



## INFORMATION CIRCULAR

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**Subject:** **CORONERS ACT 1996**

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This Information Circular replaces Operational Circular 2066/06 to reflect the introduction of the Death in Hospital Notification form and guidelines.

The aim of this Information Circular is to:

- (a) Remind WA Health officers of statutory reporting obligations under the *Coroners Act 1996*.
- (b) Encourage the whole of WA Health to give reasonable and timely assistance to Coroners and Coroner's Investigators responsible for investigating 'reportable deaths' under the above Act.

This document is not intended to provide a comprehensive overview of the coronial process. More detailed information is available on the Legal & Legislative Services web site accessible through *Holii*. In particular, the web site contains information about human tissue donation, post-mortems and exhumations in coronial matters.

The web site also contains information on preparing witness statements and comprehensive medical reports for coronial investigations and appearing as a witness at Coronial Inquests.

This document is not intended to be, nor should it be relied upon as, a substitute for legal or other professional advice. WA Health officers who are unsure of applicable legal obligations, should request legal advice tailored to the individual circumstances from Legal & Legislative Services. Royal Perth Hospital, Sir Charles Gairdner Hospital, Fremantle Hospital, King Edward Memorial Hospital and Princess Margaret Hospital may alternatively seek legal advice from the State Solicitor's Office.

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**HEALTH SYSTEM SUPPORT**

# CORONERS ACT 1996

CONTENTS	Page
<b>Definitions</b>	3
<b>Definition of 'reportable death'</b>	
What is a 'reportable death'?	3
What is a 'Western Australian death'?	4
<b>Duty to report a death that is or may be a 'reportable death'</b>	
Persons responsible for reporting 'reportable deaths'	5
Failure to report a 'reportable death'	5
<b>Action upon a 'reportable death'</b>	
Action where 'reportable death' occurs at health service	6
Action where unclear if death reportable	7
<b>Control and disposal of deceased's body and registration of death</b>	
Control of body	7
Disposal of body	7
Registration of death	8
<b>Investigation powers</b>	
Restricting access to place where death occurred	8
Coroners' powers of entry, inspection and possession	8
Coroner's Investigators' powers of entry, inspection and possession	8
<b>Assisting coronial investigators</b>	
Reasonable and timely assistance	9
Requests for deceased patient's medical records	9
Requests for medical records of a living patient	10
Requests for staff interviews and witness statements or comprehensive medical reports	10
Options available to WA officers requested to attend interviews and give witness statements	11
Provision of a comprehensive medical report on behalf of the health service	12
<b>Coronial Inquests</b>	
Decision to hold Coronial Inquest	12
Summonses and orders	12
The Coronial Inquest	13
<b>The Coroner's Findings</b>	
Findings to be made by the Coroner	13
No finding of fault to be made	14
Referrals to professional bodies	14
Comments and recommendations	14
Dissemination and review of Coroner's Findings	14
<b>Contacts</b>	15
<b>Annexure A:</b> Acknowledgement of receipt of medical records	16
<b>Annexure B:</b> Authorisation of Coroner's Investigator	17

## Definitions

### 1. Terms used in this document have the following meanings:

<b>Coroner</b>	A public official appointed under the Coroners Act to inquire into the manner and cause of a 'reportable death' and preside over Coronial Inquests. Includes the State Coroner, Deputy State Coroner and every magistrate.
<b>Coroners Act</b>	The <i>Coroners Act 1996</i> .
<b>Coroner's Investigator</b>	A person appointed under the Coroners Act to assist a Coroner in carrying out his or her duties under that Act and includes every member of the Western Australian Police Force.
<b>Coronial inquest</b>	A formal hearing of the Coroner's Court of Western Australia into the circumstances surrounding a 'reportable death' occurring in Western Australia.
<b>Coronial inquiry or investigation</b>	The process by which a Coroner investigates the circumstances surrounding a 'reportable death' occurring in Western Australia and includes a Coronial Inquest.
<b>Coronial investigator</b>	The Coroner or Coroner's Investigator responsible for investigating the 'reportable death'.
<b>Death scene</b>	The place where the body of a deceased person is located or where the event that caused or contributed to the death occurred.
<b>Health service</b>	As applicable, an area health service, hospital, clinic, centre or other health care facility falling within the Western Australian public health system.
<b>Coronial liaison officer</b>	The designated officer responsible for ensuring compliance with the Coroners Act and for the coordination of responses to coronial investigations.
<b>Non-teaching hospitals</b>	Means all public hospitals and related health care facilities not included in the definition of 'teaching hospitals' but excluding Bunbury Regional Hospital.
<b>Teaching hospitals</b>	Means <u>only</u> Royal Perth Hospital, Sir Charles Gairdner Hospital, Fremantle Hospital, King Edward Memorial Hospital and Princess Margaret Hospital.
<b>Reportable death</b>	Means a death falling within the definition set out in paragraphs 2 and 3.
<b>WA Health officer</b>	A person employed by the Department or a health service as a public service officer or employee under the <i>Public Sector Management Act 1994</i> or a contract of service.

## Definition of 'reportable death'

### 2 What is a 'reportable death'?

- 2.1 A death must be reported to a Coroner or to any member of the Western Australian Police Force immediately where the death is a 'Western Australian death' and one or more of the following applies:

- 2.1.1 The death appears to have been unexpected, unnatural or violent, or to have resulted directly or indirectly from injury. For example, complication following the administration of medication, or a physical or sexual assault.
- 2.1.2 The death occurs during an anaesthetic, or as a result of an anaesthetic and is not due to natural causes.
- 2.1.3 The death occurs in prescribed circumstances. There are currently no legislated 'prescribed circumstances'.
- 2.1.4 The deceased immediately before death was a person 'held in care'. A person held in care includes individuals in the control, care or custody of the Police or Prison Service or the Chief Executive Officer of the Department for Community Development under the *Children & Community Services Act 2004*. It also includes individuals admitted to a centre under the *Alcohol & Drug Authority Act 1974*; a person who is an involuntary patient under the *Mental Health Act 1996* or who is apprehended or detained under Part 3 of that Act; as well as an individual detained under the *Young Offenders Act 1994*.
- 2.1.5 The death appears to have been caused or contributed to while the deceased was held in care (see paragraph 2.1.4).
- 2.1.6 The death appears to have been caused or contributed to by any action of a member of the Police Force.
- 2.1.7 The deceased is a person whose identity is unknown.
- 2.1.8 The death occurs within Western Australia but the cause of death has not been certified under section 44 of the *Births, Deaths & Marriages Registration Act 1998*.

Section 44 requires the medical practitioner who immediately before death was responsible for the medical care of the deceased or of the mother of a stillborn child, or who examined the body after death, to complete and sign a medical certificate of cause of death within 48 hours of the death, and provide the certificate to the funeral director. However, the medical practitioner is not required to issue a certificate of cause of death in circumstances in which the death is reportable to a Coroner.

- 2.1.9 The death occurred outside Western Australia but a medical practitioner legally qualified as such in the place concerned has not issued a certificate of cause of death.
- 2.1.10 In the opinion of any medical practitioner present at or soon after death, the cause of death cannot be determined or the death has or may have occurred under suspicious circumstances (eg, as the result of a criminal act).

### **3 What is a 'Western Australian death'?**

- 3.1 A 'Western Australian death' is a death:
  - 3.1.1 That occurred in Western Australia; and
  - 3.1.2 Where the body is in Western Australia; or

- 3.1.3 Where the cause of death occurred in Western Australia; or
- 3.1.4 Where at the time of death, the deceased ordinarily resided in Western Australia; or
- 3.1.5 Where the deceased is a person in an industry to which the *Industrial Relations Act 1979* applies due to the operation of section 3 of that Act. For example, an employee of an oil rig company with connections to Western Australia but operating offshore.

## Duty to report a death that is or may be a 'reportable death'

### 4 Persons responsible for reporting 'reportable deaths'

- 4.1 It is open to any person to report to a Coroner or member of the Western Australian Police Force where they believe a 'reportable death' has or may have occurred.
- 4.2 The Coroners Act imposes a legal obligation on the following persons to report deaths that are or may be 'reportable deaths' under the Coroners Act:
  - 4.2.1 Any person who has knowledge of an actual or possible 'reportable death' must immediately he or she becomes aware of it, report the death to a Coroner or a member of the Western Australian Police Force unless there are reasonable grounds to believe the death has already been reported.
  - 4.2.2 Any medical practitioner present at or soon after an actual or possible 'reportable death' must report the death immediately to a Coroner if:
    - 4.2.2.1 The medical practitioner is unable to determine cause of death; or
    - 4.2.2.2 In the opinion of the medical practitioner, the death has occurred under any suspicious circumstances.

If more than one medical practitioner is present at or soon after the death and one reports to a Coroner, the others need not do so but must give to the Coroner investigating the death any information that may help the investigation.
- 4.2.3 Where immediately before death the deceased was a person held in care (see paragraph 2.1.4), the person under whose care the deceased was held must immediately report the death to a Coroner.
- 4.3 The Coroners Act imposes a legal duty on the person reporting the death to give to the Coroner investigating the death any information that may help the coronial investigation. The obligation is to provide factual information to the Coroner, including the provision of the deceased patient's medical records where the same is in the person's possession, custody or control.

### 5 Failure to report a 'reportable death'

- 5.1 A failure to report a death that is or may be a 'reportable death' is an offence in respect of which a fine may be imposed.

## Action upon a 'reportable death'

### 6 Action where 'reportable death' occurs at health service

- 6.1 As far as possible, leave the body and the death scene as it is until instructed otherwise by the coronial investigator or Duty Forensic Pathologist. Should difficulties arise (e.g., where there is a need to prepare the deceased patient's body for viewing by next-of-kin), the coronial investigator or Pathologist (as applicable) should be telephoned for guidance and a file note of the conversation prepared and placed on the health service coronial investigation file (see paragraphs 6.4.2).
- 6.2 In the case of a hospital death, complete a Death in Hospital (DIH) Form. A DIH Form and accompanying guidelines and Information Circular is available on the Office of Safety & Quality website at <http://intranet.health.wa.gov>.
- 6.3 Report the death by telephone to the Police Coronial Investigation Unit (PCIU) for deaths in the Perth metropolitan area or the local police for deaths in country areas. For deaths in hospital, a completed DIH Form should also be faxed to the PCIU or country police (as applicable). In all cases, ensure the PCIU or country police are provided with the name and contact details of the health service's coronial liaison officer. That is the person to whom the coronial investigator should direct initial enquiries and requests for information.
- 6.4 Where the death is confirmed by the PCIU, police or coronial investigator to be a coroner's case, arrange for:

- 6.4.1 The deceased patient's medical records as well as the staff roster for the 48-hour period immediately preceding the death (or such other relevant period applicable in the circumstances) to be made available to the coronial investigator or Duty Forensic Pathologist.

WA Health officers should comply with their health service policies with respect to the release of patient medical records. However, where original records are released, a photocopy must be retained at the health service.

Health services are responsible for ensuring they have adequate procedures and policies in place to ensure the security and integrity of the deceased patient's original medical records at all times prior to any release of the same to coronial investigators or the Duty Forensic Pathologist.

It is recommended that Coroner's Investigators to whom confidential medical records are released be asked to sign an acknowledgement of receipt similar to that appearing at **Annexure A**.

- 6.4.2 A designated health service coronial investigation file (separate from the deceased patient's medical file) to be opened. All communications and documentation relating to the coronial investigation (including witness statements, medical reports and legal advice) should be placed on this file (not the deceased patient's medical file).
- 6.4.3 The health service's claims manager to assess the necessity or otherwise for notification of the incident to RiskCover (or private insurer) and to arrange the same.

The mere fact a death is a coroner's case does not prevent civil proceedings being commenced (e.g., by or on behalf of the deceased patient's dependents under the *Fatal Accidents Act*) where an allegation of negligence has been made.

Notifications to RiskCover on behalf of non-teaching hospitals are made through Legal & Legislative Services. Teaching hospitals and Bunbury Regional Hospital should follow their own internal procedures.

6.5 Consider whether there are any other reporting obligations that need be complied with and arrange for the same. For example, the death may also be reportable to the:

- Department of Health's Executive Director Public Health under Part XIII of the *Health Act 1911*. For more information, visit the Statutory Medical Notifications web site at [www.health.wa.gov.au/notifications](http://www.health.wa.gov.au/notifications).
- Chief Medical Officer (via the Hospital Executive) in accordance with the Sentinel Event reporting policy. For more information, visit the Office of Safety & Quality website at <http://intranet.health.wa.gov.au/osqh/program/sentinel.cfm>.
- Chief Psychiatrist in the case of a death of a patient (voluntary or involuntary) under the care of a mental health service. For more information, visit the Chief Psychiatrist's website at [www.chiefpsychiatrist.health.wa.gov.au/reporting/index.cfm](http://www.chiefpsychiatrist.health.wa.gov.au/reporting/index.cfm).

## **7 Action where unclear if death reportable**

7.1 Telephone the PCIU (Perth metropolitan area) or the local police (country areas) to discuss the case and obtain clarification as to whether or not the death is reportable. See page 15 for PCIU's contact details. Telephone numbers for country police are available through relevant telephone directory services.

7.2 The health service officer making the above telephone call should prepare a comprehensive file note of the conversation to be placed on the deceased patient's medical file if the advice received is that the death is not reportable; or on the health service's coronial investigation file (see paragraph 6.4.2) if the death is reportable and is to be investigated.

## **Control and disposal of deceased's body and registration of death**

### **8 Control of body**

8.1 Where a 'reportable death' occurs and the body of the deceased person is in Western Australia, the Coroner investigating the death has control of the body until he or she has issued a certificate permitting the disposal of the body.

8.2 While the body is under the control of the Coroner, he or she is to ensure (unless determined to be undesirable or dangerous) that any of the deceased person's next-of-kin who wish to view or touch the body are permitted to do so.

### **9 Disposal of body**

9.1 The deceased person's body must not be disposed of until the Coroner investigating the death has issued a certificate in the prescribed form permitting burial, cremation or other disposal of the body or any parts of the body.

## **10 Registration of death**

- 10.1 The Coroner investigating the death must notify the Registrar of Births, Deaths and Marriages as soon as possible of the particulars found by the Coroner that are needed to register the death.

## **Investigation powers**

### **11 Restricting access to place where death occurred**

- 11.1 A coronial investigator may take reasonable steps to restrict access to the place where the death the subject of the coronial investigation occurred, or the place where the event that caused or contributed to the death occurred. The restriction ceases to have effect 6 hours after it is imposed unless the Coroner agrees, in writing, to further restriction.
- 11.2 A Coroner must ensure that access to an area is not restricted for any longer than necessary. Any person aggrieved by the restrictions imposed may apply to the State Coroner and he may order the variation or removal of the restriction.
- 11.3 A person, who enters a restricted area without good cause or interferes with it, commits an offence in respect of which a penalty may be imposed.

### **12 Coroners' powers of entry, inspection and possession**

- 12.1 A Coroner investigating a death may (with any help thought fit) enter and inspect any place and anything in it where the Coroner reasonably believes it is necessary for the purpose of the coronial investigation.
- 12.2 The Coroner may also, where physically present at the site where the inspection is taking place:
- 12.2.1 Take a copy of any document relevant to the coronial investigation; and
  - 12.2.2 Take possession of anything the Coroner reasonably believes is relevant to the coronial investigation.

### **13 Coroner's Investigators' powers of entry, inspection and possession**

- 13.1 Where a Coroner's Investigator believes the death is or may be a 'reportable death', he or she may exercise the following powers:
- 13.1.1 Enter and inspect the place where the body is located.
  - 13.1.2 Enter and inspect the place where in his or her opinion the death or event that caused or contributed to the death occurred.
  - 13.1.3 Take possession of anything he or she reasonably believes is directly relevant to an investigation of the death.
- 13.2 Neither the consent of the occupier of the place to be searched nor a Coroner's Authorisation is required for the purpose of a Coroner's Investigator exercising the powers in paragraph 13.1. However, the powers given to Coroner's Investigators may only be exercised at the death scene.

- 13.3 A Coroner's Investigator (other than a member of the Western Australian Police Force in uniform) exercising the powers referred to in paragraph 13.1 must (where requested by the occupier of the place to be searched) produce written evidence that he or she is a member of the Western Australian Police Force or other identity card.
- 13.4 The Coroner may in writing (by means of a 'Coroner's Authorisation') authorise a Coroner's Investigator at or between specified times during a specified period (not exceeding one month after the Authorisation is given) to enter and inspect a specified place; to take a copy of specified documents or classes of documents; and to take possession of specified things or classes of things. In such circumstances, the Coroner's Investigator must give a copy of the Coroner's Authorisation to the owner or occupier of the premises before exercising the power. An example of a blank Coroner's Authorisation appears at **Annexure B**.
- 13.5 Nothing in the Coroners Act affects a police officer's powers to investigate offences and exercise powers of investigation given to them pursuant to other legislation (e.g., the power to obtain a search warrant under section 711 of the *Criminal Code 1913* where the commission of an offence is suspected).

## Assisting coronial investigators

### 14 Reasonable and timely assistance

- 14.1 The conduct of a coronial investigation is the responsibility of the Coroner who is assisted, as necessary, by Coroner's Investigators (generally members of the WA Police Force).
- 14.2 Subject to the following paragraphs, WA Health officers are encouraged as a general rule to give all reasonable and timely assistance to coronial investigators by providing access to information required for the purpose of coronial investigations.

### 15 Requests for deceased patient's medical records

- 15.1 The medical records of a deceased patient the subject of a coronial investigation may generally be released voluntarily to a coronial investigator or Duty Forensic Pathologist for the purpose of the coronial investigation into that person's death. In these circumstances, a written authority to release, Coroner's Authorisation or search warrant is not required before the records are released.
- 15.2 Health service staff should comply with their health service policies with respect to the release of patient medical records. However, where original records are released, a photocopy must be retained at the health service.
- 15.3 Health services are responsible for ensuring they have adequate procedures and policies in place to ensure the security and integrity of the deceased patient's original medical records at all times prior to any release of the same to coronial investigators or the Duty Forensic Pathologist.
- 15.4 It is recommended that Coroner's Investigators to whom confidential medical records are voluntarily released be asked to sign an acknowledgement of receipt similar to that appearing at Annexure A.
- 15.5 Where the patient's death did not occur at the health service and doubt exists as to whether the records are in fact required for a coronial investigation, or whether the

person making the request is a coronial investigator or is acting in that capacity (e.g., police), the person making the request should be asked to produce a Coroner's Authorisation, search warrant or appropriate authority to release before any confidential records are released.

- 15.6 Wherever a deceased patient's medical records are sought for a purpose other than a coronial investigation (e.g., by the police for the purpose of an investigation of a suspected offence), the person making the request must be required to produce a search warrant or appropriate authority to release before any confidential records are released.

## **16 Requests for medical records of a living patient**

- 16.1 The medical records of a patient who is living must not be provided to a coronial investigator, Duty Forensic Pathologist or any other person in the absence of an appropriate authority to release, a Coroner's Authorisation, search warrant or similar order.

## **17 Requests for staff interviews and witness statements or comprehensive medical reports**

- 17.1 For the purpose of a coronial investigation into the death of a patient, Coroner's Investigators will generally either request to:

17.1.1 Interview and obtain witness statements from individual WA Health officers;  
or

17.1.2 Be provided with a comprehensive medical report prepared on behalf of the health service concerned;

that summarises (as appropriate) the deceased patient's relevant medical history, treatment and other events preceding the patient's death.

- 17.2 Coroner's Investigators are entitled to approach witnesses direct to request interviews and witness statements and should not be prevented from doing so. Requests for medical reports should be directed through the health service's coronial liaison officer or other designated officer.

- 17.3 Where health service management (e.g., through the health service coronial liaison officer) coordinate the provision of witness statements or a medical report, they must:

17.3.1 Do so expeditiously and without unreasonably delaying the progress of the coronial investigation.

17.3.2 Ensure they have a clear understanding of the request being made. For example:

17.3.2.1 Whether the Coroner's Investigator wishes to interview staff and take witness statements or simply wants a single, comprehensive medical report prepared on behalf of the health service.

17.3.2.2 The identity of the individuals (by name or other description that enables identification) whom the Coroner's Investigator wishes to interview and take witness statements.

17.3.2.3 Any specific matters to be addressed in the witness statements or medical report.

Wherever possible and practicable, the Coroner's Investigator should be asked to make his or her request in writing addressed to the health service. Alternatively, a comprehensive file note of the verbal request should be prepared and placed on the health service coronial investigation file.

17.3.3 Ensure (where the request is to interview and take witness statements) that the individuals concerned are informed of the request made by the Coroner's Investigator as soon as reasonably possible. The Coroner's Investigator should also be informed of each individual's response to the request (i.e., whether or not they are prepared to give assistance).

17.3.4 Ensure (where the request is to interview and take witness statements) that the individuals concerned are clearly informed of their options (see paragraph 18).

17.3.5 Keep a record of the dates when individual witnesses have been contacted and monitor progress in respect of each witness statement or the medical report to ensure the same are obtained in a timely manner.

17.3.6 Ensure the Coroner's Investigator is kept informed of progress and any difficulties or delay in obtaining or responding to the request made.

## **18 Options available to WA Health officers requested to attend interviews and give witness statements**

18.1 In Western Australia, there is no general legal duty imposed on individuals to assist Coroner's Investigators by attending interviews, answering questions or giving witness statements.

18.2 However, WA Health officers are encouraged to cooperate with Coroner's Investigators where requested to provide witness statements where it is reasonable to do so in the circumstances.

18.3 WA Health officers requested by Coroner's Investigators to attend interviews and give witness statements have a number of options available. These include:

18.3.1 Providing a witness statement through the health service with legal assistance from Legal & Legislative Services or the State Solicitor's Office (teaching hospitals only).

18.3.2 Providing a witness statement through their own independently appointed lawyers or union (e.g., the Australian Nursing Federation). There is no entitlement to reimbursement from WA Health of any legal costs incurred in exercising this option.

18.3.3 Providing a witness statement to the Coroner's Investigator direct by attending an interview. The witness then has an option of:

18.3.3.1 Having the prepared statement reviewed by a lawyer or union (as outlined in paragraph 18.3.1 and 18.3.2) prior to signing; or

18.3.3.2 Signing the prepared statement at the time of the interview.

It should be noted that witnesses have ultimate responsibility for the content of their statements and must satisfy themselves as to the accuracy and truthfulness of the events described within them.

Where a witness wishes to obtain legal/union assistance or wishes to conduct enquiries to check the factual accuracy of their statement or simply want to have time to read and consider the content, the statement **must not** be signed.

18.3.4 Refusing to attend an interview or give a witness statement.

## **19 Provision of a comprehensive medical report on behalf of the health service**

19.1 It is recommended that a senior clinician (and preferably one who has had direct involvement with the deceased patient) prepare medical reports on behalf of health services for the purpose of coronial investigations.

19.2 Legal & Legislative Services (or the State Solicitors' Office in the case of teaching hospitals) is available to review draft medical reports prepared on behalf of health services and other WA Health agencies for the purpose of coronial investigations.

## **Coronial inquests**

### **20 Decision to hold Coronial Inquest**

20.1 Once the coronial investigation is complete, the Coroner investigating the death will decide whether or not to hold a Coronial Inquest. Not all coronial investigations result in a Coronial Inquest although one is mandatory in Western Australia if the deceased was 'held in care' (paragraph 2.1.4) immediately prior to his or her death.

20.2 Where the Coroner investigating the death considers a Coronial Inquest is unnecessary, the matter will be concluded by way of findings made in chambers (i.e., in private).

20.3 Any person may ask a Coroner to hold a Coronial Inquest. If the Coroner refuses the request, the reasons for such refusal must be given in writing.

20.4 Once a Coroner decides to hold a Coronial Inquest, a date and venue for the hearing is fixed and all interested parties notified. Counsel Assisting the Coroner will prepare a list of witnesses to be called to give evidence at the Coronial Inquest. The Office of the State Coroner will prepare and serve summonses on witnesses to be called to give evidence at the Coronial Inquest.

### **21 Summonses and orders**

21.1 For the purpose of a Coronial Inquest, a Coroner may:

21.1.1 Summon any person to attend as a witness or produce any document or other material.

21.1.2 Inspect, copy and keep for a reasonable period any thing produced at the Coronial Inquest.

21.1.3 Order a witness to answer questions.

- 21.1.4 Order a witness to take an oath or affirmation to answer questions.
- 21.1.5 Give any other directions and do anything else the Coroner believes necessary.
- 21.1.6 Be assisted by counsel.
- 21.2 A person must obey a summons, order or direction or face a penalty. If a witness fails to comply with a summons, the Coroner may issue a warrant to apprehend the individual concerned.
- 21.3 Any potential or actual Coronial Inquests involving or likely to involve a public health service or other WA Health agency or WA Health officers should be immediately notified to Legal & Legislative Services (non-teaching hospitals) or the State Solicitor's Office (teaching hospitals). Bunbury Regional Hospital should follow its own internal procedure for such matters.
- 21.4 Legal & Legislative Services or the State Solicitor's Office will then consider the necessity or otherwise for legal representation at any such Coronial Inquest and make appropriate arrangements for the same if required.

## **22 The Coronial Inquest**

- 22.1 A Coronial Inquest is a formal court hearing in which the Coroner hears evidence to assist in determining the manner and cause of the 'reportable death'. The hearing is usually open to members of the public.
- 22.2 A Coronial Inquest is an inquisitorial process, in other words, its purpose is to establish the facts and not attribute fault. There is no prosecution, no defence and no trial. A Coroner is not bound by the rules of evidence and may be informed and conduct a Coronial Inquest in any manner he or she reasonably thinks fit.
- 22.3 If a person called as a witness declines to answer any question on the ground that his or her answer will tend to incriminate him or her, the Coroner may grant the witness a certificate. Where a certificate is offered, the person is not entitled to refuse to answer questions on the ground of incrimination and his or her evidence is inadmissible in any criminal proceedings against that person (except a prosecution for perjury).
- 22.4 Before the Coroner makes any finding adverse to the interests of a person, that person must be given the opportunity to present submissions against the making of such finding.
- 22.5 The Coroner can order that proceedings of the Coronial Inquest not be published if it would be likely to prejudice the fair trial of a person or be contrary to the public interest.

## **The Coroners Findings**

### **23 Findings to be made by the Coroner**

- 23.1 At the conclusion of the coronial investigation and/or Coronial Inquest, the Coroner will make a finding indicating (where possible) the identity of the deceased, the circumstances surrounding the death, the cause of death and the particulars needed to register the death.

## **24 No finding of fault to be made**

- 24.1 The Coroner must not make any finding or comment which determines any question of civil liability or suggest that any person is guilty of any offence. However, the Coroner does have the power to report to the Commissioner of Police and the Director of Public Prosecutions where the commission of an offence is suspected.

## **25 Referrals to professional bodies**

- 25.1 The Coroner has the power to refer matters to a health professional's registration board for investigation and possible disciplinary action should he or she consider it appropriate in the circumstances.

## **26 Comments and recommendations**

- 26.1 The Coroner will also consider whether any lessons can be learned from the death. In this regard, the Coroner may comment and make recommendations on any matter connected with the death including public health and safety or the administration of justice, to help prevent a similar event from happening again.

- 26.2 Where the death is of a person 'held in care' (see paragraph 2.1.4), the Coroner must comment on the quality of the supervision, the treatment and the care of that person.

- 26.3 Recommendations and comments made by a Coroner have no direct legal force. However, they are matters that need to be carefully considered by senior management within the Department and the health service concerned so that:

26.3.1 Appropriate policy, procedural or other changes can, where necessary, be made.

26.3.2 The Department is able to advise the State Coroner of the action taken as a result of the Coroner's Findings including the implementation or otherwise of any recommendations. The State Coroner routinely requests this information from the Department for inclusion in his Annual Report to the Attorney General on deaths investigated during the preceding year.

## **27 Dissemination and review of Coroner's Findings**

- 27.1 All Coronial Findings must be forwarded to the Director General with a copy to the Chief Medical Officer and (where the deceased is a mental health patient or mental health issues arise) the Chief Psychiatrist by:

27.1.1 Legal & Legislative Services where instructed in the matter; or

27.1.2 The health service coronial liaison officer where Legal & Legislative Services is not instructed in the matter (eg, teaching hospitals and Bunbury Regional Hospital).

- 27.2 The Chief Medical Officer or the Chief Psychiatrist will then make arrangements for the Coronial Findings to be sent to one or more of the following (as appropriate):

27.2.1 The Directors of Clinical Services for review and advice on the implementation or otherwise of the Coroner's recommendations.

- 27.2.2 The Office of Mental Health (where issues pertaining to the *Mental Health Act* arise) for review and advice on the implementation or otherwise of the Coroner's recommendations.
- 27.2.3 The Chief Executives, Regional Directors, Chief Nursing Officer and other Departmental Directorates as appropriate for review and advice on the implementation of or otherwise of the Coroner's recommendations (if applicable) within their specific spheres of responsibility.
- 27.3 Where the Coroner's recommendations are to be implemented, policies and protocols will be developed by appropriate personnel within the Department or under the auspices of the Directors of Clinical Services and reported to the Office of Safety and Quality (OSQ).
- 27.4 OSQ will also coordinate on behalf of the Director General the report to the State Coroner outlining the action taken on the Coroner's recommendations (see paragraph 26.3.2).
- 27.5 Where Coroner's recommendations and comments are reviewed at an individual health service level and a decision made to implement policy changes, consideration should be given to the necessity or otherwise of consulting with the Chief Medical Officer or (where issues under the *Mental Health Act* arise) the Chief Psychiatrist. The purpose of the consultation will be to ensure (as far as appropriate) that there is a consistent response to the recommendations and comments both at the individual health service level and within the wider public health system. It may also avoid unnecessary duplication of work.

## Contacts

<b>Office of the State Coroner</b>	-	9425 2900 / 1800 671 994
<b>Police Coronial Inquiry Unit (PCIU), Perth</b>	-	9420 5200 (24 hours)
<b>Duty Forensic Pathologist</b>	-	9346 2613
<b>Coronial Counselling Services</b>	-	9245 2900 / 1800 671 994

**ANNEXURE A**

**ACKNOWLEDGEMENT OF RECEIPT  
OF MEDICAL RECORDS**

I, ..... of .....  
..... **HEREBY DECLARE** that I am a  
Coroner’s Investigator pursuant to Section 14(1) or 14(2) of the *Coroner’s Act 1996* (“the Act”) and in that capacity I am assisting the Coroner investigate the circumstances surrounding the death of ..... (“the deceased”), date of birth ..... For the purpose of the said coronial investigation, I **HEREBY ACKNOWLEDGE RECEIPT** of the deceased’s copy\* or original\* medical file held at .....

SIGNED: .....  
NAME (print): .....  
RANK: .....  
BADGE OR ID NO: .....  
POLICE STATION: .....  
DATE: .....

- Delete as applicable

**ANNEXURE B**

**FORM 8:**  
[Reg. 14(1)]

**Coroner's Act 1996**  
(Section 33(3))

**AUTHORISATION OF CORONER'S INVESTIGATOR**

I, ....., Coroner, reasonably believing it necessary for investigating the death of .....

AUTHORISE ....., a Coroner's investigator:

- To enter (*specify place*):.....
- To inspect (*specify place*): ..... and anything in it.
- To take a copy of (*specify documents or classes of documents*):  
.....
- To take possession of (*specify things or classes of things*):  
..... at or  
between the hours of ..... and ..... during the  
period commencing the .....day of ..... 200.... and  
concluding on the ..... day of ..... 200.... (*such period not to exceed one month after the date of this authority*).

DATED at Perth the ..... day of ..... 200....