ANNUAL REPORT OF THE STATE CORONER
FINANCIAL YEAR 2007-2008

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

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31 October 2008

The Honourable Michael Atkinson
BA (Hons), LLB, MP
Attorney-General

Dear Attorney-General

In accordance with section 39 of the Coroners Act 2003 I have prepared a report on the administration of the Coroner's Court and the provision of coronial services under the Coroners Act 2003 during the financial year ending on 30 June 2008.

The report is forwarded with this letter.

Yours sincerely

Mark Johns
State Coroner

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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 Coroner's Court and the provision of coronial services under the Coroners Act 2003 during the financial year ended 30 June 2008.

1. Foreword

The Coroner's Court is established by the Coroners Act 2003. The Courts Administration Authority provides administrative support to the Coroner's Court. It employs the staff that process reports of death, organise Inquests and liaise with bereaved families.

The Coroner's Court is located in the Adelaide CBD and manages all death investigations pursuant to the Coroners Act 2003 from all regions of South Australia. Currently there are two full-time Coroners who hold Inquests in Adelaide and regional locations.

The cornerstone on which the coronial system in South Australia is built is section 28 of the Coroners Act 2003 which is headed 'Reporting of deaths':

> *(1) A person must, immediately after becoming aware of a death that is or may be a reportable death, notify the State Coroner or (except in the case of a death in custody) a police officer of the death, unless the person believes on reasonable grounds that the death has already been reported, or that the State Coroner is otherwise aware of the death.*

In the majority of cases reports of death are made by a member of the public to a police officer who then makes a detailed report to the Coroner. The remaining reports of death may be divided into two broad categories. The first is the report made by a medical practitioner in a hospital setting. The second, and final category is the report made directly from aged care facilities.

In the cases where the police report a death to the Coroner, there is a standard process that officers must follow and this is set down in SAPOL General Orders. SAPOL also provide the State Coroner with a team of police officers known as the Coronial Investigation Section (CIS). They are formally attached to the Major Crime Investigation Branch. The CIS advise patrols as to standard protocols, investigative criteria and completion timeframes, in addition to carrying out their own investigations on behalf of the State Coroner. In the case of deaths in

custody and sudden unexpected death in infants, the investigations follow standards that are rigorously defined. The coroners expect and demand a high standard of adherence to these protocols.

It is incumbent upon medical practitioners, especially those reporting from a hospital setting, to understand their obligations under the Coroners Act 2003 so that accurate reporting is made in all applicable instances. I continue to support education and information provision to medical practitioners and nurses about the coronial process and obligations to report. Upon invitation, senior staff from the Coroner's Court attend hospitals and residential facilities to provide in-service information to medical staff.

It is equally important that the South Australian community has some level of understanding of the Coroner's role in society. To that end, senior staff members attend community groups to deliver information about the coronial process. I am committed to supporting initiatives within the office to improve the level of information available to bereaved families.

The timeframe experienced by families in waiting for a resolution to cases is often lengthy. Families may struggle to understand the timeframes and processes of a coronial investigation and part of the role of the staff of the Court is to balance the judicial functions required by the Coroners Act 2003 with the empathy we feel for the need of families to finalise estate matters and come to terms with the death of a loved family member. Whilst the individual pain of a family impacts on judicial officers and administrative staff it is incumbent on all of us to maintain focus on the function of inquiring into the cause and circumstances of each death even if that is inconsistent with individual family expectations.

I acknowledge the assistance of the Deputy State Coroner, Tony Schapel. I appreciate his advice and his dedication to the coronial jurisdiction. Deputy State Coroner Schapel completed the Wangary Bushfires Inquest in December of the year under review. He completed this complex and long Inquest after an enormous amount of consideration and intellectual application to complex issues about a series of events that had tragic outcomes.

I extend thanks to the Counsels Assisting who support both myself and the Deputy State Coroner in the preparation of investigations, recommendations for Inquests and presentation in court.

I express my thanks and appreciation to the administrative staff of the Coroner's Court who manage large volumes of work in a complex and emotionally challenging environment.

I acknowledge the work of Forensic Science SA, SAPOL, the Hanson Institute, the Forensic Odontology Unit and the support of the Courts Administration Authority.

2. Role of the Coroner

The role of the State Coroner is to administer the Coroner's Court and oversee and co-ordinate coronial services in this State. The State Coroner fulfils those roles by inquiring into the cause and circumstances of reportable deaths.

The State Coroner and the Deputy State Coroner review all reportable deaths with the assistance of the staff of the Court. The review encompasses the cause of death, the identity of the deceased and the circumstances preceding death. The review might include directing post mortem examinations and reviewing SAPOL investigation briefs and other relevant documents.

2.1. South Australia Police

SAPOL investigations play an important role in assisting the Coroner to determine the focus of the investigation. It is probably not generally understood that police officers play an integral role in the coronial process.

Except where a death occurs in a medical setting, the police are at the forefront in gathering basic information about the deceased, including identity and the circumstances surrounding the death. This work is carried out by police officers throughout the State. Reportable deaths occur in circumstances that are often extremely distressing to families and it is sometimes quite confronting for families to find that police are in attendance. The first reaction of some people, quite naturally, is that the presence of police implies that there has been a crime. They are not aware that police are carrying out the important work of coronial investigation. It is a credit to police throughout the State that they manage the process of carrying out their duties while displaying tact and sensitivity to people who are distressed by the sudden death of a loved one or a friend or neighbour. In those rare cases where a sudden death occurs in suspicious circumstances, it is of course imperative that police be involved at the earliest stage. For all of these reasons, their role in the coronial process is crucial and I commend the work of ordinary members of SAPOL throughout the State in this process. It is important that the value of that work be appropriately recognised.

Despite the efforts of police officers to show tact and sensitivity when attending at a death scene, family members who are also present will not see the situation in the same way. What is a death scene and a place of work to a police officer may well be their home. They are likely to be completely surprised to find a number of police officers in their home. They may not have called the police themselves - in most situations they will have called an ambulance. It is the South Australian Ambulance Service that, quite properly, may have alerted police to the need to attend. From the perspective of family members the police may be an unwanted and intrusive presence. This sometimes leads to complaints and suggestions that the presence of police in these circumstances is an over-reaction. That is particularly so where the deceased is an elderly person who appears to have died of natural causes. When the provisional cause of death is the result of a natural process of disease, they may feel reinforced in this view by hindsight. On the other hand, society has always expected that sudden

unexplained death will be rigorously investigated, and this has been the function of the coroner for hundreds of years.

Despite the best efforts of police officers to carry out their duties without intruding unnecessarily into the grief of family members, sometimes there will be complaints. It is difficult to see how this can be avoided. In my view it is best addressed by careful explanation when a complaint is subsequently made, and by a combination of public information about the coronial process and appropriate training for front line police officers. In this regard, I particularly acknowledge the efforts of Detective Superintendent John Venditto, Officer in Charge of Major Crime Investigation Branch, in identifying the need for CIS to devise training programs for uniformed officers and for cadets at the Police Academy. I have expressed my support to Detective Superintendent Venditto for this and my willingness to participate in training programs personally, at the Academy and with operational officers.

Detective Superintendent Venditto has also been extremely helpful in overseeing coronial investigation generally. His work is to be commended.

2.2. Medical Practitioners

Medical practitioners also provide valuable information to the Coroner about medical circumstances of death and possible adverse event analysis. The role of medical practitioners in the coronial process is very important. Of the many reportable deaths that occur each year, approximately half are the subject of post mortem examination. In the remaining cases the opinion of a medical practitioner, particularly one who treated the deceased in life, is accepted by the State Coroner, or the Coroner's Court, as the formal cause of death. Although the Coroners Act requires a medical practitioner who was responsible for the medical care of a deceased person to give an opinion as to the cause of death, if they are giving notice of the death, some medical practitioners are reluctant, in today's litigious environment, to give an opinion which may prove, after post mortem examination, to have been incorrect. I try to reassure medical practitioners that an opinion conscientiously arrived at in good faith, even if shown to be wrong subsequently, will not lead to admonishment. It is in the public interest that medical practitioners continue to offer their expert opinion as to cause of death. While such opinions are not necessarily accepted on all occasions, medical practitioners can rest assured that this is not an implied criticism of their expertise, but merely the exercise of an independent duty vested in the State Coroner to determine cause of death. Without the medical opinion of general practitioners and clinicians in the hospital system, the coronial system would be placed under enormous strain, and families would be subject to intolerable delays. Their continued participation is crucial.

2.3. Notification of Reports

It is important to note that the coronial system relies entirely on proper compliance with the obligation to notify the State Coroner of reportable deaths. Problems in other jurisdictions have arisen out of non-compliance with the obligation to report to the Coroner within the jurisdiction. It is not possible to be certain that all reportable deaths are in fact notified to the State Coroner. Unfortunately the system is not infallible and vigilance by all concerned in the coronial and medical systems is necessary to prevent problems such as those encountered in other jurisdictions.

There have been a number of instances in the year under review where deaths were not reported when they should have been. In these cases the coronial process has been compromised. The opportunity to carry out a post mortem examination may have been lost. At worst, the opportunity to obtain evidence of possible wrongdoing has been lost. Certainly the opportunity to learn from the event, and to make recommendations that may prevent a recurrence, has been lost. These are matters that society should be concerned about. When I become aware of a failure to report, I contact the relevant person or organisation to seek an explanation. In some cases the matter will be reported to police to investigate the breach of section 28 of the Coroners Act, which is an offence punishable by a maximum penalty of a $10,000 fine or imprisonment for 2 years.

It has come to my attention that Families SA failed to notify the State Coroner of the deaths of three children under Guardianship of the Minister as per the definition of a 'reportable death'*(f)* where the person was, at the time of death-*(ii)* in the custody or under the guardianship of the Minister under the *Children's Protection Act 1993*.

The circumstances of these deaths are as follows, with excerpts taken from correspondence provided by the Department for Families and Communities:

JL (DOB 26/02/90) (DOD 31/01/08)

JL had significant physical and intellectual disabilities from birth and was placed with a Life Without Barriers carer in September 2003. A Guardianship Order to 18 years was granted in August 2004 with the consent of J's mother.

In October 2006 a Palliative Care Plan was developed by treating professionals at the Women's and Children's Hospital (W&CH) which stated, 'The emphasis of management will be on good Palliative Care, and directed at the continuing relief of symptoms and discomforts. For that reason, no artificial measures designed to replace or support bodily function will be undertaken'. Medical opinion was clear that J would not survive far into the future and a care plan was developed that resulted in the relevant documentation being signed by the then Minister for Families and Communities. J's condition continually declined, culminating in his death on 31 January 2008.

A briefing was provided to the then Minister for Families and Communities on 13 February 2008 advising of J's death.

AO (DOB 14/07/06) (DOD 17/07/07)

AO was born with a rare neuromuscular disorder Nemaline Myopathy. This condition causes severe muscular weakness affecting motor skills. A would have had significant limitations, ie would have been unable to walk, crawl or sit up, and would have had difficulty with using limbs and rolling over. The condition affected A's ability to feed and he had to be fed via a transpyloric tube, or he could have been at risk of asphyxiation. A's respiration was also affected.

A's parents found it difficult to cope with their situation, and Families SA obtained consents to place A in care (two Voluntary Custody Agreements and a Parental Authority). A was placed in foster care on 15 January 2007. On 12 June 2007 Families SA was advised that A had returned to hospital, had only 24-48 hours to live, and had returned to foster care to die (as requested by the foster carer). A died on the 17 July 2007. Following pre-arranged plans, the foster carers contacted Crisis Response Unit (CRU).

A briefing advising the Minister of A's death was provided on 30 July 2007.

ML (DOB18/4/89) (DOD 11/09/06)

ML was one of twin boys born on 18 April 1989. Prior to his birth it was known he had spina bifida however it was thought unlikely he would survive his birth. However he did survive, although shortly after he contracted meningitis which affected his brain function. He was placed for adoption and the consent papers were signed in 18 May 1989. M was placed under the Guardianship of the Director-General pursuant to the Adoption Act. Attempts to find an adoptive family were unsuccessful and M was placed with a foster carer in a long-term placement. Families SA applied for Guardianship until 18 years and this was granted on 24 September 1997.

M was aware of the possibility that his condition would limit his life expectancy and took an active part in the decision making regarding his health. It was M's wish not to have invasive medical procedures and he requested a non-resuscitation plan which was signed by the then Minister for Families and Communities on 26 September 2005. M contracted pneumonia in September 2006 and deteriorated until his death on 11 September 2008.

A briefing advising the Minister of M's death was provided on 14 September 2006.

The Department did not its their obligations to report these deaths and has informed me that it has since developed appropriate policies and procedures to address these serious breakdowns in reporting responsibility. Amongst other measures I have been assured that a requirement has been developed whereby the Executive Officer for Adverse Events assumes the delegated responsibility for notifying the Coroner and the Office of the Guardian of the death of Guardianship children, and, a Divisional Circular on this topic will be issued to all field staff.

2.4. Statistical Information

There was a slight increase in the number of deaths reported to the Coroner in 2007-08 compared to the previous year. There were 12,445 deaths registered with the Registrar of Births, Deaths and Marriages. Of those, 1,899 deaths were reported to the State Coroner.

Cases Reported by NCIS Cause of Death Code

Cause	Deaths	Cause	Deaths
Aircraft	1	House Fire	7
Aspiration of Vomitus	1	Industrial Accident	6
Burn	0	Marine	0
Death in Custody	15	Natural	567
Death in Institution	216	Other	8
Dehydration	1	Petrol Sniffing	2
Disease	0	Poison	0
Domestic Accident	6	Refer back	0
Drowning	17	SIDS	0
Drug Overdose	67	Skeletal Remains	0
Fall	39	Suicide	164
Homicide	19	Undetermined Cause	92
Hospital	540	Vehicle Accident	131

3. State Coroner's Report

3.1. Year in Review

During the year under review 1,899 deaths were reported to the Coroner's Court and 1776 cases were finalised. There were 31 Inquests with 13 of those being deaths in custody.

At A Glance	2005-06	2006-07	2007-08
Number of Staff *	^15	^15.4	^15
Number of deaths reported	2070	1880	1899
Number of post mortems	1368	1285	1221
Number of Inquest Findings delivered	23	30	38
Number of court sitting hours	#917	#808	#465

* Does not include judicial officers

^ Plus 2 Counsel Assisting

The decrease in sitting hours reflects the Wangary Bushfire Inquest finalising oral evidence just prior to the start of the 2007-08 financial year.

3.2. Delays in Coronial Investigations

The 2006-2007 Annual Report noted that delays in coronial investigations seriously hamper the quality of evidence that can be gathered for an inquiry into a death. Approximately 2 years ago SAPOL introduced a system called the 'Gateway Process' under which all initial coronial reports from police patrols are sent directly to CIS to be vetted for adherence to procedure. The reports are then delivered to the coronial administrative staff for processing. Coronial staff then 'case manage' the reports and liaise with the CIS to ensure that all necessary reports are submitted.

This system only works if the patrols are diligent in submitting completed investigations. Having made that observation, I note that SAPOL officers often need to wait for the completed post mortem report which inevitably delays the submission of the final coronial police report.

Once the case is reviewed by Counsel Assisting the case may be referred to the CIS for further investigations, such as interviewing medical practitioners. Delays have been experienced in the carrying out of some CIS investigations and interviews. This has in turn created further delay in cases being submitted to me or the Deputy State Coroner for finalisation. I am aware that SAPOL have initiated a review of the CIS and I await the results of the recommendations of the review.

3.3. Delays in Post Mortems and Pathology Services

The South Australian State Government, through the Department of Justice, provides funding to Forensic Science SA (FSSA) to perform post mortem and pathology services to the Coroner.

As reported in the 2006-2007 Coroners Annual Report there continues to be a delay in the production of the completed post mortem report. Coroner's Court staff have been informed by FSSA that the timeframe for a completed report is up to 12 months, and Coroner's Court staff routinely inform families of that timeframe. Not surprisingly, some families are appalled and saddened by this. They simply cannot understand the reason for such a delay.

It has also been a disappointing development throughout this year that the timeframe between death and post mortem has lengthened. It goes without saying that a post mortem should be completed as soon after death as possible. The coronial investigation is compromised as the body deteriorates, even when kept in optimum conditions. During the year under review, there have been times when the period between death and post mortem is between three and seven days. This situation adversely impacts upon the coronial investigation, the forensic examination and the family.

Notwithstanding the above, I am informed that there is a worldwide shortage of forensic pathologists and so it seems inevitable that this situation will not improve in the near future. I am assured by FSSA that the delay in the provision of completed post mortem reports will improve over the next year.

The Coroner's Court receives many letters of complaint from families about this situation. Coronial staff take numerous phone calls every week from families seeking updates on the current waiting times on post mortem reports. These calls are often highly charged with emotion and I acknowledge the skills displayed by administrative staff in responding, especially when they are unable to resolve issues to the satisfaction of the family. Of course, time spent by staff in dealing with such inquiries is time lost to the ordinary work of progressing investigations.

Whilst the Coroner's Court waits for the completed post mortem report there is sometimes little in the investigation that can be progressed. For this reason it follows that further delays ensue once the report is received whilst other investigations continue, especially those inquiries that might arise from issues raised in the post mortem report.

3.4. Removal/Conveyance of bodies

When the death of a person is reported pursuant to the Coroners Act 2003, the deceased is regarded, for legal purposes, as being under the exclusive control of the State Coroner.

In most cases the deceased will be transported to the FSSA mortuary. In some cases they will be transported to the Women's & Children's Hospital or Royal Adelaide Hospital mortuaries.

Until recently, the FSSA has managed the conveyance of coronial cases in the metropolitan area using its own staff. I have been satisfied with the competency and timeliness of this service. The service has now been contracted to a private funeral director for a trial period and will shortly be contracted out on a full and long-term basis. I expect that this service will continue to be provided on a professional and timely basis according to the usual principles of confidentiality and codes of conduct by which public servants are bound.

Country removals and conveyancing of coronial cases are managed differently. When a person dies in regional South Australia, and there is a report to the State Coroner, the removal and conveyance is undertaken by local funeral directors on a rotational basis as directed by local SAPOL. Where necessary, the deceased is conveyed to Adelaide for post mortem. Although this system has been in place for many years, I have become concerned about it. In one instance there was an inappropriate communication by a conveyancer about the condition of a deceased person to a third party not involved in the coronial system. I am concerned to ensure that if forensic conveyancing is to be undertaken by private contractors, the system is properly accountable to the State Government by proper terms of contract. In particular, there should be appropriate obligations of confidence backed by appropriate contractual penalties.

I have had discussions with senior officers of the Department of Justice and they are aware of my views on this matter. I am assured by the Department of Justice that this matter will be reviewed when the metropolitan conveyancing contract is settled.

The difficulty with these arrangements is that the State Coroner has statutory control, but no real ability to influence the arrangements which are all effected by Government agencies. I am not satisfied that appropriate accountability mechanisms are in place at present. This requires an urgent solution and I hope the Department of Justice will achieve one in the very near future.

3.5. Backlog of Inquests

During the year under review the State Coroner and Deputy State Coroner completed 31 Inquests and delivered 38 Findings.

As at 30 June 2008 there were 49 Inquests pending with 2 from 2004, 8 from 2005, 14 from 2006, 17 from 2007 and 8 from 2008.

In order to bring a matter to court an enormous amount of preparation must occur. Counsels Assisting already carry a load of cases for review of approximately 80 cases each. Their two administrative assistants liaise with legal practitioners, media and the family, as well as preparing all legal and administrative paperwork for court. Given current resources I cannot envisage that the backlog will change in any way. It is unacceptable that, as a general rule, families wait 3-4 years for a matter to come to court. It is also difficult for witnesses to give evidence that relies on their memories of events 3 years prior. The opportunity to make recommendations reasonably contemporaneously with death is lost. These recommendations have the potential to prevent the recurrence of other deaths in similar circumstances. It is obviously in the interests of the community of South Australia that Inquests be held at the earliest possible time.

As stated previously, my office regularly receives letters from members of the public, often via their local Member of Parliament, complaining about the length of time taken to resolve a loved one's death. Families do not discriminate between government departments such as police or forensics - in their eyes the coroner is the official who oversees and controls all aspects of the process. At each stage of the process there are regrettable delays.

3.6. Jurisdiction to Make Recommendations

During the year under review a judge of the Supreme Court held that the power to make a recommendation extends only to such matters as might prevent or reduce the likelihood of recurrence of a death in like circumstances to those in the case at hand, or to prevent death from the same or like causes to those in the case at hand. Thus recommendations that related to events that occurred after death were beyond power. One recommendation that had been made in that case concerned the circumstances in which a doctor with an interest in a nursing home should be permitted to sign a certificate allowing cremation of a deceased resident of the home. The resident's death had not been reported to the State Coroner. The Court held, in a finding upheld by the Supreme Court, that the resident's death had been reportable. Thus the recommendation would, if within power, have prevented the recurrence of the signing of a cremation certificate in a future case where a reportable death had not been reported, thus preventing the destruction by cremation of the deceased's remains, and the opportunity to determine by autopsy the cause of death.

In other jurisdictions the power to make recommendations extends to recommendations relating to the administration of justice (for example, Coroners Act 2003 (QLD), s46(1)(b)). A coroner in Queensland would have been able to make the recommendation about doctors and their ability to sign certain cremation certificates. Furthermore, a Queensland coroner might be able to recommend disciplinary action be taken against a particular person, a power that is not open to a coroner in this State.

In my opinion, it would be desirable to amend the Coroners Act 2003 to extend the power to make recommendations to include those relating to the administration of justice. If the Act is to be amended in that way, it would be useful to further amend it to extend the obligation to report a death, to a death that appears to be reportable, to avoid arid legal arguments about jurisdiction.

3.7. Case Management System

In my opinion, the Coroner's Court needs to have an effective, computerised, case management system. At present there is no such system. In the event that I wish to obtain a report about, for example, the number of disappearances that have been reported to the State Coroner over a stated period, and the year in which they were reported, it is necessary to search the paper files of the Court, not all of which continue to be held by the Court, due to archiving requirements.

It is not possible to determine whether a police investigation is completed in a particular case, or what steps have been taken in a particular case, except by reference to the paper file for that case. It is not possible to obtain management reports that give a 'helicopter' view of the status of all investigations in the office, or investigations of a particular class.

The National Coroners Information System (NCIS) maintains national data including South Australian case data coded by staff in my office. However, the NCIS system is not a case management system, and although it provides limited capacity to search (for example, whether a post mortem report has been received in a particular case), it is no substitute.

The Coroner's Court would be aided operationally and strategically by the implementation of a case management system.

3.8. Section 63C – Young Offenders Act 1993

Section 63C of the Young Offenders Act 1993 provides as follows:

'(1) A person must not publish, by radio, television, newspaper or in any other way, a report of proceedings in which a child or youth is alleged to have committed an offence, if—

(a) the court before which the proceedings are heard prohibits publication of any report of the proceedings; or

(b) the report—

(i) identifies the child or youth or contains information tending to identify the child or youth; or

(ii) reveals the name, address or school, or includes any particulars, picture or film that may lead to the identification, of any child or youth who is concerned in those proceedings, either as a party or a witness.

(2) The court before which the proceedings are heard may, on such conditions as it thinks fit, permit the publication of particulars, pictures or films that would otherwise be suppressed from publication under subsection (1)(b).

(3) A person who contravenes this section, or a condition imposed under subsection (2), is guilty of an offence.

Maximum penalty: $10 000.'

Section 63C is capable of having an application to allegations against a person who was a child even after his or her conviction. That is because, notwithstanding the ultimate conviction of the child, the matters complained of against the child can still be described as allegations, or could have been up until his conviction. Even where allegations were never brought before the Youth Court, once they are mentioned in the Coroner's Court, they may attract the operation of section 63C. It seems to me that section 63C must be interpreted on the assumption that the subsequent conviction of a person of allegations against them does not permit thereafter the publication of information identifying the child or tending to identify the child.

In my view the Coroner's Court, in publishing its finding of the cause and circumstances of the death of a person, is not prohibited by section 63C from referring to a child who was convicted of an offence or about whom allegations were made by name and otherwise identifying him. The prohibition in section 63C does not in my opinion apply to a Court. Nor does it apply in my opinion to prevent the receipt of information by the Coroner's Court, or any other Court, of information which would otherwise be prohibited from publication by section 63C. I am of that view because the prohibition in section 63C applies to 'a person' and this expression is not apt to include a 'Court'. Furthermore it would not operate to prohibit the Coroner's Court from making reference in its finding

to a circumstance in which a child was alleged to have committed an offence in such a way as to identify him.

The effect of section 63C it seems to me would be to prohibit the publication by newspaper, radio or television of a report of a finding of the Coroner's Court if that report identified such a child by name or otherwise tended to identify him. I note that section 63(2) permits the Court before which the proceedings relating to the allegations against the child have been heard, to make an order permitting publication of material that would otherwise be suppressed from publication under subsection (1). The Coroner's Court, not being the Court before which the proceedings against such a child are heard, does not have power to permit the publication of particulars that would identify the child. During the year the Court made a recommendation that section 63C be amended to permit the Coroner's Court to make an order permitting publication of the name of a youth.

An obvious situation in which that might be necessary is that in which a child, remanded in custody, dies while in custody. It is not difficult to envisage that the circumstances leading up to a child being charged with the offence that leads to his or her remand in custody would be relevant to the circumstances of his or her incarceration, and if he or she died as a result of a self-inflicted injury, may very well be relevant to the circumstances of that death. Section 63C would prevent the publication of a report of such an Inquest in which the child was identified. That may not always be appropriate. In my opinion, the Coroner's Court should have the power to permit publication. A similar difficulty arises with section 59A of the Children's Protection Act 1993, which is identical to section 63C but applicable to child welfare proceedings before the Children's Court. Such proceedings are likely to be relevant in an Inquest into the death of the child the subject of the proceedings and so a corresponding amendment should be made to section 59A.

3.9. Provision of Information about Open Files

I have found that a great deal of the Court's resources is expended on determining questions of access to information on open files where disputes exist between family members as to who is entitled to gain access. Unfortunately there are a significant number of cases in which there are disputes amongst family members as to whether information about the deceased (for example, a copy of the post mortem report) may be obtained by particular members of the family. This may entail the making of an assessment of claims by one family member that another was estranged from the deceased, or that the deceased had been mistreated in some way by the other family member. These matters can be extremely time consuming, and the evidence available to support a decision as to access is often scant. Resources do not permit the conduct of a full inquiry to determine the truth or otherwise of assertions in these situations. However, public expectations in these situations are high, and becoming more onerous. There may be a need for additional resources to deal with the problem, or some other solution. I intend to monitor the situation for the time being.

3.10. Retrospective Analysis of Coronial Cases of Suicide Project

The Retrospective Analysis of Coronial Cases of Suicide Project grew from one of a raft of recommendations made by the Ministerial Advisory Council on Prevention of Suicide and Deliberate Self Harm (SUIMAC). The Council was convened to advise on the reduction of the incidence of suicide and deliberate self harm amongst people of all ages in South Australia, whilst maintaining a focus on those identified as most at risk. SUIMAC ceased its operations at the end of June 2005 after it had resolved various recommendations across its Terms of Reference.

SUIMAC recommended the Department of Health (DH) develop a system for the enhanced surveillance of completed suicide in SA, in collaboration with the Coroner's Court, and advised consideration of the resources and organisational location of such a system. The suggestion was that there should be research into the quality and content of recording coronial cases of suicide in order to facilitate broader suicide prevention initiatives in South Australia. This initial six-month funded scoping project constituted the action subsequently taken by the Mental Health Unit (MHU) in response to this recommendation.

A research officer, Ellen Rosenfeld, was appointed in March 2007, a National Ethics Application Form (NEAF) was devised and passed by both the DH Research Ethics Committee (HREC) and the Aboriginal Health Council Research Ethics Committee (AHREC) in South Australia. A Letter of Agreement was established between the MHU, DH and the Coroner's Court.

The objectives of the project were to analyse data of closed cases of suicide, analyse data of probable or possible suicides, for example some 'lone' deaths in car accidents, deaths due to drug toxicity and other potential but not immediately obvious self-harm and/or suicide but where the investigations were inconclusive and to identify any links that the deceased may have had with mental health services.

I have been very supportive of this research project and am impressed with Ellen Rosenfeld's rigorous analysis and insight. Further, I believe a great potential exists for analysing data within the office of the State Coroner that falls into the category of potential suicide. Such research might eventually provide for government some firmer basis for making decisions about resource allocation concerning suicide prevention if the base figures are more accurate than they are now. Unfortunately, the Coroners Act as it now stands, prevents a finding of suicidal intent without an Inquest, and even if that were not so, the resources for the work that might potentially be undertaken are not available in this office.

I am disappointed that funding to continue this research work was not made available and the opportunity to analyse the wealth of coronial narrative data has not been pursued by the Department of Health.

3.11. Wangary Report

The Wangary Bushfires Inquest, which commenced in November 2005, concluded on 18 December 2007 with the delivery of the Deputy State Coroner's findings and recommendations. The Inquest investigated the deaths of nine people in the course of a bushfire in the Wangary region on the Lower Eyre Peninsula on 10 and 11 January 2005. This Inquest was one of the most complex ever undertaken by the South Australian Coroner's Court. It involved hearing evidence in both Port Lincoln and Adelaide. The Court undertook several tours of the fireground and received evidence from 140 witnesses in relation to the cause and circumstances of the fires and of the nine deaths, the response by emergency services and the progression and spread of the fires.

The Deputy State Coroner was supported during the Inquest by Mr William Boucaut as Counsel Assisting the Coroner, Mrs Elizabeth O'Keeffe, Senior Research Officer, Ms Tanya MacPhedran, Inquest Support Officer and Mr Dean Turnbull, Sheriff's Officer.

The Deputy State Coroner wishes to acknowledge and thank the members of the Lower Eyre Peninsula community for their cooperation and patience.

The Deputy State Coroner's findings and recommendations with regards to the Wangary Bushfire Inquest are contained within a published report of some 700 pages. The Deputy State Coroner endorsed and expressed agreement with the recommendations that had already been made in the report of the investigation initiated by the Chief Executive of the Country Fire Service, the Phoenix Report. As well, the Deputy State Coroner endorsed and expressed agreement with the recommendations contained in the report of Dr Robert Smith whose investigation had been commissioned by the Minister for Emergency Services. The Deputy State Coroner made 34 additional recommendations as follows:

RICHARDSON, Neil George & MURNANE, Trent Alan & BORLASE, Star Ellen & BORLASE, Jack Morley & GRIFFITH, Judith Maud & KAY, Jody Maria & RUSSELL, Graham Joseph & RUSSELL-KAY, Zoe & CASTLE, Helen Kald (Coroner Schapel)

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1) I recommend that the Minister for Emergency Services, the Chief Officer of the South Australian Country Fire Service, the President of the Farmers' Federation of South Australia and the Minister for Local Government, with a view to developing a Code of Practice, establish a body to investigate the impact of existing farming practices on bushfire risk and prevention.

2) I recommend that the Minister for Emergency Services cause independent scientific or other research to be undertaken to identify the effects of continuous cropping, minimum tillage, direct drilling seeding practices and of the retention of cropping stubble, in respect of bushfire risk and prevention.

3) I recommend that the Minister for Emergency Services cause independent scientific or other research to be undertaken to establish means by which risk of bushfires, as created by continuous cropping, minimum tillage, direct drilling seeding practices and the retention of cropping stubble across the landscape, can be minimised.

4) I recommend that the Minister for Emergency Services and the Minister for Local Government consider the enactment of legislation that would empower Local Government to require the owners or occupiers of rural land to create fire breaks on the land of a kind that Local Government may determine and/or to require the removal of flammable materials from the land, as measures for preventing the outbreak of a bushfire, or for preventing the spread or extension of a bushfire.

5) I recommend that the President of the South Australian Farmers' Federation of South Australia draw these recommendations and findings to the attention of its members and constituents.

6) I recommend that the South Australian Farmers' Federation encourage its members and constituents to keep and maintain on rural land in proper working order machinery that is capable of removing, modifying or reducing cropping stubble at short notice in order to minimise or mitigate bushfire risk.

7) I recommend that the Minister for Local Government cause rural councils to appoint an Officer whose duties consist entirely of bushfire prevention, such Officer being required to become a trained, operative member of the South Australian Country Fire Service during the currency of his or her appointment.

8) I recommend that the Minister for Emergency Services in conjunction with the Chief Officer of the South Australian Country Fire Service, the Chief Officer of the South Australian State Emergency Services and the Commissioner of South Australia Police develop policies and practices regarding the issuing of public warnings that address the risk posed to the public by an existing fire incident with a view to disseminating such warnings to the public at a time before the escalation of an existing fire incident occurs.

9) I recommend that the Minister for Emergency Services, the Chief Officer of the South Australian Country Fire Service, the Chief Officer of the South Australian State Emergency Services and the Commissioner of Police establish a panel to develop policies and practices to ensure that at the time bushfire warnings are created and delivered, all such warnings are made known to all emergency service entities, and to ensure that warnings of an approaching fire are delivered in a timely manner with detailed and specific information relevant to the circumstances of the section of the public to whom they are directed.

10) I recommend that South Australian Country Fire Service create and develop the role of a Regional Public Warnings Officer as a member of the paid staff of the SACFS whose role it would be to identify the need for, and to deliver, timely bushfire warnings to the public during the course of a bushfire incident.

11) I recommend that the South Australian Country Fire Service empower the Regional Public Warnings Officer to create and deliver public warnings on that Officer's initiative without the necessity of seeking the approval of personnel at State Headquarters.

12) I recommend that the Minister for Emergency Services in conjunction with the South Australian Country Fire Service conduct tuition courses to be made available to the general public to enable members of the public to acquire the necessary knowledge and skills to implement their preparation and planning for bushfires.

13) I recommend that the Minister for Emergency Services and the South Australian Country Fire Service implement programs to develop in the minds of citizens a heightened awareness of bushfire risk, and in particular to encourage citizens to listen for radio announcements relating to the progression of a fire during the course of a bushfire incident.

14) I recommend that the Minister for Emergency Services, the South Australian Country Fire Service, the South Australia Police and the South Australian Farmers' Federation together continue to develop strategies to reduce the risk of harm to private firefighters and in particular:

    a) Formulate a code of practice to ensure that the South Australian Country Fire Service and the South Australia Police are aware of the presence of private firefighters and private fire appliances at a fireground so as to discourage the ad hoc deployment of private firefighters and private farm appliances;

    b) Develop an education program for private firefighters dealing with implementation of safe practices for private firefighters, with emphasis on but not limited to, consideration of the effect of wind changes and the dangers associated with proceeding into a fireground with lack of information about the existing circumstances pertaining to that fireground.

    c) Formulate a structure whereby private firefighters at a fireground act in conjunction with, and not separately from, South Australian Country Fire Service resources;

    d) Develop protocols relating to minimum requirements in respect of reliability of private firefighting units, dress for private firefighters, the need for appropriate radio communication, but not limited to those issues;

    e) Develop a position within the structure of Level 2 and Level 3 Incident Management Teams of a Private Firefighting Liaison Officer.

15) I recommend that the Minister for Emergency Services and the Chief Officer of the South Australian Country Fire Service cause to be included among the SACFS' Standard Operating Procedures (SOPs) a requirement that Incident Management Teams responsible for the management of bushfire incidents make all reasonable attempts to contact and maintain contact with the owners and/or occupiers of rural land on which a fire is situated.

16) I recommend that the Minister for Emergency Services and the Chief Officer of the South Australian Country Fire Service cause to be included among the SACFS' Standard Operating Procedures (SOPs) a requirement that Incident Management Teams responsible for the management of bushfire incidents seek information from the owners and/or occupiers of rural land on which a fire is situated as to the topography, vegetation, existing fire breaks, accessibility and local weather conditions pertinent to that land.

17) I recommend that the Minister for Emergency Services and the Chief Officer of the South Australian Country Fire Service cause to be included among the SACFS' Standard Operating Procedures (SOPs) a requirement that Incident Management Teams responsible for a bushfire incident seek advice from the owners and/or occupiers of rural land on which a fire is situated as to the possible firefighting strategies and possible containment measures that might be implemented in order to bring a fire on the land under control, and to take such advice into consideration in the management of the incident.

18) I recommend that the Minister for Emergency Services and the Chief Officer of the South Australian Country Fire Service consider the creation of a position within an Incident Management Team of a Landowner Liaison Officer the duties and responsibilities of whom is to establish contact with and liaise with the owner and/or occupiers of rural land on which a fire is situated.

19) I recommend that the Minister for Emergency Services and the Chief Officer of the South Australian Country Fire Service reinforce in the minds of those Officers who perform the role of Regional Duty Officer the duties and responsibilities attaching to that position insofar as they apply to an ongoing fire incident, and in particular to recognise the need to conduct a risk assessment in relation to an incident and the need to scrutinise, evaluate and validate the strategies and Incident Action Plans of Incident Management Teams.

20) I recommend that the Minister for Emergency Services and the Chief Officer of the South Australian Country Fire Service reinforce in the minds of those Officers who perform the role of Regional Duty Officer the need to deliver to the Deputy State Coordinator timely, accurate and relevant information pertaining to an ongoing fire incident.

21) I recommend that the Minister for Emergency Services and the Chief Officer of the South Australian Country Fire Service reinforce in the minds of all Incident Management Team members, in particular but not limited to the Incident Controller and Planning Officer, of the need to conduct a full risk assessment that not only addresses operational risk, but the risk posed to the general public by an existing incident and at all times to consider and identify the 'worst case scenario' outcome.

22) I recommend that the South Australian Country Fire Service develop as part of competency for inclusion on a Level 2 or Level 3 Incident Management Team a minimum requirement of demonstrated skill and competency in risk assessment.

23) I recommend that the South Australian Country Fire Service design tuition courses aimed specifically at developing among its member's skill and competency in risk assessment.

24) I recommend that the South Australian Country Fire Service develop as part of competency for inclusion on a Level 2 or Level 3 Incident Management Team a minimum requirement of demonstrated skill and competency in identifying and implementing feasible and appropriate containment measures designed to bring control to a fire incident so as to minimise the risk posed to the general public.

25) I recommend that the South Australian Country Fire Service design tuition courses aimed specifically at developing among its members skill and competency in identifying and implementing feasible and appropriate containment measures designed to bring control to a fire incident so as to minimise the risk posed to the general public.

26) I recommend that the South Australian Country Fire Service establish pre-planned Level 2 Incident Management Teams in each Region for deployment to Level 2 incidents.

27) I recommend that the South Australian Country Fire Service utilise wherever possible the skills of paid, professional staff to perform the roles of Incident Controller and/or Planning Officer in Level 2 Incident Management Teams.

28) I recommend that the South Australian Country Fire Service identify and impart minimum skills and competencies to members who fulfil the roles of the four core AIIMS functionaries of a Level 2 Incident Management Team.

29) I recommend that the South Australian Country Fire Service create as part of a Level 2 and 3 Incident Management Team Logistics Division an Officer whose function it is to seek out, locate and identify sources of water, be they on land or provided by carrier.

30) I recommend that the Minister for Emergency Services give further consideration to acquiring a firefighting helicopter to be permanently or primarily stationed in South Australia.

31) I recommend that the Chief Officer and the Editors of all newspapers and other media outlets develop a Memorandum of Understanding that ensures that all CFS press releases concerning total fire ban days and ongoing bushfire incidents are published in full.

32) I recommend that the Minister for Transport, in conjunction with any other relevant authority, conduct research in relation to the question as to whether or not after-market, non-standard mufflers are suitable devices to be fitted to vehicles that are used in rural environments.

33) I recommend that the Minister for Emergency Services, the Minister for Environment, the Chief Officer of the CFS and the Native Vegetation Council, together develop a Code of Practice relating to the management of native vegetation as it affects bushfire prevention.

34) I recommend that the Minister for Emergency Services and the Minister for Local Government cause local council plant and equipment that is suitable for use in bushfire fighting be fitted with radios connected to the Government Radio Network.

4. Inquests for the Year 1 July 2007 to 30 June 2008

- Allen, Richard Grant
- Austin, Grant Aaron
- Carter, Kenneth Morton
- Cecere, Rolando
- Clark, Paige Louise
- *Cox, Ricky*
- Daniels, Robert George
- *Davies, Harold Leslie*
- Edwards, Natasha Anne
- Forsaith, Renald Lance
- Gill, Andrew Stephen
- Hackett, Jake Vincent
- Johnson, Robert Allen
- Krol, Riley
- Leslie, Mona Belle
- Parrott Aka White, Jenisha
- Pudney, Martin Craig
- Randall, Treenor Heather
- Schaer, Simon
- Schupelius, Zara Marie
- Smith, Arthur Charles
- Smith, Callum Daryl Walter
- Smith, Rachel Von
- Stehbens, Jarrod David
- Sweetland, Charles James
- Tarnowski, Marek Tomasz
- Velkos, Basile
- *Wanganeen, John Frederick*
- *Watkins, Maureen*
- Wells, Gladys Ruth
- Wheaton, Rowan Scott

*** Italics denote that the matter is part heard.*

4.1. Inquest Statistics relating to Inquests held during the Year 1 July 2007 to 30 June 2008

No	Name	Date of Death	Inquest Number	Inquest Start Date	Finding Delivered	Period (mths) From DOD	Period (mths) From Inquest
1	LESLIE, Mona Belle	28/09/04	14/2007	16/07/07	02/08/07	35	1
2	SMITH, Arthur Charles	13/01/05	18/2007	01/08/07	19/09/07	33	2
3	DANIELS, Robert George	09/11/03	20/2007	05/07/07	09/11/07	49	4
4	JOHNSON, Robert Allen	21/09/05	21/2007	10/09/07	26/09/07	25	1
5	PUDNEY, Martin Craig	12/01/05	22/2007	11/10/07	09/11/07	34	1
6	RANDALL, Treenor Heather	28/08/04	23/2007	22/10/07	09/11/07	39	1
7	WELLS, Gladys Ruth	18/07/07	24/2007	12/12/07	07/02/08	7	2
8	KROL, Riley	11/03/05	1/2008	21/01/08	23/05/08	39	4
9	FORSAITH, Renald Lance	06/04/05	2/2008	29/01/08	06/06/08	39	4
10	CARTER, Kenneth Morton	08/06/05	3/2008	30/01/08	22/08/08	39	7
11	AUSTIN, Grant Aaron	27/04/05	4/2008	05/02/08	06/06/08	38	4
12	TARNOWSKI, Marek Tomasz	16/05/04	5/2008	11/02/08	17/07/08	51	5
13	SCHUPELIUS, Zara Marie	22/06/05	6/2008	18/02/08	25/06/08	37	4
14	SMITH, Callum Daryl Walter	08/07/05	6/2008	18/02/08	25/06/08	36	4
15	HACKETT, Jake Vincent	20/07/05	6/2008	18/02/08	25/06/08	36	4
16	SMITH, Rachel Von	05/08/05	6/2008	18/02/08	25/06/08	35	4
17	CLARK, Paige Louise	02/07/06	6/2008	18/02/08	25/06/08	24	4
18	EDWARDS, Natasha Anne	11/07/05	7/2008	25/02/08	15/08/08	38	6
19	STEHBENS, Jarrod David	24/08/05	8/2008	25/02/08	14/03/08	31	1

No	Name	Date of Death	Inquest Number	Inquest Start Date	Finding Delivered	Period (mths) From DOD	Period (mths) From Inquest
20	DAVIES, Harold Leslie	18/07/05	9/2008	13/03/08	-	-	-
21	GILL, Andrew Stephen	02/06/05	10/2008	26/03/08	-	-	-
22	SCHAER, Simon	15/12/05	10/2008	26/03/08	-	-	-
23	WANGANEEN, John Frederick	24/08/05	11/2008	26/03/08	-	-	-
24	CECERE, Rolando	22/01/06	12/2008	07/04/08	-	-	-
25	ALLEN, Richard Grant	02/11/05	13/2008	16/04/08	19/09/08	35	5
26	COX, Ricky	24/02/06	14/2008	30/04/08	-	-	-
27	PARROTT aka WHITE, Jenisha	18/07/04	15/2008	06/05/08	-	-	-
28	SWEETLAND, Charles James	27/08/05	16/2008	11/06/08	16/10/08	38	4
29	WATKINS, Maureen	14/07/06	17/2008	24/06/08	-	-	-
30	WHEATON, Rowan Scott	21/04/06	18/2008	16/06/08	-	-	-
31	VELKOS, Basile	12/06/06	19/2008	17/06/08	-	-	-

4.2. 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 all recommendations made by the Coroner's Court during the year the subject of this report:

EDWARDS, Elizabeth Rose (Coroner Johns)

I recommend that for foster carers, education and training should be compulsory not only prior to registration, but as a necessary prerequisite to the renewal of registration.

I recommend that there should be an objective assessment of the aptitude of the foster carer as part of their training and that foster carers should achieve an acceptable level of knowledge about the caring of children.

I recommend that the assessment of foster carers for registration should take into account their physical capabilities together with their fitness and energy levels, with a view to ensuring that their physical capabilities match the demands that would be anticipated in caring for children of the ages for which the carers are registered.

I recommend that foster carers should be provided with a summary of all relevant details about the history of a child coming into their care in order that they can make proper arrangements for the child's care.

I recommend that the Minister for Families and Communities give consideration to the appropriateness of the participation of Anglicare and other providers in the process of assessment and review of foster carers. This should include a consideration of whether the present arrangement is consistent with the Families and Communities Act 1972, and if so, whether it is in any event desirable given the conflicting objectives referred to earlier in this finding.

I recommend that the Minister for Health issue a further reminder to the general public about the serious risks involved in placing a baby in a cot with U-shaped pillows.

GILLAM, Peter Roy (Coroner Johns)

I recommend that public hospitals maintain a system by which the whereabouts of doctors who they think are likely to leave Australia for a protracted time or permanently can be ascertained, if necessary, for coronial investigations.

KEOUGH, Thomas Ryan (Coroner Johns)

That the Department of Health investigate the introduction of a system for reconciling the quantity of methadone or other opiate pain relief drugs that have been prescribed to palliative care patients as soon as convenient after their death, with appropriate sensitivity to the deceased's family.

I recommend that Palm Lodge and similar facilities institute a policy of reporting allegations of illicit drug use or dealing to police expeditiously upon receiving such allegations.

I recommend that Palm Lodge policies and procedures be thoroughly reviewed by the Department of Health.

I recommend that Palm Lodge carry out room checks daily, whether or not the resident is thought to be absent.

I recommend that South Australia Police introduce protocols to ensure a more rigorous investigation of the cause and circumstances of deaths suspected to have been caused by drug overdose, particularly with a view to ascertaining the involvement of drugs that are illicit or have been illegally obtained or provided.

I recommend that South Australia Police be required to report to the Minister of Police all deaths in which the deceased is believed by the initial investigating officers to have died as a result of ingesting an unknown drug and where South Australia Police has been unable, within three months of the date of death, to ascertain the source of the drugs involved.

I recommend that the Minister of Police make such reports publicly available, with appropriate protections for the identity of the deceased to prevent unnecessary distress to their relatives.

KROL, Riley (Coroner Schapel)

I recommend that the Minister for Health cause a review to be undertaken in respect of hospitals that provide obstetric services with a view to establishing their capability of responding appropriately and timely to emergencies that involve the carrying out of caesarean section procedures with particular regard to the following:

a) existence of emergency protocols relating to delivery by caesarean section;

b) availability of operating staff at night;

c) availability of suitably qualified and experienced clinicians capable of performing and permitted to perform various types of anaesthesia including general anaesthesia.

I further recommend that the Minister for Health in the light of that review implement or cause to be implemented measures designed to facilitate efficient and expeditious carrying out of emergency caesarean section procedures.

LESLIE, Mona Belle (Coroner Johns)

I recommend that Canterbury Close Nursing Home reinforce with its staff that in circumstances where residents are found to be in distress from coughing during a meal, staff should not dismiss the possibility of a choking episode until they have taken proper steps to satisfy themselves that the incident is not a choking episode.

LYDEN-BAKER, Elizjah Monique Ivy (Coroner Johns)

I recommend that the Minister for Health give consideration to providing midwives who carry out home visits the resources to enable them to check that safe sleeping practices are understood and being practised by the carers of infants.

MARKANTONAKIS, Stefanos (Coroner Johns)

I note that Flinders Medical Centre instituted a number of changes in the Emergency Department following the findings in Inquest 39 of 2004 (Louise Kay O'Neill). In that case, the former State Coroner recommended the creation of the triage assist position, together with the carrying out of half hourly observations. These recommendations had not been made at the time of Mr Markantonakis' attendance at Flinders Medical Centre in March 2004. The O'Neill findings were not handed down until December 2004. They have since been implemented. I agree with counsel for South Australian Ambulance Service and Flinders Medical Centre that it would be useful to further alter the system by requiring that the nurse assist have the task of chasing up the SAAS ambulance card and considering it at the time of the first set of half hourly observations, and specifically considering whether the SAAS report form should cause a reassessment to be made of the triage category given to the patient. I recommend accordingly pursuant to section 25(2) of the Coroners Act 2003.

SCHUPELIUS, Zara Marie, SMITH, Callum Daryl Walter, HACKETT, Jake Vincent, SMITH, Rachel Von, CLARK, Paige Louise (Coroner Schapel)

That the Minister for Families and Communities and the Minister for Health act upon, and provide the funding for the implementation of, the recommendations of the Child Death and Serious Review Committee as contained within the Committee's annual reports for the years 2005-2006 and 2006-2007, namely;

- The Committee recommends that a public health campaign for young parents be developed concerning safe sleeping. Careful consideration should be given to the ways in which this campaign is delivered both in terms of the material that is developed and the ways it is disseminated. The campaign should involve Government and non- Government agencies who deliver services to infants and their families in South Australia.
- The Committee strongly recommends that a product safety analysis be undertaken as soon as possible if the death of a child has been attributed to a product such as a bed or cot. This recommendation should apply to any deaths of infants attributed to a particular product.
- Every infant be provided with a safe sleeping environment.
- State-wide programs or campaigns be developed and resourced to build the knowledge and confidence of parents or carers so that they know how to provide safe sleeping arrangements for infants.
- State-wide support programs be developed and resourced to provide safe sleeping environments for infants in disadvantaged families, including if necessary the provision of appropriate cots or beds and ongoing support to ensure that safe sleeping arrangements be maintained.

That the Minister for Families and Communities and the Minister for Health cause to be developed a single set of consistent guidelines that define the appropriate strategies to be implemented by parents, carers and health professionals for the reduction of risk factors in sudden unexpected death in infancy (SUDI).

That the Minister for Health and the Minister for Families and Communities cause to be developed strategies for the education of the wider community as to safe and unsafe infant

sleeping practices. That such strategies should be designed to enable members of the wider community to identify, and assist in the elimination of, unsafe infant sleeping practices that they may encounter.

That the Minister for Families and Communities and the Minister for Health cause educational programs to be directed to the nursing profession, carers and other health professionals concerning safe sleeping practices for infants so as to enable members of the nursing profession, carers and other health professionals to properly, accurately and consistently impart to parents and families the essentials of safe sleeping practices for infants.

That the Minister for Families and Communities and the Minister for Health undertake the necessary measures to direct the nursing profession, carers and other health professionals, who provide advice on how to get infants to sleep, to ensure that the safe sleeping message imparted to parents and families is consistent and in accordance with the recommendations of SIDS and Kids, Kidsafe and the Women's and Children's Hospital, and in particular to disseminate advice (a) that infants should be slept on their backs from birth, and (b) that parents should only deviate from what is considered to be a safe sleeping practice upon advice from a medical practitioner.

That the Minister for Families and Communities and the Minister for Health develop strategies to identify new parents who are, or might be, at particular risk of their infant being subjected to an unsafe sleeping environment, that this risk assessment be conducted prior to the mother's discharge from hospital and that appropriate and accurate information is provided to parents who are identified as at risk in order to minimise that risk.

STEHBENS, Jarrod David (Coroner Schapel)

I have already referred to the recommendation of the former State Coroner in the Buckland Inquest. In my view, nothing revealed in this current Inquest brought into question the validity of that recommendation. The recommendation, reproduced earlier in this finding, is repeated.

'I therefore recommend, pursuant to section 25(2) of the Coroners Act, that commercial and recreational divers, when operating in waters where there is a risk of the presence of sharks, should wear a shark repellent device of the 'Shark Pod' or 'Shark Shield' type, provided that the equipment should be used in accordance with the manufacturers instructions, and should be turned on for the entire duration of time in the water.' [1]

It is difficult for this Court to impose its own views on a private organisation such as the Adelaide University in respect of its operational requirements. Their views in relation to the mandatory wearing of shark repellent devices obviously differ from mine and those of SAPOL and SARDI. That to my mind is a matter for them. So be it. The University needs to be reminded, however, that divers within their employ, as a matter of law, have to be protected. The University is now on notice. While in all of the circumstances I have decided not to make a recommendation that the University should make the wearing of shark repellent devices mandatory, I do recommend that no person in authority at the University discourage their use. Indeed, I would recommend that provided effective shark repellent devices remain available, the use of such devices among the University diving community should be actively encouraged. I direct this recommendation to the Manager of Health Safety and Well Being of the University and to the Head of the School of Earth and Environmental Sciences.

[1] Inquest 6/2003

WELLS, Gladys (Coroner Johns)

I recommend that the Attorney-General consider the introduction of a Bill to amend the Cremation Act 2000 by extending the prohibition in section 6(5) to cover the certification of deaths in a nursing home in which a medical practitioner has a financial or proprietorial interest. In considering this measure, the Attorney-General may wish to consider other interests which might disqualify a doctor from certifying a person for cremation in particular cases.

I recommend that the Medical Board of South Australia give consideration to whether the conduct of either of the Doctors Saraf was in breach of the Medical Practitioners Act. I have found their conduct to be inappropriate in the sense described in these findings. I make it clear that I do not in any way intend to pre-empt any finding of the Medical Board.

I recommend that the Attorney General consider these findings with a view to determining what action, if any, should be taken against any person pursuant to section 28 of the Coroners Act 2003 and section 6(4) of the Cremation Act 2000.

WILSON, Christopher Stuart (Coroner Johns)

In my opinion this Inquest has shown that the Police Complaints and Disciplinary process in South Australia is in need of review. As noted in the Victorian Office of Police Integrity report[2] an effective disciplinary process must operate promptly. A delayed outcome with lingering uncertainty is often stressful for the employee concerned and may well be worse than the penalty itself. It is also a potential cause of dysfunction within the workplace. I therefore recommend as follows:

I recommend that the Government review the Police (Complaints and Disciplinary Proceedings) Act 1985 in light of reforms adopted in other States of Australia, the United Kingdom and New Zealand[3].

In the meantime I recommend that section 48 of the Police Complaints Act be amended to remove the barrier created by the secrecy provision to full disclosure of all relevant evidence to the Coroner's Court.

I recommend that section 63C of the Young Offenders Act 1993 and section 59A of the Children's Protection Act 1993 be amended to permit the Coroner's Court to allow publication of material that would otherwise be prohibited from publication by these provisions.

[2] 'A Fair and Effective Victoria Police Discipline System', page 20
[3] See generally, 'A Fair and Effective Victoria Police Discipline System', Office of Police Integrity, Victoria, October 2007.

4.3. 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:

AUSTIN, Grant Aaron (Coroner Johns)

I recommend that the Department of Health consider the options available to ensure that information is accurately and faithfully disseminated between the various medical practitioners involved in the care of the intellectually disabled.

I further recommend that the Royal Adelaide Hospital conduct a review of the system of nursing specials, with particular reference to the circumstances in which specials can be revoked and by whom, and the documentation required to authorise such revocations including a system for recording such documentation upon the patient's medical records.

FORSAITH, Renald Lance (Coroner Johns)

I find that Mr Forsaith's death by suicide could not have been foreseen by prison authorities having regard to his behaviour during the period of his incarceration. Mr Forsaith suspended himself from the structure supporting the shelf in his prison cell. This very structure or its equivalent in other cells has been used by other prisoners for the same purpose. I refer to previous recommendations in relation to the removal of hanging points from prisons. A letter from Mr Peter Severin, Chief Executive of the Department for Correctional Services dated 21 January 2008 was provided to the Court. It was received and admitted as Exhibit C32b. It refers to various projects which have been undertaken by the Department with a view to improving the safety of prison cells. Unfortunately, the fact remains that the issue of hanging points remains to be properly addressed at Yatala Labour Prison. Similar bookshelves continue to exist in the prison today and the problem has not been eliminated. I can do no more than refer to previous recommendations and indicate that I endorse them and adopt them for the purposes of this Finding.

MANN, Richard Lesley (Coroner Johns)

I recommend that these Findings be considered by the Nurses Board of South Australia.

I recommend that these Findings be considered by the Strathmont Centre and the Department of Health to ensure that the protocols are formulated to establish clear roles and responsibilities when nursing and residential staff are working together.

SANSBURY, Colin Craig (Coroner Johns)

I recommend that the deployment of Aboriginal Community Constables for the purposes of 'debriefing' as that concept is used in the debriefing policy, Exhibit C78b, be discontinued.

I recommend that the Attorney General raise with his State and Commonwealth counterparts the proposal that the States and the Commonwealth enter into an arrangement with each other such that a death in the custody of the police force of a particular jurisdiction is investigated by or under the supervision of police from another jurisdiction, including the Federal Police.

SMITH, Arthur Charles (Coroner Johns)

I recommend that the Department for Correctional Services make a renewed effort to implement the recommendation of Mr Smedley in relation to the removal of towel rail hanging points. I furthermore reiterate previous recommendations made in Inquests in relation to safe cell practices.

4.4. 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:

SMITH, Arthur Charles (Coroner Johns)

Recommendation - That the Department for Correctional Services make a renewed effort to implement the recommendation of Mr Smedley in relation to the removal of towel rail hanging points. I furthermore reiterate previous recommendations made in inquests in relation to safe cell practices.

- The removal of towel rail hanging points was recommended by Mr Smedley during an investigation of an earlier death in custody.
- In response to the Coroner's recommendation, the Department has been able to remove some of these fixtures, but many of the rails are an integral part of the plumbing fixtures and would be extremely difficult to remove without substantial refurbishment of each cell.
- The Department has, and continues to address the issue of ligature point removal from cells. Cells are refurbished to safe cell design standards through an holistic approach that incorporates bed, shelving and associated cell requirements. This approach is preferred over focussing on removing one item (eg. towel rails) from cells whilst leaving multiple other ligature points available.
- As advised in reports of the Minister previously tabled in Parliament, a departmental audit resulted in the removal of hanging points and the refurbishment of certain existing cells in accordance with available funding.
- The Government has also announced that new prison infrastructure will comply with 'safe cell' standards, as will any new cell accommodation in existing facilities. The new standards are the benchmark for future prison construction and have been adopted by all States and Territories for new facilities. Cells constructed under the 'safe cell' standards are free of ligature points.

TRENORDEN, John (State Coroner Johns)

Recommendation - The Minister for Correctional Services and the Chief Executive of the Department for Correctional Services give consideration to the issue of non-tearable blankets and sheets within South Australian prisons.

- In response to the Coroner's recommendation, the Department has explored the issue of non-tearable blankets and sheets and determined that it would not be appropriate to adopt such a practice at this time.
- Canvas has been identified as the only available fabric for the purpose. This fabric is not suitable for constant use as it is stiff and does not provide any level of comfort. It would therefore be likely that use of canvas as the only form of bedding would result in adverse reactions from prisoners, increasing instead of decreasing risk.
- Notwithstanding, each institution has cells equipped with canvas bedding to allow such an alternative for prisoners that are identified as being at high risk of self harm.

CHALKLEN, Stuart Murray (State Coroner Johns)

Recommendation - That the Department for Correctional Services commence negotiations with the Public Service Association and the Correctional Officers Legal Fund with a view to developing a protocol under which some greater level of cooperation with coronial inquiries might be achieved. A simple expedient would be for officers to advise that they do or do not have any useful information to provide, always reserving the right to decline to answer questions that might incriminate them. This could be achieved without the need for each officer to be interviewed by a police officer in the presence of a solicitor, most obviously in cases where the officer has no knowledge or information to impart. If such a protocol cannot be settled upon within the time at which a report is required pursuant to section 25(5)(a) of the Act to laid before each House of Parliament giving details of any action taken or proposed to be taken in consequence of this recommendation, I further recommend that a subsequent report be laid before each House of Parliament at a point where such a protocol exists or efforts to negotiate for one have been abandoned by the Department for Correctional Services. A copy of any such further report should also be provided to the State Coroner.

- Consistent with the Coroners recommendation the Department, in conjunction with the Public Service Association, the Correctional Services Officers' Legal Fund and South Australia Police (SAPOL) have agreed on procedures to be followed, should circumstances occur again where information is to be sought from large numbers of staff.
- It has been agreed that large numbers of staff identified as being essential to an inquiry will be advised of the situation and be required to indicate, on a form, whether or not they have any information that will assist the investigation. Police will interview those who indicate they have such information.
- Additionally, SAPOL, in conjunction with the Department, has recently established an integrated Police/Corrections Unit. The SAPOL operated Unit will be responsible for specific investigations within prisons including those related to drug activity, deaths in custody, escapes and extraditions as well as the coordination of intelligence material common to both Police and Correctional Services.
- Future investigations into the death of any person in the custody of the Department for Correctional Services will be investigated by this Unit which will be bound by the 'Protocol For Investigation Into Deaths in Custody' issued by the State Coroner. As part of its practices, the Unit will adopt the recently agreed procedures.

COCKBURN, Michael Philip (Deputy Coroner Schapel)

Recommendation 1 - That the RAH formally remind all nursing and medical staff of the need to carefully examine a patient's file for the existence of and contents of any medication alerts before medication that is known to produce adverse side effects is administered.

- The introduction of the new National Inpatient Medication Chart in January 2007 clearly provides for (and standardises) documentation and checking of medication alerts.
- Staff training covered the importance of identifying and checking alerts. The allocation of bed numbering throughout the wards and generation of a standardised printed patient bed card includes alert status.
- The RAH funded a six month project to deliver an education program aimed at improving documentation in the medical record. An information pack has been distributed to

medical staff concerning medical documentation. Information will be formalised and will be sent to all staff via various inter-hospital forums and mechanisms.

- As part of the Australian Pharmaceutical Advisory Council (APAC) guidelines, Clinical Pharmacists have been appointed and have commenced work in the Emergency Department and Pre-Anaesthetic Admission Clinic. Medication reconciliation (including alerts) is part of the pharmacists' role in these areas.
- Staff are regularly reminded of the importance of checking for allergies prior to administration of medications. On at least four occasions the importance of checking medication orders and good documentation have been the subject of a Central Northern Adelaide Health Services Acute Services Risk Alert newsletter circulated for staff (May, September and October 2006; February/March 2007) and posted on the IntraNet.

Additional Comments/Required Actions

- Work with standardising the patients' blue folders will consider a sticker for the front of the folder featuring alerts.
- Medium term solution includes building an alert screen into the computerised clinical information system, OAGIS.
- The long term solution would require an electronic medication system with inbuilt decision support to prevent a medication being supplied / given if an alert is recorded.

Recommendation 2 - That the RAH consider implementing measures to ensure that medical practitioners of the level of registrar or above are preferentially called to restraint situations, or are at least made aware of the existence of a restraint situation and are tasked to be ready to provide advice to junior practitioners if necessary.

- The RAH is in the process of reviewing allocation of staff tasked to attend urgent restraint situations. This work is being undertaken by the Aggressive Behaviour Management Committee. The RAH will endeavour to ensure as part of this review process that, wherever possible, registrar level of involvement is incorporated.

Additional Comments/Required Actions

- Further work to review attendance to restraint process is ongoing.

Recommendation 3 - That the RAH formally impress upon its nursing and medical staff, especially interns, to consult more senior staff if in doubt about the appropriateness of prescribing particular medication.

- Clinical staff are currently advised through a variety of mechanisms of the importance of seeking the advice of more senior staff, if in doubt or if they require assistance. This is communicated through initial orientation to the Hospital, as well as regular in-service and via orientation to the home units.
- The RAH also employs clinical pharmacists who assist and educate medical staff on medication related issue including safety.
- As part of the implementation of the APAC guidelines Clinical Pharmacists have been appointed and commenced work in the Emergency Department and PreAnaesthetic Admission Clinic. Medication reconciliation (including alerts) is part of the pharmacists' role in these areas. Further pharmacists will be appointed in other areas over time.

- The RAH will continue to explore ways of ensuring that clinical staff are reminded of the need to consult with their senior colleagues as appropriate.

Additional Comments/Required Actions

- Further reviews of adverse events to be shared with medical staff through Grand Rounds.
- Risk Alerts to continue to highlight to staff the importance of seeking senior advice.

Recommendation 4 - That Glenside implement measures to ensure that a substitution of one patient's documentation for that of another does not happen again.

- To improve patient identification, Glenside Hospital Campus introduced 'Patient Medication Chart Labels' in November 2005 whereby a photograph of each patient is included on their medication chart. This has resulted in patient medication charts, for all patients of Glenside Campus, uniquely identifying each patient to reduce the possibility of information being assigned to the wrong patient and/or the substitution of one patient's documentation for that of another.

DOOMA, Renato (Coroner Sheppard)

Recommendation 1 - That provision be made to increase the number of closed ward extended care beds available at Glenside Hospital (or a suitable alternative facility), for persons with chronic mental illness who have not responded sufficiently to treatment in an acute facility and who are deemed unsuited to management in the community.

- The Coroner has recommended increasing the number of closed ward extended care beds in the South Australian mental health system. As part of it's mental health reform agenda, the State Government has injected $107.9 million to be spent over the next five years. This is a commitment to a new "stepped care" model.
- The stepped care model has five graduating steps: 24 hour supported accommodation; community rehabilitation centres; intermediate care beds; acute beds and secure care beds. This new model of care will add an estimated 76 extra beds across all five levels of care.
- The State Government has committed $18.2 million for 90 new intermediate care beds, 60 at four centres across Adelaide and 30 in country hospitals; $20.46 million for an extra 73 supported accommodation beds across Adelaide; $1.84 million to allow a smooth changeover between the current system and the new five tiered system and $1.47 to provide priority access to services for about 800 people with chronic and complex needs.
- The new stepped care model will help reduce congestion in the mental health system, provide more alternatives closer to people's homes and people will be more supported in the first stages of developing a mental illness.
- There are currently 10 closed extended care beds which will be replaced by alternative treatment options under the new stepped care model. The Government has already committed $14 million to build a new 30-bed Secure Mental Health Rehabilitation Unit. When in place, this will directly address the Coroner's recommendation 16.1.1. In the interim, access to new services such as Community Recovery Centres (60 places) and intensive community packages all assist to meet the needs of people with a mental health related diagnosis or disability and which frees up acute beds.

Recommendation 2 - That administrators and senior nurses in acute psychiatric facilities examine their observation policies and practices to ensure that patients who have been detained in these facilities and have not been granted leave in the community, are adequately supervised.

- Since Mr Dooma's death in September 2004, metropolitan health services with approved treatment centres (ATCs) have reviewed nursing observation policies, guidelines and standards for detained patients.
- Following Mr Dooma's death, The Queen Elizabeth Hospital immediately reviewed all nursing observation policies and procedures. This review resulted in the introduction of 24 hour checklists to record the frequency of observation. At the conclusion of each 24 hour period, the checklist is filed in the individual's case notes.
- There are four different categories of observation frequency assigned to reflect both risk status and the environment in which the person is held (e.g. a closed or an open unit). The categories of observation level are:
    - 'Continuous' (within sight of nursing staff at all times);
    - 'Close' (at least every 15 minutes);
    - 'Regular' (at least every 60 minutes); or
    - 'General' (at least every two hours).
- The frequency is increased if there is a clinical need to do so.
- The Queen Elizabeth Hospital again reviewed the nursing observation policy and procedures in 2005-06 prior to an external review for the EQuIP (Evaluation and Quality Improvement Program) accreditation process.
- In 2006-07, the Central Northern Adelaide Health Service (CNAHS) developed a Nursing Observation Policy for the whole region. The policy was endorsed in July 2007 and extends to all the ATCs that are a part of CNAHS including The Queen Elizabeth Hospital, Royal Adelaide Hospital, Lyell McEwin Health Service and Modbury Public Hospital.
- From a state perspective, the Principal Mental Health Nursing Advisor for South Australia has also initiated the development of a Statewide Nursing Observation Policy for all metropolitan and regional public inpatient units.
- The Principal Mental Health Nursing Advisor is a leading member of a newly formed Mental Health Nursing Leadership Forum (MHNLF), chaired by the Chief Nurse, Department of Health.
- The membership of the MHNLF is made up of the Mental Health Nursing Leads from the Central Northern Adelaide Health Service, Southern Adelaide Health Service, Children Youth and Women's Health Service, Country SA and the Repatriation General Hospital.
- The MHNLF will take a lead role in finalising a state-wide policy which is currently available for comment.

5. Counsel Assisting the Coroner

During the year under review the State Coroner and Deputy State Coroner have been ably supported and advised by Senior Counsel Assisting, Kate Hodder until 17 August 2007 and Counsel Assisting, Amy Davis and Dr Rachael Gray.

Miss Amy Davis was appointed as Senior Counsel Assisting on 17 September 2007 and Dr Rachael Gray was appointed as Counsel Assisting on 10 December 2007.

The role of Counsel Assisting is to provide legal services to the State Coroner and Deputy State Coroner including overseeing investigations conducted for the State Coroner and Deputy State Coroner, preparing matters for Inquest, ensuring that matters are listed for Inquest before the State Coroner and the Deputy State Coroner in an orderly and efficient manner to make the best use of the Court's resources, and appearing as counsel to assist in Inquests.

During the year Miss Davis appeared at 14 Inquests, Dr Gray at 16 Inquests and Ms Hodder at 1 Inquest.

The State Coroner and Deputy State Coroner are reliant on the expertise of Counsel Assisting to review cases, direct investigations and ultimately recommend cases that they assess as warranting consideration for Inquest. Counsel Assisting then prepare and present the case in court so that the presiding Coroner can consider a well balanced case. Counsel Assisting liaise with families, legal practitioners representing other parties, as well as SAPOL and those experts presenting specialist opinion to the Coroner.

6. Manager's Report

6.1. Registry Report

The Principal Administrative Officer of the Coroner's Court is Michele Bayly-Jones and she is tasked to ensure efficient and effective management of the State Coroner's Court, and to provide the statutory, administrative, quasi-judicial functions of the Court and for effective service delivery to all stakeholders and families.

There are 15 full-time equivalent (FTE) administrative staff plus 2 full-time equivalent (FTE) Counsels Assisting attached to the Coroner's Court.

As mentioned previously, the State Coroner is committed to supporting professional and community education in understanding the role of the coronial process. To that end the Manager of the court conducted 23 speaking engagements throughout the year under review and the Social Workers conducted six.

The registry operates on a 7-day per week basis and the staff undertakes a series of complex administrative tasks that facilitate the coronial process from the time of report of death to the preparation of the Inquest. The tasks require that staff report matters to the coroner, arrange for identification of deceased and body transport, provide official paperwork to the mortuary to undertake post mortems and release of bodies. Staff arrange for delivery and return of medical case notes and manage a high volume of correspondence in relation to case matters.

At the direction of Counsel Assisting, staff preparing Inquests organise the case to be presented in court on behalf of the coroner and provide all relevant information to parties who appear in court. Two administrative staff assist in the preparation of matters for Inquest as directed by Counsels Assisting, and, the State Coroner and Deputy State Coroner are assisted in the preparation of Inquest findings by one Personal Assistant. The volume of work at this executive assistant level is high. All staff of the court are required to provide accurate information and advice in an empathic and calm manner to family members who are often distressed, angry and confused.

Throughout the year under review staff continued to progress the goals defined by the Coroner's Court Business Plan 2007-2009. A number of initiatives were progressed or completed. Highlights of the achievements of the Business Plan include:

- Review of Job Profiles
- Improved staff induction process
- Improved in service training
- Development and use of a 'complaints register'
- Production of fact sheets for stakeholder groups such as aged care facilities
- Improvements in Staff Performance Management

Early in 2008 the Courts Administration Authority undertook a Staff Survey across all courts. Participation in the survey was voluntary and the aggregated, de-identified results were made available to all staff. The survey explored issues in relation to four sub sections namely, Workforce; Services, Processes; Infrastructure; and Communication.

The satisfaction ratings for the Coroner's Court in relation to all subsections were lower than other CAA courts and a summary of results showed that Coroner's Court staff were less satisfied in the areas of job satisfaction, career opportunity and the retention of staff than staff in other courts. Despite this, staff rated highly in the area of integrity, respect for others and professionalism and are to be congratulated for their continued commitment to the coronial jurisdiction.

Staff retention has been of particular concern this year with a number of new recruits leaving after a short period of time. Exit interviews show that new staff were overwhelmed by the daily volume of work undertaken by the Coroner's Court as well as the degree of difficulty in handling the contact with families who are angry over the delays and extended timeframes. Even professional advice on recruitment and selection has not resolved the fact that new staff were unprepared for the confronting nature of the work and high volume workload. The staff members who enjoy the work at the Coroner's Court and want to stay are frustrated because there is currently little career path available in this small office environment.

An emerging problem over the year under review has been the inability to adequately store documents and archive files for State Records. Certain documents must be stored for a number of years and coronial files must be archived according to State Record requirements. Many hundreds of files are stored on site, however, when storage reaches capacity the files must be dispatched to State Records. Storage of files has become an Occupational Health Safety and Welfare issue as well as a physical space issue.

6.2. Counselling Service

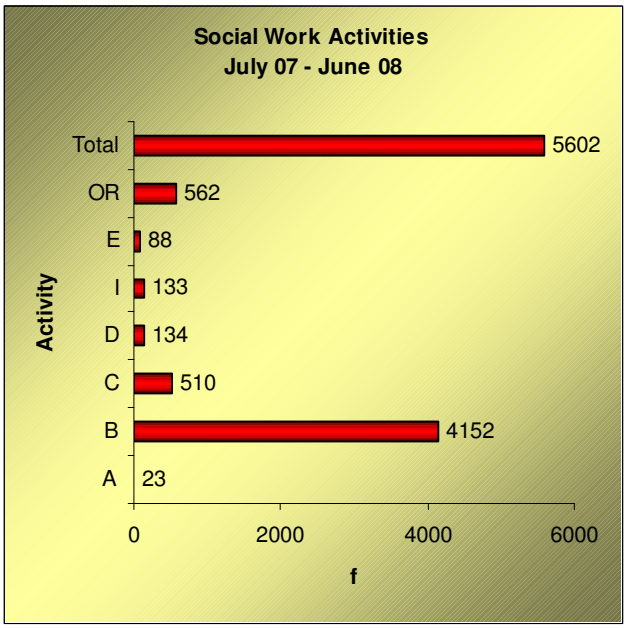
The Coronial Social Workers provide short-term grief counselling, support and referral. They support families by providing them with information about the coronial process, accompanying families to viewings and by supporting families who are eligible for government assisted funerals, and families who wish to object to a post mortem. The social workers also assist families in their preparation in attending an Inquest.

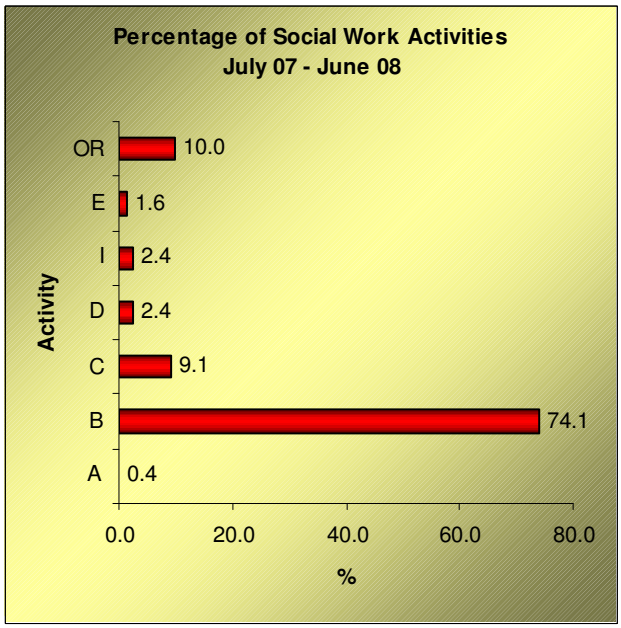
The social workers perform an integral role within the Coroner's Court. They counsel and support family members as they face very difficult and traumatic circumstances. Unfortunately, due to resources currently available, the social workers must perform these duties over the phone rather than face to face. There are many circumstances, such as communicating with parents whose baby or child has died, where a face-to-face meeting would deliver a more appropriate

and compassionate service. At present the social workers are working with families on the phone almost all day every day. This leaves little time for professional development, or to progress goals such as training a team of social workers in Disaster Victim Identification ante mortem collection, providing community education and visiting regional country areas to provide in-service training to professionals, and to visit bereaved families who live in the country.

During the year under review the social workers have improved the statistical collection of data relating to organ retention and numbers of contacts with families. They have provided invaluable training to staff on the subject of understanding grief and managing difficult phone calls as well as debriefing with staff after exposure to traumatic death information.

The following tables show the breakdown of contact that Coronial Social Workers have with families throughout the year.





Legend

A	Viewing a body
B	Telephone contact with family
C	All contact with other than family
D	View File in office
I	View/discuss Inquest
E	Meetings
OR	Discussion/action re Organ Retention

Activity	Frequency	%
A	23	0.4
B	4152	74.1
C	510	9.1
D	134	2.4
I	133	2.4
E	88	1.6
OR	562	10.0
Total	**5602**	**100.0**

6.3. Organ Retention

As the Coroner's Court is responsible for the investigation of the circumstances and cause of reportable deaths within South Australia, the circumstances and cause of a death is often determined via a post mortem examination. In certain deaths, however, an autopsy does not always clearly reveal the circumstances and cause of a person's death. In these situations further investigations and tests must be carried out. These investigations and tests can involve the retention of whole organs. The Court's social workers have primary responsibility to inform, and take directions from, the senior next-of-kin with respect to organ retention. The family is informed of the organ retention within 24 hours of the Coroner approving the examination of the organ.

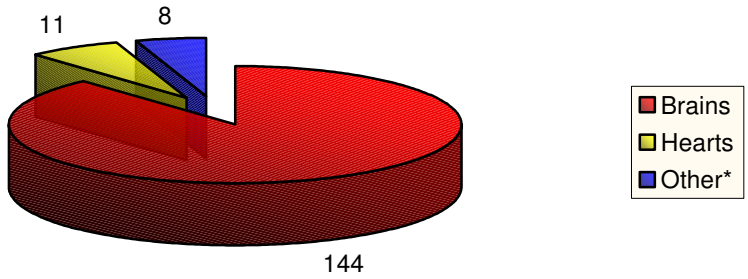
6.3.1. Frequency of Organs Retained

Between 1 July 2007 and 30 June 2008, there were 151 deaths that involved the retention of one or more organs for specialist tests. Expressed as a percentage, deaths where organ retention was required accounted of 7.9 per cent of all deaths reported to the SA State Coroner's Court.

6.3.2. Types of Organs Retained

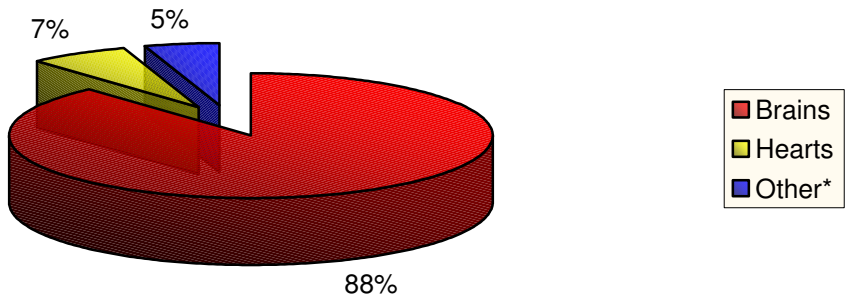
In total 163 organs were retained for the 2007-2008 financial year. 88% (n=144) of organs retained were brains. Hearts accounted for about 7% (n=11). Cervical spinal cords/columns and eyes made up the remaining 5% (n=8).

Organs Retained for Specialist Examination
July 07 - June 08



* Cervical Spinal Cords/Columns and Eyes

Organs Retained for Specialist Examination by Percentage - July 07 - June 08

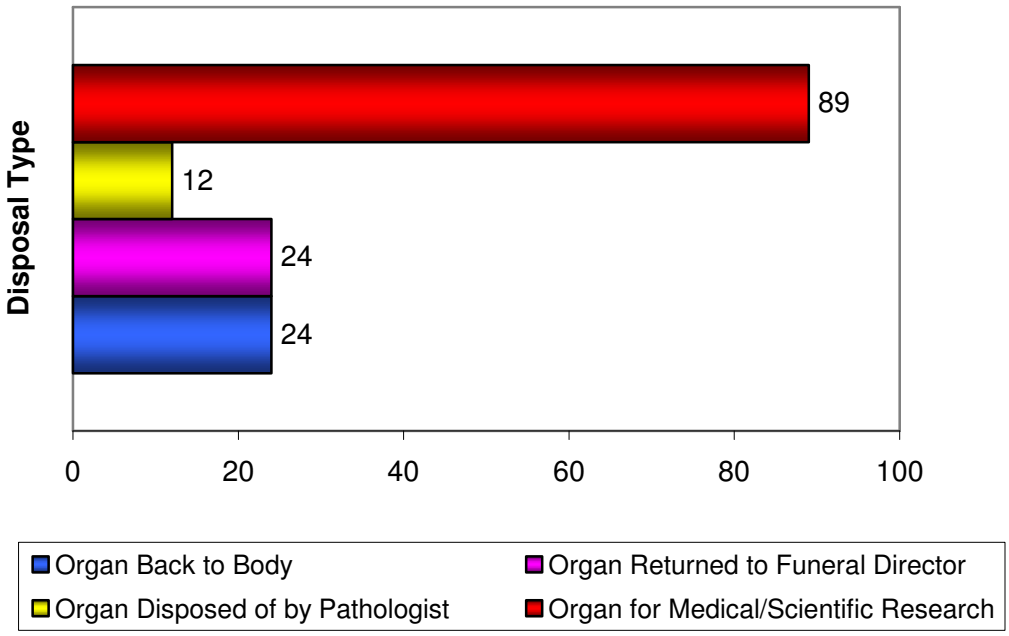


* Cervical Spinal Cords/Columns and Eyes

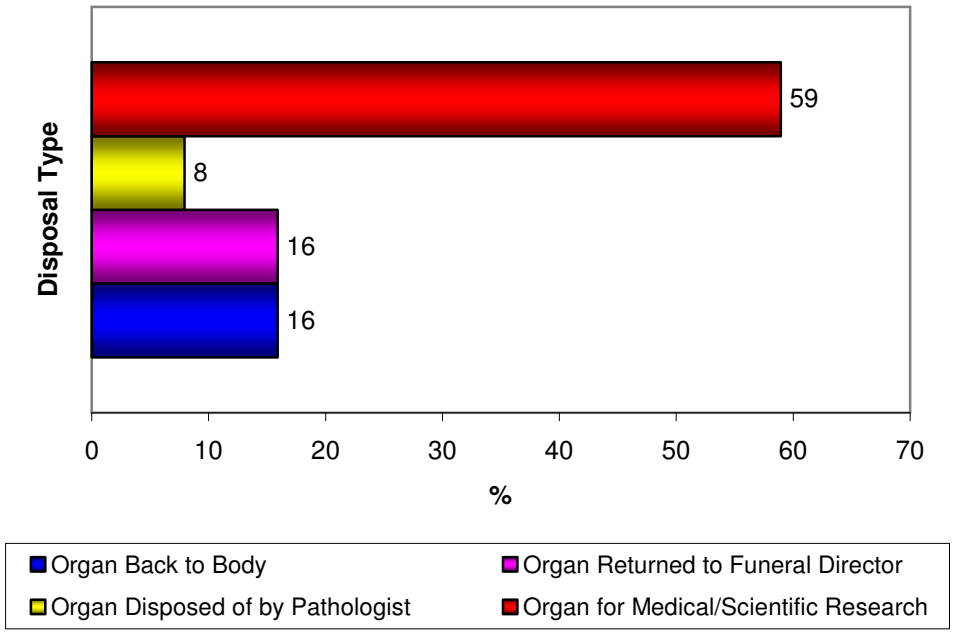
6.3.3. Disposal of Retained Organs

Once testing on organs was completed, the deceased's family are able to direct the Court on how to dispose of their deceased relative's organ(s).

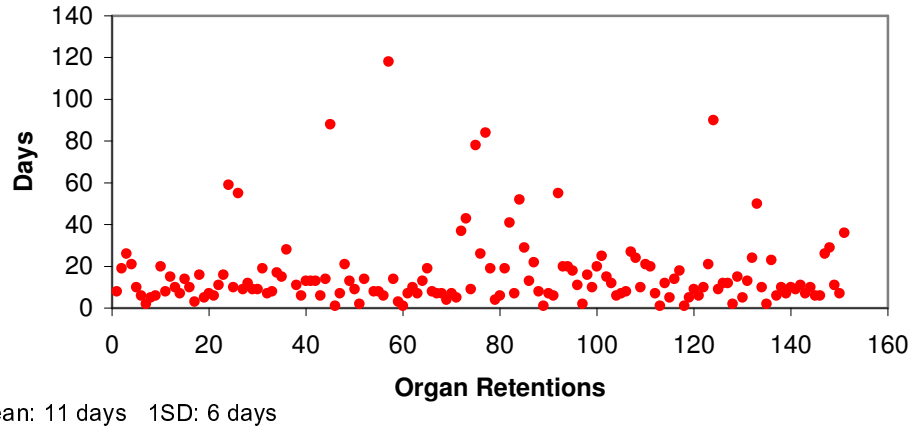
Directions for Disposal of Organs per Death July 07 - June 08



Directions for Disposal of Organs per Death by Percentage - July 07 - June 08



Days Taken to Finalise Organ Retention Process



Mean: 11 days 1SD: 6 days

6.4. Disaster Victim Identification (DVI)

During the year under review the Manager and Social Workers of the Coroner's Court were members of the State Disaster Victim Identification committee. The committee contributes to planning responses to DVI in relation to the role of the coroner in such events.

During the year under review the Coroner's Court participated in a seminar hosted by the DVI committee to provide information to police officers, funeral directors, government social workers about DVI ante mortem collection. The aim of the coronial social workers is to provide training to interested government social workers in supporting family members whilst the ante mortem collection process is in progress.

6.5. National Coronial Information System (NCIS)

The National Coronial Information System (NCIS) is a national Internet based data storage and retrieval system for Australian coronial cases. Information about every death reported to an Australian coroner since July 2000 (January 2001 for Queensland) is stored within the system. The aim is to provide a hazard identification and death prevention tool for coroners and research agencies.

The NCIS has a primary role to assist coroners in their role as death investigators, by providing them with the ability to review previous coronial cases that may be similar in nature to current investigations, enhancing their ability to identify and address systematic hazards within the community.

Approved research and government agencies also utilise the NCIS to obtain valuable information concerning the circumstances of reported fatalities, to assist in the development of community health and safety strategies.

The NCIS is managed by the Victorian Institute of Forensic Medicine on behalf of the State/Federal funding agencies. The NCIS is funded by each State/Territory Justice Department around Australia, the Australian Departments of Health & Ageing and Employment & Workplace relations, the ACCC, the ATSB and the AIC.

6.5.1. Document Attachment – Post Mortem and Toxicology

For a number of years, NCIS and the SA State Coroner's Court have been working to determine the best way to attach autopsy and toxicology reports to the NCIS.

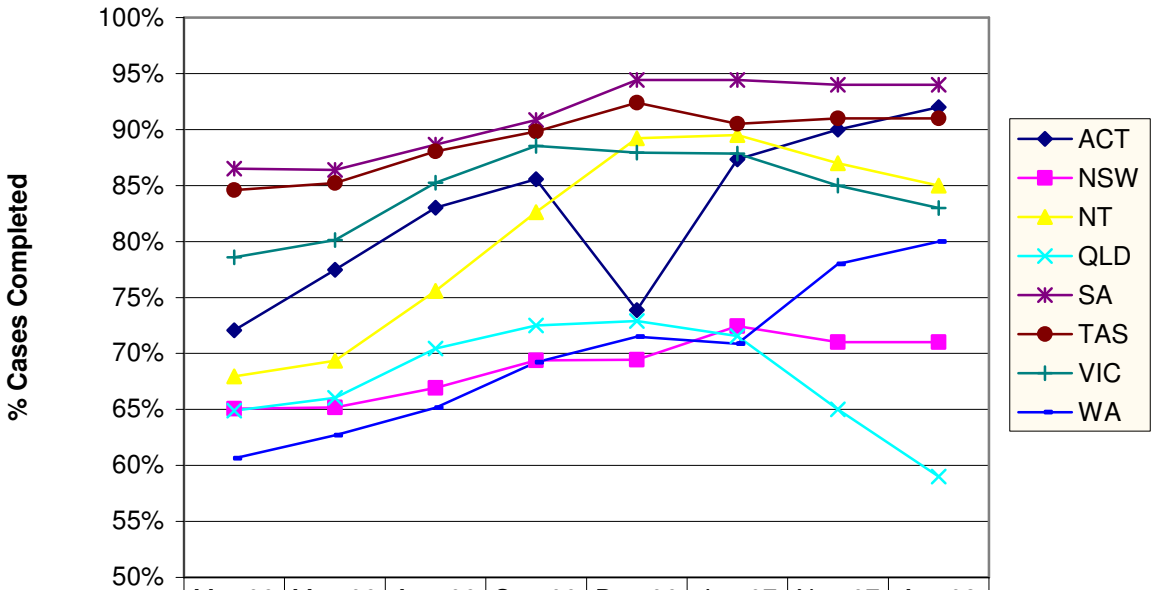
Recently, the State Coroner agreed to allow the direct electronic transfer of these reports from the Forensic Science SA to the NCIS. This should ensure that the level of full text documentation on the NCIS about reported deaths in South Australia starts to equal that of other states.

The State Coroner has stipulated that the post mortem and toxicology reports must be lodged with his office in the first instance, and can then be sent to the NCIS.

6.5.2. Document Attachment – Case Closure

South Australia has the highest percentage rate of case closure on the NCIS. This excellent result is achieved by having one administration staff member dedicated to quality assuring the coding of data and closing cases on the system soon after a finding is made.

% Cases Closed on NCIS Over Time



	Mar-06	May-06	Aug-06	Sep-06	Dec-06	Jan-07	Nov-07	Apr-08
ACT	72%	77%	83%	86%	74%	87%	90%	92%
NSW	65%	65%	67%	69%	69%	72%	71%	71%
NT	68%	69%	76%	83%	89%	90%	87%	85%
QLD	65%	66%	70%	73%	73%	72%	65%	59%
SA	86%	86%	89%	91%	94%	94%	94%	94%
TAS	85%	85%	88%	90%	92%	91%	91%	91%
VIC	79%	80%	85%	89%	88%	88%	85%	83%
WA	61%	63%	65%	69%	71%	71%	78%	80%

Date

6.5.3. Enhancements to the Local Case Management System (LCMS)

The South Australian Coroner's Court has not previously had the funds available to make enhancements to the local case management system (LCMS) software, which is used to enter data for, upload to the NCIS, and also record and manage the operational details of deaths reported to the State Coroner's Court. This has hampered the ability of the SA Coroner's Court to use the LCMS for production of statistics and operational reports.

An amount of $15,000 was authorised by the NCIS Board from the NCIS Budget during 2007/08 to make upgrades to the SA LCMS, which should improve the ability of the LCMS to undertake reporting, operational and possibly workflow functions.

6.5.4. Training of Staff

Staff have participated in a variety of training programs throughout the year including in-house training with the Coroner's Court Social Workers. Courses include:

Type of Training	No. of Staff
Advanced Use of Medical Terminology	8
Aboriginal Cultural Awareness	3
Corporate Induction Programme	4
DVI Conference	1
NCIS Coder Training	2

In July 2007 two Coroner's Court administrative staff were funded by the NCIS to attend training in Melbourne on the NCIS Code set upgrade.

7. Organisational Chart