A report to the Attorney General pursuant to section 39(1) of the Coroners Act 2003 on the administration of the Coroners Court and the provision of coronial services under the Coroners Act 2003.
9 November 2018

The Honourable Vickie Chapman MP
Attorney-General
Government of South Australia
GPO Box 464
ADELAIDE SA 5000

Dear Attorney-General

In accordance with section 39 of the Coroners Act 2003 I have prepared a report on the administration of the Coroners Court and the provision of coronial services under the Coroners Act 2003 during the financial year ending on 30 June 2018.

The report is forwarded with this letter.

Yours sincerely

Mark Johns
STATE CORONER
# ANNUAL REPORT OF THE STATE CORONER

## TABLE OF CONTENTS

1. State Coroner’s Overview ................................................................. 1
2. Acknowledgements ............................................................................ 3
3. Reportable Deaths and the Role of the Coroner ................................. 5
4. Matters Arising During 2017-2018 .................................................. 8
   4.1. Domestic Violence Research Project ............................................ 8
   4.2. Department for Health and Wellbeing - Expert Reports ............... 9
   4.3. Department for Health and Wellbeing - Safety Learning System .... 9
   4.4. Forensic Science SA – Delays in Completion of Post Mortem Reports 9
   4.5. Coroners Court Succession Planning ......................................... 10
   4.6. Research Projects ...................................................................... 10
   4.7. Budget and Staffing Resources .................................................. 10
   4.8. Death Report to Coroner Medical Practitioners Deposition .......... 11
   4.9. Guardianship and Administration Act 1993 ................................. 11
   4.10. Hierarchy of Senior Next of Kin ............................................... 12
   4.11. Superannuation and Insurance ................................................. 13
5. Statistical Information ........................................................................ 14
   5.1. Cases Reported by Local Case Management (LCM) Cause of Death Code 14
   5.2. Year in Review ........................................................................... 15
   5.3. Case Statistics - Operational ...................................................... 15
6. Backlog of Inquests .......................................................................... 16
7. Professional Presentations of State Coroner and Deputy State Coroner .... 17
8. Asia Pacific Coroners Conference ..................................................... 18
9. Inquests for the Year 1 July 2017 to 30 June 2018 ............................. 19
   9.1. Inquests Held During the Year 1 July 2017 to 30 June 2018 .......... 20
   9.2. Recommendations ..................................................................... 22
   9.3. Recommendations - Deaths In Custody ..................................... 26
   9.4. Response to Recommendations - Deaths In Custody ................. 28
10. Manager’s Report ........................................................................ 33
    10.1. Registry Report ......................................................................... 33
    10.2. Continuous improvement ......................................................... 34
    10.3. Professional Development ........................................................ 34
    10.4. Social Work Service ................................................................. 36
    10.5. Organ Retention ...................................................................... 36
    10.6. Disaster Victim Identification .................................................... 36
11. Staff Roles and Organisational Chart ............................................. 37
Annual Report of the State Coroner

Annual Report pursuant to section 39 of the Coroners Act 2003

To the Attorney General

Pursuant to section 39(1) of the Coroners Act 2003 I make the following report to you on the administration of the Coroners Court and the provision of coronial services under the Coroners Act 2003 during the financial year ended 30 June 2018.

1. **State Coroner’s Overview**

I present the thirteenth Annual Report of the State Coroner to be tabled in Parliament reporting on the administration and operations of the Coroners Court during the financial year 2017-2018.

The South Australian Coroners Act 2003 provides for the establishment of the Coroners Court and the administration that supports the functions of the Court. The Act defines what constitutes a reportable death, the practice and procedures of the Court, establishes the power of inquiry and of the inquest and other legal processes that enable the jurisdiction of the Coroner to undertake inquiries and make recommendations.

This report documents the activities and initiatives of the Coroners Court during the year under review. The number of reported deaths has increased from those of previous years with 62 more reported deaths this year than last.

In 2017-2018 2599 deaths were reported and throughout the year 2813 were closed. This represents a clearance rate of 108.2% which is a 35.3% increase in the rate of closed cases from last year. The backlog indicator of cases that are more than 12 months old has marginally increased from 37% to 37.2%.

Cases that are greater than 24 months old and still open pending inquiries are 17.8% of our cases, being a 4.7% increase from the year before. The types of cases in this category usually represent the more complex cases requiring specialised investigations, or deaths in custody investigations, SafeWork SA investigations, cases pending charges in other courts and open homicide cases.

The challenge of reviewing and completing cases in a timely manner when our modest resources do not match our workload is ever present. I am pleased to report that we have achieved a greater closure rate this year for cases that are open for longer than 12 months. The staff who review cases and the Counsels Assisting have focussed on progressing cases that contribute to the backlog. This process takes dedicated time in reading and reviewing cases, reports and volumes of case notes. The staff have made it their aim to reduce the backlog and I am enormously impressed with their efficiencies of work this year.
In addition to that level of effort I would also like to highlight the effect that having three Coroners to consider findings has on the ability of the Court to progress matters enabling families to obtain a death certificate and move towards finalising estate issues.

During this year, as in previous years, administration staff and Counsel Assisting have endeavoured to provide the public of South Australia with a professional and impartial service within the resources available to the Court.
2. **Acknowledgements**

I extend my thanks and gratitude to Deputy State Coroner Tony Schapel and Deputy State Coroner Jayne Basheer for their outstanding commitment to coronial work this year. This has been a challenging year for inquests. The Court has heard or part heard a number of complex, intense and intricate inquests within what has seemed like a short period, but nevertheless is the year under report. Some of the cases will stretch into a total 18-month period. Whilst much of this was anticipated, the reality has been professionally and personally challenging for all involved. For Coroners presiding over inquests which intricately explore the death of an individual, as well as the part played by professionals involved in the circumstances of death, the weight of commenting impartially is heavy. I am confident that each Coroner has undertaken their responsibilities with diligence and utmost care.

I thank Senior Counsels Assisting who have worked for the Court this year. Naomi Kereru has supported the Court on a full-time basis throughout the year. Ms Kereru continues to be a great asset to the Coroners Court. I consider her a dedicated and gifted lawyer. She has ably led the Counsel Assisting team this year and provided sound advice to the Coroners, particularly in matters of high complexity. She is astute, well prepared and it has been a great pleasure to work with her.

I also welcomed two new Counsels Assisting this year. Ahura Kalali joined the team on an ongoing basis and Kathy Waite for an 18-month contract. Both fitted into the role seamlessly and undertook their tasks with professionalism. They ‘hit the ground running’ and have not stopped. I sincerely wish that this Court could continue to have three Counsels Assisting as they are all needed to keep the significant workload and backlog under some semblance of control. I acknowledge the assistance of Andrew Harris QC in the inquest into the death of Alexander Kuskoff and Anthony Crocker in the inquest into the death of Wayne Fella Morrison.

Each year I have cause to reflect on the significant contribution made by the staff of the Court. Whilst we had some new staff join our team during the year, the majority of staff are highly experienced, long standing members of the Coroners Court. There is a dedicated camaraderie amongst staff that makes this institution a very satisfying place to work. The staff are experienced and knowledgeable. This enables the Coroners to place a high degree of trust in the work completed and in the information that is presented. I congratulate the staff on their dedication and continued high standards of accuracy when faced with enormous volumes of work. I must also mention their unwavering compassion towards grieving families and their focus on progressing the necessary pathways that must be met before a deceased person can be released to a family for burial ceremonies. This year has seen a focus on reviewing backlogged matters and the staff can be rightly proud of the progress.
I thank the SAPOL officers in the Coronial Investigation Section (CIS) for managing reports of death that are provided by SAPOL members who are tasked to attend sudden deaths. A proper investigation into a death provides a coroner with a basis for continuing inquiries. It is essential that police officers approach a coronial inquiry with a mindset that seeks to establish the manner and circumstances of the death, whilst also relating the inquiries to the aim of preventing similar deaths in the future.

During the year under review the staff of the Court continued a positive relationship with Forensic Science SA (FSSA). I thank the forensic pathologists for their expertise and knowledge and for being readily available to me, the Deputy State Coroners and relevant staff to discuss cases as issues and queries arise. I also extend thanks to the broader scientific and technical staff of FSSA for the invaluable and sophisticated information they provide to support coronial investigations. During the year under review coronial senior staff and Coroners, and, FSSA senior staff and pathologists formally met on four occasions to discuss strategic issues relating to the provision of forensic services to the State Coroner. Topics for discussion of mutual interest included CT and MRI imaging, neuropathology examinations, recording of date of death issues and general updates on research projects.

I extend my thanks to Professor Peter Blumbergs for his continued work in special brain examination and Professor Tony Thomas for special examination of hearts. Both practitioners are the sole experts in their fields in this State. I am indebted to them for continuing to apply their expert specialisation to the coronial jurisdiction.

I express my appreciation to the Women’s and Children's Hospital (WCH) for providing specialist post mortem advice on paediatric cases.

I acknowledge the contribution made by the team of forensic odontologists who provide the Coroners Court with dental identification analyses in the circumstances where other methods of identification of deceased persons have not been successful or possible.

I express my gratitude to the Manager of the Coroners Court, Michele Bayly-Jones, for her untiring efforts in the very big job of managing the Court and staff. She is immensely knowledgeable and an indispensable member of the office. She has again, as in past years, gone above and beyond the strict requirements of her position. I thank her for her wise counsel, her leadership and at a personal level, her friendship.
3. **Reportable Deaths and the Role of the Coroner**

The Coroners Act 2003 requires that the State Coroner investigates all reportable deaths.

The role of the Coroner is to investigate any sudden, unexpected or unknown cause of death. The Coroner establishes the cause of death, the identity of the deceased and the circumstances preceding the death.

The Coroners Act 2003 tells us what constitutes a reportable death. Regardless of the age of the individual or any subjective opinion of a third party about the death, if the death falls within the definition of a reportable death as defined by the Act, then the death is reportable. There is no discretion to choose whether or not a death is reportable.

The Coroners Act 2003 provides that deaths falling under the following categories are reportable deaths:

- Unexpectedly, unusually or by a violent, unnatural or unknown cause;
- On a flight or voyage to South Australia;
- While in custody;
- During, as a result or within 24 hours of certain surgical or invasive medical or diagnostic procedures, including the giving of an anaesthetic for the purpose of performing the procedure;
- Within 24 hours of being discharged from a hospital or having sought emergency treatment at a hospital;
- While the deceased was a 'protected' person;
- While the deceased was under a custody or guardianship order under the Children's Protection Act;
- While the deceased was a patient in an approved treatment centre under the Mental Health Act;
- While the deceased was a resident of a licensed supported residential facility under the Supported Residential Facilities Act;
- While the deceased was in a hospital or other facility being treated for drug addiction;
- During, as a result or within 24 hours of medical treatment to which consent had been given under Part 5 of the Guardianship and Administration Act;
- When a cause of death was not certified by a doctor.

I have stated in previous Annual Reports, and I reiterate, that there is no penalty for reporting a death that upon closer analysis proves not to be reportable under the Coroners Act. However, it is an offence to fail to report the death of a person whose death must be reported.
In investigating the cause and circumstances of a death I rely on a range of professional opinions. Such opinion may extend to how a practice or system should operate and how practices and systems, if changed, may prevent a death in similar circumstances to the one under investigation.

In order to explore these matters I am able to exercise wide powers of inquiry, such as:

- Entering premises and viewing a body;
- Inspecting and removing anything pertaining to the coronial investigation;
- Taking photographs, film, video or other recordings;
- Remove a body;
- Exhume a body (with the consent of the Attorney-General) and;
- To direct a medical practitioner to examine a body and perform any tests that are necessary to establish the cause of death.

The above powers enable coronial investigators to gather information and provide me with evidence on which to base decisions about whether it is necessary or desirable to hold an inquest.

Extensive work is undertaken by staff in the Coroners Court, as well as by FSSA and SAPOL, to review the circumstances of the death so that a Coroner can receive a recommendation to assess whether a case should proceed to inquest.

The process of investigating a case from report of death to gathering the necessary information and evidence, and then a decision as to whether to inquest or finalise the case, can be quite lengthy. The process may take between 9 to 24 months.

A death does not have to be suspicious in order to have it reported to the Coroner. Many of our inquiries reveal that although a person died suddenly, they died as a result of natural causes. This office makes every effort to process these cases in a timely manner. This can be achieved in a case where a post mortem examination is not necessary.

Many people believe that all cases reported to a Coroner are the subject of an inquest. This is not so. On average approximately 2% of deaths reported to a Coroner in South Australia proceed to the Court for an inquest. All deaths are investigated to the extent of establishing whether the circumstances of the death warrant the conduct of an inquest which is held in an open court. Only when the often lengthy investigations are finalised is a determination made as to whether an inquest is necessary or desirable.

For those cases that do not proceed to inquest, the Coroner makes a finding as to the cause of death (Coroners Act Part 5 Section 29 (b)). There is no other narrative written about the circumstances of death and no recommendations can be made. This is sometimes surprising to families who are expecting a formal and detailed
description of the circumstances of the death at the end of the process. However, family members are generally permitted to read material held on file including statements and medical and other expert reports that give a very comprehensive picture of the circumstances of their loved one's death, and the thorough investigations that have been carried out by my office.

Section 25 of the Coroners Act 2003 provides that when making findings upon inquests, the Court may add to its findings any recommendation that might, in the opinion of the Court, prevent, or reduce the likelihood of, a recurrence of an event similar to the event that was the subject of the inquest.

In deciding which cases proceed to inquest, section 25 provides an important benchmark against which to judge and balance the various factors for consideration.

However, an inquest may be extremely beneficial even if no recommendation is made. The holding of an inquest can shine a light on events that have given rise to public disquiet or concern. The beneficial effects of opening events to public scrutiny, and highlighting events that would otherwise remain hidden from public scrutiny, cannot be overestimated.
4. Matters Arising During 2017-2018

4.1. Domestic Violence Research Project

In 2011 the Office for Women and the SA Coroners Court established a partnership to research and investigate domestic violence related deaths. The position of Senior Research Officer (Domestic Violence) has been in place since January 2011 and has reported to the relevant Minister and Chief Executives since that time.

The Senior Research Officer identifies domestic violence issues, contexts and relevant service systems issues, whilst investigating the adequacy of responses and providing advice to the Coroner. This advice forms part of the coronial brief and builds the capacity of the coronial inquest to make recommendations for improvement, with a preventative focus.

To date over 240 deaths have been reviewed with ten domestic violence inquests held resulting in 43 specific coronial recommendations for system improvement. In this reporting period the findings into the death of Deborah McKenzie were handed down by the Deputy State Coroner on 25 July 2017.

The Senior Research Officer has delivered presentations to the Domestic Violence Court Magistrates national meeting and the Asia Pacific Coroners Society Conference 2017 as well as guest lectures at the University of South Australia and several organisations including Centacare domestic violence teams.

The Senior Research Officer also contributes to the provision of data at a State and National level. The South Australian Coronial Domestic Violence Information System (CDVIS) specifically houses data relating to domestic violence related deaths. The CDVIS has been operational since May 2015 and incorporates over 120 different perpetrator and victim-specific variables and provides the capacity to record data and track trends.

In 2017-18 the CDVIS expanded to include analysis of the dynamics of domestic violence to determine system contact and support, as well as vulnerability and risk factors. This data capture and analysis has been ongoing throughout 2017-18.

The Australian Domestic and Family Violence Death Review Network (The Network) was established in May 2011 in recognition that the systematic and forensic alignment of domestic and family violence death review processes, at a national level, would enable progression towards aligned investigation standards and produce comparative data.

The Senior Research Officer represents the SA Coroners Court as a member of the Network, and is the current Chair of the Network.

The Network has collaborated to develop a national minimum data set relating to domestic and family violence homicides. The Network's inaugural National Data Report 2018¹ was released in May 2018. This is the first national report with

specific focus on deaths occurring in a domestic violence context. This report specifically focuses on intimate partner homicides occurring in a domestic violence context (2010-2014).

4.2. **Department for Health and Wellbeing - Expert Reports**

For some time the SA Department for Health and Wellbeing has caused its consultants to doubt that they are permitted to provide the Coroners Court with expert reports about aspects of the public health system.

The apparent basis for the doubt is the notion that as an employee of the Department of Health and Wellbeing the consultant owes the Department an obligation not to express any opinion that may reflect adversely on the Department. For at least the last 12 months I have attempted to persuade the Department to make it clear to its consultants that they are free to assist the Coroners Court in providing expert reports. My view is that it is in the public interest that they be free to do so without fear of disciplinary sanctions by their employer. Unfortunately the Department has been extremely slow in responding to my concerns. This is a simple problem that should be resolved quickly and easily. I hope the coming year produces a sensible outcome.

4.3. **Department for Health and Wellbeing – Safety Learning System**

I have noted cases where adverse medical events have been recorded in the Department for Health and Wellbeing Safety Learning System, but that an ensuing death may be thought, correctly or otherwise, not to be reportable. It seems to me that an amendment to the Coroners Act 2003 is necessary to include within the definition of 'reportable death' a death following a period of hospitalisation during which a Safety Learning System report about the patient has been entered by any staff member.

4.4. **Forensic Science SA – Delays in Completion of Post Mortem Reports**

It has come to my attention over the past 12-18 months that the timeframe for the completion of post mortem reports is getting longer. I must emphasise that I have no issue with the quality of the reports produced. The level of professionalism and dedication remains high. However, my staff are now in a position where they are routinely advising families that the waiting time for the completion of a post mortem report is between 9-12 months. Unfortunately, there are currently outstanding reports of 14 months duration.

Firstly, this delays the progression of the coronial inquiry as the review of the case material cannot begin until the post mortem report is completed and the cause of death established. Secondly, families are waiting a very long time to receive the cause of death and in many cases progress estate matters. The Coroners Court staff are increasingly subjected to the anger of next of kin who simply lose patience with the system and cannot understand how even people who die from
natural causes can take so long to resolve. I am told there is a shortage of forensic pathologists in Australia and I am sympathetic to the issues of low levels of resources to undertake complex and voluminous work, however, I would like to see the performance indicators for completion of post mortems reduce to a level that the system and the community can reasonably tolerate.

4.5. Coroners Court Succession Planning

The standing complement of the Coroners Court, excluding Coroners, is 18 staff (including vacancies and locum social workers and staff employed on contract with the additional funding). This number is too few to permit orderly succession planning. The plain fact is that if the Court were to lose one or more key persons, it would experience severe disruption to the provision of coronial services. Within the existing complement of staff it is not possible to train potential replacements for key positions.

4.6. Research Projects

During the year under review the Coroners Court approved research access to the Pregnancy Outcome Unit and the Child Death and Serious Injury Review Committee.

I believe that it is important to support research where possible. To this end, where I can collaborate with bona fide and approved researchers to enhance and inform public health and safety, and when it does not impact on my limited staff and budget resources, I am happy to do so.

4.7. Budget and Staffing Resources

I report that substantive staffing levels remained the same during the year under review.

The State Government provided extra assistance funding to the Coroners Court to undertake four major inquests into the deaths of:

- Alexander Kuskoff
- Dion Muir and Graziella Dailler
- Wayne Fella Morrison
- Jorge Castillo-Riffio

The inquests for all five deceased commenced during the year under review. All but the Morrison inquest were completed during the year under review. I expect that all findings will be published next reporting year.

The additional funding enabled the Court to engage a second Deputy State Coroner, a third full time Senior Counsel Assisting, and counsel from the independent bar to act as Counsel Assisting in the Kuskoff and Morrison inquests. Additional administrative support and auxiliary services were also procured for the express purpose of hearing these inquests.

I continue to hold the view I have expressed in previous Annual Reports that my office is under-resourced to cope with the volume of cases that are reported each
year. With the resources available the office cannot progress research partnerships, or undertake proactive continuous improvements such as the development of improved work practices, new publications and enhancements to the website, or the finalisation of the review of the operational procedures manual. Staff are wholly occupied with processing the day to day operational work and can rarely take time 'off-line' to develop new processes, policies and practices.

When a decision is made to conduct a lengthy inquest with far reaching community interest my Senior Counsels Assisting are consumed with preparing the inquest and are then occupied in Court for weeks at a time. There is consequently limited time for them to devote to reviewing other cases that also require analysis and preparation. Ultimately, the coronial process is often cumbersome and results in delays for families in having their matters finalised. But I am confident that staff work to full capacity each day to progress cases, and the system can only operate within the resources that are provided. However, I profoundly regret that families are subjected to lengthy delays in having matters brought to inquest.

4.8. Death Report to Coroner Medical Practitioners Deposition

After the death of a person in a hospital the medical practitioner who has been responsible for the treatment of the person must complete a 'Death Report to Coroner Medical Practitioners Deposition' form. I have mentioned in previous Annual Reports that I consider the quality of the completion of these forms to be poor. Often sections of the form are not even completed and the clinical progress summary is often illegible, with brief information. This year, the Deputy State Coroner and I have noticed a worrying trend which is to have a medical intern complete the form. Often the intern has barely treated the patient which results in a deposition that is difficult to understand and may lead to the direction for post mortem which may not have been necessary if a senior medical practitioner had completed the form and given me the benefit of their clinical expertise. This is not a reflection on the interns themselves, I support their ongoing education and experience and acknowledge they are placed in a difficult position. However, it is a fundamental requirement that when a patient dies and their death is reportable to a Coroner, that the medical practitioner who had knowledge of and responsibility for the patient completes the form giving a Coroner the benefit of their knowledge of the patient's presentation, diagnosis, treatment, interventions and ultimate events that lead to the patient's demise.

4.9. Guardianship and Administration Act 1993

The introduction of s76a of the Guardianship and Administration Act 1993 has meant that a death by natural causes of a person subject to a protection order under that Act is not to be taken to be a death in custody for the purposes of the Coroners Act 2003.

This provision came into effect on 1 March 2018 and its effect was therefore marginal during the year under report. It is hoped that it will ameliorate the need for unnecessary inquests in this category in the year ahead.
4.10. **Hierarchy of Senior Next of Kin**

During the year under review the Court was contacted by relatives of deceased persons who do not have senior next of kin status seeking to receive information about their relatives. Such approaches from relatives demand time and resources in managing disputes about who gets to access information from a case file. I have adhered to the policy position that only the senior next of kin is eligible to receive information about the deceased. Another party is only able to access the same information with the written permission of the senior next of kin. This office does not have the resources to engage in inquiries into the merits of a family dispute and whether an individual with a poor relationship history, either with the deceased when they were alive or the senior next of kin, should be entitled or disentitled to have information about the deceased.

It might be suggested that it would be possible to set up a dispute resolution process to deal with these issues. However, any dispute resolution process would have to be thorough as a cursory attempt to unravel a delicate and complicated set of relationships and longstanding grievances would be likely to cause more harm than good. The Coroners Court does not have the resources to manage a dispute resolution process to arbitrate between parties who may never agree on who has the right to information.

There is an exception to the policy. In some cases members of a family are contacted and informed about post mortem results. That occurs where the forensic pathologist recommends in a post mortem report that family members be tested for a hereditary or genetic medical problem that the deceased was found to have. When such a recommendation is made a Social Worker from the Coroners Court contacts family members and advises them of the results of the post mortem and suggests that they seek medical advice.

The Coroners Court Rules 2005 defines ‘senior available next of kin’ as follows:

Senior available next of kin means-

(a) in relation to a child, the first in order of priority of the following persons whose contact details are known to the Manager:

(i) a parent of the child;
(ii) a brother or sister, who has attained the age of 18 years, of the child;
(iii) a guardian of the child; and

(b) in relation to any other person, the first in order of priority of the following persons whose contact details are known to the Manager:

(i) the spouse of the person;
(ii) the domestic partner of the person;
(iii) a son or daughter, who has attained the age of 18 years, of the person;
(iv) a parent of the person;
(v) a brother or sister, who has attained the age of 18 years, of the person.
Domestic partner is defined by the Family Relationships Act 1975. For the purposes of the Coroners Act domestic partner will include *de facto* partner who on the date of the deceased's death was cohabiting with the deceased in a close personal relationship and so cohabited with that other person as the husband or wife (*de facto*) of the deceased person continuously for the period of three years immediately preceding the date of death, or, during the period of 4 years immediately preceding that date so lived with that other person for periods aggregating not less than 3 years, and/or there is a child/ren of which the domestic partner (*de facto*) and the deceased were the parents.

As a matter of policy the Coroners Court applies the hierarchy of senior available next of kin to requests for access to information and approval to access items such as tissue samples for DNA testing. If the designated senior next of kin chooses/agrees to another person also having senior next of kin status that will be determined with the Coroners Court Social Worker in consultation with the Manager, Coroners Court.

4.11. **Superannuation and Insurance**

I have been concerned about the policies of superannuation and insurance companies over a number of years. Many families involved with the coronial process have suffered financial hardship because superannuation and insurance companies will not pay the entitlements owed to families after the death of a loved one.

Superannuation and insurance companies require that a final death certificate be produced before a claim can be honoured. This continues to have an impact on the operations of the Coroners Court. Much time is occupied in dealing with the consequences for families of their insurer/superannuation fund insisting on completion of the coronial process. In my opinion it is entirely unnecessary. In the vast majority of cases proof of death alone ought to be sufficient for payment to the deceased's estate of monies due.
5. **Statistical Information**

There were 14 023 deaths registered with the Registrar of Births, Deaths and Marriages in 2017-2018. Of these, 2 599 deaths were reported to the State Coroner, an increase when compared with last year.

In 2017-2018, 21 inquests were held into individual deaths, of which eight related to deaths in custody. The significant decrease in the number of inquests held has been a result of the number of complex large inquests that were undertaken this year.

Eight inquests were part-heard from the 2016-2017 financial year. There were nine matters part heard as at 30 June 2018 and will continue into the 2018-2019 financial year. There were 15 252 pages of transcript produced representing the length and complexity of inquests heard during this year.

There were 35 inquest findings delivered during 2017-2018. This figure is the actual number of findings delivered, regardless of the number of deaths per inquest. Court sitting hours for the period were 534 hours.

No country inquests were held during the financial year 2017-2018.

5.1. **Cases Reported by Local Case Management (LCM) Cause of Death Code**

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<th>Cause</th>
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<td>0</td>
<td>Marine</td>
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<tr>
<td>Burns</td>
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<td>Natural</td>
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*Please note that the LCM Cause of Death code is a ‘snapshot’ of broad categories as each death must be coded in one major ‘cause’ category, e.g. death in custody must be recorded as the primary code even if the death was as a result of suicide.*
5.2. Year in Review

During the year under review 2,599 deaths were reported to the State Coroner and 2,813 cases were finalised (finalised cases includes cases that were opened in previous years).

<table>
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<th>At A Glance</th>
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<td>Number of Coroners</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Number of Staff</td>
<td>16.2</td>
<td>16.7</td>
<td>16.7</td>
<td>18.0</td>
</tr>
<tr>
<td>Number of deaths reported</td>
<td>2290</td>
<td>2430</td>
<td>2537</td>
<td>2599</td>
</tr>
<tr>
<td>Number of post mortems</td>
<td>1683</td>
<td>1391</td>
<td>1344</td>
<td>1355</td>
</tr>
<tr>
<td>Inquest findings delivered</td>
<td>21</td>
<td>29</td>
<td>61</td>
<td>35</td>
</tr>
<tr>
<td>Number of Court sitting hours</td>
<td>373.5</td>
<td>318.5</td>
<td>276</td>
<td>534</td>
</tr>
</tbody>
</table>

* From 2015-16 staffing numbers are based on AFTE (Average Full Time Equivalent) which includes vacancies and locum social workers. An increase in staffing numbers for 2017-18 appears due to the additional funding to hear four inquests over a 2 year period. Actual substantive staffing establishment has not changed.

5.3. Case Statistics - Operational

<table>
<thead>
<tr>
<th>Pending Matters</th>
<th>2015-16</th>
<th>2016-17</th>
<th>2017-18</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lodgements pending completion &lt;12 mths old</td>
<td>1330</td>
<td>1561</td>
<td>1428</td>
</tr>
<tr>
<td>Lodgements pending completion &gt;12 mths old and &lt;24 mths old</td>
<td>490</td>
<td>593</td>
<td>442</td>
</tr>
<tr>
<td>Lodgements pending completion &gt;24 mths old</td>
<td>230</td>
<td>324</td>
<td>405</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Clearances and Backlogs</th>
<th>2015-16</th>
<th>2016-17</th>
<th>2017-18</th>
</tr>
</thead>
<tbody>
<tr>
<td>Case clearance rate</td>
<td>89.8%</td>
<td>72.9%</td>
<td>108.2%</td>
</tr>
<tr>
<td>Total cases pending finalisation</td>
<td>1723</td>
<td>2478</td>
<td>2275</td>
</tr>
<tr>
<td>Backlog (% &gt;12 months)</td>
<td>35.1%</td>
<td>37.0%</td>
<td>37.2%</td>
</tr>
<tr>
<td>Backlog (% &gt;24 months)</td>
<td>11.2%</td>
<td>13.1%</td>
<td>17.8%</td>
</tr>
<tr>
<td>All cases - lodgement to finalisation</td>
<td>2214</td>
<td>1850</td>
<td>2813</td>
</tr>
</tbody>
</table>
6. **Backlog of Inquests**

As at 30 June 2018, 106 inquests awaited hearing in the Coroners Court, including 96 cases involving a death in custody. There were 1,723 open cases pending inquiry. This represents an increase from the previous year taking into account the similar number of reported deaths. These open cases are at varying levels of investigation. Some may progress to a review by Counsel Assisting, the State Coroner and the Coronial Investigation Section.

As at 30 June 2018 there were 74 cases under high-level investigation by Senior Counsels Assisting. This represents an increase in cases under review by Senior Counsel Assisting when compared to last year.

The SAPOL Coronial Investigation Section (CIS) had 13 Tier 3 cases referred to the Detective Investigators by Senior Counsel Assisting, and 386 Tier 2 cases assigned for investigation to CIB and overseen by CIS. SAPOL patrols reported 1,489 Tier 1 cases to the State Coroner which were quality assured by CIS.
7. **Professional Presentations of State Coroner and Deputy State Coroner**

**State Coroner**

*Member*
- SA Indigenous Justice Committee
- Heads of Jurisdiction, Courts Administration Authority

*Presentations, etc*
- Panel Member Asia Pacific Coroners Conference

**Deputy State Coroner**

*Member*
- Magistrates Association of South Australia Executive

*Presentations, etc*
- Bar Readers Course
- Magistrates Conference - Participation in panel re expert evidence
- Presentation at the Asia Pacific Coroners Conference
- Presentation to nursing staff at the St Andrews Hospital
8. **Asia Pacific Coroners Conference**

The annual Asia Pacific Coroners Society (APCS) Conference 2017 was held at the Stamford Grand Adelaide (Glenelg) from Tuesday 31 October to Friday 3 November 2017. The program ran for a total of two and a half days and comprised of a Keynote Address on Voluntary Euthanasia and the Coronial Process delivered by Marshall Perron, Former Chief Minister of the Northern Territory and a number of panel sessions on relevant topics such as child protection, domestic violence, death in epilepsy, drowning and defence deaths. Other highlights included presentations on the Lindt Café siege, and, facial recognition technology.

The most highly acclaimed session was that given by Gill Hicks about her experience as a victim of the London underground terrorist attack. It is an exceptionally rare occurrence that Coroners are able to hear first-hand about the experience of being trapped in a disaster event and the issues surrounding the rescue attempt during a multiple fatality disaster. It was enlightening to listen to Gill Hicks speak about her profound injuries, her mental strength whilst waiting for rescue and her resilience in rebuilding her life.

The conference was a success and returned a small profit to the APCS to devote to the organisation of the next conference in Canberra.

I wish to extend my thanks to the local organising committee who worked for two years to plan the logistics and program for the conference.

- Michele Bayly-Jones, Manager Coroners Court
- Tony Schapel, Deputy State Coroner
- Naomi Kereru, Senior Counsel Assisting, Coroners Court
- Dr Karen Heath, Forensic Pathologist, Forensic Science SA
- Professor Roger Byard, Forensic Pathologist, Forensic Science SA
- Jayne Basheer, Deputy State Coroner (from August 2017)
- Amy Davis, Senior Counsel Assisting, Coroners Court (until May 2017)

I also wish to extend my gratitude to the conference organiser Vicky Tropsidis and her team from Eventful Projects for their exceptional management of the conference. All went smoothly largely due to Ms Tropsidis’ attention to detail and consummate professionalism and experience.
9. **Inquests for the Year 1 July 2017 to 30 June 2018**

- Atkins, Stephen Robert
- *Castillo-Riffo Jorge Alberto*
- Chaplin, Gray Clyde
- Clavell, Rodney Ian
- Cutts, Charles Desmond
- Dailler, Graziella
- Howard, Miranda Robyn
- Jones, Heath Ryan
- La Bella, Claudia
- McNamara-Cutler, Juanita Lee
- McPherson-Smith, Aurora Holly Violet
- Mitchell, Wayne Brian
- *Wayne Fella Morrison* (Directions Hearings)
- Muir, Dion Wayne
- *Murray, Erin Paige*
- Nguyen, An Hoang Le
- *Patterson, Amy Jean*
- Ross, Chrystal Jessica
- Schulze, Brian John
- Singh, Heidi Eileen Roseanne
- Sissons, Anthony Vincent
- Sukkar, Tary

** Italics denote that the matter is part heard and will resume in the 2018-2019 financial year. **
9.1. **Inquests Held During the Year 1 July 2017 to 30 June 2018**

<table>
<thead>
<tr>
<th>No</th>
<th>Name</th>
<th>Date of Death</th>
<th>Inquest Number</th>
<th>Inquest Start Date</th>
<th>Finding Delivered</th>
<th>Period (mths) From DOD</th>
<th>Period (mths) From Inquest</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>SINGH, Heidi Eileen Roseanne</td>
<td>21/08/14</td>
<td>6/2017</td>
<td>21/11/17</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>2</td>
<td>HOWARD, Miranda Robyn</td>
<td>27/11/13</td>
<td>12/2017</td>
<td>12/09/17</td>
<td>05/03/18</td>
<td>52</td>
<td>6</td>
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<tr>
<td>3</td>
<td>McPHERSON-SMITH, Aurora Holly</td>
<td>01/07/15</td>
<td>12/2017</td>
<td>12/09/17</td>
<td>05/03/18</td>
<td>33</td>
<td>6</td>
</tr>
<tr>
<td>4</td>
<td>JONES, Heath Ryan</td>
<td>01/07/15</td>
<td>15/2017</td>
<td>8/11/17</td>
<td>30/01/18</td>
<td>31</td>
<td>3</td>
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<tr>
<td>5</td>
<td>LA BELLA, Claudia</td>
<td>29/06/14</td>
<td>16/2017</td>
<td>28/11/17</td>
<td>23/05/18</td>
<td>47</td>
<td>6</td>
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<tr>
<td>6</td>
<td>SISSONS, Anthony Vincent</td>
<td>24/06/12</td>
<td>17/2017</td>
<td>18/12/17</td>
<td>05/02/18</td>
<td>68</td>
<td>2</td>
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<tr>
<td>7</td>
<td>CLAVELL, Rodney Ian</td>
<td>15/05/14</td>
<td>1/2018</td>
<td>6/02/18</td>
<td>28/06/18</td>
<td>50</td>
<td>5</td>
</tr>
<tr>
<td>8</td>
<td>ATKINS, Stephen Robert</td>
<td>23/03/15</td>
<td>2/2018</td>
<td>12/02/18</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>9</td>
<td>ROSS, Chrystal Jessica</td>
<td>22/01/15</td>
<td>3/2018</td>
<td>30/04/18</td>
<td>-</td>
<td>-</td>
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</tr>
<tr>
<td>10</td>
<td>DAILLER, Graziella</td>
<td>15/05/14</td>
<td>4/2018</td>
<td>3/04/18</td>
<td>-</td>
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<tr>
<td>11</td>
<td>MUIR, Wayne Dion</td>
<td>15/05/14</td>
<td>4/2018</td>
<td>3/04/18</td>
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<td>-</td>
<td>-</td>
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<tr>
<td>12</td>
<td>CHAPLIN, Gray Clyde</td>
<td>05/03/16</td>
<td>5/2018</td>
<td>12/06/18</td>
<td>-</td>
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<tr>
<td>13</td>
<td>CUTTS, Charles Desmond</td>
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<td>6/2018</td>
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<td>-</td>
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<tr>
<td>14</td>
<td>NGUYEN, An Hoang Le</td>
<td>14/07/15</td>
<td>7/2018</td>
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</tr>
<tr>
<td>15</td>
<td>SCHULZE, Brian John</td>
<td>26/08/15</td>
<td>8/2018</td>
<td>23/02/18</td>
<td>-</td>
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<td>-</td>
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<tr>
<td>16</td>
<td>CASTILLO-RIFFO Jorge</td>
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<td>9/2018</td>
<td>19/03/18</td>
<td>-</td>
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<tr>
<td>17</td>
<td>SUKKAR, Tary</td>
<td>11/12/13</td>
<td>10/2018</td>
<td>24/05/18</td>
<td>-</td>
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<tr>
<td>18</td>
<td>McNAMARA-CUTLER, Juanita Lee</td>
<td>07/09/14</td>
<td>11/2018</td>
<td>30/05/18</td>
<td>-</td>
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<tr>
<td>19</td>
<td>MORRISON, Wayne Fella (DH)</td>
<td>26/09/16</td>
<td>15/2018</td>
<td>23/03/18</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>No</td>
<td>Name</td>
<td>Date of Death</td>
<td>Inquest Number</td>
<td>Inquest Start Date</td>
<td>Finding Delivered</td>
<td>Period (mths) From DOD</td>
<td>Period (mths) From Inquest</td>
</tr>
<tr>
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</tr>
<tr>
<td>20</td>
<td>MURRAY, Erin Paige</td>
<td>26/07/14</td>
<td>18/2018</td>
<td>26/06/18</td>
<td>-</td>
<td>-</td>
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</tr>
<tr>
<td>21</td>
<td>PATTERSON, Amy Jean</td>
<td>17/10/15</td>
<td>18/2018</td>
<td>26/06/18</td>
<td>-</td>
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<tr>
<td>22</td>
<td>MITCHELL, Wayne Brian</td>
<td>16/11/15</td>
<td>21/2018</td>
<td>12/06/18</td>
<td>-</td>
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</tr>
</tbody>
</table>
9.2. **Recommendations**

Section 25(2) of the Act provides that the Court may add to its findings any recommendations that might, in the opinion of the Court, prevent or reduce the likelihood of a recurrence of an event similar to the event that was the subject of the Inquest. Where a recommendation is made pursuant to section 25, the recommendation must be included in this annual report (section 39(2)). The following is a list of recommendations made by the Coroners Court during the year the subject of this report (excluding deaths in custody):

**Rita Ann Broadway (Coroner Johns)**

Professor Kelly produced a document entitled Diagnostic criteria for Catheter-Associated Urinary Tract Infection (CAUTI) in adults which might service as the basis for adoption as a protocol within the South Australian health system. Accordingly, I recommend that the Minister for Health investigate the development of a protocol for diagnostic criteria for catheter associated urinary tract infection in adults within the South Australian health system and suggest that Exhibit C12c may provide a starting point for the development of such a protocol.

**Stephen Herczeg (Coroner Johns)**

I make the following recommendations directed to the Minister for Health:

1) That EPAS modifications for CO2 retaining chronic obstructive pulmonary disease patients have both upper and lower limits on oxygen saturation levels;
2) That a password be entered into EPAS when observations are recorded;
3) That the practice of one person taking observations and another person entering data onto the EPAS system cease;
4) That if respiratory patients are not admitted to a respiratory ward, the admitting doctor provides detailed instructions to staff leaving no room for error;
5) That patients exhibiting confusion undergo a risk assessment prior to their admission to the ward.

**Miranda Robyn Howard and Aurora Holly Violet McPherson-Smith (Coroner Basheer)**

I recommend that the Fullarton Private Hospital adopt and implement a policy which prohibits transport of any patient by taxi or other chauffeured delivery service who has self-harmed or has otherwise been deemed to be at risk unless accompanied by a nurse or other suitably qualified employee of the Fullarton Private Hospital.

The following recommendations are directed to the Minister for Mental Health and Substance Abuse, the Minister for Health and the South Australian Mental Health Commissioner. I recommend that the State Government take immediate steps to identify and allocate funding for a full assessment of:

- The Spectrum Personality Disorder Service for Victoria as a prototype model for South Australia; and
- The Orygen Youth Service Helping Young People Early (HYPE) as a prototype model for the treatment of Borderline Personality Disorder in adolescents in South Australia.
I recommend that the State Government adopt and implement as a matter of urgency, the recommendations contained in the final report of the South Australian Borderline Personality Work Group entitled 'Borderline Personality Disorder: An Overview of Current Delivery of Borderline Personality Disorder Services in the Public Sector across South Australia and a Proposed Way Forward (June 2014).

I recommend that immediate steps are taken to create the position of Borderline Personality Disorder Coordinator and that the position is advertised nationally and internationally in order to find a suitably qualified person with appropriate clinical expertise to undertake this role.

I recommend that Dr Martha Kent OAM be engaged as a consultant to the State Government for the following purposes:

a) To provide advice on the development and implementation of the recommendations contained in the final report of the South Australian Borderline Personality Disorder Work Group (June 2014);

b) To oversee a revision and simplification of the South Australian Mental Health Commission Action Plan for People Living with Borderline Personality Disorder (2017-2020);

c) To provide supervision and advice to any Project Steering Committee and/or other group which is tasked to develop and implement the recommendations;

d) To ensure that the new Action Plan incorporates the key tenets of the National Health and Medical Research Council Guidelines for Health Professionals Caring for People with Borderline Personality Disorder (2013);

e) To Chair any panel which is convened to interview, assess and select any applicant for the position of Borderline Personality Disorder Coordinator in South Australia.

I recommend that the State Government enter into negotiations with key public sector stakeholders regarding any policies which exclude private psychiatrists from having a clinical role in the management and treatment of a patient who has been diagnosed with Borderline Personality Disorder, is under their care and who has been admitted to a public hospital or other public sector health facility.

Claudia La Bella (Coroner Johns)

I make the following recommendations which are directed to the South Australian Minister for Health and Wellbeing and the Australian Government Department of Health, Therapeutic Goods Administration:

1) I recommend that in hospital presentations or admissions involving cases of severe weight loss where there is any suspicion of an eating disorder, there must be a referral to the Psychiatric Liaison Service and that must be triggered as a matter of urgency if the patient wishes to self-discharge;

2) I recommend that where a patient is discharged from hospital against medical advice, but with an expectation that they will be treated by their general practitioner in the community, a personal discussion between a member of the treating team and the general practitioner is mandatory before the patient leaves the hospital.

3) I recommend that Dulcolax and like medications be classed as pharmacist only medications, the safe use of which requires professional advice. They should not be available for self-
selection from pharmacy shelves or online stores and purchases should only be made following consultation with the pharmacist.

In addition I draw this Finding to the attention of the Pharmacy Board of Australia, the Pharmacy Guild of Australia, the Royal Australian College of General Practitioners and the Australian College of Rural and Remote Medicine.

Deborah Francis McKenzie (Coroner Schapel)

The Court makes the following recommendations directed to the Commissioner of Police, the Chief Executive of SA Health, the Chief Executive of Country Health SA LHN, the Chief Psychiatrist and the Chief Executive Officer of the Australian College of Rural and Remote Medicine:

1) That a dedicated and properly staffed psychiatric unit be maintained in the Port Augusta region that has the capacity and lawful authority to accommodate, treat and if necessary detain patients who are at risk of suicide. The unit should be designated as an approved treatment centre pursuant to the Mental Health Act 2009. The unit should be staffed by at least one full-time and permanent consultant psychiatrist who is resident in the region and by at least one psychiatric registrar also resident in the region.

2) That all clinicians at regional hospitals, including general medical practitioners and nursing staff, be instructed to use tele-psychiatry services operated by the Rural and Remote Triage Service in relation to all patients who are suspected of being at risk of suicide or who have already made a suspected or actual suicide attempt.

3) That no patient who is suspected of being at risk of suicide or has made a suspected or actual suicide attempt should ever be discharged from a regional hospital without being reviewed and assessed by a medical practitioner. A psychiatrist’s input should be sought, either in person or remotely, in relation to any proposed discharge.

4) That continuity of care for patients who are perceived to be at risk of suicide should at all times be maintained. Proper in-person handovers should take place as between one medical practitioner and another. Ideally the same practitioner should maintain care in relation to the patient.

5) The need to gather collateral and corroborative information relating to a patient who is at perceived risk of suicide should be reinforced in the minds of clinicians. The discharge of a patient should not occur until all necessary collateral information has been sought and provided.

6) That clinicians practising in regional hospitals, including medical practitioners and nursing staff, should assess with a critical mind a patient’s denials of current suicidal intent and should consider the possibility that denials of important and critical circumstances may be engendered by a desire to be discharged from the hospital so as to enable the patient to act upon undisclosed or denied suicidal intent. In particular, denials of previous suicide attempts should be evaluated against the patient’s documented medical history.

7) That the Port Augusta Hospital review its practices in relation to the prescription of the drug olanzapine as a means of sedation in cases where (a) there is no evidence of psychosis, (b) where there has been an actual or suspected overdose of other medication or substances, (c) where it may be necessary to carry out a mental health assessment and where the effects...
of olanzapine may still exist at the time of such assessment and (d) where there are other
more suitable sedating medications available.

8) That the Commissioner of Police develop and establish a domestic violence protocol to cater
for instances in which the complainant is also an informant in relation to other alleged
criminal acts committed by the complainant’s domestic partner. The protocol should deal
with matters such as witness protection, the welfare of the complainant and bail. In cases
of identified high risk to the complainant, SAPOL should, as far as is possible, routinely
ensure that they are kept informed of medical issues that may be experienced by the
complainant.

9) That the Commissioner of Police ensure that police prosecutors are made fully aware of
their duties and responsibilities in connection with the issue of bail, particularly in cases
involving alleged domestic violence. Education should be delivered to prosecutors
regarding section 10A of the Bail Act 1985 and in respect of the offences that enliven that
provision. Prosecutors should be reminded that DPP advice should be read, properly
understood, evaluated and strictly adhered to. In circumstances in which strong opposition
is raised in relation to the granting of bail in a Magistrates Court, the immediate indication
of a Supreme Court bail review should be considered as the default position to be taken.

10) That the Commissioner of Police ensure that in cases involving the prosecution of serious
crime, the arresting or investigating officer, or that officer’s properly briefed nominee,
should attend court on any bail application that is opposed.

11) That the Commissioner of Police ensure that prosecution units in the Port Augusta/Whyalla
region are properly staffed and that prosecutors within those units are at all times properly
briefed.

12) That the Commissioner of Police take steps to ensure that investigating officers are made
aware of the need to protect important and vulnerable witnesses and that as far as is
possible to ensure that they are made aware of the hospitalisation of such witnesses,
especially in circumstances involving the mental health of such witnesses.

Finally, Mr Charles in his original written submission has informed the Court that Ms McKenzie’s
family have asked for a recommendation that a halfway house/psychiatric institution be built
for young Aboriginal people who find themselves in situations similar to that of their late
daughter and that it be named in her honour. I direct this request to the Minister for Health
and the Minister for Aboriginal Affairs.

Ike Jordan Zerk (Coroner Johns)

I recommend that the Minister for Health raise the issue of whether it would be appropriate to
recommend that a fixed guideline of 50mmHg be established for surgical referral with his
interstate counterparts with a view to encouraging the profession to give consideration to the
publication of guidelines in this matter.

The health system is South Australia consumes billions of dollars, and at a national level,
billions more. In a system that vast, it is absurd and unacceptable that the life of an otherwise
healthy 15 year old should be put at risk by reliance upon the ordinary mail service. There is
no paediatric cardiac surgery service in Adelaide. Therefore it is necessary to send information
to the services in Melbourne. There must be a failsafe mechanism for that to happen, whether
the patient is a public patient at the Women’s and Children’s Hospital, or a private patient of a
cardiologist such as Dr Adams.
I recommend a mandatory system be instituted for all cardiologists treating paediatric patients, under which they must register the patient with the Women's and Children's Hospital, and the patients' data must be provided to the Women's and Children's Hospital as and when it is gathered. The Women's and Children's Hospital should then be responsible for forwarding the reports to the team in Melbourne when that is required. Short of recommending that a paediatric cardiac surgical service be commenced in Adelaide, nothing less than the supervision of the safe transmission of crucial data by the Women's and Children's Hospital can suffice.

9.3. Recommendations - Deaths In Custody

Where a recommendation is made in relation to a death in custody, the Minister responsible for the agency or instrumentality of the Crown to which a recommendation is directed must, within eight sittings days of the expiration of six months after receiving a copy of the findings and recommendations, cause a report to be laid before each House of Parliament giving details of any action taken or proposed to be taken in consequence of the recommendations, and forward a copy of the report to the State Coroner. During the year under report the following recommendations were made in cases of deaths in custody:

**Rodney Ian Clavell (Coroner Schapel)**

I agree with counsel assisting Mr Kalali that the Court should appropriately make the following recommendations. I observe that the making of these recommendations does not imply that any of the underlying measures would necessarily have prevented the death of Mr Clavell, but they may do so in a future similar event. I direct these recommendations to the attention of the Commissioner of Police:

1) In compiling and releasing information to the public about an identified target, police officers must be accurate and precise in describing factual matters. Facts asserted in media releases should only in the rarest of circumstances, if ever, conflict with the findings and outcomes established in a court of law. The use of exaggerated and hyperbolic assertions of fact in media releases should be assiduously avoided.

2) Police internal reports in relation to the previous offending of an individual and to the court outcomes relating to the same should reflect not only the basis upon which the prosecution had presented its case against that individual, but also the factual basis on which the individual was dealt by the court.

3) When considering tactical measures in respect of the apprehension of high risk offenders, consideration should be given, where possible, to obtaining any historical mental health reports or psychological opinions concerning the offender. In some instances it may also be desirable to consult with officers who in the course of a previous incident have acted as negotiators in respect of the particular offender.

4) Relevant internal reports such as those compiled in respect of a Commissioner’s Inquiry should be made available to investigating officers and to those officers who are involved in tactical decision making in respect of the apprehension of high risk offenders.
Leonard Edward Dodson (Coroner Schapel)

I simply repeat the recommendations that were made in the Miller Inquest, added to as indicated:

'That the Medical Director of the South Australian Prison Health Service assign to a senior medical officer or officers within the Service the responsibility of maintaining oversight of the medical treatment and investigation of those prisoners within institutions operated by the Department for Correctional Services who are suspected of suffering from a serious or life threatening illness, especially in circumstances where the medical treatment and investigation of such prisoners is being conducted by medical practitioners who are not employees of the Service;

That the Medical Director of the South Australian Prison Health Service remind medical practitioners, both employed within the Service or otherwise, who treat prisoners within institutions operated by the Department for Correctional Services of the need to carefully explain to prisoners who are for whatever reason reluctant to undergo important medical treatment or investigation of the possible consequences of the failure of the prisoner to undergo such treatment or investigation and in particular to identify to the particular prisoner the worst case scenario that such an investigation might identify.

That the Medical Director of the South Australian Prison Health Service remind medical practitioners, both employed within the Service or otherwise, of the need to make detailed notations in a prisoner patient’s clinical record of the decision made by the prisoner not to undergo recommended medical treatment or investigation and of the stated reason for the prisoner refusing to undergo such medical treatment or investigation. I would add to this that there is also a need for a record to be made of any advice given to the prisoner that they should undergo the medical treatment or investigation.

That the Medical Director of the South Australian Prison Health Service and the Chief Executive Officer of the Department for Correctional Services be mindful of the fact that a refusal by a prisoner situated in a country correctional facility to undergo medical treatment or investigation that requires the prisoner to travel to Adelaide does not of itself mean that the prisoner cannot at least be compelled to travel to Adelaide and be accommodated in a correctional facility in Adelaide.

That the Medical Director of the South Australian Prison Health Service and the Chief Executive Officer of the Department for Correctional Services make every effort to ensure that the conditions enjoyed by a prisoner in a country correctional facility are not in any way jeopardised by the need for the prisoner to travel to Adelaide and be accommodated in an Adelaide correctional facility for the purpose of attending medical treatment or investigation.'

Heath Ryan Jones (Coroner Basheer)

I make the following recommendations directed to the Minister for Correctional Services and the Chief Executive Officer of the Department for Correctional Services:

1) That the Department for Correctional Services continue to identify and eliminate hanging points from cells in all South Australian correctional institutions.

2) That the Tier 3, 4 and 5 Priorities as set out in the Report to the House of Assembly by the Chief Executive of the Department for Correctional Services dated 9 February 2016 be implemented as a matter of urgency.
Shaun Martin Keane (Coroner Schapel)

The Court recommends that DCS staff members responsible for compiling Bail Inquiry (Home Detention) Reports be instructed to make specific reference to any information that is relevant to the applicant’s risk of self-harm or suicide. I direct this recommendation to the Chief Executive of the Department for Correctional Services.

Tiffany Jayne Michie (Coroner Schapel)

The Court recommends that attention be given to the question of the maintenance of handover documentation to ensure that matters of concern are not deleted from that documentation.

The Court further recommends that nursing staff should ensure that they are familiar with recent patient progress notes, particularly those that have been created since their last shift, so that nursing staff are aware of recent events concerning patient safety and in particular events involving self-harm.

I make a further general recommendation that measures are implemented to ensure that important information relevant to a patient’s risk is passed from one shift to the next.

I further recommend that those administering the Noarlunga Hospital Morier Ward ensure that junior medical staff are properly supervised and are actively encouraged, both verbally and in writing, to seek advice and assistance from senior medical staff and not to make important clinical decisions autonomously without input from senior medical staff.

I direct these recommendations to the attention of the Chief Executive Officer of the Southern Adelaide Local Health Network.

9.4. Response to Recommendations - Deaths In Custody

During the year the subject of this report, the following reports detailing any actions taken or proposed to be taken in consequence of recommendations made in the case of a death in custody, were received by the State Coroner:

Leonard Edward Dodson (Coroner Schapel)

Response from the Minister for Health and Wellbeing

Recommendation 1 - that the Medical Director of the South Australian Prison Health Service assign to a senior medical officer or officers within the Service the responsibility of maintaining oversight of the medical treatment and investigation of those prisoners within institutions operated by the Department for Correctional Services who are suspected of suffering from a serious or life threatening illness, especially in circumstances where the medical treatment and investigation of such prisoners is being conducted by medical practitioners who are not employees of the Service.

• A number of strategies have been put in place over recent years to improve the continuity of clinical care provided to prisoners within institutions operated by the Department of Correctional Services (DCS). The overarching South Australian Prison Health Service (SAPHS) Model of Care was published in 2016 and has been widely distributed to medical officers. Information sharing guidelines between SA Health and DCS were implemented in 2015 along with annual health checks across sites for all prisoners. Clinical Pathways for Chronic Disease Management have been in place since 2014 and continue to be refined.
Recommendation 2 - that the Medical Director of the South Australian Prison Health Service remind medical practitioners, both employed within the Service or otherwise, who treat prisoners within institutions operated by the Department for Correctional Services of the need to carefully explain to prisoners who are for whatever reason reluctant to undergo important medical treatment or investigation of the possible consequences of the failure of the prisoner to undergo such treatment or investigation and in particular to identify to the particular prisoner the worst case scenario that such an investigation might identify.

- The findings have been discussed at a number of SAPH clinical governance committees and disseminated to all medical and senior nursing staff. Prisoners that decline to accept medical treatment are always advised of the potential benefits and risks of their decision. All sites now use the standard SA Health MR82C Acknowledgement of Medical Advice which allows documentation of informed decision making.

Recommendation 3 - that the Medical Director of the South Australian Prison Health Service remind medical practitioners, both employed within the Service or otherwise, of the need to make detailed notations in a prisoner patient’s clinical record of the decision made by the prisoner not to undergo recommended medical treatment or investigation and of the stated reason for the prisoner refusing to undergo such medical treatment or investigation. I would add to this that there is also a need for a record to be made of any advice given to the prisoner that they should undergo the medical treatment or investigation.

- Refer to response to recommendations 2 and 4.

Recommendation 4 - that the Medical Director of the South Australian Prison Health Service and the Chief Executive Officer of the Department for Correctional Services be mindful of the fact that a refusal by a prisoner situated in a country correctional facility to undergo medical treatment or investigation that requires the prisoner to travel to Adelaide does not of itself mean that the prisoner cannot at least be compelled to travel to Adelaide and be accommodated in a correctional facility in Adelaide.

- SAPHS implemented an ‘advice of medical appointment’ system which has been rolled out to all sites. This gives the patient the opportunity to advise SAPHS directly of their intent to attend or not attend their health appointments. Subsequently, SAPHS can document this appropriately and provide the patient with advice on the consequences of non-attendance. Irrespective of whether or not the patient intends to keep their appointment, SAPHS will maintain the appointment and request the transfer of the prisoner to attend the appointment.

- The Nurse Consultant Clinical Care Systems has set up a regular visit schedule and meets staff at all sites to reinforce complex case management. This role also liaises with the acute sector and DCS for discharge planning of prisoners including follow up appointments.

- The Medical Head of Unit has established a comprehensive data base of prisoners with complex chronic health conditions and terminal diseases, including demographics, assessment and review dates, referral and appointment dates, and the outcomes of any interventions and investigations.

Recommendation 5 - that the Medical Director of the South Australian Prison Health Service and the Chief Executive Officer of the Department for Correctional Services make every effort to ensure that the conditions enjoyed by a prisoner in a country correctional facility are not in any way jeopardised by the need for the prisoner to travel to Adelaide and be accommodated.
in an Adelaide correctional facility for the purpose of attending medical treatment or investigation.

- Whilst prisoner placement is at the discretion of DCS, SAPHS offers advice to DCS on the placement of prisoners with special health needs and those transferring through the prison system for health appointments. Furthermore, SAPHS advises DCS regarding those prisoners who are likely to be adversely affected by refusing treatment. SAPHS also advises DCS if refusal is based on the perception of a potential loss of privileges. This process is documented in accordance with the SA Health Providing Medical Assessment and/or Treatment where Consent cannot be obtained policy directive and associated guidelines.

Shaun Martin Keane (Coroner Schapel)

Response from the Department for Correctional Services

Recommendation - that DCS staff members responsible for compiling Bail Inquiry (Home Detention) Reports be instructed to make specific reference to any information that is relevant to the applicant’s risk of self-harm or suicide. I direct this recommendation to the Chief Executive of the Department for Correctional Services.

- In response to the Deputy State Coroner’s recommendation, the Executive Director, Community Corrections and Specialist Prisons, initiated consultation between relevant departmental staff to consider how best to implement the recommendation and ensure that information in relation to an offender’s risk of self-harm or suicide is specifically referenced in future reports.

- During consultation, the current practice of compiling bail enquiry reports was considered, and noted that the compilation of bail enquiry reports includes an assessment of a number of factors including risks and personal safety. It was also noted that this is reflected in the current Community Corrections Practice Manual, a streamlined manual prepared to assist Community Corrections staff by providing clear guidance and parameters to inform best practice offender supervision. It was also noted that reports are compiled with guidance notes and instructions attached to the report templates.

- To implement the recommendation, bail enquiry report templates have now been amended to include an instruction to staff that where an individual has a current or recent Suicide or Self Harm history or have been monitored by a prison High Risk Assessment Team, they are, to provide a summary of the individual’s self-harm history and known risk factors, and the likely impacts on the individual of release, or remaining in custody. Communication of this amendment has been co-ordinated to ensure all relevant staff members are aware of the instruction and incorporate relevant information when preparing reports. Updated report templates have been published on the Department’s Intranet and changes have been made to the Justice Information System where these reports can be completed in on-line templates.

Tiffany Jayne Michie (Coroner Schapel)

Response from the Minister for Health and Wellbeing

Recommendation 1 - that attention be given to the question of the maintenance of handover documentation to ensure that matters of concern are not deleted from that documentation.

- Separate handover sheets are no longer used in the unit involved.
Handover documentation is now maintained in the patient’s case notes and via the electronic journey board (EJB) and is conducted at the board. A print out is only used if and when required.

The multi-disciplinary team has access to the EJB and the patient’s case notes.

Most other mental health units across SA Health continue to use a combination of EJBs and handover sheets. This information is reviewed and updated at least daily.

Sites are transitioning away from reliance on separate written handover notes through increased use of electronic formats, where appropriate software platforms are in place. Staff in the Office of the Chief Psychiatrist are actively engaged with SA Health Safety and Quality Unit to develop a consistent approach to recording and noting a deterioration in mental state in both the hard copy and electronic medical records. This information will be consistent across all of SA Health and guide staff on processes and interventions to be utilised when a change in behaviour or risk occurs. This will improve the recording of matters of concern in the medical record and reduce reliance on the written handover documentation.

**Recommendation 2** - that nursing staff should ensure that they are familiar with recent patient progress notes, particularly those that have been created since their last shift, so that nursing staff are aware of recent events concerning patient safety and in particular events involving self-harm.

- In August 2017 EJB education was provided to the relevant staff.
- This included how to use the EJB and advice on what information needs to be provided about the evening handover. This process enables staff to highlight at risk patients thus enabling staff to prioritise the review of clinically unstable patients’ case notes.
- It is expected practice that nursing staff will review the patients’ medical records and that information is shared between one shift to another shift via the handover practices described above.

**Recommendation 3** - that measures are implemented to ensure that important information relevant to a patient’s risk is passed from one shift to the next.

- The EJB has an incorporated flag system. The flag system helps to identify new information and higher acuity patients.
- In March 2018 an audit occurred to ensure that what is included in the flag field is documented in the case notes.
- Handovers occur between shifts and in clinical meetings. Most services now also include ad hoc huddles when a change has been noted in a person’s presentation.
- A broader review of Escalation of Care is currently underway. SA Health is developing procedures and practices consistent with the national requirements of the Australian Commission on Safety and Quality in Health Care’s National Safety and Quality Health Service (NSQHS) Standards, Standard 9: Recognising and Responding to Clinical Deterioration in Acute Health Care.
- It is anticipated that this review will be completed by November 2018.
Recommendation 4 - that those administering the Noarlunga Hospital Morier Ward ensure that junior medical staff are properly supervised and are actively encouraged, both verbally and in writing, to seek advice and assistance from senior medical staff and not to make important clinical decisions autonomously without input from senior medical staff.

- Orientation documentation for medical staff has been reviewed to include information about escalation processes.

- There are twice daily multi-disciplinary team huddles, attended by consultants and junior medical staff where information pertaining to patients, including concerns relating to deterioration, can be discussed.

- Any changes to a person's clinical care plan are made in conjunction with the consultant psychiatrist who has oversight of the patient.
10. **Manager's Report**

10.1. **Registry Report**

I am pleased to report on the activities and administration of the Coroners Court this year.

I offer my profound thanks and appreciation to the staff of the Coroners Court for the work completed this year. This has been a difficult and challenging year for staff. A number of long term staff left this year and the recruitment process for replacement took quite some time. Nevertheless, all staff covered the vacancies as required and pressed on with the work seamlessly. It was, at times, daunting to be so low on staff numbers. When also factoring in times of illness and annual leave there were periods when we were working with numbers so low that parts of our Business Continuity Plan was enacted by default.

I acknowledge that these were exhausting months for staff yet all staff maintained a high standard of work and resilient attitude towards getting the day to day work completed. Staff also focussed on clearing a significant backlog of cases under review. We now have a full complement of wonderful staff and their willingness to assist each other and guide new staff is very satisfying.

In addition to the periods of low staff numbers the Court also had the challenge of organising a number of large inquests. The bringing of an inquest to Court is a major logistical challenge, particularly when there are large volumes of documents to prepare, many witnesses to arrange and various parties with whom to communicate. Also there were new Counsels Assisting to guide through the coronial process and an additional courtroom to refurbish.

I acknowledge the staff by publicly sharing a section of a letter that was written to me by a senior and respected Adelaide lawyer:

> ‘Without exception the Inquest Support Officers and others who we deal with on a lesser frequent basis have always been professional, prompt, efficient and courteous and invariably helpful. In my experience, no other Court in South Australia provides such a high level of service.’

It is gratifying to receive such appreciation. Whilst we cannot always meet the needs of grieving families, I do receive messages of appreciation and thanks from families for the helpfulness and kindness of staff during their time of deep grief and loss. We are always mindful of the difficulty that families experience when the death of a loved one is reported to the Coroner. We hope that by taking the time to clearly and empathically explain the coronial process we can help them to understand the role of the coroner and the timeframes associated with gathering the information about the circumstances of a death.
10.2. Continuous improvement

During the year under review the administration of the Coroners Court undertook a 'Workflow Discovery Process' project. The discovery process informed the manager on:

- Developing realistic and achievable key result areas for allocation and review of case files
- Addressing the backlog of files and future file allocation
- Identifying how long the review of a file should take and how long a file remains at one stage of the process
- Developing key performance indicators

Fifteen recommendations were made and the Manager and staff along with the IT section of the Courts Administration Authority are now working towards addressing the recommendations with a range of tasks to complete.

Key tasks currently being undertaken include;

- A number of IT enhancements are being made to the Coroners Court case management system
- Key performance indicators are being developed
- Job profiles reviewed
- A comprehensive file review checklist is in draft form
- The Procedure Manual is being reviewed and rewritten as necessary
- Improvements in sending documents to Forensic Science SA and Births, Deaths and Marriages

10.3. Professional Development

Staff participated in three professional development activities during the year under review:

- Tour of Forensic Science SA – toxicology laboratory
- National Coronial Information System Coding training
- Two workshops in dealing with difficult situations and conversations with clients

Staff also had the opportunity to attend sessions of the Asia Pacific Coroners Society Annual Conference in Adelaide.

All staff have a bi-annual performance development meeting with their supervisor. All staff have access to the Employee Assistance Program which provides counselling to assist with any level of professional or personal wellbeing issues.

Staff at the Coroners Court actively enjoy many at work social gatherings such as morning teas, shared lunches for special occasions, Christmas lunch and Christmas drinks provided personally by the State Coroner.

Again this year I mention the challenge the Coroners Court faces with records management. We have no space to store documents, closed cases and medical
case notes. There is no budget allocation to assign staff to undertake the specialised task of consigning files to State Records and the problem grows each year. Again this year I raised the issue under the auspices of the Occupational Health, Safety and Welfare audit by Galpins Accountants and Auditors.

Team leaders from the Coroners Court and FSSA meet bimonthly to discuss issues of relevance to both agencies. This meeting focuses on operational issues between the Coroners Court registry and the FSSA mortuary. The issues discussed this year included improvements in efficiencies in transferring documents, legally obtaining tissue for laboratory control testing, updates on issues pertaining to transfer of bodies and issues relating to SA Health EPAS case notes. These meetings are valuable in analysing and improving processes and are the foundation of our good relationship with FSSA technical staff and I sincerely thank them for their cooperation. I particularly thank Kim Williams and Simon Moretta for their responsive attitude to our many requests.

The Manager is a member of the following committees:

- Court Services Executive
- Systems Management Committee
- CAA Operational Leadership Team
- Security Steering Group
- State Disaster Victim Identification
- International Framework for Court Excellence
- A Women’s Right to Safety

Once again the Court met all of its occupational health, safety and welfare requirements this year after a rigorous audit by Galpins Accountants and Auditors in preparation for a review in the next reporting period by Deloitte Australia.

As Manager I have continued to be available to outside agencies such as hospitals, health related professionals and students along with attending various seminars and conferences as a guest speaker. These sessions enable the Court to educate the community and health care professionals about the Coroners Act and the coronial process. During the year under review I attended eight speaking engagements and addressed approximately 180 people.

I would like to express my thanks to Chris Doull, Executive Director, Court Services, for the support and guidance she has provided throughout this year.

I also thank the Coroners for their accessibility to staff on a daily basis. The Coroners are always interested in the staff and openly and often express their appreciation for the work of the staff. The accessibility and friendliness of our Coroners is pivotal in maintaining our motivated and dedicated team.

I wish to record my thanks and gratitude to the State Coroner for his personal support and professional guidance and leadership shown to me over many years of working together.
10.4. **Social Work Service**

The South Australian Coroners Court employs two senior social workers. They provide first contact calls to families as well as providing ongoing social work services to senior next of kin throughout the coronial process. The social work services include providing information and updates about the coronial process, arranging formal identification, facilitating viewing of deceased persons with family members when appropriate, supporting next of kin to view closed files, and referral to external services.

Both substantive social workers left during the year under review. This has meant that whilst the recruitment process was underway the social work tasks were undertaken by a rotating group of six locum social workers. I am truly indebted to them for being available, often on short notice, to manage the workload and offer a high standard of service to families. They each work well alongside the staff and ensure that they leave efficient and robust information for the handover to the next social worker.

The social workers make themselves available to government and non-government services who deal with families and individuals experiencing grief. They attend speaking engagements and staff development sessions to explain the role of the Coroner and the social work service.

10.5. **Organ Retention**

The Coroner is responsible for the investigation of the cause and circumstances of reportable deaths in South Australia. In certain deaths however, an autopsy does not always reveal the cause of a person’s death. In these situations further investigations and tests are required. These investigations and tests can involve the retention of organs and tissue. The Court’s social workers advise the senior next of kin of the decision to retain one or more organs, and ensure the release or disposal of organs are consistent with the wishes of the senior available next of kin.

10.6. **Disaster Victim Identification**

The Manager of the Coroners Court is a member of the State Disaster Victim Identification Committee. The Committee is responsible for the coordination of the identification of the victims of any single incident where the number of fatalities is more than three.

There were no DVI incidents in South Australian during the year under review. The Manager attended one Disaster Victim Identification meeting this year.
11. **Staff Roles and Organisational Chart**

The Business Unit is structured according to the following organisational chart: