with the proposed increase of capacity, the Strategic Review estimates it will take 2.5 years to catch up on the backlog assuming the current trend in reportable deaths continue.

To openly convey to the community the basis upon which cases are prioritised, the Strategic Review formed a view that it would be beneficial for the OSC to openly demonstrate the basis for sequencing inquests and also the situation factors for elevating certain cases. Whilst this openness may draw criticism, it would demonstrate that delays and priorities are characteristic of the coronial process and that a distinction should be made with other jurisdictions that can list well ahead due to the absence of undertaking investigations by the Court itself i.e. unlike the Coroner's Court.

A further point that surfaced during the consultation process was the question of the depth of examination necessary in the context of the resources expended. As discussed in the recently published paper on inquest hearings many factors are taken into consideration, though the point of concern is the proportionate level of effort expended required to sufficiently prepare for an inquest. The paper makes the point that "such an inquest would never end, but worse it could never arrive at the coherent, let alone concise, findings required by the Act, which are the causes of death, etc".

It is acknowledged that planning and estimating resource effort is especially difficult for different types of inquests, particularly medically related deaths, and it is a judgement as to the effort required and also to determine when the point of diminishing returns has been reached.

There are two potential issues pertaining to the question of the depth of examination in the context of the resources expended.

Firstly, a key point that surfaced was the degree to which examination is warranted. An example of this point was the refugee boat tragedies and whilst these are indeed terrible tragedies, the manner and cause of death is often determined to be drowning due to the boat capsizing. Whilst the tragedy clearly warrants investigation, the point raised was to what extent resources should be expended by the OSC to investigate the manner and cause of death pertaining to the tragedy. The intent of surfacing this view by no means is intended to diminish the severity of such tragedies or that it must be immensely difficult to determine when sufficient examination of the facts has been reached. The perception however appears to exist that the depth of examination may extend beyond what should reasonably be expended for such an Inquest. The s.57 Review makes no comment on this other than reiterating the point that the absence of guidelines leaves the question as a matter of judgement and given capacity has been cited as an issue by the OSC, guidelines that assist with the resource planning and monitoring would appear to be warranted.

Secondly, planning, managing and monitoring the management of preparation for an inquest is not too dissimilar to managing projects. There is a comparison to be drawn to project management, especially in regard to the six controls applied to plan and track the schedule, budget, scope, quality, benefits and risks. Each of these controls is equally applicable to the preparation for an inquest.

The Strategic Review did not identify any form of similar controls being applied to manage the resources expended or to aid the State Coroner in giving direction. Amongst other things, the recommendations of the Strategic Reviewe are designed to support the State Coroner in giving direction.

In the context of the LRCWA Review, Recommendation 56[34] elaborates upon s.21 (2) to provide further guidance as to what cannot be discontinued.

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 care or 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.

The State Coroner expressed a view questioning how useful this provision would be and that it appeared to relate to the LRCWA Recommendation 21, authorisation to issue death certificates. The matter should be considered further by Parliamentary Counsel as part of the Legislative Project.

3.16 s.22 Jurisdiction of coroner to hold inquest into a death

The LRCWA Review considered s.22 of the Act in Section 5.5 of its report pertaining to discretionary inquests, which in turn framed the basis of its Recommendation 63 that guidance for coroners on when an inquest should be held is included in the Act.

The Strategic Review examined the ratio of mandatory inquests to discretionary inquests. From June to September 2012, 59 new coronial cases were approved for inquest. As mandatory inquests represent 1.0 to 1.5% of reportable deaths, the expected number of mandatory inquests for the entire FY2011/2012 would be 19 to 28. The additional approval of discretionary inquests far exceeds the capacity of the OSC, even with the temporarily-funded Coroners and Counsel Assisting. Thus, the Strategic Review recommended increased capacity, a revised structure and supporting processes and information systems accordingly. However, the aforementioned points pertaining to s.21 are also relevant to this Section of the Act.

The State Coroner expressed a view that this matter should not be addressed by amendment of the Act and that guidance could better be provided by Rules of Court, Practice Directions and Guidelines. Similarly, the Deputy State Coroner expressed concerns about legislation being too prescriptive and human nature is such there will always be matters that fall outside prescriptive legislation which would warrant investigation. However, if interpreted broadly this would generally be supported.

3.17 s.23 Investigation of suspected deaths

The LRCWA Review explored the question of suspected deaths and was “persuaded by these submissions [by the State Coroner, Deputy State Coroner, Former Perth Coroner David McCann and

[34] Law Reform Commission of Western Australia, 2012, Review of Coronial Practice in Western Australia, Government of Western Australia, Perth, p.79.

the Department of the Attorney General] that the current requirement of suspected death should remain and withdraws its proposal." [35]

This s.57 Review has no cause to question the views expressed.

The LRCWA Review further explored the question of the Standard of Proof citing -

In his 2008 review of the Coroners Act, Michael Barnes recommended that the standard of proof of 'beyond reasonable doubt' required under s 23(2) for a coroner to establish that a missing person is dead should be repealed.

The LRCWA Review discussed Barnes' arguments for this position in its Discussion Paper and observed that no other Australian jurisdiction requires the Coroner to find that the fact of death be established beyond reasonable doubt. The LRCWA Review therefore proposed that the standard of proof for suspected deaths be removed. This proposal received the full support of submissions and is confirmed in the subsequent LRCWA Recommendation 16.

In consultation with the State Coroner, the view was expressed that amendment to s.23 (2) should be referred to Parliamentary Counsel for inclusion in the Legislative Project. The State Coroner noted that this is a matter which has been discussed at COAG. The Deputy State Coroner also expressed a view that the LRCWA Review recommendation was supported, provided it is remembered the presumption of life and the Briginshaw principal are the relevant tests.

3.18 s.24 Application for inquest into death

The Strategic Review identified that verbal requests for inquests are taken by Counsel Assisting or the Counsellors. The purpose and process of an inquest is explained to the family / interested party and that all requests must be received in writing. The Coroner will not review a Request for Inquest until the final medical report has been received. The Coroner reviews the medical reports, investigation report and the physical file to determine if an inquest is warranted. Again, either a Direction to Inquest to Counsel Assisting is issued or a rejection letter to the Request for Inquest is sent to the family / interested party. The Requestor has the option of lodging an appeal to the Supreme Court. The Supreme Court may overrule the Coroner and the Counsel Assisting is directed to prepare an inquest.

The LRCWA Review noted that "with the exception of South Australia, all Australian jurisdictions provide a mechanism for persons to apply to the Coroner or a superior court (or both) requesting that an inquest be held in respect of a reportable death. In Western Australia, such applications are governed by s 24(1) and s 24(1a) of the Coroners Act". However, its concerns were focussed on the access to information and guidance provided to apply for an inquest.

Recommendation 65 Application to coroner for inquest

That an application for inquest form be developed and made available for download from the Coroners Court website. The form should provide clear fields for the information required by a coroner to make a decision pursuant to the Coroners Act whether or not to hold an inquest.

The Strategic Review noted that the inquest determination process is mainly concerned with internal activities within the OSC (albeit with consulting externally where required), though considered the assessment of serviceability by focussing on providing a service to the community to assist with understanding the determination process and how to go about requesting an inquest.

As discussed, a family member or interested party must contact the OSC directly to discuss their reasoning and provide a written submission for the Coroner to review.

[35] Law Reform Commission of Western Australia, 2012, Review of Coronial Practice in Western Australia, Government of Western Australia, Perth, p.84.

Unlike its counterparts in Queensland, Victoria and Tasmania, the Coroner's Court website in Western Australia does not provide any forms or as detailed an explanation of the process. In particular, it would be helpful if hypothetical examples were given to guide people on how to go about writing a request for inquest.

The recently published paper on inquest hearings[36] sets out points that are considered, though this is in the publications section and not immediately obvious to providing guidance. The content however in the section 'When it is "desirable" to hold an inquest (section 22(2))' could easily be replicated and adapted for use on the website. Whilst the document facilities improved understanding, it is clearly not intended to guide someone in making an application.

As with post mortem objections, there may be some reticence in publishing the process, forms and guidelines by the OSC, which could be a way to manage a potential increase in requests for inquests because there would be greater awareness and understanding of how to go about it. The view formed by the Strategic Review is the intent of the OSC is not to misinform the community, and the OSC would clearly want to encourage genuine requests if something was untoward. However, there is a fine balance between making information available to assist those with genuine cases and unnecessarily stimulating an increase in request for inquests simply because of increased awareness. Given the limited capacity of the OSC to manage the current processes, it is reasonable that the OSC would not want to unnecessarily stimulate an increase in requests.

Due to the variability in skills, knowledge, expertise and experience in regional Western Australia as identified by the LRCWA Review, an online resource would further enable communicating how to go about requesting an inquest and key points to be addressed. The Strategic Review would go further than the LRCWA's Recommendation 65 - Application to Coroner for inquest and make better use of online technologies. It is not uncommon these days for contemporary online services to be used that enables a video to be shown explaining how to go about things as evidenced by You Tube and other online resources.

The State Coroner questioned what "fields for information" should be provided, but was supportive of placing an application form on the website and further expressed the form itself should be in Rules of Court or a Practice Direction.

3.19 s.25 Findings and comments of coroner

Chapter 5 of the LRCWA Review devoted 29 pages to matters pertaining to coronial findings and inquests, which gave rise to 34 of the LRCWA's 113 recommendations (R48 to R81).

Recommendations 48-56 dealt specifically with coronial findings and comments. Out of these nine recommendations, five were generally supported by the State Coroner and Deputy State Coroner and where applicable[37] can therefore be referred to the Legislative Project for consideration by Parliamentary Counsel. These included:

Recommendation 48 Statement of referral in record of investigation

Recommendation 49 Coroner's discretionary comment function

The State Coroner question why this only referred to section 25(2) and not also to section 25(3) of the Act.

Recommendation 53 Superior court review of coroner's findings

Recommendation 54 Power to correct errors in records of investigation

[36] Office of the State Coroner Western Australia, 2012, Inquest Hearings in Western Australia, Government of Western Australia, Perth, p.6-p.10

[37] Some of these recommendations do not require legislative change.

Recommendation 55 Non-narrative findings

The Deputy State Coroner noted that the Barnes Review was not supportive of the abridged administrative finding. The Deputy State Coroner acknowledged this would expedite some findings, though would prefer an adequately resourced OSC to pay each deceased person and their family the respect of a brief narrative.

Some of these recommendations were not considered further by the Strategic Review, though others were relevant. Recommendation 55 Non-narrative findings for example would be beneficial for cases deemed not to require intensive investigation and can be finalised by way of non-narrative administrative findings. The Strategic Review recommended that updating the National Police Form take the place of a police summary report, thereby enabling the National Police Form to accompany any collected evidence. Whilst the finding would be non-narrative, the supporting police summary report would provide further supporting information. This approach forms part of an initiative to introduce a gated-process embracing the concept of a triage in some ways, thereby facilitating investigation pre-assessment. As discussed, the potential increase in health-related reportable deaths stimulated in part by increased penalties could result in 600 additional health-related cases being reported each year. Many of these deaths may not require intensive investigation however and may be conducive to non-narrative findings. WA Police Coronial Investigation Unit estimated that approximately 35-40% of coronial investigations relate to elderly persons who pass away either in hospital or a home and more effective and efficient processes would enable improved effectiveness in responding to or providing a higher level of scrutiny over other deaths which may warrant more detailed investigation (e.g. child, drug overdose, suicide, and workplace deaths).

In amongst its report, the LRCWA Review also identified issues pertaining to quality, which have been further considered in the Strategic Review. Whilst the LRCWA Review did not make specific recommendations to address the root cause of quality issues other than Recommendation 5 to undertake a strategic review, its basis for Recommendation 54 power to correct errors in records of investigation stems from the following preceding description of the justification for powers to correct errors in records of investigation.

"As part of its research for the reference the Commission examined inquest records from the past decade and found a large number of clerical errors and inconsistencies. In many cases the errors were typographical, but in others the mistakes were more significant."

Contributing factors to the issues with quality are underpinned by the issues identified in the LRCWA Review and the Strategic Review, such as the variability of skills, knowledge, expertise and experience and high error rates. The LRCWA Review and the Strategic Review clearly points to quality management issues that requires proactive measures as well as the power to correct the record of investigation if the error is material.

The Strategic Review was supportive of Recommendation 71 in the use of "pre-inquest hearings" to assist in the determination of the issues and the collection of the required evidence. The effect would be positive on the length of the inquest and the expectations of the family and interested parties on the purpose of the inquest.

The following four LRCWA Review recommendations require further consultation with the coroners in relation to an agreed direction. Whilst they are generally supported, they may be better addressed through Regulations, Rules of Court and Guidelines as opposed to amending the Act.

Recommendation 50 Re-opening of investigation or inquest on coroner's initiative

Recommendation 51 Application to coroner to re-open investigation or inquest

Recommendation 52 Form of application to coroner to re-open investigation or inquest

Recommendation 56 Power of coroner to discontinue investigation in certain cases

These recommendations were not considered by the Strategic Review.

Notwithstanding the views expressed by the LRCWA Review, in the context of Section 25 itself, the Strategic Review considered matters relevant to this section of the Act.

The Strategic Review examined the processes pertaining to Administrative Findings and noted that in 2012, there has been considerable effort applied by the OSC to reduce the backlog of Administrative Findings coronial cases older than 12 months. The Coronial Court Monthly Status Report from August 2012 indicates that only 12 non-natural cases are awaiting findings drafting, and 19 cases are awaiting approval by a Coroner. This is a much improved result than the 56 cases awaiting drafting and 333 cases awaiting approval by a Coroner from third quarter 2011/2012. In the data analysis conducted by the Strategic Review, a physical file spot check was conducted on natural files from 2010-2012 and the non-natural files from 2010-2011, and NCIS data from 2001-2012 was analysed. This analysis shows that while the natural Administrative Findings are just within the targeted days for cycle completion, the non-naturals are well outside of the target.

Table 3-1: Cycle Time for Administrative Finding

Median average days for Event	Source	Naturals	Non-Naturals	ALL
P100 Police Report to the signing of the Administrative Finding	The Review's physical file spot check (47 records)	89	211	135
	NCIS Data from 2001-2012 (10593 records)	n/a	n/a	98
P98 form to signing of the Administrative Finding	The Review's physical file spot check	180	487	335
Date of Death to signing of Administrative Finding	NCIS Data from 2001-2012 (17223 records)	n/a	n/a	315
Target Completion Cycle from P98 to signing of Administrative Finding		90-180	365	n/a
Measure of allowance in achieving target		0%	-33%	n/a

Of a concern is the amount of time that elapsed from when the P100 Police Report is received to the signing of the Administrative Findings. 89 days waiting for a one-page computer generated report is extensive. Likewise, waiting 211 days for processing a non-natural administrative finding is excessive. As reportable deaths that are closed through Administrative Findings represent 97.5% of the Perth Metropolitan Area deaths and 95.8% for the regions, the production of the Administrative Findings, arguably the 'bread and butter' of the OSC should be better. The OSC targets from when the P100 Police Report is received to the signing of the Administrative Findings should be 30 days for naturals and 90 days for non-naturals. With the elimination of the Administrative Finding backlog under the control of the OSC, hopefully the Registry and Coroners can work towards these targets.

A sample of Administrative Findings was assessed, which determined the percentage of value-added activity for the production of natural administrative findings was estimated to at 74% to 84% while the production of non-natural Administrative Findings was from 61% to 70%. The non-value added time is primarily attributed to quality issues.

Fundamental to some of the issues is the lack of supporting information systems, documented processes, and training. A number of system and process improvements have been recommended by the Strategic Review, including an upgrade to the MUNCCI system to generate more of the non-natural Administrative Findings, which would be beneficial. Without the proposed changes the

supporting systems, processes and procedures encourage the continuation of errors, under-developed skills and ultimately delays. “An Introductory Guide to Writing Draft Administrative Findings” by Coroner Dominic Mulligan provides a good start to providing guidelines.

The issues also flow through to the Registry of the Births, Deaths and Marriages, which requires further effort to ensure the appropriate cause and manner of death is recorded. Timeliness is also an issue with notifications to the Registry of the Births, Deaths and Marriages and it is understood that they would often receive a quantum of closed findings, which causes workflow issues. The issues pertaining to timeliness of advice to the Registry of the Births, Deaths and Marriages is discussed further in the LRCWA Review[38].

Based upon the level of variability in the quality of regional Administrative Findings, it would be more effective and efficient to draft Administrative Findings in the OSC. The views of the LRCWA in its review were consistent with the Strategic Review in that regard. Regionally prepared Administrative Findings are the most variable in quality, which is understandable given the diversity of skills, knowledge, expertise and experience in coronial processes. Because of this inconsistency, the Registry of the Births, Deaths and Marriages began the protocol of requesting the Administrative or Inquest Findings along with the BDM204 RG form to ensure accuracy for its records.

There is still a need for regional services to be provided by the Coroner’s Delegates, to respond to inquiries during office hours; liaising with local WA Police, liaising with families and Coronial Counselling and Liaison Services, and arranging for body transport. These are therefore duties up to completion of Police Report, excluding objections and after hours.

The Strategic Review made several recommendations comprising both strategic and operational improvements. In addition, a series of “quick wins’ were also identified, many of which pertain to Administrative Findings.

In regard to s.25 (1) (b) and s.25(1)(c) pertaining to *how death occurred* and *the cause of death* respectively, this is central to the OSC’s reason for being as the advocate for the deceased and determining the truth and facts. The OSC is highly dependent on external agencies in conducting investigations, particularly the WA Police Coronial Invitation Unit (CIU), though it is equally dependent on other divisions of WA Police such as Major Crime, Major Crash, Internal Affairs and Regional District Offices. The OSC is also dependent on specialist investigative agencies such as WorkSafe. Collectively, this ecosystem of parts affects other parts such that the performance and capacity of investigative agencies will determine the pace with which the OSC can carry out coronial investigations. It is also dependent on PathWest, the ChemCentre and the Forensic Neuropathologist at RPH. The OSC however cannot practically orchestrate the coronial system as a whole. Continual improvement in the system as a whole requires adopting a broader governance perspective and working collectively on streamlining processes across the system.

Fundamental to determining *how death occurred* and *the cause of death* respectively is conducting post mortems, which is discussed further in the context of s.34 of the Act.

Where the death is of a person held in care, s.25(3) states a *coroner must comment on the quality of the supervision, treatment and care of the person while in that care* which was discussed at length in the LRCWA Review and further commented on in the context of s.39 in this report.

From the coronial websites of the Australian states (excluding Tasmania as Inquest Findings were not published), the Strategic Review sampled 20 inquest findings to analyse the duration of time from Date of Death to the Date of Finding. The statistical data shows the median average of days from end of inquest to inquest findings was 129 days or about 4 months; and that Western Australia was

[38] Law Reform Commission of Western Australia, 2012, Review of Coronial Practice in Western Australia, Government of Western Australia, Perth, p.41

amongst the longest to complete the inquest cycle (from date of death to date of finding) at 1025 days or 2.8 years. Three points are made in the context of process ineffectiveness: (1) the weight of the findings and recommendations can be diminished to some degree by the passage of time; (2) the stress created from lengthy investigations, inquest findings and recommendations on persons involved in the Inquest, especially if there is a possibility of disciplinary action and/or it casts a shadow on an individual's credibility to perform their duties; and (3) the caseload fatigue must begin to come into effect in the OSC and in the broader coronial system.

As identified in the LRCWA Review and the Strategic Review, there are many opportunities for improvements in the attainment of s.25.

3.20 s.26 Record of findings and comments

One of the most pertinent statements in the LRCWA Review pertaining to records is the statement prior to Recommendation 54, which was briefly discussed in relation to s.25.

Recommendation 54 Power to correct errors in records of investigation

That a section modelled on s 76 of the *Coroners Act 2008* (Vic) enabling the correction of clerical errors and defects of form in a coroner's record of investigation be inserted into the Coroners Act.

As outlined in the discussion pertaining to s.25, contributing factors to the issues with quality are underpinned by the issues identified in the LRCWA Review and the Strategic Review.

The preceding sentence caused the Strategic Review more concern however, which stated "the Commission examined inquest records from the past decade and found a large number of clerical errors and inconsistencies. In many cases the errors were typographical, but in others the mistakes were more significant."

A physical file spot check of 23 inquest files from 2008 to 2010 conducted by the Strategic Review identified several errors including wrong date of death, wrong place of death, spelling mistakes, and wrong date of signing the finding.

The LRCWA Review and this Review clearly points to quality management issues that requires proactive measures as well as the power to correct the record of investigation if the error is material.

The Strategic Review has made a series of recommendations pertaining to quality of the data (and therefore records) and the ability to better utilise the data for the identifying trends in manner and causes of death. During the Strategic Review of the MUNCCI / NCIS database extract, a number of data errors and inconsistencies were identified. Some of these issues will mainly affect case management related data, such as dates that events occur, though as noted by the Strategic Review, critical dates such as the Date of Death appears to be referenced incorrectly (though it is uncertain if these dates are derived from incorrect dates in MUNCCI / NCIS). However, some of the issues relate to the coding of the manner or cause of death.

Strategic Review Recommendation 23 (a)(i) There were a number of errors in the database comparisons undertaken that could be as a result of unclear business processing, i.e. should the date entered into the system be the report date, the received date, or the processed date? The Business Rules relating to what is entered and when, needs to be reviewed. This review, in conjunction with an update to the data dictionary provided with the system, should provide the basis for a new guideline or process document relating to the entry of information into the system. Of particular relevance are any instances, such as the Manner of Death field, where the operator is required to interpret lines of text and assess what should be entered into the system – there should either be clear guidelines as to how to do this, or a change in process such that medically trained personnel make this judgement call.

The Strategic Review proposed the introduction of a new Business Analyst position, which is critically important to support the OSC informing on the prevention of death. In particular, the Strategic Review has recommended a data integrity project to review and correct the quality issues and increase the confidence in the integrity among other activities. In the context of Whilst the focus of s.26 is to ensure *a coroner or the coroner's registrar must keep a record of each investigation into a death in the prescribed form*, these records also provide the basis of further research.

The extensiveness of records was also considered by the Strategic Review, which identified that the structure of the inquest finding template encourages lengthy story-telling rather than factual reporting. A sampling of inquest findings across Australia illustrates that Western Australia produced the inquest findings almost twice as long as most other states. The Strategic Review recommended a compilation of the summary pages of the four states to be adopted into the Inquest Finding template.

To assist in communicating the important facts a summary page should be included at the beginning of the inquest finding in a table-like format that includes citation, title of court, hearing dates, date of finding, place of findings, findings of, finding, manner of death, recommendations, representation, file numbers, and keywords.

The State Coroner and Deputy State Coroner were both supportive of the LRCWA Recommendation 54, which should be addressed by Parliamentary Counsel as part of the proposed Legislative Project. There appears to be no reason to delay amending Section 9 of the Act accordingly.

Many of the Strategic Review's recommendations are designed to improve the quality and accuracy of records of findings pertaining to s.26 of the Act.

The Strategic Review received several comments regarding the relevancy of the inquest recommendations from stakeholders. Due to the length of time from the date of death to the inquest hearing and then to the Inquest Findings and Recommendations being finalised, there are recommendations to change procedures or protocols that have long since been corrected. Moreover, some stakeholders commented that recommendations cannot practically be implemented.

3.21 s.26A Access to evidence

The LRCWA Review's focus pertaining to s.26A was specific to medical reports whereas the Act is broader than any reports given to a Coroner as a result of a medical examination performed on the deceased. The LRCWA Review -

Recommendation 95 Release of post mortem examination report

1. That, upon written request of the senior next of kin of a deceased person, and unless otherwise ordered by the coroner, the Office of the State Coroner must provide the senior next of kin of a deceased person with any reports given to a coroner as a result of a medical examination performed on the deceased.
2. That where a post mortem examination report is sent to a medical practitioner to assist the senior next of kin of a deceased to interpret the findings, a second copy of the report is to be given to the medical practitioner along with instructions that the medical practitioner is to provide the copy of the report to the senior next of kin after the contents of the report have been interpreted and explained, if requested.
3. That a notice be placed on the Coroners Court website stating that the senior next of kin of a deceased person may request a copy of the post mortem examination report.

The State Coroner expressed a view that he does not support providing medical reports through the mail to grieving family members and that current approach of the office is to provide a post mortem

report to a general practitioner who can provide an explanation in a supportive environment. He continued by saying that very few family members request copies of post mortem reports and almost none object to the current procedure.

The Deputy State Coroner expressed opposition to this recommendation, questioning the legal consideration to the deceased's rights. The Deputy State Coroner elaborated by stating that if they [the deceased] are protected from that information in life why should it not continue in death? Unless there is a good reason, related to the medical health or welfare of that person, it should not be divulged. The Deputy State Coroner further explained that currently when a post mortem report is sent to a doctor to explain to family members it is stamped with the instruction the information it contains is confidential. The expectation is the information goes on the file of the deceased person and remains confidential to that person. It is sent to the doctor to allow them to inform next of kin of matters relevant for their information, without transcending confidentiality aspects which may arise. There is a whole legal ethos about medico-legal confidentiality which arises. Basically, medical information about a deceased person remains confidential unless release of that information is beneficial to relatives in some way. That should be left to the discretion of the treating doctor. The release of information which may relate to the genetic aspects of blood relatives is always communicated where relevant. In fact families are advised in some cases they should receive counselling and are provided with relevant reason for that to occur, by this office.

The Strategic Review considered the issue of the post mortem report further, though primarily in the context of information presented on the Interim PM Report being written in complex medical terms that are sometimes abbreviated. As a consequence counsellors need to be well-versed in a variety of medical terminology in order to explain the reasoning behind any organ sampling in layman's terms to the family. The counsellors use glossaries for common medical terms, but also rely on internet searches and advice from colleagues and the Medical Advisors. What is clear is that Interpreting a post mortem report can be difficult and it takes time for counsellors to become familiar with the terms.

The Strategic Review formed a view that forensic pathologists should provide the medical cause of death and any follow-up actions that need to occur in both medical terminology and a layman's understanding. The need to consult with others in the OSC also consumes time; though it is also acknowledged that time saved in the OSC would invariably be an impost on the forensic pathologists' time that appear to have limited capacity.

Returning to the question of the LRCWA Review's Recommendation 95 and notwithstanding the views expressed by the State Coroner and Deputy State Coroner, it would appear that the ability of families to interpret a post mortem report requires either advice from a medical practitioner or assistance from the OSC counselling service.

Overall, apart from the views of the LRCWA Review, there appears to be limited support to amend s.26A or treat it any differently than now, especially given that s.26A makes provision for *the coroner to give that person access to that evidence, unless the coroner believes it is not desirable or practicable to do so.*

In the context of point 3 of Recommendation 54, that a notice be placed on the Coroners Court website stating that the senior next of kin of a deceased person may request a copy of the post mortem examination report, the principle of access to information is supported, though in this case it should be amended to access to professional advice to explain post mortem findings.

3.22 s.27 Reports

The LRCWA Review made the following recommendations pertaining to access to information -

Recommendation 82 Publication of inquest findings, comments and recommendations

Recommendation 94 Coronial information service

Recommendation 96 Coroner's Court website

In regard to preparing the annual report to address s.27 (1), the Strategic Review noted that the preparation for the Annual Report consumes much time and its production could be better supported by statistical data being available or able to be easily extracted from MUNCCI / NCIS. These systems do not readily facilitate extraction of reliable statistical data. The difficulties in compiling statistics are more apparent in previous years, which were not easily reconcilable and there appeared to be inconsistencies in the figures reported. The issues appear to occur in earlier years such as 06/07 (p.35), 04/05 (p.30) and 03/04 (p.76) where they did not total. The counting rules could also be confusing if trying to reconcile the year to year figures across multiple Annual Reports.

The Annual Report is the primary method for disseminating coronial findings to the community and given that it is only published annually its currency is not conducive to keeping the community up-to-date. The ease of use in terms of accessing Inquest Findings and Recommendations is not as open and transparent as other jurisdictions. Western Australia is the only jurisdiction that does not publish Inquest Findings and Recommendations (other than the Annual Report summary). Interestingly, the Department of Health, Office of Safety and Quality in Healthcare offers a more useful service by publishing the health-related Inquest Findings.

By comparison, the results from a brief assessment of coronial websites showed that Queensland's and Victoria's were among the most advanced, followed closely by Tasmania. Western Australia's coronial website was assessed as less informative, apart from the availability of the Annual Reports and the translation of the 'When a Person Dies Suddenly' Brochures.

The Strategic Review and LRCWA Review made recommendations about improved access to information accordingly.

The State Coroner expressed a view that implementing the LRCWA Recommendation 82 was a resourcing and practical issue. The Deputy State Coroner was also supportive, though expressed concern about the way in which the website is implemented, advocating summaries should be used to inform people of the outcome of inquests without the more detailed personal background, unless extremely relevant to the outcome.

Appearances can give the impression of effectiveness and the Strategic Review noted that the design and presentation of the Annual Report could reflect a more contemporary design, thereby creating an improved professional image for the OSC. The website design presents a more professional image, but could also benefit from a design refresh. The presentation of the Annual Report, the website and publications in general should have a consistent theme, graphical design and information design so that anyone sighting information can readily associate it with the OSC.

In the interests of promoting openness and transparency more information should be included in the Annual Report such as the Operating Expenses of the Office, Statistical breakdown of cases (found in the Coroner's Court Monthly Stats Reports) for the financial year and for the last four years, and register of approved, genuine research and follow-up on research approved by the Coronial Ethics Committee.

Whilst Section 27(3) is closely linked to s.27 (1), its intent is quite different and goes to the question of the State Coroner making recommendations.

This particular matter is sufficiently prominent in the LRCWA Review and the Strategic Review to warrant a specific section in the Act, particularly as it is proposed for inclusion in the Objects of the Act.

As stated in the LRCWA Review[39] –

> Coroners in Western Australia often use the recommendation function under s 27 of the *Coroners Act 1996 (WA)* ('the Coroners Act') to make recommendations aimed at preventing future deaths in similar circumstances. This 'prevention role' is one that many of those consulted for this reference (including the coroners) saw as being an appropriate role for the modern day coroner and it is one that has been explicitly included in legislation in Queensland, Victoria, South Australia and New Zealand. The Commission has embraced the prevention role of the coroner in many of the recommendations featured throughout this Report. Chief among these is Proposal 1 for the insertion of an objects clause into the Coroners Act to provide, among other things, that a primary object of the Act is to contribute to a reduction in the incidence of preventable deaths and injury by the findings, comments and recommendations made by coroners and by the timely provision by coroners of relevant data to appropriate authorities and research bodies. This chapter examines ways in which this object may practically be achieved.

The LRCWA Review also stated[40] –

> A feature of many coronial inquests in Western Australia and elsewhere is the making of recommendations aimed at improving practices, procedures or policies of agencies, hospitals or workplaces in order to prevent, so far as possible, deaths in similar circumstances in the future. In Western Australia, coronial recommendations are made in approximately 40% of inquests. Recommendations remain distinct from coroner's findings and, like comments, are not subject to judicial review.

The basis that provides further support for the Act to better address coronial recommendations is set out in Chapter 6 of the LRCWA Review, which includes -

> **Recommendation 84 Coroner's power to make recommendations**
>
> **Recommendation 85 Considerations relevant to the making of comments or recommendations**
>
> **Recommendation 86 Notification of coroner's recommendations**
>
> **Recommendation 87 Mandatory response to coronial recommendations**

The Strategic Review also made specific recommendations pertaining to promoting open and transparent accountability, with specific initiatives for tracking and cataloguing responses to coronial recommendations and publishing findings, recommendations and responses.

The State Coroner expressed mixed views on these four recommendations, though was supportive of Recommendation 84 by way of advocating it could be directed to the Legislative Project for consideration by Parliamentary Counsel. Conversely, Recommendation 85 appeared to be unnecessary and Recommendation 86 was considered to be a practical matter. In regard to Recommendation 87, the State Coroner noted that this is an important matter which has been the subject of considerable debate within Australia and internationally. The State Coroner supported a requirement that a report be provided within three months which should be ample to enable a response. It was further noted that prior to a recommendation being made, the authority or entity would have had some notice of the relevant concerns which form the basis of the recommendation. The question of point 4 of Recommendation 87 to give consideration to whether private entities

[39] Law Reform Commission of Western Australia, 2012, Review of Coronial Practice in Western Australia, Government of Western Australia, Perth, p.101

[40] Law Reform Commission of Western Australia, 2012, Review of Coronial Practice in Western Australia, Government of Western Australia, Perth, p.103

performing public functions be subject to the same mandatory response requirement as public statutory authorities and public entities, the State Coroner commented that this aspect of the recommendation can be considered by Parliamentary Counsel as part of the Legislative Project.

Similarly, the Deputy State Corner expressed mixed views in regard to these four recommendations. Whilst generally supportive of Recommendation 84, there was no support for recommendations by coroners to be limited to the context of an inquest. By way of example, some of the matters investigated by police in regional areas do have input from all the relevant departments in that area and it would be possible for a regional Coroner to make a recommendation, approved by the various departments in their area as uncontroversial, without it requiring an inquest. The Deputy State Coroner noted that in the event regional magistrates are no longer coroners it would cease to become an issue.

The Deputy State Coroner cited the example of the "Kimberly Inquest" by way of commenting on Recommendation 85, concluding that if coroners are not able to explore some of these issues, where they are clearly relevant to the lifestyles resulting in some of these deaths, then who does?

The Deputy State Coroner expressed a view that the basis for Recommendation 86 seems to have missed the point that a number of recommendations are made with expert input and frequently acknowledge the fact there may be some problems with implementation. The discussion extended beyond this and for brevity is not covered further here other than to say that consequently, the Deputy State Coroner was not supportive of Recommendation 87.

In regard to s.27(5), the LRCWA Review proposed that in the interests of transparency of the coronial function the *Coroners Act 1996 (WA)* should legislatively authorise the making of referral statements; however, these should be positioned at the end of the record of investigation and should not identify any person who may be implicated in a possible offence.

Recommendation 48 Statement of referral in record of investigation

The Strategic Review did not comment on this particular recommendation.

The State Coroner expressed a view that in cases where the Record of Investigation is not made public (administrative findings) there is no reason to mention a referral having taken place. In the case of inquest hearings, to which this [LRCWA] recommendation presumably is intended to relate, this recommendation is reasonable although its usefulness is questionable. Following an inquest if a Coroner advises that there has been a referral to the Director of Public Prosecutions or the Commissioner of Police, there will usually be little or no doubt as to who has been referred.

The Deputy State Coroner was supportive of its inclusion.

3.23 s.28 Notification of reported deaths to the Registrar of Births, Deaths and Marriages

The LRCWA Review considered the question of definitions of or term of 'death' in the context of the *Coroners Act 1996*, the *Interpretation Act 1984(WA)* and the *Births, Deaths and Marriages Registration Act 1998 (WA)*, which formed the basis of its Recommendation 14.

Also relevant to s.28 is the LRCWA Recommendation 21.

Recommendation 21 Authorisation to issue a cause of death certificate

1. That notwithstanding that a death is a reportable death under the Coroners Act, a coroner be permitted to authorise a medical practitioner to issue a cause of death certificate, without any post mortem examination being undertaken, if –

(a) the death is not a death of a person held in care or a person held in custody; and

(b) the cause of the death is, in the coroner's opinion, sufficiently certain; and

(c) the coroner is satisfied that no further investigation of the death is warranted.

That the coroner report to the Registry of Births, Deaths and Marriages any cause of death certificates approved for issue under this section.

The Strategic Review noted that the current guidelines and associated forms to doctors, hospitals, aged-care and mental health facilities are not sufficient as evident by the high volume of calls and anecdotal stakeholder feedback. The Strategic Review would agree with the LRCWA Review Recommendation 21 Authorisation to issue a cause of death certificate and Recommendation 24 a review of the 'Medical Certificate of Cause of Death' form are required.

The delays in delivering the Administrative Findings has a tremendous effect on the family that may lead to financial hardship since insurance and superannuation firms require a death certificate in order to process claims. No interim certificate is available that satisfy the legal requirements of the financial institutes. The only course of action is for the surviving next of kin to persistently request the OSC for expedition of the coronial case. The other avenue families may pursue is to contact the Attorney General's Office, which carries more weight, though consequently results in a flurry of activity that is actually detrimental to the effective use of resources.

The Registry of Births, Deaths and Marriages has commented on the accuracy and completeness of information provided on the Perth Metropolitan Area-produced BDM204 RG form. Conversely, regionally produced Administrative Findings are not as accurate and complete.

Timeliness is also an issue with notifications to the Registry of the Births, Deaths and Marriages and it is understood that they would often receive a quantum of closed findings, which causes workflow issues. The issues pertaining to timeliness of advice to the Registry of the Births, Deaths and Marriages is discussed further in the LRCWA Review[41].

The LRCWA Review and Strategic Review generally concurred on issues and opportunities for improvements pertaining to s.28.

The LRCWA Review included in its recommendations –

Recommendation 22 State Coroner's Guidelines: Authorisation to issue a cause of death certificate

Recommendation 23 Guidelines: Authorisation to Issue a cause of Death Certificate

Recommendation 23 Review of 'Death in Hospital' form

Recommendation 24 Review of 'Medical Certificate of Cause of Death' form

Recommendation 25 Coroner to inform Registrar of Births, Deaths and Marriages of certain information

Recommendation 26 Provision of interim coronial determinations to the Registrar of Births, Deaths and Marriages

The State Corner expressed a view that while LRCWA Recommendation 21 may not have significant implications for the Court, it is supported and should be referred to the Legislative Project for consideration by Parliamentary Counsel. However, the Deputy State Coroner expressed concerns with this proposal in view of the fact it is reported 85% of death certificates providing a cause of death, when re-examined at post mortem, failed to accurately identify the actual cause of

[41] Law Reform Commission of Western Australia, 2012, Review of Coronial Practice in Western Australia, Government of Western Australia, Perth, p.41

death. It should be noted that the Strategic Review's recommendations are intended to help address the accuracy of such information.

As with all recommendations pertaining to the provision of guidelines, the view expressed is it is a practical matter for the OSC and the Deputy State Coroner is supportive if LRCWA Recommendation 21 proceeds.

The State Coroner expressed a view that the review of the 'Death in Hospital' Form is a matter which can be addressed after proposed changes to the legislation, which is therefore supported. The Deputy State Coroner added that the proposal seems to be unaware of the fact the original "Death in Hospital" form was produced by the Office of the State Coroner for this very purpose.

In regard to Recommendation 25 and 26, the State Coroner was of a view that these are practical matters which can be addressed without legislative change. However, the Deputy State Coroner expressed concern about the motives of some of the entities requesting information necessitating interim coronial determination to the Registrar, Births, Death and Marriages. The Deputy State Coroner conveyed a reluctance to provide unconfirmed extremely confidential information about a death where insurance companies and superannuation funds are refusing to settle claims on an interim death certificate. The Deputy State Coroner explained that it used to be insurance companies and superannuation funds would accept a letter from a registrar of this court, providing them with relevant confirmed information, which would satisfy their provisions. They are no longer prepared to do this even though it usually covers their concerns. It appears to be a spurious request on their behalf and used to excuse not providing payouts in a timely manner. It is the ethics of the relevant funds which needs to be questioned, not the failure of this office to comply with their demands for quite irrelevant material.

3.24 s.29 Certificate of disposal of body and s.30 Control of body

The LRCWA Review considered the release of bodies by a Coroner, which was also examined by the Strategic Review in the context of the process for the release of a body.

The LRCWA Review noted that Section 30 of the *Coroners Act 1996* gives control of a body the subject of a coronial investigation to the Coroner but there is no provision in the Act explicitly governing its release. Instead a body is effectively released when the Coroner, or his or her delegate, issues a certificate under s 29 authorising disposal of the body by burial or cremation. The practicalities of securing a certificate were set out in the Commission's Discussion Paper.

The LRCWA recommended that s.29 be repealed –

Recommendation 110 Release of body by a coroner[42]

1. That the provision for certifying disposal of a body in the Coroners Act (currently s 29) be repealed and replaced by a provision specifying that the coroner may order that a body under the control of the coroner be released if the coroner is satisfied that it is no longer necessary for the coroner to have control of the body in order to exercise his or her functions under the Coroners Act.

The State Coroner expressed a view that the LRCWA Recommendation 110 was not necessary and the Deputy State Coroner also did not concur with the LRCWA Review.

As with all core processes, the Strategic Review mapped the process for the release of a body and examined the process from effectiveness, efficiency and qualitative assessment criteria aligned to the proposed objects of the Act. The release of Body process comprises 121 process steps inclusive

[42] Law Reform Commission of Western Australia, 2012, Review of Coronial Practice in Western Australia, Government of Western Australia, Perth, p.136

of 21 key decision making points. By way of example, the following presents an extract from the Strategic Review, highlighting there are a number of circumstances surrounding the release of body that require additional steps by the Assistant Registry Officer or Counsellors. Whilst the example is lengthy, it is included to provide further insight into the processes pertaining to s.29 and s.30 and also to convey some of the complexities that the OSC must manage in administering the Act.

- *Body Retention*: For homicide cases, the Counsellor liaises with the WA Police Family Liaison Officer (FLO) about the Interim PM Report to determine who will contact the family. For non-homicide cases or at the request of the WA Police FLO, the Counsellor contacts the senior next of kin, and if already engaged the funeral director, to notify them of the body retention and the reasoning.
- *Organ Retention*: Before contacting the senior next of kin, the Counsellor may need to clarify the reasoning behind the organ retention and if it is compulsory or optional with the Forensic Pathologist. Where the senior next of kin gives permission for optional organ retentions or for compulsory organ retentions, the Counsellor must receive instructions regarding the disposal of the organ by the senior next of kin. The instruction from the senior next of kin is verbal, which is written down on the Interim PM Report. The Counsellor notes all instructions on the Interim PM Report and provides it to the Coroner's Delegate. The Coroner's Delegate completes and faxes an Organ Instruction form to the State Mortuary. The State Mortuary is required to complete and return the form upon completion of organ disposal. The completed form requires a signature by the Mortuary Manager, which is scanned and sent back via email.

  If compulsory, the senior next of kin does not need to give permission. The senior next of kin must advise how they want organ disposal - return to the body, cremated separately or cremated and disposed of by the State Mortuary. If returned to the body option is selected, the body is pending the availability of the organ. Most families decide to wait, which usually takes 4-7 days and most families accommodate this into their plans for the funeral.
- *Micro-neurology*: Requirements for micro-neurology must be approved by the Principal Registrar. The Forensic Pathologist emails the Principal Registrar the reasoning behind the need for micro-neurology. In the majority of cases, the Principal Registrar approves the requirement. The Principal Registrar saves the email and forwards it to the appropriate registry officer for inclusion on the physical file. In practice, the Forensic Pathologist emails the Forensic Neuropathologist direct requesting micro-neurology and copies the Principal Registrar as a means to inform and seek implicit approval. Whilst the Principal Registrar has the right to veto, this rarely occurs and the request continues without question.
- *ID Bands*: It is the responsibility of WA Police to ensure the body has positive identification bands. The Registry needs confirmation from WA Police of the ID bands before Release of Body can occur. Positive identification may be made by family visual identification. If the body is decomposed or disfigured to the extent that the family cannot identify it, the pathologist may need to undertake dental record examination, DNA, fingerprints / footprints, or seek circumstantial evidence, such as examining bank account social security activity, or even look for recognisable scars. If the identification is to be based upon circumstantial evidence, WA Police provide a Circumstances Report to the Coroner for review to determine if the circumstantial evidence is sufficient for identification. If the Coroner accepts the report, WA Police provides ID Band confirmation to the Registry and the Counsellors inform the senior next of kin.
- *Body Overseas*: There is an international convention requiring a certificate that a body is free of disease. Repatriated bodies are required to have either a full post mortem in order for the Forensic Pathologist to issue the Free of Infectious Disease form or must be embalmed (which has the effect of killing off any disease). For full post mortems, the Assistant Registry Officer faxes the Free of Infectious Disease form to the funeral director; otherwise the Counsellor reminds the funeral director of the embalmment requirement.

- *Body Dispute*: If two Request for Body forms are received, the Assistant Registry Officer places a hold on the body at the State Mortuary. Generally the order of next of kin will determine who the body can be released to but there are occasions where there is an equal ranking such as a divorced mother and father or the parents of a deceased might be in dispute with a defacto partner. Aboriginal families can present complications in regards to kinship; for example, it could be a grandmother that raised a child claiming to be the mother. Another issue may be one section of the family wants the body to be buried in one location whereas another wants it to be elsewhere.

  The Counsellors contact both parties to understand the reasoning behind both requests. The Counsellors then instruct the parties to resolve the issue within a prescribed timeframe. The Counsellors may need to engage an acceptable mediator to assist in finding a resolution. The Principal Registrar will often become involved in trying to resolve body disputes. If no resolution can be reached, both parties are instructed to write down why their claim takes precedence for submission to the Coroner. The Coroner reviews the reasoning and provides a letter of direction with reasoning behind the decision. The party that is withdrawing the claim instructs the funeral director to notify the OSC by way of the Withdrawal of Request for Body form. Some families may try to seek an injunction to the Supreme Court to overturn the Coroner's decision. There is recognition with the Supreme Court that it is incumbent on the Coroner to make a determination in accordance with the *Coroners Act 1996*.

- *Unclaimed Body*: In cases where the next of kin is not known or the senior next of kin will not claim the body, the Counsellors contact any of the deceased's distant family, acquaintances and associates in attempt to find someone who will claim the body. If unsuccessful after three months, the WA Police contact the Public Trustee to determine if there are sufficient funds in the deceased's estate to pay for a burial by a private funeral director. If the Public Trustee determines that the deceased does not have the means to pay, the DCP is requested to pay for a pauper's funeral. The reason why this falls to DCP is continuation of the role from the previous Department for Community Development. Once the police receive approval from the Public Trustee to fund the funeral, then the Form 4 to release the body process is followed.

When the instructions from the State Mortuary are received that the body is ready for release, the Assistant Registry Officer ensures MUNCCI and the physical file are updated before generating a Release of Body form (Form 4) from MUNCCI. The form is saved onto the shared drive and printed. The Coroner's Delegate reviews the file to ensure completeness then signs and dates. The signed form is faxed to the funeral director and returned to the physical file.

Whilst body disputes are rare, they take a considerable amount of a counsellor's time. The Senior Counsellor estimated that 50% of all body disputes require the Coroner to make a final ruling. The Principal Registrar often gets involved in body disputes as well and in effect provides a form of mediation if the matter cannot easily be resolved. This sometimes requires parties to come into the OSC office. Some of the body disputes can consume a reasonable amount of time to bring to a close.

The following LRCWA Review recommendations are relevant to s.29 and s.30.

Recommendation 107 Preparation of bodies from release from State Mortuary

Recommendation 111 Application for release of body by a coroner

Recommendation 112 Supreme Court review of coroner's decision to release a body

Recommendation 113 Providing information about release to families

The State Coroner expressed a view that LRCWA Recommendation 107 was a practical issue. The release of bodies from the State Mortuary was considered by the Strategic Review in the context of the OSC processes as the scope did not extend to the examination of other organisations. However, issues affecting effectiveness and efficiency were taken into consideration including the capacity of

PathWest, which appears to perform more autopsies than other jurisdictions per forensic pathologist in Australia. The Strategic Review heard similar views pertaining to the complaints noted in the LRCWA Review by people involved in the funeral industry about the condition of bodies on release from the State Mortuary in Perth following a post mortem examination.

The State Coroner expressed a view that LRCWA Recommendation 111 can be referred to the Legislative Project for consideration by Parliamentary Counsel. The Deputy State Coroner however was not supportive, expressing a view that current next of kin provisions give a much better direction, especially when considering the difficulties with extended families and different cultures. Recommendation 112 however would significantly limit the power of the Supreme Court to review as it would only apply to 'an error of law' and the Deputy State Coroner was of a view that this already happens and questioned the need for it to be legislated. The State Coroner advised that Recommendation 113 has been implemented, and the Deputy State Coroner noted support in principle, but also noting that grieving people often do not take in this information, even when it is in writing. The OSC frequently has situations where families dispose of the brochure or letters because it is all too much to deal with.

3.25 s.31 Aid to coroners in other places

The LRCWA Review considered cross-jurisdictional assistance[43] pertaining to coronial investigations that may require access to information and assistance from coroners and coronial investigators in other jurisdictions. The LRCWA Review Discussion Paper noted that 'a draft model provision for the giving of aid by one coroner to another' had been proposed by the Standing Committee of Attorneys-General in 2007, which led to its Recommendation 47.

Recommendation 47 Assistance to and from coroners in other jurisdictions

That the following provision be inserted in the Coroners Act (in place of the present s 31):

(1) The State Coroner may request in writing that the person holding a corresponding office in another state or a territory provide assistance in connection with the exercise by the State Coroner or another coroner of any power under this Act.

(2) The State Coroner, at the written request of the person holding a corresponding office in another state or a territory, may provide assistance to that person or a coroner of that state or territory in connection with the exercise of a power under the law of that state or territory.

(3) For the purpose of providing assistance, the State Coroner or a coroner may exercise any of his or her powers under this Act irrespective of whether he or she would, apart from this section, have authority to exercise that power.

(4) If the Attorney General so directs, the State Coroner must use any of the powers of a coroner under this Act to help a coroner of another state or a territory to investigate a death.

(5) For the purposes of this section, this Act applies as if the matter that is the subject of the request or direction was the subject of an investigation under this Act.

(6) The State Coroner may use any of the powers of a coroner under this Act to assist a coroner, or a person who performs a role that substantially corresponds to that of a coroner, of another country to investigate a death as if that death were a reportable death.

The Strategic Review did not consider this recommendation as such assistance could be absorbed into day-to-day operations.

[43] Law Reform Commission of Western Australia, 2012, Review of Coronial Practice in Western Australia, Government of Western Australia, Perth, p.67

The State Coroner expressed a view that this is a non controversial matter which has been discussed by COAG and should be referred to the Legislative Project for consideration by Parliamentary Counsel. The Deputy State Coroner was equally supportive.

3.26 s.32 Restriction of access to area

The LRCWA Review considered Section 32, which empowers coroner's investigators to control the scene where a death occurred by restricting access to premises and made the following recommendation.

Recommendation 29 Restriction of access to area

That the power to restrict access to an area under the Coroners Act (currently contained in s 32) provide that:

1. A coroner, or coroner's investigator, investigating a death may take reasonable steps to restrict access to the place where the death occurred, or the place where the event which caused or contributed to the death occurred.
2. A restriction imposed by a coroner's investigator ceases to have effect 6 hours after it is imposed unless approved in writing by a coroner or a senior police officer of the rank of sergeant or above.
3. A restriction that has been approved by a senior police officer ceases to have effect 24 hours after it is imposed unless a continuance of the restriction is approved by a coroner in writing.
4. A prescribed notice must be put up at the place to which access is to be restricted.
5. A person must not without good cause enter or interfere with an area to which access is restricted under this section. **Penalty:** $12,000 or 12 months' imprisonment
6. A coroner is to ensure that access to an area is not restricted for any longer than necessary.
7. Any person aggrieved by the operation of this section may apply to the State Coroner and the State Coroner may order the variation or removal of the restriction.

The Strategic Review did not consider this recommendation in detail other than in its proposed amended role for the Principal Registrar in the context of the LRCWA Recommendation 11. In the proposed restructuring of the OSC, authorising restriction of access to premises and sign off on first extension to time for access (with further extensions to be approved by a Coroner) would be undertaken by a Duty Coroner.

The State Coroner expressed a view that this is non controversial and should be referred to the Legislative Project for consideration by Parliamentary Counsel.

The Deputy State Coroner was equally supportive, noting that if WA Police ultimately will need to use the provisions of the *Investigation of Crimes Act* it is just as easy to do so from the start.

3.27 s.33 Powers of entry, inspection and possession

The LRCWA Review considered Section 33, noting that coroner's investigators have wide search and seizure powers under Section 33. The LRCWA Discussion Paper set out the provision and discussed amendments made in 2003 to enable investigators to enter, search and seize without a warrant, and made the following recommendation. The LRCWA Review's focus is on the issue of obstructing a coroner or coroner's investigator.

Recommendation 30 Penalty for obstructing a coroner or coroner's investigator

That the penalty for delaying, obstructing or otherwise hindering a coroner or a coroner's investigator exercising a power of entry, inspection and possession under the Coroners Act (currently s 33) be increased to a fine of $12,000 or 12 months' imprisonment.

The Strategic Review did not consider this recommendation other than the management of exhibits. Both the Counsel Assisting and Listing Manager manage the required exhibits for the Inquest, including creations, attainment, transportation, supporting technology, security and storage. The Counsel Assisting finalise their court documents and the Listing Manager prepares the court before continuing to court proceedings. The management of exhibits is a manual process without supporting a system.

The State Coroner expressed a view that this should be referred to the Legislative Project for consideration by Parliamentary Counsel. The Deputy State Coroner was equally supportive.

3.28 s.34, s.35, s.36 and s.37 pertaining to post mortems

This section considers -

Section 34 Post mortem examinations

Section 35 Independent doctor at post mortem examination

Section 36 Application for post mortem examination

Section 37 Objections to post mortem examinations

Note, Section 35 was not considered by the LRCWA Review or the Strategic Review and is not discussed further.

The LRCWA Review had much to say about post mortem examinations and devoted ten pages of its report to post mortem rights and issues[44], giving rise to the following recommendations.

The State Coroner and Deputy State Coroner expressed the following views in the context of the LRCWA Review's recommendations.

Recommendation 99 Viewing and touching the deceased

The State Coroner expressed a view that this is a resourcing and practical issue.

Recommendation 100 Police to Seal Body Bags

The State Coroner expressed a view that this is the type of practical issue which is solved almost every day by this [OSC] office.

Recommendation 101 Coroner may order external or preliminary post mortem examination

The State Coroner expressed a view that this is a matter which should be referred to Parliamentary Counsel. The Deputy State Coroner expressed a view that this is already done where people lodge an objection and was concerned about the extent to which coronial processes should be regulated.

Recommendation 102 Principles governing conduct of post mortem examinations

The State Coroner expressed a view that this is not a matter which should be addressed by amendment of the legislation. This recommendation requires further consultation with the coroners in relation to the agreed direction.

[44] Law Reform Commission of Western Australia, 2012, Review of Coronial Practice in Western Australia, Government of Western Australia, Perth, p.124-134.

Recommendation 103 Factors that a coroner must consider when ordering an internal post mortem examination

The State Coroner expressed a view that this is not a matter which should be addressed by amendment of the legislation and could be addressed by guidelines. The Deputy State Coroner expressed a view that this already occurs and questioned if it needs to be regulated. This recommendation requires further consultation with the coroners in relation to the agreed direction.

Recommendation 104 Objection may only be made to internal post mortem examination

The State Coroner expressed a view that this is agreed and should be referred to Parliamentary Counsel. Similarly, The Deputy State Coroner was supportive of this recommendation.

Recommendation 105 Time for objection to internal post mortem examination

This recommendation requires further consultation with the coroners in relation to the agreed direction.

Recommendation 106 Supreme Court of Western Australia website

Whilst the State Coroner did not comment on this, the Deputy State Coroner was supportive of this recommendation.

Recommendation 107 Preparation of bodies for release from state mortuary

The State Coroner expressed a view that this and Recommendation 108 for the preparation of bodies for transport outside the Perth Metropolitan Area are practical issues. The Deputy State Coroner expressed a view that the matter should be best dealt with at the appropriate level between the establishments involved.

Recommendation 109 need for urgent attention to state mortuary

The State Coroner expressed a view that the State Mortuary requires urgent improvement, though this is a matter for the Health Department.

The Strategic Review also considered the post mortem objection process and conducting of post mortems.

The Strategic Review summarised some of the key points from its assessment in the context of the post mortem objection process -

- Objections to external post mortem are steadily increasing and accounted for more than 10% of all reportable deaths in Financial Year (FY) 2011/2012.
- Handling objections is largely a manual process that is reliant on the communication skills of the Counsellors, or in some cases the Coroner's Delegates in the regions, to liaise and coordinate matters between the family, Coroner, Forensic Pathologist and WA Police.
- New Coroners in Perth and the regions receive minimal training in how to assess objections but no written guidelines exist for reference. It has been eluded that the ruling on the same objection would vary from Coroner to Coroner and from the same Coroner on two different days. This inconsistency in applying the intent of the *Coroners Act 1996* has caused problems in parties understanding and being able to reasonably predict the timing and outcomes of the process.
- The statistics are limited to total number of client contacts per category (i.e. objection, cause of death, retention). More useful information is not collected, such as all the contacts involved in an objection, the total length of time for an objection, how many contacts per objection are made, issues surrounding the objection, or total time for objection to outcome.

- The Counsellors appear to be very attentive to the family members during the objection process as the process is given urgent priority, the service as a whole is marginally conducive the provision of a service due to its limited capacity, limited system support and limited professional counselling services being available in the regions.

The Strategic Review summarised some of the key points from its assessment in the context of the post mortem process -

- Timeliness of conducting post mortems and providing the interim post mortem (PM) reports are dependent on the type of death, daily volume, geographical constraints, religious and cultural beliefs, requirements for macroscopic and microscopic forensic analysis, storage capacity at the State Mortuary, and the objection process.
- There is an inherent risk for mistakes to occur in the Counsellors interpreting the hand-written Interim PM Report which often contain complex medical terminology in abbreviation in order to explain the medical terms to the family, for cases of organ retention or sampling.
- An external post mortem may take approximately 30 minutes whereas an internal post mortem may take between 1 to 3 hours, depending on the circumstances. Homicides may take between 5 to 6 hours to complete.
- The percentage of external only post mortems has increased from 2.0% of all reportable deaths in FY2008/2009 to 7.1% in FY2011/2012. Consequently, the number of coronial cases referred to ChemCentre has grown year-over-year from FY2005/2006 to FY2010/2011 at median average of 9.26%.
- The percentage of organ retentions, and in particular brain retentions, to all internal post mortems has increased from 15.73% to 20.35%, and 13.99% to 18.30%, from FY2008/2009 to FY2011/2012.
- The number of internal post mortems being performed per Forensic Pathologist in Western Australia was between 349 and 436 in FY2011/2012, well-above the international standard of 220 to 250.
- The inconsistent naming convention of the medical cause of death by the Forensic Pathologist makes subsequent analysis difficult if not inconclusive. It undermines a key mission to inform on the prevention of death if the quality of data cannot be relied upon.

The Strategic Review also identified challenges and constraints such transportation in Western Australia, the capacity of the State Mortuary and the limited resources qualified to undertake forensic neuropathology in the State.

As the State Coroner's directive for mandatory post mortems for all deaths is being examined, it is not the belief of the Strategic Review or the State Mortuary that the current process is agile enough to accommodate a fundamental change to accommodate directional post mortems. Representatives from the State Mortuary conveyed they are deeply concerned by this proposition and is of a view that it would be counter-productive because it would require a daily meeting to go through the list with the OSC. Whilst some time may be saved by deciding to undertake external post mortems rather than the practice of undertaking full post mortems by default, the time saved may be offset by the administrative overhead of debating the merits to undertake an external or full post mortem.

The statistics provided for the ChemCentre, from FY1995/1996 to FY2010/2011, show the number of samples for chemical analysis has maintained a steady average of 7.48 per coronial case. However, the increase in the number of coronial cases referred to ChemCentre has grown year-over-year at a median average of 4.45%, and from FY2005/2006 to FY2010/2011 at median average of 9.26%.

Similarly, the OSC provided statistics of the breakdown of organ retentions conducted to the number of reportable deaths for the FY2008/2009 to FY2011/2012. The trend show the increasing

percentage of organ retentions, in particular brain retentions, in relation to reportable deaths and more specifically internal post mortem.

The arrangements with the ChemCentre has been an ongoing debate for the OSC and in November 2011 DotAG undertook an independent review of the costing and pricing methodology adopted by ChemCentre in connection with toxicology services rendered to the OSC. The question should be asked in the context of what is best for the State, rather than the operational requirements of the ChemCentre and the OSC. Whilst the Strategic Review has not examined the issue between the ChemCentre and the OSC in detail, it appears unlikely that breaking the nexus will occur unless a brorder, strategic approach is taken. Given there is no overarching inter-agency governance framework that can dispense with operational issues in order to focus on improving the system as a whole, it is probable that this debate will continue and consume resources until such time there is a change in disposition, which may be never.

PathWest faces a different set of challenges to the ChemCentre, some of which are discussed in the LRCWA Review. The Strategic Review's concern is more focussed on the same issue as the ChemCentre, which is that changes in the coronial ecosystem and the operational effects this has on organisations such as PathWest. Decision making on matters such as directional post mortems need to take into consideration the end-to-end process and the impacts across the system.

It appears that Path West is running to capacity and changes in policies, processes and/or procedures could affect its effectiveness and efficiency, which needs to be considered through a regular forum and escalated to a broader governance group if needs be.

Path West and ChemCentre are part of the OSC's service-chain and like the WA Police CIU, are intrinsic to the service delivery model.

3.29 s.38 Exhumation

With the exception of proposed delegations, the LRCWA Review did not consider the question of exhumation.

The extent to which exhumations was considered by the Strategic Review was also limited to the revised organisation structure, roles and responsibilities.

It was noted during the consultation process of the Strategic Review that exhumations are rare, though provision in the Act is necessary for such occasions it is warranted.

3.30 Part 5 Inquests into deaths

Part 5 comprises the following Sections of the Act -

Section 39 Advertisement of an inquest
Section 40 Two or more deaths
Section 41 Rules of evidence not to apply
Section 42 Rights of interested persons
Section 43 Attorney General may appear at inquest
Section 44 Other persons may appear at inquest
Section 45 Exclusion from an inquest
Section 46 Powers of coroners at inquests
Section 46A Disobeying coroner
Section 47 Statements made by witness
Section 48 Record of evidence
Section 49 Restriction on publication of reports
Section 50 Reference to a disciplinary body
Section 51 Interruption of an inquest

Section 52 New inquests and re opening of inquests
Section 53 Inquest not to proceed where criminal proceedings instituted

Chapter 5 of the LRCWA Review devoted 29 pages to matters pertaining to coronial findings and inquests, which gave rise to 34 of the LRCWA's 113 recommendations (R48 to R81).

Recommendations 57-82 dealt specifically with coronial inquests. Out of these 26 recommendations, twelve were generally supported by the State Coroner and Deputy State Coroner and where applicable[45] can therefore be referred to the Legislative Project for consideration by Parliamentary Counsel. The following therefore are considered to reflect consensus, though additional notes are included where specific views pertaining to the recommendations were expressed.

Recommendation 57 Two categories: persons held in custody and persons held in care

The Deputy State Coroner highlighted the difficulty with respect to this proposal and the definition of "person held in care" is the quality of the investigation where the investigators are not forced to examine the issue as though it was going to inquest. A mandatory inquest on the whole produces a better police coronial investigation than does one where investigators are encouraged to believe if nothing appears worthy of investigation it will not be inquested.

Recommendation 58 Definition of 'person held in custody'

Recommendation 59 Definition of 'person held in care'

Recommendation 62 Removal of standard of proof for suspected deaths

The Deputy State Coroner noted that while accepting of the discretionary aspect of this recommendation, though expressed concern that, as a matter of respect, these deaths have a formal hearing of some description.

Recommendation 64 State Coroner's Guidelines: When inquest should be held

A recently published paper on inquest hearings[46] provides guidance in accordance with s.58 of the Act. Recommendation 64 could materially affect s.25 as the guidelines provided would need to be in the context of the Act.

Recommendation 65 Application to coroner for inquest

The State Coroner supported this recommendation in principle but expressed minor concerns about the "fields for information" that should be provided.

Recommendation 66 Superior court review of coroner's decision to refuse inquest

Recommendation 71 Pre-inquest hearings

The Deputy State Coroner noted that whilst accepting pre-inquest hearings can be useful, there is concern that lawyers do not use such hearings to limit an inquest by confining it to predetermined issues which cannot be extended when it becomes clear other relevant factors are involved.

Recommendation 77 Use of concurrent expert evidence at inquest

The State Coroner expressed a view that this is unlikely to be of much use but is not opposed. The Deputy State Coroner appears to be supportive, noting that the coronial jurisdiction relies very heavily on expert evidence. One of the most useful exercises in a coronial proceeding is to hear evidence from at least two experts who have the benefit of hearing each other's evidence and being able to discuss the issues.

[45] Some of these recommendations to not require legislative change.
[46] Office of the State Coroner Western Australia, 2012, Inquest Hearings in Western Australia, Government of Western Australia, Perth, p.6

Recommendation 79 Interruption of an inquest

Recommendation 80 Power to exclude from inquest

Recommendation 81 Restriction of publication

Recommendation 82 Publication of inquest findings, comments and recommendations

Note: R82 is also discussed in s.20 and s.27.

The following thirteen LRCWA recommendations require further consultation with the coroners in relation to an agreed direction. Whilst there is general support for some of the recommendations, they may be better addressed through Regulations, Rules of Court and Guidelines as opposed to amending the Act.

Recommendation 60 State Coroner's Guidelines: Persons held in custody and care

The State Coroner expressed a view that this is the matter for the State Coroner on completion of current reviews and any relevant amendment of the Act. The Deputy State Coroner was supportive providing it is clear the examples are inclusive, and not exclusive. This does not require legislative change however as Section 8 (5), 34 (6) and specifically Section 58 already addresses the provision for guidelines.

Recommendation 61 Informing people about relevant changes to the definitions of 'person held in custody' and 'person held in care'

This recommendation was not considered relevant to making changes to the Act or Regulations and would be addressed through guidelines, the proposed education program and broader governance framework. The Deputy State Coroner added that the OSC would need to be adequately resourced to enable this to occur.

Recommendation 63 Guidance for coroners on when an inquest should be held

The State Coroner expressed a view that this does necessitate the Act being amended. The Deputy State Coroner expressed concern about legislation being too prescriptive. Human nature is such there will always be matters that fall outside prescriptive legislation which would warrant investigation. However, if interpreted broadly this would generally be supported.

Recommendation 67 Joint inquests

The State Coroner expressed a view that this is not a matter which should be addressed by changes to the Act. Rules of Court, Practice Directions and Guidelines would more appropriately enable change to be effected. The Deputy State Coroner however was supportive of its inclusion.

Recommendation 68 Interested persons

These recommendations require further consultation with the coroners in relation to the agreed direction.

Recommendation 69 Inquest brief to be provided by Coroners Court

The State Coroner expressed a view that this is not a matter which should be addressed in the Act. Arrangements in relation to the copying of documents and provision of briefs of evidence are significantly impacted upon by resourcing issues. In the event that resourcing issues are addressed, any perceived need for such provision will fall away.

Recommendation 70 Inquest brief in electronic form

The State Coroner expressed a view that this is a practical and resourcing issue.

Recommendation 72 Notification and publication of pre-inquest and inquest hearing dates

The State Coroner expressed a view that this is a matter for Rules of Court, not changes to the legislation.

These recommendations require further consultation with the coroners in relation to the agreed direction.

Recommendation 73 Procedural fairness – identifying interested persons

The State Coroner expressed a view that this is a practical and resourcing issue. The Deputy State Coroner was supportive of this recommendation.

Recommendation 74 Funding of legal representation at inquest

The State Coroner expressed a view that this is an issue for government. The Deputy State Coroner was supportive, noting that it should be remembered many families find counsel assisting the coroner to be very helpful and at least explain the function of the court. This cannot always be said for members of the legal profession not experienced in the coronial process. If funding were more readily available it would be expected there would be better, more appropriate representatives to act on behalf of families.

Recommendation 75 State Coroner's Guidelines: Conduct of hearings

The State Coroner expressed a view that the conduct of hearings could be the subject of a Practice Direction or Guidelines. Any Guidelines would be issued after the current reviews and any changes to the Act. The Deputy State Coroner was supportive of this recommendation.

Recommendation 76 Enhance legal professional education

The State Coroner was of a view that this is a matter being addressed. The Deputy State Coroner was supportive, noting there is an Annual Coroners Conference run by the Australasian Coroners Association. It is the only association which attempts to adequately educate in the coronial system. Currently there is no other suitable professional development program to assist in educating the legal profession about coronial matters.

Recommendation 78 Use of affidavits at an inquest

The State Coroner and Deputy State Coroner expressed views that this is unnecessary.

The Strategic Review considered the supporting processes leading up to and including:

- Inquest Determination.
- Preparing for Inquest.
- Listing the Inquest.
- Court Proceedings.
- Inquest Findings and Recommendations.

The Strategic Review identified many points for consideration some of which are summarised from its assessment in the context of the coronial processes pertaining to inquests and therefore Part 5 of the Act. The following points should not be considered all inclusive as opposed to drawing out some of the key points from the Strategic Review[47].

[47] Some of these points have been cited previously but are included here for completeness int the context of Part 5 of the Act.

Inquest Determination

- The decision to hold discretionary inquests may come after the police investigation is completed, after the administrative findings is drafted, or even after the coronial case is closed. Thus, more often than not backtracking occurs causing duplication of work effort. More timely determination to hold discretionary inquests may reduce the need to resurrect dated records and locate witnesses that have moved on.
- Information coming to hand or an instinctive sense that something needs to be looked into further is a key part of Coroner-initiated monitoring of coronial cases. However, no impartial trend analysis is currently being undertaken at the OSC.
- Despite the OSC's reticence in publishing the process, forms and guidelines, 80 to 100 written requests for inquests are received every year from family members and interested parties.
- From June to September 2012, 59 new coronial cases were approved for inquest. As mandatory inquests represent 1.0 to 1.5% of reportable deaths, the expected number of mandatory inquests for the entire FY2011/2012 would be 19 to 28. The additional approval of discretionary inquests far exceeds the capacity of the OSC, even with the temporarily-funded Coroners and Counsel Assisting.
- Whereas the overarching monitoring could be directed by Senior Counsel Assisting; the labour-intensive physical monitoring should be performed by other resources.
- Whilst it is acknowledged that the OSC is distinctly different to agencies such as the Director of Public Prosecutions, the State Solicitors Office and Legal Aid WA, it is understood that practice management in regard to capacity planning is not too dissimilar as they face similar resource constraints in deciding to take on a case.
- Whilst there are opportunities for improvements in supporting the prevention of death role in determining an inquest process, it needs to be balanced with the OSC's capacity, especially given that other agencies are empowered to investigate and enforce change and the broader coronial system extends the prevention role beyond the OSC.

Preparing for Inquest

- The reliability of a continual process is susceptible to disruption due to Counsel Assisting staff turnover every 1-2 years, which places greater need for a supporting case management system, quality management and consistency of practice to facilitate a recurring transition of cases. One way to counter instability of resource turnover is to create stability in the underlying systems and processes so that tacit and explicit knowledge can be embedded in such systems.
- Setting listing dates earlier provides more adequate notice to other agencies, organisations and individuals, and would facilitate improved responsiveness in obtaining the documentation required by Counsel Assisting.
- Counsel Assisting do not have the benefit of paralegal support and therefore manage much of the caseload and file management themselves, to the extent that they appear to spend hours standing at photocopiers and undertaking other administrative tasks.
- The internal interaction between the Counsel Assisting, the Medical Advisors, and the in-house police officers/CIU is fundamental to the development of the inquest cases. The Strategic Review identified that if this interaction were to occur earlier in the overall process prior to and during the initial police investigation it would avoid a lot of backtracking, re-investigation, and following up on old cases for all parties.
- Planning, managing and monitoring the management of preparation for an inquest is not too dissimilar to managing projects. There is a comparison to be drawn to project management,

especially in regard to the six controls applied to plan and track the schedule, budget, scope, quality, benefits and risks. Each of these controls is equally applicable to the preparation for an inquest. Caseload management would benefit by taking a portfolio management approach.

- There are no management directions regarding electronic directory structure, electronic file naming conventions, correspondence management, document and file management, shared diary, or record keeping.
- With adequate guidelines, training and the ability to ascertain the status preparing for a case, the counselling service could maintain the interface with the families throughout the coronial process, especially imparting information such as no developments have been made. There is a degree of reticence to allow this to occur.

Listing the Inquest

- The Inquest brief is available to external lawyers and an interested party too close to the inquest date, in some cases as little as one week beforehand. This practice places a strain on the ability to prepare and respond with witness statements and documents. The delayed repercussions are then reciprocated in the frequency in which the OSC receive documentation the day before or on the day of the inquest.
- The lack of adequate notification and the variable protocol of keeping officers in other agencies informed of summons was a common issue. There is a downstream impact on agencies that need to carefully manage the process. For example, with the Department of Corrective Services (DCS), issuing a summons to an offender serving time gives rise to a chain of events that need to be carefully managed, not least of which is consideration to the mental condition of the offender when they receive the summons. DCS need to consider if counselling services are required to coincide with the delivery of the summons, make plans for transport, ensure there is capacity at another facility if being transported to Perth, and various other factors that need to be taken into consideration. Other agencies consulted reported similar issues when assisting with cases. A minimum two month window should be allowed for to enable agencies adequate time to prepare for an inquest and agreed protocols should be consistently followed.
- The reliance on the availability and expertise of the Listing Manager in the listing process and preparation of the Brief is a risk, especially as there are no guidelines, written processes or system assistance in performing these functions so that others can step in if required.
- The statistical data indicates that the median average from listing date to inquest date is 32 days and from summons date to inquest date is 28 days, far below the recommended 8 weeks.
- Photocopying, tabbing and distributing the Brief appears to be a waste of resources expended in this day and age.
- To be at par with other states' coronial websites, the listings information should include inquest status, name of deceased, inquest dates, case location, Coroner, reportable type, issues to be considered, date of death, and place of death.
- The schedule of inquest must be made available to the OSC receptionist, the Central Law Courts information desk, and the electronic Magistrates listing board (CRAMS) in order to inform the public. Also, all the OSC personnel should be aware of the schedule.

Court Proceedings

During the initiation of the Strategic Review, the scope of the Strategic Review was discussed with representatives from DotAG and it was agreed that the Strategic Review would not take into consideration the effectiveness and efficiency of court proceedings because the scope was focussed specifically on the OSC as opposed to the Coroner's Court. The Strategic Review was also mindful

that assessing the Coroner's Court would step into the realm of judicial practice, protocols and procedures. However, the following were highlighted.

- The Review assessed the process in relation to cycle time as conducive to being efficient given 68.42% to 73.70% of all inquests take 1 to 3 days to complete.
- The directional goal of a paperless court should be implemented where possible to encourage greater efficiency and greener practices. The stationery budget for the OSC in FY2011/2012 was 10 times larger than the amount spent on computer upgrades illustrates a heavy reliance on paper-based support systems. Records for exhibit management are also paper-based.
- Counselling services are not offered to family members during inquests. The Strategic Review recommends that counselling services be offered to family members at the onset and periodically throughout the inquest.

Inquest Findings and Recommendations

- Three points are made in the context of process ineffectiveness: (1) the weight of the findings and recommendations can be diminished to some degree by the passage of time; (2) the stress created from lengthy investigations, inquest findings and recommendations on persons involved in the Inquest, especially if there is a possibility of disciplinary action and/or it casts a shadow on an individual's credibility to perform their duties; and (3) the caseload fatigue must begin to come into effect in the OSC and in the broader coronial system.
- The coronial system as a whole is not conducive to being orchestrated, which leaves it vulnerable to the heterogeneous workings of the sums of the parts.
- A limitation in the OSC is the lack of supporting information systems and processes to track the status of recommendations and the responses.
- Responses to recommendations are not openly published other than a summary included in the Annual Report. 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.
- The statistical data shows the median average of days from end of inquest to inquest findings was 129 days or about 4 months; and that Western Australia was amongst the longest to complete the inquest cycle (from date of death to date of finding) at 1025 days or 2.8 years.
- The extended wait time in the production of the inquest findings appear to be attributable to the Coroners' capacity, which would be exacerbated by the backlog.
- The structure of the inquest finding template encourages lengthy story-telling rather than factual reporting. A sampling of inquest findings across Australia illustrates that Western Australia produced the inquest findings almost twice as long as most other states.
- To assist in communicating the important facts a summary page should be included at the beginning of the inquest finding in a table-like format that includes citation, title of court, hearing dates, date of finding, place of findings, findings of, finding, manner of death, recommendations, representation, file numbers, and keywords.
- Operating as a whole would be a more effective way of preventing deaths than relying solely on the recommendations alone. The OSC should work more closely with the relevant agencies to construct more meaningful recommendations that have the power to incite the necessary change to foster collaborative relationships within the broader coronial system.
- An intrinsic instrument in quality management is internal audit and some of the issues identified may have been detected earlier if quality audits had been undertaken or scrutinised in more detail. It would be prudent for DotAG Management Assurance to focus its energies further on

the operations of the OSC and extend its audit examination over the coming two years to provide continued independence.

3.31 s.53A State Coroner may provide information about deaths to human tissue donation agencies

Section 53A was not directly considered by the LRCWA Review, though the question of access to information was considered.

The Strategic Review did not consider this Section of the Act.

3.32 s.54 Obstruction

The LRCWA Review considered Section 33, which also affects Section 54. The LRCWA focus was on the issue of obstructing a coroner or coroner's investigator.

Recommendation 30 Penalty for obstructing a coroner or coroner's investigator

That the penalty for delaying, obstructing or otherwise hindering a coroner or a coroner's investigator exercising a power of entry, inspection and possession under the Coroners Act (currently s 33) be increased to a fine of $12,000 or 12 months' imprisonment.

The Strategic Review did not consider this Section of the Act.

3.33 s.55 and s.56

Section 55 Protection from legal proceedings.

Section 56 Coroner not to be called as witness.

The LRCWA Review did not consider Section 55 and 56 and the Strategic Review had no reason to consider these either.

3.34 s.57 Review of Act

The LRCWA Review did not consider Section 57.

The Strategic Review had no reason to consider Section 57 other than referring to what would be reviewed in the context of differentiating between the Strategic Review and the s.57 Review.

This s.57 Review however suggests amending s.57 to:

The Attorney General is to carry out a review of the operations of this Act as soon as practicable after every fifth anniversary of the commencement of this Act and in the course of such review the Attorney General is to consider and have regard to —

(a) the attainment of the objects of this Act;

(b) the administration of this Act;

(c) the effectiveness and **efficiency** of the operation **of the Office of the State Coroner** and the court; and

(d) such other matters as appear to be relevant to the operation and effectiveness of this Act.

3.35 s.58 Guidelines

The LRCWA Review made several recommendations pertaining to guidelines including –

Recommendation 19 Guidelines on Reportable Deaths

Recommendation 22 Guidelines Authorisation Death Certificate

Recommendation 27 Police Guidelines

Recommendation 39 Death in Custody Guidelines (Excluded from Review)

Recommendation 46 Guidelines for possible Mental Health Related Deaths

Recommendation 60 Guidelines persons held in custody and care

Recommendation 63 Guidance for Coroners when an inquest should be held

Recommendation 64 Guidelines for Coroners: when an inquest should be held

Recommendation 75 State Coroner's Guidelines: Conduct of hearings

Recommendation 97 State Coroner's Guidelines: Review, update and publish

Overall, there is general support for the provision for guidelines.

The Strategic Review also made specific recommendations pertaining to the development of guidelines being undertaken in such a way to facilitate the creation of e-learning modules. The Strategic Review noted that whilst proposing an e-learning initiative may sound ambitious, adopting an approach similar to that proposed for quality management system should provide an effective and efficient way to develop e-learning content. In particular, as procedures and guidelines are developed, these can be adapted to create e-leaning modules using inexpensive software.

The LRCWA Review's ten recommendations and the Strategic Reviews recommendations pertaining to training and education suggest that the attainment of this Section of the Act is marginally conducive to being met.