Tackling the Increase of Reportable Deaths in the Coronial Jurisdiction of Western Australia

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The coronial jurisdiction

The Coroner's Court is a specialist court established under the *Coroners Act 1996* (WA) (*Coroners Act*) to investigate certain types of deaths.

The Coroner investigates deaths that are considered reportable deaths according to section 3 of the *Coroners Act*. In broad terms a reportable death is a death that appears to have been unexpected, unnatural or violent or to have resulted, directly or indirectly, from injury.

The primary role of the Coroner investigating a death under section 25 of the *Coroners Act* is to find, if possible, the identity of the deceased, how the death occurred, the cause of death and the particulars needed to register the death under the *Births, Deaths and Marriages Registration Act 1998* (WA).

The Coroner's Court is not a jurisdiction which apportions blame. Section 25(5) of the *Coroners Act* prevents a coroner from framing any finding or comment in such a way as to appear to determine any question of civil liability or to suggest any person is guilty of any offence.

The coronial process

Medical

Forensic Pathologists at the direction of the authorising Coroner, perform an examination of the body and undertake sampling and additional medical investigations to form an opinion on the cause of death. This often requires detailed testing and analysis that can take many months to yield results.

In addition to a detailed external examination of the body, including a post mortem CT Scan, the Forensic Pathologist may also undertake a limited or full internal examination of the body, review the deceased's medical records and refer samples for toxicology analysis, specialist neuropathology, biochemistry, genetics, microbiology testing and undertake histology.

On average it takes 9 months for the Forensic Pathologist, depending on the complexity of the case, to form an opinion on the cause of death.

Coroner's Investigators

In accordance with section 14 of the *Coroners Act*, every member of the Western Australia Police Force is contemporaneously a coroner's Investigator. Coroner's Investigators are tasked with undertaking an investigation into the death, on behalf of the Coroner.

Once the Coroner's Investigator receives the opinion on cause of death from the Forensic Pathologist, they will complete any remaining investigatory steps and provide a report to the Coroner.

Where a criminal investigation was connected with the death, the Coroner's Investigator cannot progress their report to the Coroner until the criminal investigation and any associated prosecution is complete.

Coroner's Review and Record of Investigation (Finding)

The Coroner's Court receives a report from the Coroner's Investigator and considers whether any remaining investigatory steps are required. This may include obtaining expert reports, depending on the circumstances surrounding the death.

Where a WorkSafe investigation is connected with the death, the Coroner may await the outcome of the investigation before finalising the coronial investigation. If a WorkSafe prosecution connected with the death is progressed, the Coroner must wait until the prosecution is complete before completing the coronial investigation.

Once all outstanding matters are complete, the file is prepared for a coroner to complete the coronial investigation by way of a finding.

The Coroner is under an obligation to investigate deaths by reference to the date of death, with the aim of progressing the older cases first. The court makes every attempt to finalise investigations as efficaciously as possible.

An Inquest is a public hearing conducted by a coroner. The Coroner is required to hold an Inquest in certain circumstances, as outlined in the *Coroners Act*, including if the deceased was immediately before death a person held in care or if it appears that the death was caused, or contributed to, by any action of a member of the Police Force. There may be an Inquest held in other cases, if the Coroner believes it is necessary or desirable in all the circumstances.

When an investigation is finalised other than by an inquest, the coroner's record of investigation is referred to as an administrative finding. These make up 98% of findings completed by the Coroner's Court. For these matters the Coroner or the Principal Registrar makes findings on the evidence before them, in chambers. They are not public proceedings. These findings are provided to the deceased's next of kin and they are not published on the Coroner's Court website.

Section 19A of the *Coroners Act* allows the Coroner to finalise a coronial investigation if the death is due to natural causes and the death is a reportable death solely because it appears to have been unexpected. Section 25(1A) of the *Coroners Act* allows a coroner not to make a finding as to how a death occurred, if the Coroner determines

that there is no public interest to be served in making a finding as to how the death occurred. In each case, a non-narrative finding is issued, in chambers.

Addressing the Backlog of Coronial Cases and Increase in Reportable Deaths

A reference to the coronial backlog is a reference to any coronial investigation which is older than 12 months old, since the death was reported to the Coroner. The Coroner's Court is focused on progressing these coronial investigations to finalisation and reducing the number of coronial cases in the backlog.

There has been a 64% increase in reportable deaths in the past 10 years. While there has been a significant increase in reportable deaths there has also been a significant increase in total finalisations. There have been variations in the backlog at the Court over time. As at 31 December 2023, the backlog was at 850 cases, which is a reduction of 24%, or 270 cases compared to 30 June 2022, creating a finalisation rate of 113%.

Improvement processes to address the backlog

The following initiatives have contributed to this outcome:

- The Coroner's Court temporarily employed additional resources for staff drafting administrative findings from October 2022, which resulted in more finalisations of non-inquest cases.
- A concentrated focus by police and the Coroner's Court to complete approximately 460 fast track matters under section 19A and section 25(1A).
- The Coronial Investigation Squad of WA Police obtained funding for 10 FTE to recruit temporary additional public service staff, with a view to those staff being appointed as Coroner's Investigators under section 14 of the *Coroners Act*. Following recruitment, staff commenced in those positions in January 2023. To date, at the recommendation of the State Coroner, the Attorney General has appointed nine Coroner's Investigators under section 14 of the *Coroners Act*. These appointments have resulted in an increase of 42% more police reports being submitted to the Coroner's Court in a timely manner, enabling the Coroner to work towards finalisation on those matters.

How PathWest is Addressing the Backlog of Coronial Cases and Increase in Reportable Deaths

To assist the Court with the coronial backlog a number of measures have been introduced along with significant staffing changes over the last 2 years.

Staffing

Due to the high case loads carried by individual Forensic pathologists with the increasing admission numbers, delays in completing post mortem examinations after admission and finalising case reports were noted to be increasing.

To address this, three additional Forensic pathologists have been employed since February 2023 along with mortuary support staff to complement the extra medical staff.

The addition of these pathologists in 2023 and 2024 has made a significant impact already on daily operations and work output, with the Forensic Pathology consultant staff now able to be rostered on scheduled days off to complete outstanding work allowing more cases to be finalised in a timely manner. This will also assist to reduce the overall individual annual caseload for the pathologists at the current annual admission rates of greater than 3,000 cases, from around 450 cases down to 350 cases per year and eventually down to 300.

It is anticipated, with the current growth rate in daily admissions, that an 11th pathologist is likely to be required within the next financial year 24/25 to further reduce the caseload numbers to improve turnaround times across the board for the Department, as is the expectation from the State Coroner's Office and the Department of Justice.

The State Mortuary upgrade

The State Mortuary was commissioned in 1971 and, aside from limited improvements, the facility has operated without substantial refurbishment since that time.

In 2019 a feasibility study confirmed the poor condition of the mortuary, noting a number of inadequacies, including outdated design and insufficient clinical workspace and cool room racking, and the lack of a dedicated crime suite.

Subsequent to this, a capital works project was facilitated and commenced in January 2022, led by PathWest, WA Police and the State Coroner's Office, in collaboration with the Department of Finance, Building Management and Works.

As part of this project, the upgraded mortuary now has the following features:

> an expanded cool room; a dedicated level 3 infectious autopsy theatre with improved access and functionality, multiple new clinical workstations within an expanded main theatre; a new X-ray room and machine; a dedicated crime suite for Western Australian Police criminal case work, including elevated viewing platform and workspace for investigating officers complete with audio-visual recording capabilities; a dedicated meeting room to accommodate all pre and post-casework meetings and educational sessions; new functional spaces for staff break times to ensure physical and mental wellbeing; a dedicated long term crime store facility and anthropological examination suite; new and larger admissions area; and greater CCTV security and oversight.

The project was rolled out in a series of 4 stages over some 19 months, with minimal disruptions over the duration, and has since completion in July 2023 significantly improved daily workflow and efficiencies throughout the mortuary service.

New Case Management system

SoftForensics is the SoftSCC module developed and now implemented in conjunction with WA Health, PathWest and the PathWest Forensic Pathology and State Mortuary Service.

This software is a unique and complete electronic case management system that incorporates all of the Department's processes in one place, from admission of the body to completion of the final report.

The new system allows for all case-related data to be kept in one place, providing oversight and better tracking of the case's progress through the system, allowing mortuary and medical staff to order tests electronically and receive all results directly into the electronic case file which automatically updates the case status when documents are sent and received, improving efficiencies across all areas.

Toxicology analysis

Forensic Toxicology analysis plays an essential role in coronial casework and determining cause of death. Over recent years the growing case numbers, case complexity and evolving novel drugs requiring analysis has caused increasing pressure on ChemCentre resources.

To address this, discussions between ChemCentre, the State Coroner's Office and Forensic Pathology were undertaken and a number of strategies were developed to streamline casework. These initiatives include rapid screens to fast track cases where a probable natural cause is suspected or an external only examination is recommended by and undertaken by the pathologist, and the storage of some reportable death cases. The aim of these changes is to reduce overall turnaround times for the above case types whilst releasing valuable resources for the more complex analyses.

PathWest is aware of the ongoing challenges and increasing demands on the PathWest Forensic Pathology and State Mortuary Service and like all agencies working within the State Coronial system continues to review its processes and services, for continuing improvement opportunities within the service and for the Western Australian community. ■