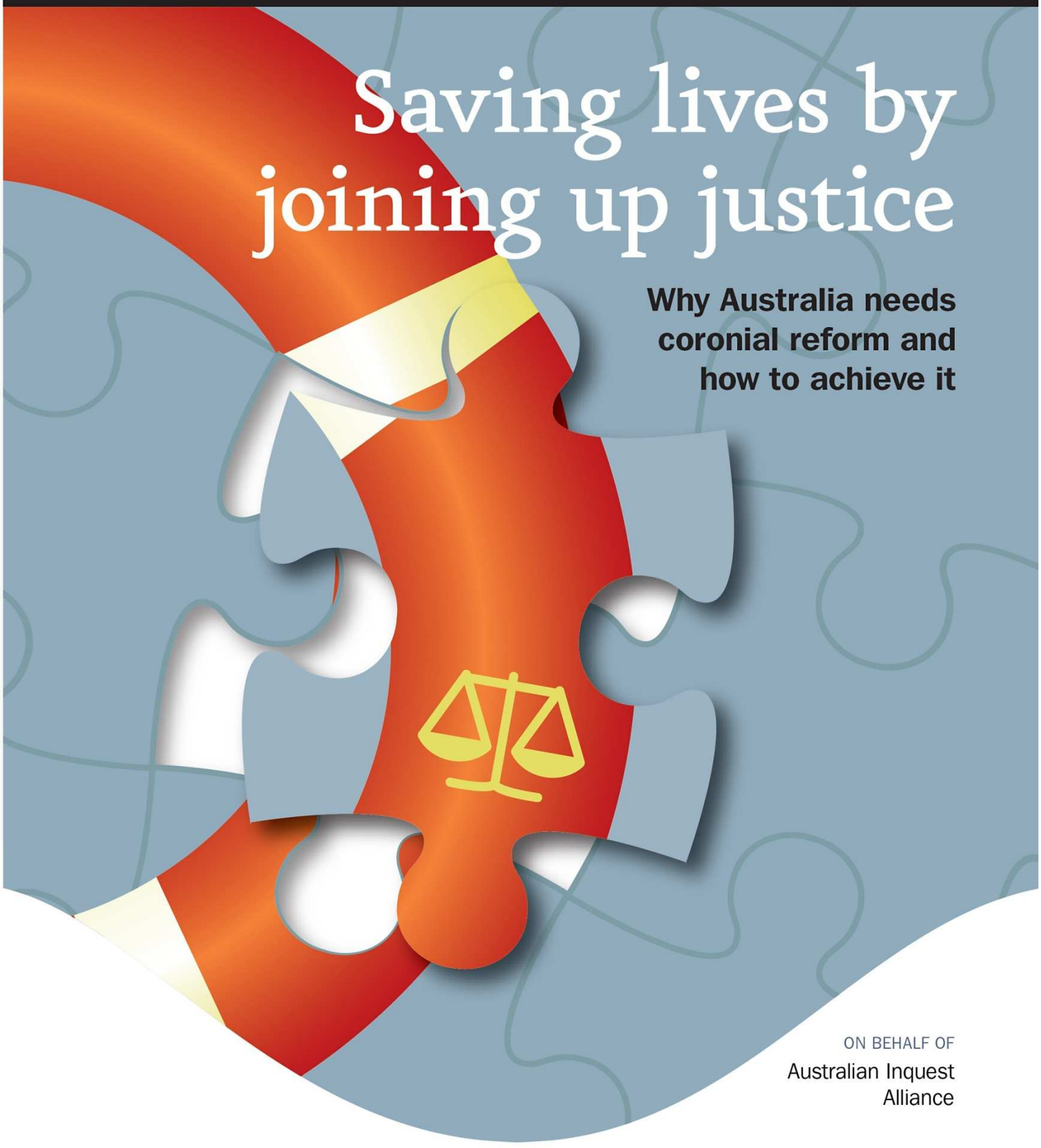
Federation of
Community Legal Centres
VICTORIA

Issues Paper

March 2013

Saving lives by joining up justice

Why Australia needs coronial reform and how to achieve it



ON BEHALF OF
Australian Inquest
Alliance

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About the Federation of Community Legal Centres (Victoria) Inc

The Federation is the peak body for Victoria's 51 community legal centres (CLCs). The Federation leads and supports CLCs to make justice accessible for all.

The Federation:

- provides information and referrals to people seeking legal assistance;
- conducts law reform and policy work to improve the justice system;
- works to build a stronger and more effective community legal sector;
- provides services and support to CLCs; and
- represents CLCs with stakeholders.

The Federation assists its membership to collaborate for justice. CLC workers come together through working groups and other networks to exchange ideas and improve CLC services. The Federation regularly works in partnership with government, legal aid, the private legal profession and community partners.

About community legal centres

Community legal centres are independent, community organisations that provide free legal services to the public. CLCs provide free legal advice, information and representation to more than 100,000 Victorians each year.

Generalist CLCs provide services on a range of legal issues to people in their local geographic area. There are generalist community legal centres in metropolitan Melbourne and in rural and regional Victoria. Specialist CLCs focus on groups of people with special needs or particular areas of law such as mental health, tenancy, consumer law and the environment.

CLCs receive funds and resources from a range of sources including state, federal and local government, philanthropic foundations, pro bono contributions and donations. Centres also harness the energy and expertise of over a thousand volunteers across Victoria.

CLCs provide effective and innovative solutions to legal problems based on their experience within their community. It is CLCs' community relationship that distinguishes them from other legal providers and enables them to respond effectively to the needs of our communities as they arise and change.

CLCs integrate legal assistance for individual clients with community legal education, community development and law reform projects that are based on client need and that are preventative in outcome. CLCs are committed to collaboration with government, legal aid, the private legal profession and community partners to ensure the best outcomes for our clients and the justice system in Australia.

Acknowledgments

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The Alliance also expresses its grateful thanks to various family members, advocates, and staff of Coroners Courts and legal aid/pro bono bodies for responding to requests for information or comment.

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Executive Summary

> 'Put yourself into the situation of a family that has just lost someone. Why put ourselves through this anyway?...[I]t is a hardship reading through every detail in a coronial inquest, but if at the end of the day you know that, "Such-and-such happened, that is why your son is dead", then all right. I knew three and a half years ago that the death should have been avoidable. There was no need for anyone to plough through 11 days of evidence for that. But if something else comes out of it, if systems can change, then yes, it is worth doing.'[1]

The Australian Inquest Alliance has developed the Australian Coronial Reform Project, which has two main aims: reform of Australia's coronial system, and establishment of a National Inquest Clearing House.

We need coronial reform across Australia so that all states and territories have independent and effective coronial systems that learn from past deaths in order to prevent future avoidable deaths. System responses must also effectively address social justice issues if they arise from particular deaths. Coronial reform should include consistent best practice support and sensitively facilitated participation of families in investigations, inquests and all other aspects of the required systemic response. We also need to establish a National Inquest Clearing House to facilitate effective coronial systems and enhance the participation of families.

The Project seeks to advance these goals via discussion with key stakeholders in the coronial system: bereaved families and friends, advocates, researchers, and other supporters.

In **Part 1** of the Paper, we outline why national coronial reform is needed. The coronial system has a distinctive place in Australian legal practice. Coroners investigate certain types of deaths, such as those that are sudden, unexpected or violent. In some cases, the coroner also presides over an inquest, which is a court hearing that is usually public. Coroners are required to discover the truth about a death — generally, who the deceased was, how they died, and the circumstances of their death. This process means investigating not only the immediate but also the underlying causes of death.

Coronial investigations and inquests are formally inquisitorial (truth-seeking) rather than adversarial (against someone), and are not bound by the rules of evidence and procedure in other courts. Instead, coroners take a broad public health approach, which means that in a best practice investigation the focus is on drawing any relevant systemic lessons from the death in order to try to prevent, or at least minimise the chances of, similar deaths occurring in the future. Systemic issues can arise from contexts as diverse as those involving faulty products, medically related deaths, industrial accidents, the treatment of persons in custody and care, or the way that governments respond to family violence. Coronial investigations therefore often also have social justice implications. Families seeking some comfort from investigations and inquests, along with advocates working to oppose systemic injustices, expect comprehensive coronial findings and appropriately targeted recommendations as the key to preventing similar deaths in the future.

Each Australian state and territory has its own coronial legislation, court and office support. As a result, the official procedures for inquiring into a death, following up on any systemic issues, and providing information to families and the general public can differ between jurisdictions. When it comes to providing publicly accessible, clear and thorough information about the outcomes of coronial investigations and inquests, there is also considerable variation across states and territories. In some

[1] Mrs M. Kaufmann, mother of Mark who was fatally shot by police, *Minutes of Evidence*, 22 August 2005, 68–9, Law Reform Committee, Parliament of Victoria, *Inquiry into the Review of the Coroners Act 1985* <http://www.parliament.vic.gov.au/images/stories/committees/lawrefrom/coroners_act/transcripts/22-08-2005_Kaufmanns_and_Springvale_Monash_Legal.pdf>.

jurisdictions, information is simply not available. Under-resourcing of Coroners Courts and Offices also hampers their ability to provide public information and to cooperate with external researchers and advocates. While the National Coronial Information System is a very valuable tool, it is only automatically accessible to coroners, and other potential users must seek approval to use it and in most cases pay a significant fee.

Nevertheless, in all state and territory jurisdictions, procedures and standards for coronial investigations and inquests are required to adhere to Australia's international treaty obligations to respect, protect and fulfil the human right to life. Best practice approaches to inquests that have been developed in the last few decades therefore focus on the goals of truth, fairness, accountability, healing and an increased emphasis on prevention. Best practice consequently also requires independent inquiry into system failure and identification of any institutional responsibility and systemic issues to be backed up by appropriately directed practical recommendations to prevent future deaths.

In reality, however, many families who have lost loved ones experience the coronial process and its aftermath as traumatic, mystifying, frustrating and disempowering. The human rights standard that coronial investigations be independent is also not usually adhered to when police are potentially implicated in a death. Another common source of anguish for family members concerns the considerable time that can elapse between when a death is first discovered and when coroner's findings are made. Delays of up to five years are not uncommon, and in 2011–12, no state or territory reached the national standard for acceptable backlog of cases. Many other difficulties experienced by families are due to a general failure across jurisdictions to fully implement into practice the right of families to participate in coronial processes concerning their loved ones.

The content of coronial recommendations and their potential influence on death prevention are of particular concern to family members and advocates. Although there have been recent reforms in several states and territories, the emphasis on prevention and on the role of coronial recommendations varies considerably. Coroners also often have little assistance to help them formulate their findings and recommendations.

Families and advocates also need to know what responses have been made by government departments and other agencies to coronial recommendations addressed to them, together with information about how recommendations are being implemented, and how implementation will be monitored to ensure that avoidable deaths are prevented in the future. However, most states and territories do not legally require responses to all coronial recommendations in their jurisdiction, meaning that particular recommendations may never be followed up, and can even be lost. In most jurisdictions it is also difficult to find public information about whether recommendations are responded to, and in what manner.

Due to a lack of monitoring and little in the way of collection of information about implementation, it is difficult to assess the impact of coronial recommendations upon the prevention of deaths in Australia, either generally or in relation to any particular kind of death. Jurisdictions that mandate responses to recommendations are likely to have a better rate of implementation. However, in general, implementation of recommendations is an ad hoc process. Whether or not particular recommendations are implemented is influenced by the way in which recommendations are framed and targeted by coroners, whether implementation accords with government policies and priorities, and whether a proactive system for review of recommendations exists within the targeted organisation. Other relevant factors include media, family, community and advocacy group pressure.

Coroners may therefore make potentially life-saving recommendations, only for them never to be responded to or implemented, with no follow-up and no public awareness of what has happened. Within any particular jurisdiction, even where recommendations are implemented, this may not happen in time to prevent other similar deaths. The present patchwork system also means that even though

coroners may be sharing information across Australia, government and other agencies in one jurisdiction are unlikely to learn effectively and in a timely way from a death, or even a pattern of deaths, in another jurisdiction. This is evident even in contexts where there are clear national ramifications, such as deaths in custody. For this reason, the Royal Commission into Aboriginal Deaths in Custody recommended reform of the state and territory coronial systems. However, over 20 years later, none of the Royal Commission's recommendations have been implemented in a systematic, nationwide manner.

The piecemeal approach to death prevention means that there are other striking examples where lessons have failed to be learned across and even within jurisdictions, resulting in more avoidable deaths. The systemic failure that led to the death is often perpetuated due to an inability of governments and other entities to respond effectively. One tragic illustration is the example of blind cord deaths, where infants are accidentally strangled or hanged due to becoming entangled in a blind or curtain cord. Despite the risks having been raised by coroners and researchers for many years, infants have continued to die, and even now it is unclear whether all states and territories have implemented ongoing community campaigns and strategies to render safe those blinds and curtains that are already installed. Blind cord deaths therefore starkly demonstrate the lack of clear recommendation and implementation pathways across states and territories, together with, in most jurisdictions, few if any mechanisms to monitor the progress of recommendations, and consequently little in the way of public accountability.

This Paper therefore makes recommendations aimed at 'joining up' independent and effective coronial systems across Australian jurisdictions, in order to enhance death prevention via learning from past deaths. While there are some limited opportunities to contribute to joining up justice at the state and territory level, State, Territory and Commonwealth Governments are increasingly recognising that in order to more effectively and consistently address many legal and social issues in Australia, a federally coordinated, cross-border approach of some kind is needed. We discuss the examples of national initiatives to better prevent and respond to violence against women and children, the coronial recommendations and Federal Government response concerning the death of Dianne Brimble, and proposals to centrally record coronial recommendations and share information across states and territories concerning family/domestic violence homicides.

Greater emphasis on prevention must be accompanied by best practice support and sensitively facilitated participation of families in investigations, inquests and all other aspects of the required systemic response. **Part 2** of the Paper discusses how families need legal representation and other support in order to be able to exercise their human rights to fully participate in the inquest. However, legal assistance is often not affordable, and appropriate support is not always available. Within the limits of accessible public information, we paint a picture of the legal assistance currently available for families, and describe the role of various public legal service providers. The reality for many families is that they may not even be aware that they have the right to a lawyer, let alone be able to obtain legal help throughout the process. We therefore make recommendations that aim to ensure equity in legal assistance for families in the inquest process and coronial-related matters.

Public interest organisations also play an important role in supporting and advocating on behalf of families, or raising prevention issues as interveners, yet their involvement is often limited by lack of resources. The Paper therefore goes on to outline why a new national non-government organisation — a National Inquest Clearing House (NICH) — is needed to consolidate and share the knowledge and understanding gained by legal assistance providers over many years. In playing this 'joining up' role, the NICH will both enhance inquest representation for families and community organisations, and improve the coronial process by consolidating and sharing knowledge in order to focus on prevention of avoidable deaths.

We hope that stakeholders will work with us in developing and advocating for the directions and strategies we should use to support 'joined up' independent and effective coronial systems across

Australian jurisdictions — systems which facilitate learning from past deaths in order to prevent future avoidable deaths, and which provide enhanced support for families at all stages of the coronial process.

Recommendations

1. All State and Territory governments should act to adopt core best practice and guarantee that the preservation of life is central to their coronial systems, by introducing, as appropriate to the jurisdiction, prevention and reporting amendments to their coronial legislation.

These amendments should include or have the effect of:

- a preamble that expresses the role of the coronial system as involving the independent investigation of deaths, for the purpose of finding the causes of those deaths and to contribute to the prevention of avoidable deaths and the promotion of public health and safety and the administration of justice, across Australia;
- purpose and objects provisions that include the prevention of avoidable deaths through the findings of the investigation, and the making of findings, comments and recommendations, by coroners;
- a provision empowering coroners to make comments and recommendations on any matter connected with a death investigated at an inquest, including public health or safety and the administration of justice; and
- a provision empowering coroners to make recommendations to any Minister, public statutory authority or entity.

2. The Commonwealth Government should work with State and Territory governments to achieve a uniform national coronial public reporting and review scheme for coronial findings and recommendations which:

- guarantees that all coronial recommendations will be considered and meaningfully responded to by the government agencies or entities to whom they are directed (updates on progress towards implementation should be provided by the relevant agency or entity where the initial response was only a holding response);
- provides ready public access to all coronial findings, recommendations, responses and updates;
- records and makes publicly available (including via a Coroners Annual Report to the relevant State or Territory Parliament and on the Internet) whether or not coronial recommendations have been implemented by responsible government agencies or entities;
- enables evaluation of the impact of coronial recommendations upon the prevention of deaths;
- adheres to timeliness at every step of the recommendations process; and
- provides feedback to families (including a copy of recommendations and responses to families, other parties and legal representatives) at every step of the recommendations process.

3. As an important element of Recommendation 2, State and Territory Governments should:

- appoint coronial liaison officers to enable public sector agencies to respond to coronial recommendations in a timely and appropriate manner; and
- allocate, for each jurisdiction, the responsibility for monitoring the implementation of coronial recommendations to an independent statutory body adequately resourced for the task and with powers to alert government and public about any key implementation issues.

4. The Commonwealth Government should work with State and Territory governments to enable each jurisdiction to effectively recognise the international human rights obligation to respect, protect and fulfil the right to life by introducing, as appropriate, amendments to their coronial legislation so that coronial investigation is independent, appropriately and adequately resourced, and considers systemic issues.

In particular, in investigations into deaths in police custody or in the course of police operations, the agency conducting the primary investigation at the direction of the Coroner must have practical, institutional and hierarchical independence from the police.

5. Primary and secondary coronial legislation in the various jurisdictions should be amended or introduced in recognition of the principle that participation of families in the inquest process is a fundamental component of Australia's international human rights obligations.

Specifically, reforms must enable families and friends of the deceased to experience the coronial process in as sensitive, timely and fully informed a manner as possible, regardless of the circumstances of the death.

These reforms must include:

- provision of proper and timely notification of family members and proactive provision of accessible, timely and explanatory information, at every stage of investigation and inquest processes. This should include as comprehensive as possible access to police and coronial documents, and accessible material on families' legal rights;
- no unreasonable delays in investigations and inquests;
- resolution of any cultural or spiritual conflicts raised by the coronial process;
- recognition of the need to have Aboriginal and Torres Strait Islander legal and health services and communities involved in the coronial process; and
- provision of quality, accessible, and culturally and spiritually appropriate support and counselling services for families.

6. All States and Territories should establish or continue funding for their own Coroners Prevention Unit similar to the current Victorian model, including funding to facilitate an effective role for the Unit in the reforms in Recommendations 1 – 5.

7. State and Territory Governments should adequately fund their Coroners Courts with the aim of reducing delays in inquests, investigations and the delivery of findings, in order to at least conform to current national standards.

8. The remaining recommendations of the National Report of the Royal Commission into Aboriginal Deaths in Custody (1991) must be implemented.

9. As a fundamental component of Australia's international human rights obligations under the right to life, funding and availability of legal assistance providers must be sufficient to enable all families to obtain, without financial hardship, effective legal advice and representation for investigations and inquests, at a level that is consistent with the level of legal representation accorded to government and other institutional parties in the inquest. A specific pool of funds should be made available to enable community legal centres to provide legal representation for families at inquests.

10. Legal assistance services must be sufficient to enable all advocacy organisations with a sufficient interest to intervene in inquests, as a fundamental component of Australia's international human rights obligations under the right to life.

11. An independent National Inquest Clearing House, along the lines of INQUEST (UK), should be established and adequately funded.

Introduction

The Australian Inquest Alliance

In March 2010, the Federation of Community Legal Centres convened the first meeting of the Australian Inquest Alliance (the Alliance). Community legal centres have a long history of supporting and representing in coronial inquests families and friends of those who have died, and of advocating for legal and social change so that future deaths can be prevented.

The Alliance consists of a growing number of organisations and individuals across state and territory borders, including community legal centres, Aboriginal and Torres Strait Islander Legal Services (ATSILS), advocates for imprisoned women and men, academic researchers and policy/law reform advocates. Our members include:
Aboriginal Legal Rights Movement of South Australia;
Aboriginal Legal Service (NSW/ACT) Limited;
Aboriginal & Torres Strait Islander Legal Service (Qld) Ltd;
Aboriginal Legal Service of WA (Inc);
Community Legal Centres NSW Inc;
Deaths in Custody Watch Committee WA;
Federation of Community Legal Centres Victoria;
Flemington & Kensington Community Legal Centre Inc;
Human Rights Law Centre Ltd;
Indigenous Social Justice Association Inc;
North Australian Aboriginal Justice Agency;
Prisoners' Legal Service Inc;
Public Interest Advocacy Centre;
Queensland Association of Independent Legal Services Inc;
Sisters Inside Inc;
Victorian Aboriginal Legal Service Co-operative Limited;
Villamanta Disability Rights Legal Service Inc;
Ray Watterson, Adjunct Professor of Law, La Trobe University.

The Alliance has a significant depth of advocacy, research and social policy experience and expertise gained over many years. This knowledge encompasses coronial investigations, inquests, human rights and broader coronial frameworks across jurisdictional boundaries. We recognise the key influence played by systemic inequality in many preventable deaths.

As a priority, the Alliance is committed to addressing the shamefully high number of deaths of Aboriginal and Torres Strait Islander peoples, particularly deaths in custody and, for women especially, deaths from family violence. Despite overwhelming evidence and practical recommendations on what is required, provided by investigations such as the Royal Commission into Aboriginal Deaths in Custody, these deaths continue. This fact profoundly illustrates the present systemic failure to redress the ongoing impact of colonialism, racism, misogyny and economic and cultural dispossession on Australia's first peoples.

We also recognise that effective systemic responses to preventable deaths require an understanding of other forms of structural inequality and disadvantage that contribute to a disproportionate number of deaths, including deaths of: people in police custody and prison; people with mental illness; women killed by male partners; migrants from CALD communities; asylum seekers and refugees; young people; and people with disabilities.

The Alliance welcomes new members.

The Australian Coronial Reform Project

As an integral part of our focus on systemic change, the Alliance has developed the Australian Coronial Reform Project. The Project aims for reform of coronial systems across Australia, so that social justice may be effectively pursued for those who have died in circumstances where the death may have been prevented. This must be accompanied by best practice support and sensitively facilitated participation of families in investigations, inquests and all other aspects of the required systemic response.

The Project seeks to advance these goals via discussion with key stakeholders in the coronial system: bereaved families and friends,[2] advocates, researchers, and other supporters of an independent and effective coronial system that is sensitive to the bereaved and learns from past deaths in order to prevent future avoidable deaths.

In **Part 1** of the Paper, we outline why national coronial reform is needed. We examine current Australian coronial systems and show that while there have been recent reforms in various jurisdictions, the emphasis on prevention and on the role of recommendations varies considerably. It is even difficult to assess and compare processes in different states and territories, due to the lack of consistent publicly accessible information on inquests, recommendations, and responses by relevant agencies. Most states and territories also do not legally require responses to all coronial recommendations in their jurisdiction, meaning that particular recommendations may never be followed up, and can even be lost.

The piecemeal approach to death prevention means that there are striking examples where lessons have failed to be learned across and even within jurisdictions, resulting in more avoidable deaths. We therefore make recommendations aimed at 'joining up' independent and effective coronial systems across Australian jurisdictions, in order to enhance death prevention via learning from past deaths.

Greater emphasis on prevention must be accompanied by best practice support and sensitively facilitated participation of families in investigations, inquests and all other aspects of the required systemic response. **Part 2** of the Paper discusses how families need legal representation and other support in order to be able to exercise their human rights to fully participate in the inquest, and yet legal assistance is often not affordable, and appropriate support is not always available. Public interest organisations play an important role in supporting and advocating on behalf of families, or raising prevention issues as interveners, but their involvement is often limited by lack of resources. We therefore make recommendations that aim to ensure equity in legal assistance for families in the inquest process and coronial-related matters.

We also outline why a new national non-government organisation — a National Inquest Clearing House (NICH) — is needed to consolidate and share the knowledge and understanding gained by legal assistance providers over many years, and how in playing this role the NICH will enhance inquest representation for families and community organisations, and improve the coronial process.

Note

Some of the weaknesses in the current coronial system discussed in this report mean that relevant data is either difficult to obtain or simply not collected. Accordingly, our analysis has been limited to the best available information.

[2] This Paper uses 'family' as a shorthand for those who may have been close to the deceased and wish to find out the truth on their behalf. A significant caveat is that in some deaths, such as those of people who were mentally ill or deemed to be so, or in some family violence deaths, the family may have been in conflict with the person who died, or the deceased person may have been socially isolated. In these contexts it is especially important that an appropriate person or organisation is able to ask questions on behalf of the deceased person and represent their interests.

Part 1 Why we need national coronial reform

The coronial system

The coronial system has a distinctive place in Australian legal practice. Coroners investigate certain types of deaths, such as those that are sudden, unexpected or violent. In some cases, the coroner also presides over a court hearing, usually public, called an inquest. Coroners are required to discover the truth about a death — generally, who the deceased was, how they died, and the circumstances of their death. This process means investigating not only the immediate but also the underlying causes of death.[3]

Coronial investigations and inquests are formally inquisitorial rather than adversarial, and are not bound by the rules of evidence and procedure in other courts. Instead, the coronial jurisdiction takes a broad public health approach, which means that the focus of the investigation is on drawing any relevant systemic lessons from the death in order to try to prevent, or at least minimise the chances of, similar deaths occurring in the future.[4]

Systemic issues can arise from contexts as diverse as those involving faulty products, medically related deaths, industrial accidents, the treatment of persons in custody and care, or the way that the government responds to family violence. Coronial investigations therefore often have social justice implications.

Each state and territory has its own coronial legislation, court and office support. This means that the official procedures for inquiring into a death, following up on any systemic issues, and providing information to families and the general public can vary between jurisdictions.

When is there a coronial investigation?

All jurisdictions except the Australian Capital Territory define 'reportable deaths'.[5] This category includes any death that is, or is suspected of being, violent or unnatural, occurring under anaesthetic, or occurring while the deceased was in care or custody. Many jurisdictions also require investigation of: deaths in suspicious or unusual circumstances; sudden deaths of unknown cause; those resulting from an accident or injury; where death was not the expected medical outcome; where there is no death certificate; or where the identity of the deceased is not known.[6]

As a general rule, Australian coroners must investigate reportable deaths, or any death when directed to investigate (usually by the State Coroner, Chief Magistrate or relevant Minister),[7] unless that death

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[3] Graeme Johnstone, 'An Avenue for Death and Injury Prevention' in Hugh Selby (ed), *The Aftermath of Death* (1992) 140, 145.

[4] Victoria, *Parliamentary Debates*, Legislative Assembly, 9 October 2008, 4034 (Rob Hulls, Attorney-General).

[5] *Coroners Act 2009* (NSW) ss 6(1), 23–24; *Coroners Act 1993* (NT) s 12(1); *Coroners Act 2003* (Qld) s 8(3); *Coroners Act 2003* (SA) s 3; *Coroners Act 1995* (Tas) s 3; *Coroners Act 2008* (Vic) s 4; *Coroners Act 1996* (WA) s 3.

[6] *Coroners Act 1997* (ACT) ss 13(1), 14(2); *Coroners Act 2009* (NSW) ss 6(1), 23–24; *Coroners Act 1993* (NT) ss 12(1), 12(1A); *Coroners Act 2003* (Qld) ss 8–10, 10AA; *Coroners Act 2003* (SA) s 3; *Coroners Act 1995* (Tas) s 3; *Coroners Act 2008* (Vic) s 4; *Coroners Act 1996* (WA) s 3. Victoria also requires investigation of reviewable deaths, which are where a child dies and they are the second or subsequent child of the deceased child's parent to have died, and they did not spend their entire lives in hospital: *Coroners Act 2008* (Vic) s 5.

[7] Victorian coroners must also investigate fires if requested to do so by the Country Fire Authority or Metropolitan Fire and Emergency Services Board, unless the coroner determines that it is not in the public interest: *Coroners Act 2008* (Vic) s 30. Similar provisions apply in New South Wales, in the Australian Capital Territory where they also refer to disasters, in Tasmania where they also refer to explosions, and in the Northern Territory only in relation to disasters: *Coroners Act 1997* (ACT) ss 18(1), 19; *Coroners Act 2009* (NSW) s 32; *Coroners Act 1993* (NT) s 29; *Coroners Act 1995* (Tas) s 40(2).

has been, is being, or is intended to be, investigated in another jurisdiction.[8] Coroners also have some discretion to investigate other categories of deaths.[9]

When is there an inquest?

An investigation need not necessarily proceed to an inquest. However, generally inquests are mandatory where the person was in custody, and in various jurisdictions are also required when the person was in care or where homicide is suspected.[10] Inquests are also mandatory in some jurisdictions for other types of reportable deaths, such as drowning or as the result of medical procedures;[11] or where the identity of the deceased is unknown.[12] As with investigations, a coroner must not hold an inquest if he or she does not have jurisdiction to do so.

Other than the contexts where inquests are required, coroners often have discretion to decide whether to hold an inquest. Where coronial discretion is expressly provided for, the relevant legislation usually does not give specific guidance, but instead enables coroners to make their own judgment if they believe an inquest is unnecessary, or if it is deemed desirable in the interests of justice.[13] The current Review of Coronial Practice undertaken by the Law Reform Commission of Western Australia has found that 'the primary catalyst to a decision to hold an inquest in a particular case [is] family pressure'.[14]

The WA Law Reform Commission believes that the Queensland approach provides more useful guidance to coroners as to when they may use their discretionary power.[15] In Queensland, the coroner

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[8] Coroners must not investigate or continue investigations in other specified circumstances. For example, in Tasmania, if a coroner suspects the body in a reported death may be Aboriginal remains, he or she must refer the matter to an approved Aboriginal organisation, which must then investigate: *Coroners Act 1995* (Tas) s 23. A coroner who has begun investigating must cease in certain circumstances, including, in Queensland, if the investigation shows that the body is Indigenous burial remains: *Coroners Act 2003* (Qld) s 12(2).

[9] For example, in NSW and Victoria a coroner may investigate a death that occurred less than 100 years before it was reported: *Coroners Act 2009* (NSW) s 19; *Coroners Act 2008* (Vic) ss 14(1), 15(c) (in Victoria, if the death appears to have been a reportable death occurring less than 50 years before being reported, investigation is mandatory). Victorian coroners may also investigate deaths reported by a member of the immediate family if the deceased person was discharged from an approved mental health service within 3 months immediately before the person's death: *Coroners Act 2008* (Vic) ss 12(2), 14(2). Coroners also have discretion to investigate fires in some circumstances; and also in NSW and Tasmania, explosions: *Coroners Act 1997* (ACT) s 18(2); *Coroners Act 2009* (NSW) s 31; *Coroners Act 1995* (Tas) s 43(2); *Coroners Act 2008* (Vic) s 31. In the Northern Territory, in addition to deaths, coroners may investigate disasters: *Coroners Act 1993* (NT) s 30.

[10] *Coroners Act 1997* (ACT) ss 13(1)(a), (k); *Coroners Act 2009* (NSW) ss 27(1)(a)–(b) (includes deaths as a result of police operations); *Coroners Act 1993* (NT) s 15(1) (includes deaths in care); *Coroners Act 2003* (Qld) s 27 (includes deaths in care and deaths related to police operations); *Coroners Act 2003* (SA) s 21(1)(a); *Coroners Act 1995* (Tas) s 24(1) (includes deaths in care, deaths while attempting to escape from custody or care, and deaths in the process of attempts to detain the deceased person); *Coroners Act 2008* (Vic) ss 52(2)(a)–(b) (includes deaths in care); *Coroners Act 1996* (WA) s 22(1) (includes deaths in care).

[11] *Coroners Act 1997* (ACT) ss 13(1)(b), (e).

[12] *Coroners Act 1993* (NT) s 15(1)(c); *Coroners Act 1995* (Tas) s 24(1)(c); *Coroners Act 2008* (Vic) s 52(2)(c). In South Australia, in some circumstances the Coroner's Court must also hold an inquest into a fire or accident that causes injury to person or property, and into any other event if required under other legislation: *Coroners Act 2003* (SA) s 21(1).

[13] *Coroners Act 2009* (NSW) s 25(3); *Coroners Act 1993* (NT) s 15(2); *Coroners Act 2003* (Qld) s 28; *Coroners Act 1996* (WA) s 22(2). In South Australia, the Coroner's Court must hold an inquest into any reportable death or disappearance if the State Coroner considers it necessary or desirable to do so: *Coroners Act 2003* (SA) s 21(1)(b). In Victoria, a coroner may hold an inquest into any death he or she is investigating: *Coroners Act 2008* (Vic) s 52(1). The Tasmanian Coroners Act does not expressly provide for coronial discretion as to whether to hold an inquest. The ACT Coroners Act provides for some coronial discretion to hold a hearing as part of an inquest or inquiry, and for the Chief Coroner to hold a fresh inquest or inquiry: *Coroners Act 1997* (ACT) ss 34A, 68(2).

[14] Law Reform Commission of Western Australia, *Review of Coronial Practice in Western Australia Discussion Paper* (June 2011), 134.

[15] *Review of Coronial Practice in Western Australia Discussion Paper*, 134; Law Reform Commission of Western Australia, *Review of Coronial Practice in Western Australia Final Report* (January 2012), 85–6.

investigating a reportable death may hold an inquest if satisfied that it is in the public interest. In determining whether it is in the public interest, the coroner may consider:

(a) the extent to which drawing attention to the circumstances of the death may prevent deaths in similar circumstances happening in the future; and

(b) any guidelines issued by the State Coroner about the issues that may be relevant for deciding whether to hold an inquest for particular types of deaths.[16]

In all jurisdictions except South Australia, any person can also apply for an inquest to be held, although some jurisdictions require the person to have a 'sufficient interest'.[17] In some contexts, the person applies directly to the Chief or State Coroner who may then arrange for an inquest.[18] If the application is refused, the person can usually apply or appeal to a higher authority (the Chief or State Coroner, Minister, District or Supreme Court) for an inquest to be held.[19]

In some jurisdictions, a person seeking an inquest may apply directly to the District or Supreme Court for an order that an inquest be held.[20] In still other cases, authorities such as the relevant Minister can direct that an inquest be held without another person needing to request it,[21] or can make an application themselves to the Supreme Court.[22] The District or Supreme Court may generally only order an inquest where satisfied that it is in the interests of justice or the public interest.[23]

Human rights, coronial investigations and inquests

Procedures and standards for coronial investigations and inquests are required to adhere to Australia's international treaty obligations to respect, protect and fulfil the human right to life.[24] In addition, Victoria and the Australian Capital Territory are directly obligated to honour the right to life via their respective charters of human rights.[25] With respect to coronial investigations, the right to life has been interpreted as encompassing the following minimum requirements:

- the investigation must be independent;
- the investigation must be effective;
- the investigation must be reasonably prompt;
- there must be a sufficient element of public scrutiny;
- the next of kin must be involved to an appropriate extent; and

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[16] *Coroners Act 2003* (Qld) s 28. See also Queensland State Coroner's Guidelines (December 2003), [8.1] <http://www.courts.qld.gov.au/__data/assets/pdf_file/0004/84919/state-coroners-guidelines.pdf>.

[17] *Coroners Act 1997* (ACT) s 64(2)(b); *Coroners Act 1995* (Tas) s 27(1). Tasmania also permits senior next of kin to apply for an inquest to be held, or for an inquest not to be held where a workplace death is concerned: *Coroners Act 1995* (Tas) ss 26(2), 26A(2). Persons may also apply for an inquest into a fire in Tasmania and Victoria: *Coroners Act 1995* (Tas) s 44; *Coroners Act 2008* (Vic) s 53(2).

[18] *Coroners Act 1997* (ACT) s 64; *Coroners Act 2003* (Qld) s 30; *Coroners Act 1995* (Tas) s 27; *Coroners Act 2008* (Vic) s 52(5); *Coroners Act 1996* (WA) s 24.

[19] *Coroners Act 1997* (ACT) ss 91–92; *Coroners Act 2003* (Qld) ss 27(1)(c)–(d), 30; *Coroners Act 1995* (Tas) ss 26–27; *Coroners Act 2008* (Vic) s 82; *Coroners Act 1996* (WA) s 24.

[20] *Coroners Act 2009* (NSW) ss 84–85; *Coroners Act 1993* (NT) s 16.

[21] *Coroners Act 2009* (NSW) s 28; *Coroners Act 2003* (Qld) ss 27(1)(b)–(c); *Coroners Act 2003* (SA) s 21(1)(b); *Coroners Act 1996* (WA) s 22(1)(d); *Coroners Act 1995* (Tas) ss 24(1)(g)–(h). In Tasmania, the Chief Magistrate may also hold an inquest into a death if he or she considers it desirable to do so: *Coroners Act 1995* (Tas) s 24(2). In South Australia the Attorney-General can direct a coroner to hold an inquest into a fire or or accident that causes injury to person or property: *Coroners Act 2003* (SA) s 21(1)(b)(iv).

[22] *Coroners Act 1997* (ACT) ss 92–93; *Coroners Act 2009* (NSW) ss 84–85.

[23] *Coroners Act 1997* (ACT) ss 91–93; *Coroners Act 2009* (NSW) ss 84–85; *Coroners Act 2003* (Qld) s 30(8); *Coroners Act 1995* (Tas) ss 26(3), 27(4); *Coroners Act 1996* (WA) s 24(3).

[24] Australia is a signatory to the *International Covenant on Civil and Political Rights* (opened for signature 16 December 1966, 999 UNTS 171, entered into force 23 March 1976). Article 6 outlines the right to life.

[25] *Charter of Rights and Responsibilities Act 2006* (Vic) s 9; *Human Rights Act 2004* (ACT) s 9.

- the State must act of its own motion and cannot leave it to the next of kin to conduct any part of the investigation.[26]

Coronial comments, recommendations and implications for prevention

As the result of his or her investigation, the coroner must determine, if possible: the identity of the deceased, the cause of death, and, usually, the circumstances in which the death occurred.[27] These determinations are usually known as 'findings'.[28]

The coroner generally also has discretion to comment on any matter connected with the death, including public health and safety or the administration of justice.[29] In all Australian jurisdictions, coroners are also empowered to make recommendations aimed at avoiding preventable deaths.[30] In terms of prevention of similar deaths in the future, while comments by coroners are important for governments, media and the general public, any coronial recommendations that are made are the key outcome of the investigation. Several states and territories expressly frame the power of coroners to make comments and recommendations in terms of the prevention of future deaths.[31]

This more recent increased focus on prevention serves several purposes. Emphasising the preventative role of coroners and inquests helps to meet Australia's obligations concerning the right to life, by requiring independent inquiry into system failure and identification of institutional responsibility to be backed up by appropriately directed practical recommendations to prevent future deaths.[32] This ap-

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[26] *Jordan v United Kingdom* (2001) 37 EHRR 54, [105]–[109]; *R v Secretary of State for the Home Department; Ex parte Amin* [2003] UKHL 51 [18]–[23] (Lord Bingham); *R (Middleton) v West Somerset Coroner* [2004] AC 182, [3], [47]; *R on the Application of D v Secretary of State for the Home Department* [2006] All ER 946, [9(iii)]; Jonathon Hunyor, 'Human Rights in Coronial Inquests' (2008) 12 (6) *Australian Indigenous Law Review* 4, 64.

[27] *Coroners Act 1997* (ACT) s 52(1); *Coroners Act 2009* (NSW) ss 3(c), 81(1); *Coroners Act 1993* (NT) s 34(1)(a); *Coroners Act 2003* (Qld) s 45(2); *Coroners Act 1995* (Tas) s 28(1); *Coroners Act 2008* (Vic) s 67; *Coroners Act 1996* (WA) s 25(1). In South Australia, the Coroner's Court must attempt to find the cause and circumstances of the death: *Coroner's Act 2003* (SA) s 25(1). In Tasmania, the coroner must also attempt to find the identity of any person who contributed to the cause of death: *Coroners Act 1995* (Tas) s 28(1).

[28] In New South Wales, if the investigation includes an inquest, a jury may be appointed, in which case the jury delivers a verdict rather than findings: *Coroners Act 2009* (NSW) ss 48, 81. In the Northern Territory, Tasmania, Victoria and Western Australia, coroners are expressly empowered to make findings if an inquest is not held, but in Victoria are not required to make a finding as to circumstances of death: *Coroners Act 1993* (NT) ss 3, 11, 34(1)(a), 35; *Coroners Act 1995* (Tas) s 28; *Coroners Act 2008* (Vic) s 67(2); *Coroners Act 1996* (WA) s 25(1). Comparable provisions with respect to findings in fire investigations (generally, findings on cause, origins and circumstances) are *Coroners Act 1997* (ACT) s 52(2); *Coroners Act 2009* (NSW) ss 3(d), 81(2); *Coroners Act 1993* (NT) s 34(1)(b); *Coroners Act 1995* (Tas) s 45(1); *Coroners Act 2008* (Vic) s 68.

[29] *Coroners Act 1997* (ACT) s 52(4); *Coroners Act 1993* (NT) s 34(2); *Coroners Act 2003* (Qld) s 46(1); *Coroners Act 1995* (Tas) s 28(3); *Coroners Act 2008* (Vic) s 67(3); *Coroners Act 1996* (WA) s 25(2). South Australian legislation does not expressly provide such a broad discretion for comments, as it requires coroners to set out in their findings the cause and circumstances of the death (*Coroner's Act 2003* (SA) s 25(1)); however, South Australian coronial jurisdiction is interpreted broadly: *WRB Transport v Chivell* [1998] SASC 7002 (23 December 1998) [21] (Lander J).

[30] *Coroners Act 1997* (ACT) s 57; *Coroners Act 2009* (NSW) s 82(1); *Coroners Act 1993* (NT) s 26(2); *Coroners Act 2003* (Qld) ss 46–47, sch 2; *Coroners Act 1995* (Tas) s 28(2); *Coroners Act 2008* (Vic) ss 1(c), 72(2). In Western Australia, only the State Coroner has this express power, although in practice all WA coroners may make recommendations: *Coroners Act 1996* (WA) s 27(3); Law Reform Commission of Western Australia, *Review of Coronial Practice in Western Australia Final Report* (January 2012), 103. In South Australia, the coronial power to make recommendations is limited to 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: *Coroners Act 2003* (SA) s 25(2).

[31] *Coroners Act 1993* (NT) s 26(2); *Coroners Act 2003* (Qld) s 46(1)(c); *Coroner's Act 2003* (SA) s 25(2); *Coroners Act 1995* (Tas) 28(2); *Coroners Act 2008* (Vic) s 1(c).

[32] *R v Secretary of State for the Home Department; Ex parte Amin* [2003] UKHL 51 [58]–[62] (Lord Hope); Jonathon Hunyor, 'Human Rights in Coronial Inquests' (2008) 12 (6) *Australian Indigenous Law Review* 4, 64. Some Australian coroners have expressly agreed that the right to life requires States to adopt positive measures to prevent future avoidable deaths; see eg, Magistrate Jacqueline Milledge, The 'Brimble' Recommendations, 3 December 2010, 2 <http://www.lawlink.nsw.gov.au/lawlink/Coroners_Court/ll_coroners.nsf/vwFiles/Brimblerecs2.pdf/$file/Brimblerecs2.pdf>.

proach means that coronial investigations, and particularly coronial recommendations, play a crucial part in producing long-term solutions to any systemic problems at the heart of the death.[33]

The preventative aspect of investigations and inquests is also consistent with their therapeutic jurisprudence approach, in which the aim is to help with the healing process for the family and others involved in the inquest, together with the broader community and society.[34] The linked goals of prevention and healing are also associated with other issues in the public interest, such as truth, accountability and fairness.

Because systemic issues can arise from diverse contexts and there are often social justice implications, the content of coronial recommendations and their potential influence on death prevention are of particular concern to family members and advocates.

Coroners try to draw any systemic lessons from deaths in order to prevent future avoidable deaths. Often there are social justice implications to a coronial investigation. This makes coronial recommendations especially important for families and advocates.

Experiences of families

Despite the therapeutic ideal, many families and communities experience the coronial process and its aftermath as neither fair nor healing. Exacerbation of the family's trauma often begins with lack of access to free legal representation (see **Part 2**). Families commonly experience additional suffering and frustration during the investigation and, if it takes place, the inquest. For example, the human rights standard that coronial investigations should be independent means that police should not investigate deaths that may have been caused or contributed to by police. Nevertheless, police investigating police is standard practice in Australian jurisdictions.[35]

The human rights standard that coronial investigations be independent is not usually adhered to when police are implicated in a death.

Delays

Another common source of anguish for family members concerns the considerable time that can elapse between when a death is first discovered and when coroner's findings are made. Delays can begin with forensic medical examinations and then continue at the police investigation stage.[36] A Law Reform Commission of Western Australia study showed that between 2004 and 2010, the average time for a death in prison to reach inquest actually increased by 10 months, to 31 months. This was despite the fact that almost all of the 2010 cases were deaths from natural causes, whereas most of

[33] David Ranson, 'The Role of the Pathologist' in Hugh Selby (ed), *The Aftermath of Death* (1992) 80, 120–21; *Royal Commission into Aboriginal Deaths in Custody* ('RCIADIC') *National Report Vol 1* (1991), [4.7.4]; Graeme Johnstone, 'An Avenue for Death and Injury Prevention' in Hugh Selby (ed), *The Aftermath of Death* (1992) 140; James Reason, 'Human Error: Models and Management' (2000) 320 *British Medical Journal* 768.

[34] David Wexler, 'Therapeutic Jurisprudence: An Overview' (2000) 17(1) *Thomas M Cooley Law Review* 125; Michael King, 'Therapeutic Jurisprudence in Australia: New Directions in Courts, Legal Practice, Research and Legal Education' (2006) 15 *Journal of Judicial Administration* 129.

[35] See eg Law Reform Commission of Western Australia, *Review of Coronial Practice in Western Australia Discussion Paper* (June 2011), 93–6; Federation of Community Legal Centres, Human Rights Law Centre, Darebin Community Legal Centre and Flemington Kensington Community Legal Centre, *Effective Transparent Accountable: An independent system to investigate police-related deaths in Victoria* (June 2011) <http://www.fclc.org.au/cb_pages/federation_reports.php#Policeaccountability>.

[36] See eg Law Reform Commission of Western Australia, *Review of Coronial Practice in Western Australia Background Paper* (September 2010), 47.

the 2004 deaths were suicide deaths, where one might expect police investigations to be more complex.[37]

The Commission commented that if the time taken to get to inquest is any more than 12–18 months,

> 'the circumstances of the death become historical and recommendations to prevent the occurrence of future deaths in similar circumstances are less meaningful. A number of respondents to the Commission's public survey who had been involved as witnesses in prison deaths also commented that the significant delays in the coronial process meant that it was difficult to recall events accurately and this made the experience of giving evidence very stressful.'[38]

Where a person has been charged with an offence or is believed by the coroner to have committed an offence in respect of a death, generally Australian jurisdictions require that any inquest into the death not commence or be adjourned until after the conclusion of criminal proceedings.[39] This can contribute considerable delay in a significant number of investigations and inquests. For example, the 2010–11 Victorian Coroners Court Annual Report notes that as of 30 June 2011, 606 cases were currently the subject of police criminal investigations or other court proceedings.[40]

If the death proceeds to inquest, more time is needed to prepare the inquest brief. The inquest itself can take anywhere from one day to many weeks. This depends not only on whether anyone is charged with an offence which would halt the inquest at least temporarily, but also on the complexity of the issues, the nature and number of the 'parties',[41] and the potential for other legal proceedings to follow the inquest.

There is then often another period of time before the coroner's findings are released. If the parties make written submissions, this last period may be extended because lawyers require transcripts of the inquest proceedings, and this can take a significant time. As an example, a review by the Victorian Coroners Court over March–June 2011 found that the average time to receive a transcript of inquest proceedings was 89 days.[42] The Court's 2010–11 Annual Report noted:

> 'Delays in receiving transcripts of court hearings from the Victorian Government Recording Services (VGRS) has been identified as a serious impediment to the court's ongoing efforts to reduce waiting periods between the last day of an inquest and the handing down of the coroner's finding.'[43]

A long inquest hearing can also add substantially to the time taken, as it not only requires more transcription and more time to prepare submissions, but resource limitations may mean that there are gaps between sitting dates.

One way to measure overall delay in the coronial system is via measures of backlog. Some degree of backlog is not surprising because unlike other courts, the date of lodgement of the case is the time of notification of the death before any investigation is undertaken for a report to the Coroner.[44] However, the number of cases pending that are more than 12 months old is considered to be a key backlog

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[37] Law Reform Commission of Western Australia, *Review of Coronial Practice in Western Australia Discussion Paper* (June 2011), 91.

[38] *Review of Coronial Practice in Western Australia Discussion Paper*, 91.

[39] *Coroners Act 1997* (ACT) s 58; *Coroners Act 2009* (NSW) ss 78–79; *Coroners Act 2003* (Qld) s 29; *Coroners Act 2003* (SA) s 21(2); *Coroners Act 1995* (Tas) s 25; *Coroners Act 1996* (WA) s 53.

[40] *Coroners Court of Victoria 2010–2011 Annual Report*, 47.

[41] As discussed in Part 2, technically there are no parties to an inquest, but the term tends to be used in a more general sense.

[42] *Coroners Court of Victoria 2010–2011 Annual Report*, 40.

[43] *Coroners Court of Victoria 2010–2011 Annual Report*, 40.

[44] Law Reform Commission of Western Australia, *Review of Coronial Practice in Western Australia Background Paper* (September 2010), 38–9.

indicator, and national standards require that any coronial jurisdiction should have no more than 10% of such cases.[45]

At 30 June 2012, no state or territory reached the national standard, with the lowest rate being 12.4% in New South Wales, and the highest being Victoria with 41.3%.[46] National standards also set a benchmark that there should be no pending cases more than 24 months old.[47] All jurisdictions failed to reach this mark, with the worst performers being Victoria at 24.3% and the Northern Territory at 18.4%.[48]

It is also important to remember that in a significant number of cases, the delay will be considerably longer than the benchmark time length. For example, 198 of the cases in the Law Reform Commission of Western Australia study were more than three years old,[49] and for South Australian inquests where findings were delivered in 2011–12, the time elapsed since the date of death ranged from 14 months to over seven years.[50] Cases where the time elapsed between date of death and inquest findings is around eight years are not unknown.

Another measure of likely delays is the case clearance indicator, which is calculated by dividing the number of finalised cases by the number of new cases lodged in the same period.[51] The clearance indicator gives an idea of whether Coroners Courts are likely to manage to 'keep on top of' their work-load if their resources are not also increased. For example, if the indicator is under 100% it means that the court finalised fewer cases than were lodged and so the pending caseload has increased.[52] For the year ending 30 June 2012, Victoria (98.4%), Tasmania (96.7%) and the Northern Territory (93.4%) all had increased pending caseloads.[53]

> In 2011 no state or territory reached the national standard for acceptable backlog of cases. It can take five years before a reported death results in coronial findings, and sometimes up to eight years.

Often the reasons for substantial delays do not seem justified to families, who may not only be extremely emotionally distressed but can sometimes also experience financial hardship if, for example, the coroner's finding is required by a life insurance company or for payment of superannuation.[54]

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[45] Productivity Commission, *Report on Government Services 2013*, 7.30.

[46] *Report on Government Services 2013*, 7.37.

[47] *Report on Government Services 2013*, 7.30.

[48] *Report on Government Services 2013*, 7.37.

[49] Law Reform Commission of Western Australia, *Review of Coronial Practice in Western Australia Background Paper* (September 2010), 39.

[50] *Annual Report of the State Coroner Financial Year 2011–2012*, 23–24 <http://www.courts.sa.gov.au/OurCourts/CoronersCourt/Pages/Annual-Reports.aspx>.

[51] Productivity Commission, *Report on Government Services 2013*, 7.40.

[52] *Report on Government Services 2013*, 7.40; Law Reform Commission of Western Australia, *Review of Coronial Practice in Western Australia Background Paper* (September 2010), 38.

[53] *Report on Government Services 2013*, 7.42.

[54] For example, the Law Reform Commission of Western Australia found that because insurances often require formal certification of cause of death, a small number of family members reported not being able to finalise the deceased's affairs until the inquest findings were made, which might be some years after the death. Accordingly, the Commission has recommended that the Office of the WA State Coroner consider reviving its practice of providing interim coronial determinations to the Registrar of Births Deaths and Marriages in order to enable the issuing of a death certificate at the earliest opportunity (Law Reform Commission of Western Australia, *Review of Coronial Practice in Western Australia Discussion Paper* (June 2011), 60–62; Law Reform Commission of Western Australia, *Review of Coronial Practice in Western Australia Final Report* (January 2012), 41–2).

Other difficulties experienced by families

Family suffering is exacerbated if there is no clear information or regular follow-ups with the family by coronial or other official personnel.[55] Other common difficulties for families have been documented in the Victorian Parliament Law Reform Inquiry into the Coroners Act 1985 (Vic) and the current Review of Coronial Practice in Western Australia, and continue to varying degrees in all Australian jurisdictions:

- lack of clarity about the roles, functions and process of the Coroner and other personnel in the investigation or inquest;
- communication from the Coroner's Office being too formal and not sensitive enough;
- lack of adequate support services;
- not knowing what to expect from the inquest proceedings;
- lack of knowledge of legal rights, including the right to representation;
- failure of coronial systems to adequately accommodate cultural and spiritual considerations, including Aboriginal and Torres Strait Islander understandings of who is next of kin;
- the carrying out of autopsies when there were no suspicious circumstances;
- families not being able to view and touch the body of the deceased person while it is in the coroner's jurisdiction;
- inadequate case investigation caused by a lack of thoroughness in collecting witness statements or by inexperienced coroner's assistants, particularly in the context of medical investigations; and
- the inability of some families to have a case investigated adequately or at all by the coroner, in circumstances where the families had unanswered questions about the cause of death or felt that certain parties should be made accountable for the death.[56]

These kinds of issues are underpinned by a general failure across jurisdictions to fully implement into practice the right of families to participate in coronial processes concerning their loved ones.

There is a general failure to fully implement the right of families to participate in coronial processes concerning their loved ones.

Families can also be disappointed with the manner in and degree to which any goal of prevention translates into practice. Families look for coronial outcomes that might give some positive meaning to the aftermath of the death. Families, their communities and advocates, along with others more broadly concerned with the relationship between preventable deaths and social justice issues, therefore need a coronial system that consistently produces findings and recommendations that are comprehensive, as timely as possible, and appropriately targeted to specific entities, such as government departments, Ministers, and private and government corporations. For a coronial system to achieve genuine prevention, these entities must respond in a manner that addresses the issues at the heart of the death, so that similar deaths do not occur in the future.

It is therefore not sufficient to simply inform families, advocates and the general public that moves will be made to achieve a preventative outcome, and yet not specify what these moves will be. Families, and Australian communities more broadly, need to see the preventative system actually working, and so must be kept informed about what recommendations have been made, how those recommendations are being implemented, and how such implementation will be monitored so that preventable deaths are eliminated, or at least reduced in number.

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[55] Law Reform Committee, Parliament of Victoria, *Coroners Act 1985 Final Report* (2006), 428–9; Law Reform Commission of Western Australia, *Review of Coronial Practice in Western Australia Discussion Paper* (June 2011), 187–93.

[56] *Coroners Act 1985 Final Report*, 428–30; Law Reform Commission of Western Australia, *Review of Coronial Practice in Western Australia Background Paper* (September 2010), 55–7; *Review of Coronial Practice in Western Australia Discussion Paper*, 181–93. See also Shannon Chapman, 'The Coroner's Exercise of Discretion: Are Guidelines Needed?' (2008) 12 (6) *Australian Indigenous Law Review* 103.

In order to begin to address these issues in detail, we first need to consider a more fundamental difficulty — the variation in, and sometimes sheer lack of, thorough, clear and publicly accessible information about the outcomes of coronial investigations (including inquests) across Australia.

> Families and Australian communities need to see the preventative system actually working, and so must be kept informed about what recommendations have been made, how those recommendations are being implemented, and how implementation will be monitored.

Information about coronial findings

Let us assume that a member of the public wants to find out basic statistics concerning coronial findings for the different Australian jurisdictions. He or she might first wish to know the number of deaths reported to coroners, and the number of investigations completed which did or did not lead to an inquest.

Annual Reports/Reviews

Coroners Courts or Coroner's Offices generally provide some statistics on coroners' activities in their Annual Report or Review, or as a contribution to another entity's Annual Report. The relevant documents are usually available on the Internet, but can be hard to locate if the searcher is not already aware of which entity conventionally takes responsibility. It can be especially difficult to find information when the data is only a part of another Annual Report. The amount and type of publicly available information also varies considerably.

The most recent data, as available on the Internet, is summarised in **Table 1**. Figures for the Northern Territory were unavailable from the Internet at the time of publication.[57]

[57] The *Northern Territory Department of Justice Annual Report 2011–2012* does not report on the number of inquests, and there is no separate coroners annual report.

Table 1 Reported deaths, investigations without inquest, and inquests

Jurisdiction	Reporting period	Number of deaths reported	Number of death investigations without inquest	Number of in-quests[58]	Source
Australian Capital Territory	2010–11[59]	317	unknown[60]	20	*Annual Report of the Chief Coroner to the Attorney-General Pursuant to s 102 of the* Coroner's Act 1997 *2010–11*, 15
New South Wales	2011	5694	unknown	290	Attorney General's Department, *Local Court of New South Wales Annual Review* (2011), 20[61]
Queensland	2011–12	4461	4690	81	Office of the State Coroner, *Annual Report 2011–2012*, 45[62]
South Australia	2011–12	2088	unknown	45	*Annual Report of the State Coroner Financial Year 2011–2012*, 18, 23–24[63]
Tasmania	2011–12	478	462[64]	9	*Magistrates Court Annual Report 2011–2012*, 49[65]
Victoria	2010–11	4857	5050[66]	142[67]	*Coroners Court of Victoria 2010–2011 Annual Report*, 48[68]
Western Australia	2011–12	2679	2094	98	Office of the State Coroner, *Annual Report 2011–2012*, 11[69]

It might also be important to know the frequency of different types of deaths in the various states and territories, such as the number of deaths in custody or deaths in care. Most jurisdictions that are statutorily required to report this type of information do so in the relevant Annual Report. For example,

[58] Figures in this column, other than for Victoria, represent the number of inquest hearings completed in the relevant time period, irrespective of whether findings have been delivered. However, time elapses between a death being reported and the conclusion of an investigation, even if it does not result in an inquest, and especially if it does lead to inquest. This means that in any jurisdiction it is likely that many of the deaths investigated are not a subset of the reported deaths for that year but instead are deaths reported in earlier years. The figures are therefore only for approximate cross-jurisdictional comparison purposes.

[59] Updated information is unavailable for the ACT, because there is no coronial data published in the relevant Annual Report, from the Justice and Community Safety Directorate <http://www.justice.act.gov.au/page/view/197>.

[60] The ACT Annual Report does not disaggregate death investigations and fire investigations. As there were considerably more fire matters than deaths reported in 2010–11, it is not possible to estimate how many of the investigations that did not proceed to inquest were deaths.

[61] <http://www.localcourt.lawlink.nsw.gov.au/agdbasev7wr/_assets/localcourts/m401551l3/annual%20review%202011.pdf>.

[62] <http://www.courts.qld.gov.au/about/publications#Office%20of%20the%20State%20Coroner%20Annual%20Reports>.

[63] <http://www.courts.sa.gov.au/OurCourts/CoronersCourt/Pages/Annual-Reports.aspx>.

[64] This is only an approximate figure, because it is for number of cases closed.

[65] <http://www.magistratescourt.tas.gov.au/__data/assets/pdf_file/0011/192449/2010-2011_Annual_Report_.pdf>.

[66] This figure is for the number of findings without inquest, and hence cannot be directly compared to other jurisdictions' figures for completed investigations without inquest.

[67] This figure is for the number of findings with inquest, and hence cannot be directly compared to other jurisdictions' figures for completed inquests, as there may be a delay before findings are delivered. The figure also excludes inquests into fires (= 2).

[68] <http://www.coronerscourt.vic.gov.au/resources/5/2/5200ff00495ac07a86a3d647b5aa48fe/4635+coroners+annual+report+2010-2011+web+v2.pdf>.

[69] <http://www.coronerscourt.wa.gov.au/_files/Coroners_Court_Annual_report_12.pdf>.

New South Wales reports the number of deaths of children in care and disability deaths,[70] and the number of deaths in custody or during or as a result of a police operation, including the number of deaths of Aboriginal persons. New South Wales also produces a separate more detailed report on deaths in custody[71] and an annual report on domestic violence deaths.[72] Queensland and Western Australia summarise their coronial investigations into all deaths in custody. For more detail on the information required to be reported, see **Appendix 1**.

Various jurisdictions comment on notable inquests and patterns of deaths, but other than in relation to deaths in custody and care, domestic violence deaths in New South Wales, and, in some jurisdictions, reporting on responses to coronial recommendations (see pp 29–31), there is not necessarily any statutory obligation to do so.

The extent of other coronial information provided in Annual Reports varies, depending on the particular Coroners Court or Coroner's Office. The Western Australia *Office of the State Coroner Annual Report 2011–*2012 includes brief summaries of a number of inquest findings,[73] and both the *Coroners Court of Victoria Annual Report 2010–2011* and the *Queensland Office of the State Coroner Annual Report 2011–2012* include an overview of investigations or inquests of significant public interest.[74] The *Coroners Court of Victoria Annual Report* also includes developments in public health and safety as the result of coronial investigations.[75] South Australia publishes a brief case review summary of domestic violence deaths in its *Annual Report of the State Coroner 2011–2012*,[76] and Victoria has recently published a separate report on its Systemic Review of Family Violence Deaths.[77] For more detail on family/domestic violence death reviews, see *Proposals to centrally record coronial recommendations* (p 45). Most jurisdictions also provide information about their clearance rates of coronial cases.

Coroners websites

If a member of the public wishes to access particular coronial findings and recommendations, many can now be obtained via the relevant Coroners Court or Coroner's Office website.[78] The exception ap-

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[70] 'Disability deaths' broadly refer to deaths of people receiving residential care or services within the meaning of the *Disability Services Act 1993* (NSW).

[71] <http://www.lawlink.nsw.gov.au/lawlink/Coroners_Court/ll_coroners.nsf/vwFiles/DICReport2010Part1.pdf/$file/DICReport2010Part1.pdf>. The latest report available online is for 2010.

[72] NSW Domestic Violence Death Review Team, *Annual Report 2011–2012* <http://www.coroners.lawlink.nsw.gov.au/agdbasev7wr/_assets/coroners/m401601l5/dvdrt_annual_report_final_october_2012x.pdf>.

[73] *Office of the State Coroner Annual Report 2011–*2012 <http://www.coronerscourt.wa.gov.au/_files/Coroners_Court_Annual_report_12.pdf>.

[74] *Coroners Court of Victoria 2010–2011 Annual Report*, 19–23 <http://www.coronerscourt.vic.gov.au/resources/bff76d3b-fed7-4f5f-91b2-528cd624ef5b/4635%2bcoroners%2bannual%2breport%2b2010-2011%2bweb%2bv2.pdf>; Office of the State Coroner, *Annual Report 2011–2012*, 31–44 <http://www.courts.qld.gov.au/about/publications#Office%20of%20the%20State%20Coroner%20Annual%20Reports>.

[75] *Coroners Court of Victoria 2010–2011 Annual Report*, 24–6 <http://www.coronerscourt.vic.gov.au/resources/bff76d3b-fed7-4f5f-91b2-528cd624ef5b/4635%2bcoroners%2bannual%2breport%2b2010-2011%2bweb%2bv2.pdf>.

[76] *Annual Report of the State Coroner 2011–2012*, 12 <http://www.courts.sa.gov.au/OurCourts/CoronersCourt/Pages/Annual-Reports.aspx>.

[77] *Victorian Systemic Review of Family Violence Deaths—First Report* <http://www.coronerscourt.vic.gov.au/find/publications/victorian+systemic+review+of+family+violence+deaths+_+first+report>.

[78] <http://www.courts.act.gov.au/magistrates/page/view/597/title/selected-findings>;
<http://www.coroners.lawlink.nsw.gov.au/coroners/findings.html,c=y>;
<http://www.nt.gov.au/justice/courtsupp/coroner/inquestlist.shtml>;
<http://www.courts.qld.gov.au/courts/coroners-court/findings>;
<http://www.courts.sa.gov.au/CoronersFindings/Pages/All-Findings.aspx>;
<http://www.magistratescourt.tas.gov.au/decisions/coronial_numeric_index>;

pears to be Western Australia, with only one finding, from 2012 in relation to the Christmas Island Tragedy, published on the Internet.[79] The WA Coroner's Court website advises: 'Coroner's inquest findings are available on the date of delivery of the finding or later by request in writing to the Office of the State Coroner.'[80]

No coroners website provides automatic public access to all coronial findings for the jurisdiction, because coroners have some discretion to withhold findings to protect privacy or recognise suppression orders.[81] In addition, even a more comprehensive public database of findings such as Victoria's has few findings before the new legislation commenced in 2009.

Coroners websites also vary in terms of the amount and level of information available to the general public. Northern Territory, Tasmanian, Victorian and Western Australian coroners are expressly empowered to make findings when an investigation does not proceed to inquest, but only Tasmania and Victoria include these findings along with inquest findings on their respective websites.[82] The Queensland, South Australian and Victorian findings databases are searchable to some extent, and the Queensland site also includes judicial decisions relevant to coronial issues.

There is considerable variation across and even within jurisdictions in terms of how findings are set out and written.[83] It is also very difficult to find out information on whether in a specific inquest the family was legally represented, and whether advocacy organisations have been involved in particular inquests in other capacities. These problems are addressed in **Part 2**.

There are other significant limitations to most of the publicly available information. While all published findings include any coronial recommendations made, only Victoria, New South Wales, South Australia and Western Australia publish responses to recommendations. Victoria is the only jurisdiction that publishes responses as a matter of course on its coroners website alongside the relevant findings. The issue of responses to recommendations is discussed further below.

States and territories vary considerably in terms of how much clear information about the outcomes of coronial investigations and inquests is publicly accessible.

Coroners Courts/Offices

For advocates and researchers trying to prevent future deaths by learning from patterns of death via accessing findings and recommendations for all similar deaths, the information sought is often not

<http://www.coronerscourt.vic.gov.au/home/case+findings/>.

[79] <http://www.coronerscourt.wa.gov.au/I/inquest_findings.aspx?uid=9349-4756-3915-2531>. WA does publish inquest findings concerning hospital and healthcare deaths, via the Office of Safety and Quality in the Department of Health <http://www.safetyandquality.health.wa.gov.au/mortality/inquest_finding.cfm>.

[80] <http://www.coronerscourt.wa.gov.au/I/inquest_findings.aspx?uid=9349-4756-3915-2531>. The rationale for not publishing findings was given by the Parliamentary Secretary representing the Attorney General: 'The Coroner's Court used to publish findings on the website. However, this facility was suspended following complaints from families. In summary, families were concerned that details of the death of their loved ones were publicly available and open to voyeurism. . .The provision of anonymised findings is no guarantee that the deceased will not be identified. Almost every death has its own unique set of circumstances from which it is relatively easy to identify the deceased. Findings are made publicly available following the inquest and, to facilitate bone fide requests thereafter, the Coroner's Court will make them available by application via its website' (Western Australia, *Parliamentary Debates*, Legislative Council, 29 June 2010, 4719 (Helen Morton)).

[81] See eg *Coroners Act 2008* (Vic) s 73(1).

[82] The fact that findings without an inquest do not appear on a website may also be a function of them being rarely, if ever, made in this context. Public data is not available to clarify this issue.

[83] See also Law Reform Commission of Western Australia, *Review of Coronial Practice in Western Australia Discussion Paper* (June 2011), 20.

publicly accessible via the Internet. Coroners Courts or Coroners Offices are then the logical place to inquire about this data.

As the Law Reform Commission of Western Australia notes:

> 'If the coroner is to effectively discharge a death prevention role then it is clear that there needs to be a high degree of cooperation between the Office of the State Coroner and legitimate researchers and special interest advocacy groups within the community and government.'[84]

However, Coroners Courts/Offices vary in terms of the level of resourcing that they have to enable them to provide such information. For example, 'there appears to be very little direct information sharing' between the WA Office of the State Coroner and groups seeking coronial data.[85] This appears due to the lack of capacity of staff to be able to deal with internal work, let alone external requests.[86]

In contrast, the Victorian Coroners Court is supported by the Coroners Prevention Unit (CPU), which provides coroners with research and analysis to support the coronial recommendation function, as well as responding to external requests for data and research. However, even in this better resourced coronial jurisdiction, the prioritised needs of coroners combined with limited capacity mean that external requests may not be able to be actioned by the CPU. Public interest advocacy groups also appear less likely than government departments to be able to quickly obtain the data they seek.

For example, as an important part of ongoing policy work on police accountability and independent systems of investigation in policing-related deaths, the Federation of Community Legal Centres is seeking copies of all recommendations in Victorian inquests related to such deaths, including recommendations made before 2009. Despite the fact that coronial recommendations made from 2009 onward concerning police-related deaths are publicly available on the Victorian Coroners Court website,[87] the Federation must apply via the Department of Justice Ethics Committee for access to the pre-2009 recommendations. If the application is successful, it is also unlikely that findings and recommendations made before 2000 will be made available, because cases before that time are not part of the electronic system, and there is no paper index. A very time-consuming manual review of all deaths, involving a recall of all of those files, would be required to identify those cases where a relevant recommendation was made.

'If the coroner is to effectively discharge a death prevention role then it is clear that there needs to be a high degree of cooperation between the Office of the State Coroner and legitimate researchers and special interest advocacy groups within the community and government.'
Law Reform Commission of Western Australia

Under-resourcing of Coroners Courts/Offices hampers their ability to provide public information and to cooperate with external researchers and advocates.

National Coronial Information System

There are other potential sources of information that have the added advantage of recording inquest data across state and territory boundaries. The National Coronial Information System (NCIS), an initiative of the Australasian Coroners Society, is a national database for all coronial matters. The NCIS is

[84] *Review of Coronial Practice in Western Australia Discussion Paper*, 163.

[85] *Review of Coronial Practice in Western Australia Discussion Paper*, 163.

[86] *Review of Coronial Practice in Western Australia Discussion Paper*, 163–4. The Commission has accordingly recommended that a prevention team be established within the Office of the State Coroner (Law Reform Commission of Western Australia, *Review of Coronial Practice in Western Australia Final Report* (January 2012), 102).

[87] See eg <http://www.coronerscourt.vic.gov.au/home/case+findings/coroners2+-+554208+tyler+cassidy>.

based at the Victorian Institute of Forensic Medicine and managed by the Victorian Department of Justice. It is advertised as containing case detail information about every death reported to an Australian coroner since July 2000, or January 2001 for Queensland.[88] The NCIS is a very valuable tool and a significant step forward in the prevention of untimely death. Its primary role is to assist coroners by providing them with the ability to review similar previous coronial cases.

NCIS data, including the full text of coronial findings and recommendations, is not publicly available. However, the public can access a publication, *Fatal Facts*, which identifies and summarises all coronial recommendations that have been uploaded to the NCIS over the relevant period, although with a significant delay between the time that recommendations are made and when they appear in summary.[89] Each edition also provides in-depth case studies on a featured topic, such as deaths in custody.

Individuals or organisations other than coroners may apply as a 'third party' for direct access to the NCIS. A third party is an Australian individual or organisation with a bona fide role or interest in public health and safety or with a statutorily mandated statistical role. This includes Commonwealth, State and Territory government departments and agencies, university research centres, and other research or non-profit organisations with a role or interest in public health and safety.[90]

If a researcher or an organisation seeks access to information such as the full text of coronial findings and recommendations, they must therefore make an application to the NCIS, which is then subject to approval by the NCIS Research Committee and the Victorian Department of Justice Research Ethics Committee.[91] The application process takes at least two months and a fee of between $1000 and $17000 is payable.[92]

It appears that few public legal service providers acting for families seek access to NCIS data to assist in the preparation of their evidence and submissions at inquests. However, from time to time, lawyers representing government agencies and corporations whose actions are to be called into question at an inquest apparently obtain NCIS data in preparation.

Entities who are not deemed to be third parties, such as media and private organisations, may apply for access to de-identified data, for which they must pay a fee. The NCIS team can be engaged to conduct a search of the NCIS to retrieve data as agreed between the team and the applicant. The charge for this service is at the hourly rate of $165 (GST-inclusive), which covers the time taken for the research officer to perform the search and collate the results. The information provided to the applicant can range from basic statistical data to the provision of detailed reports that include additional analysis and commentary.[93]

However, access may be denied. For example, in July 2009, amidst controversy about attacks on Indian students, investigative reporters from the *Sydney Morning Herald* were reportedly denied access to NCIS data in their attempt to determine the number of deaths of overseas students in Australia reported to coroners between November 2007 and 2008.[94]

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[88] <http://www.ncis.org.au/>.

[89] <http://www.ncis.org.au/web_pages/fatal_facts.htm>. For example, the 2012 edition summarises 2009 recommendations <http://www.ncis.org.au/web_pages/Fatal%20Facts_Edition%2022.pdf>.

[90] <http://www.ncis.org.au/web_pages/NCIS%20Information%20Sheet_2012.pdf>.

[91] <http://www.ncis.org.au/web_pages/NCIS%20Information%20Sheet_2012.pdf>. Some applications for access to Western Australian data also require approval from the Western Australia Coronial Ethics Committee.

[92] Non-profit organisations and community groups would probably pay $1000, as the fee is based on an assessment of organisation size, regularity of use and capacity to pay: Jessica Pearse, Manager NCIS, email (23 May 2011), cited in Law Reform Commission of Western Australia, *Review of Coronial Practice in Western Australia Discussion Paper* (June 2011), 162 n 10.

[93] <http://www.ncis.org.au/web_pages/how_to_apply_for_access.htm>.

[94] 'Student Death Toll Set to Rise', *Sydney Morning Herald*, 1 July 2009.

45 searches for external parties were performed in 2010–11.[95] Most searches were undertaken on behalf of government (including local government) and statutory agencies, with eight performed for universities and six for health bodies.[96] Four suicide prevention organisations, three media, three community organisations and one private citizen had searches performed.[97]

The National Coronial Information System is a very valuable tool, but is only automatically accessible to coroners. Other potential users must seek approval to use it and usually pay a significant fee.

Aiming for prevention — coronial recommendations

Families seeking some comfort from the inquest, along with advocates working to oppose systemic injustices, look to coronial recommendations as the key to preventing similar deaths in the future. However, it is important to note that cases investigated by coroners do not always result in findings, and only a small minority of cases produce recommendations.[98] Even more significantly, states and territories vary not only in the way that coroners write their findings, but also according to how often coronial recommendations are made,[99] and in the scope of such recommendations.

Some of this may be due to the fact that jurisdictions still differ in the extent to which their legislation underpinning coronial practice has an express commitment to prevention. For example, while various parts of the *Coroners Act 2008* (Vic) and the *Coroners Act 2003* (Qld) directly address prevention, including in the Preamble and Purposes (Victoria) and the Objects (Queensland), the *Coroners Act 2006* (WA) does not expressly refer to any object or purpose of prevention, and the *Coroners Act 2003* (SA) refers to prevention only once, in the provision concerning the recommendation power of coroners.[100] For a detailed comparison of the various jurisdictions, see **Appendix 1**.

The scope and frequency of recommendations are also clearly influenced by the extent of coroners' powers to make recommendations. For example, in South Australia, the recommendation power is quite narrow, relating to the cause or circumstances of the death rather than also including events that occurred immediately after the death, or encompassing issues not similar to the event that was the subject of the inquest.[101] This narrow power means that, for example, in the inquest into the death of an Aboriginal prisoner in an overcrowded doubled-up cell with another prisoner who had an infectious disease, the South Australian State Coroner, although empowered to make broad comments, was unable to make any recommendations about the health risks of overcrowding, because the pris-

[95] *NCIS Annual Report 2010–11*, 10 <http://www.ncis.org.au/web_pages/Annual%20Report%202011_FINAL%20for%20web.pdf>.

[96] *NCIS Annual Report 2010–11*, 29 <http://www.ncis.org.au/web_pages/Annual%20Report%202011_FINAL%20for%20web.pdf>.

[97] *NCIS Annual Report 2010–11*, 29 <http://www.ncis.org.au/web_pages/Annual%20Report%202011_FINAL%20for%20web.pdf>.

[98] Of the 4158 cases closed by Australian coroners between 1 June 2009 and 30 September 2009, 3358 resulted in findings, and 51 of these produced recommendations (*NCIS Fatal Facts* Edition 22 (May 2012), 1 <http://www.ncis.org.au/web_pages/Fatal%20Facts_Edition%2022.pdf>).

[99] Lyndal Bugeja and David Ranson, 'Coroners' Recommendations: A Lost Opportunity' (2005) 13(2) *Journal of Law and Medicine* 173, 175; Ian Freckelton and David Ranson, 'The Evolving Institution of Coroner' in Ian Freckelton and Kerry Petersen (eds), *Disputes and Dilemmas in Health Law* (2006) 296, 309; Lyndal Bugeja, Joseph Ibrahim, Joan Ozanne-Smith, Lisa Brodie and Roderick McClure, 'Application of a Public Health Framework to Examine the Characteristics of Coroners' Recommendations for Injury Prevention' *Inj Prev* published online December 26, 2011 doi: 10.1136/injuryprev-2011-040146, downloaded from injuryprevention.bmj.com 27 December 2011.

[100] *Coroners Act 2003* (SA) s 25(2).

[101] *Coroners Act 2003* (SA) s 25(2); Christopher Charles, 'The *Coroners Act 2003* (SA) and the Partial Implementation of RCIADIC: Consequences for Prison Reform' (2008) 12 (6) *Australian Indigenous Law Review* 75, 77–80.

oner died of a drug overdose.[102] Despite the 1991 recommendation of the Royal Commission into Aboriginal Deaths in Custody, the scope of South Australian coroners' recommendation powers remains unchanged.[103]

Another factor that may affect whether recommendations are made in a particular inquest is that although coroners are independent judicial officers with the power to obtain documents and answers to questions about a death from governments, corporations and individuals,[104] coroner's offices are usually under-resourced, with little assistance provided to help them compile their findings and recommendations.[105] The only study to date of the implementation of coronial recommendations in all Australian jurisdictions, published in 2008 in the *Australian Indigenous Law Review* (the AILR study),[106] found that factors influencing whether a recommendation was implemented included:

- the manner in which a recommendation was formulated or expressed by a coroner;
- the manner in which a recommendation was distributed or communicated by a coroner;
- whether prior coronial recommendations arising from similar deaths were drawn to the attention of the relevant authorities; and
- the feasibility of a recommendation.[107]

The degree of emphasis on prevention and on the role of recommendations varies considerably among states and territories. Coroners also often have little assistance to help them formulate their findings and recommendations.

Many coroners require training in order for their recommendations to be at least potentially effective.[108] It is still possible to find examples of coronial recommendations that are not directed to a particular entity or do not target the appropriate agency, and therefore will not receive a response. In a review of coronial recommendations from inquests performed in 2007, the Law Reform Commission of Western Australia found that

> 'recommendations directed to private entities or vaguely directed to "the government" received poor or no responses. Recommendations that were broad in nature or not targeted to specific actions tended to receive platitudinous responses with little likelihood of implementation.'[109]

The AILR study also found that there were

> 'recurring instances where coronial recommendations had not been communicated or had been miscommunicated, or were lost within bureaucratic processes.'[110]

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[102] State Coroner Wayne Chivell, Findings of the Inquest into the Death of Marshall Freeland Carter, 16 June 2000 [8.23]; Christopher Charles, 'The *Coroners Act 2003* (SA)', 78–9.

[103] Recommendation 13: That a Coroner inquiring into a death in custody be required to make findings as to the matter which the Coroner is required to investigate and to make such recommendations as are deemed appropriate, with a view to preventing further custodial deaths. The Coroner should be empowered, further, to make such recommendations on other matters as he or she deems appropriate (Royal Commission Into Aboriginal Deaths In Custody *National Report Vol 1* (1991) [4.74]).

[104] *Coroners Act 1997* (ACT) ss 43–45, 66–67; *Coroners Act 2009* (NSW) s 53, Part 6.3; *Coroners Act 1993* (NT) ss 19, 41; *Coroners Act 2003* (Qld) ss 13, 37; *Coroners Act 2003* (SA) ss 22–23; *Coroners Act 1995* (Tas) s 53; *Coroners Act 2008* (Vic) ss 42, 55; *Coroners Act 1996* (WA) ss 33, 46.

[105] See eg references to understaffing and under-funding in Law Reform Commission of Western Australia, *Review of Coronial Practice in Western Australia Background Paper* (September 2010), 24; *Coroners Court of Victoria 2010–2011 Annual Report*, 15, 42–4.

[106] Ray Watterson, Penny Brown and John McKenzie, 'Coronial Recommendations and the Prevention of Indigenous Death' (2008) 12 (6) *Australian Indigenous Law Review* 4. The study tracked the response of government agencies to 484 coroners' recommendations in 185 inquests around Australia, mostly in 2004.

[107] Watterson, Brown and McKenzie, 12.

[108] See eg Law Reform Commission of Western Australia, *Review of Coronial Practice in Western Australia Background Paper* (September 2010), 51.

[109] *Review of Coronial Practice in Western Australia Background Paper*, 21–2.

[110] Ray Watterson, Penny Brown and John McKenzie, 'Coronial Recommendations and the Prevention of Indigenous Death' (2008) 12 (6) *Australian Indigenous Law Review* 4, 5.

'Recommendations directed to private entities or vaguely directed to "the government" received poor or no responses. Recommendations that were broad in nature or not targeted to specific actions tended to receive platitudinous responses with little likelihood of implementation.'

Law Reform Commission of Western Australia

'There were recurring instances where coronial recommendations had not been communicated or had been miscommunicated, or were lost within bureaucratic processes.'

AILR study

Responses to coronial recommendations

As evident from the AILR study, even where comprehensive and appropriately targeted recommendations are made, in most jurisdictions there is no guarantee that governments and other entities will respond to them. Only four of the eight jurisdictions statutorily mandate responses to coronial recommendations, with only the Northern Territory and Victoria legally requiring responses to all coronial recommendations.[111] The Australian Capital Territory and South Australia mandate responses only in relation to deaths in custody.[112]

In June 2009 the New South Wales Premier issued a memorandum to Ministers and government agencies, indicating that they should respond to coronial recommendations within six months of receiving them, outline any action being taken to implement the recommendation, and give any reasons if it is not proposed to implement a recommendation.[113] Ministers and agencies are also encouraged to provide updates to the Attorney General on any further action taken to implement recommendations following their initial advice.[114]

The Premier's memorandum instructs that if the proposed Government response to a coronial recommendation involves significant change to Government policy, impacts on more than one portfolio, or has budgetary implications, a Minister should bring forward a Cabinet Minute.[115] Unfortunately, the new Guidelines are not enshrined in the *Coroners Act 2009* (NSW), and therefore may be subject to policy change.

How can the general public find out whether responses have been made?

The Australian Capital Territory, the Northern Territory, South Australia and Victoria all legally require some form of public reporting of mandatory responses to coronial recommendations.

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[111] In the Northern Territory, a written response is required within 3 months from the Chief Executive Officer of the relevant NT Agency or the Commissioner of Police, to the NT Attorney-General, with the response including a statement of the action that the Agency or the Police Force is taking, has taken or will take: *Coroners Act 1993* (NT) ss 46A, 46B. In Victoria, a written response is required within 3 months from the relevant public statutory authority or entity, to the coroner, with the response specifying a statement of action (if any) that has, is or will be taken: *Coroners Act 2008* (Vic) ss 72(3)–(4). For more detail, see **Appendix 1**.

[112] In the ACT, the custodial agency in whose custody the death happened must give a written response within 3 months to the Minister responsible, including a statement of any action that has been or is being taken: *Coroners Act 1997* (ACT) s 76. In South Australia, the Minister responsible must within 6 months and 8 sitting days give details to each House of Parliament of any action taken or proposed to be taken: *Coroners Act 2003* (SA) s 25(5).

[113] <http://www.dpc.nsw.gov.au/announcements/ministerial_memoranda/2009/m2009-12_responding_to_coronial_recommendations>.

[114] <http://www.dpc.nsw.gov.au/announcements/ministerial_memoranda/2009/m2009-12_responding_to_coronial_recommendations>.

[115] <http://www.dpc.nsw.gov.au/announcements/ministerial_memoranda/2009/m2009-12_responding_to_coronial_recommendations>.

In the ACT, which only mandates responses concerning deaths in custody, the coroner, along with providing copies of findings concerning a death in custody to the immediate family and any witnesses,[116] must report the findings and provide a copy of the response to the Australian Institute of Criminology.[117] If the deceased was an Aboriginal person or Torres Strait Islander, the coroner must also report the findings and provide a copy of the response to an appropriate local Aboriginal legal service, and to any other person whom the coroner considers appropriate.[118] The Chief Coroner is also required to give details of responses to recommendations and any related correspondence in his or her annual report to the Attorney-General, for presentation to the ACT Legislative Assembly.[119]

In the Northern Territory, the Attorney-General must report on the coroner's report and recommendations and the response to them, and lay the report before the Northern Territory Legislative Assembly.[120] The Attorney-General may also give a copy of the report to the coroner, who may give it to the senior next of kin, a witness or any other party with sufficient interest in the inquest or investigation.[121] It is impossible to find any details concerning responses on the Internet.

In South Australia, which only mandates responses concerning deaths in custody, the responsible Minister must report to each South Australian House of Parliament giving details of any action taken or proposed to be taken in response to coronial recommendations.[122] While this report must also be forwarded to the State Coroner,[123] and findings and recommendations must be given to persons with sufficient interest, including those who appeared personally or were legally represented at the inquest,[124] families do not receive copies of responses to recommendations as of right. However, the State Coroner's Annual Report lists responses to recommendations concerning deaths in custody.[125]

Victoria requires responses to coronial recommendations to be published on the Internet,[126] and copies to be provided to any person with a sufficient interest.[127] As previously noted, the *Coroners Court of Victoria Annual Report 2010–2011* also includes discussion of selected responses in its summary of developments in public health and safety.[128] The First Report from the Victorian Systemic Review of Family Violence Deaths also summarises responses to coronial recommendations in a selection of closed investigations.[129]

The NSW Premier's memorandum indicates that the Attorney General will maintain a record of all coronial recommendations made, together with the responses received from relevant Ministers and NSW

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[116] *Coroners Act 1997* (ACT) s 75(2). For any other type of death, the coroner must provide a copy of the findings to the immediate family if they request it: *Coroners Act 1997* (ACT) s 54(1).

[117] *Coroners Act 1997* (ACT) ss 75(1)(c), 76(4).

[118] *Coroners Act 1997* (ACT) ss 75(1)(d)–(e).

[119] *Coroners Act 1997* (ACT) s 102(2)(d). See <http://www.courts.act.gov.au/magistrates/page/view/3411/title/annual-reports>.

[120] *Coroners Act 1993* (NT) s 46B(3).

[121] *Coroners Act 1993* (NT) s 46B(4).

[122] *Coroners Act 2003* (SA) s 25(5)(a).

[123] *Coroners Act 2003* (SA) s 25(5)(b).

[124] *Coroners Act 2003* (SA) s 25(4)(b).

[125] *Annual Report of the State Coroner Financial Year 2011–2012*, 34–45 <http://www.courts.sa.gov.au/OurCourts/CoronersCourt/Pages/Annual-Reports.aspx>.

[126] *Coroners Act 2008* (Vic) s 72(5)(a).

[127] *Coroners Act 2008* (Vic) s 72(5)(b).

[128] *Coroners Court of Victoria 2010–2011 Annual Report*, 24–6 < http://www.coronerscourt.vic.gov.au/resources/bff76d3b-fed7-4f5f-91b2-528cd624ef5b/4635%2bcoroners%2bannual%2breport%2b2010-2011%2bweb%2bv2.pdf>.

[129] *Victorian Systemic Review of Family Violence Deaths — First Report*, 59–68 <http://www.coronerscourt.vic.gov.au/find/publications/victorian+systemic+review+of+family+violence+deaths+_+first+report>.

government agencies.[130] In June and December each year, the NSW Attorney General publishes on the Internet detailed summary tables of findings, coronial recommendations and responses received.[131]

Queensland, Western Australia and Tasmania do not require responses to coronial recommendations concerning any type of death.[132] Following the Queensland Ombudsman's Coronial Recommendations Project in 2006,[133] a report outlining government responses to coronial recommendations is tabled annually in the Queensland Parliament and published on the Internet. The latest report concerns responses to recommendations made in 2011.[134] The most recent Annual Report from the Western Australia Office of the State Coroner includes responses to coronial recommendations together with summaries of findings.[135]

For Tasmania, a member of the general public seeking information on responses must usually try to find information via documents provided to the Attorney-General, or tabled in Parliament, or in an Annual Report, or provided on a coroners website at the coroner's discretion (for more detail, see **Appendix 1**). At present, none of these routes are likely to provide access.

The NCIS is working with each Coronial Office to develop the best process to allow access to NCIS in order to track the progress of agency responses to coronial recommendations.[136] It appears that this function will be limited to those jurisdictions that mandate responses, and as with other NCIS services, will only be available to registered users.

Even where comprehensive and appropriately targeted recommendations are made, in most jurisdictions there is no guarantee that governments and other entities will even respond to them. In most states and territories it is also difficult to find public information about responses to recommendations.

Implementation of responses to coronial recommendations

There has been scarce systematic research tracking the pathways of coronial recommendations from agency response to implementation and potential impact on preventable deaths.[137] The paucity of research is at least in part due to the continuing lack in most jurisdictions of easily accessible information about what recommendations are made, whether they are responded to, and in what manner.

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[130] <http://www.dpc.nsw.gov.au/announcements/ministerial_memoranda/2009/m2009-12_responding_to_coronial_recommendations>.

[131] < http://www.lsb.lawlink.nsw.gov.au/lsb/coronialrecommendations.html>.

[132] With the exception of the WA Department of Health, by virtue of internal policy in Information Circular IC0008/07 (cited in Law Reform Commission of Western Australia, *Review of Coronial Practice in Western Australia Discussion Paper* (June 2011), 170 n31). Summaries of inquest findings, recommendations and responses concerning hospital and healthcare deaths are published by the Office of Safety and Quality in the Department of Health. See eg <http://www.health.wa.gov.au/CircularsNew/attachments/553.pdf>.

[133] Queensland Ombudsman, *The Coronial Recommendations Project: An investigation into the administrative practice of Queensland public sector agencies in assisting coronial inquiries and responding to coronial recommendations* (December 2006). The Project also proposed that responses to coronial recommendations be made mandatory (at xiv, 31).

[134] <http://www.justice.qld.gov.au/__data/assets/pdf_file/0013/171022/qld-govt-response-to-coronial-recommendations-2011.pdf>.

[135] Office of the State Coroner, *Annual Report 2011–2012* <http://www.coronerscourt.wa.gov.au/_files/Coroners_Court_Annual_report_12.pdf>.

[136] *NCIS News* Edition 9, Winter 2011, 3–4 <http://www.ncis.org.au/web_pages/NCIS%20News%20-%20Edition%209%20(July%2011).pdf>.

[137] Lyndal Bugeja and David Ranson, 'Coroners' Recommendations: Do They Lead to Positive Public Health Outcomes?' (2005) 10(4) *Journal of Law and Medicine* 399; Lyndal Bugeja and David Ranson, 'Coroners' Recommendations: A Lost Opportunity' (2005) 13(2) *Journal of Law and Medicine* 173, 175; Ray Watterson, Penny Brown and John McKenzie, 'Coronial Recommendations and the Prevention of Indigenous Death' (2008) 12 (6) *Australian Indigenous Law Review* 4, 4.

The NCIS does not hold systematic data about the implementation of coronial recommendations. Coupled with the limitations of publicly available investigation and inquest data, this means that it is very difficult for researchers, let alone the general public, to assess the impact of coronial recommendations upon the prevention of deaths in Australia, either generally or in relation to any particular kind of death.

The one study that has examined implementation of coronial recommendations in all Australian jurisdictions, the AILR study, was undertaken before the changes in New South Wales and Victoria made responses to coronial recommendations mandatory. It found that in New South Wales, the areas of health, housing, energy, fair trading and police had 'significant problems with government organisations responding to coronial recommendations.'[138] The Northern Territory — the only jurisdiction at that time with mandatory responses for all deaths — was the exception, in that there appeared to be no matters in which coronial recommendations were not communicated to the relevant government agency or were lost or neglected within a government agency. The AILR study therefore concluded that jurisdictions that mandate responses to recommendations are likely to have a better rate of implementation.[139]

Whether or not entities are compelled to respond in a particular jurisdiction, the pathway from recommendation to response and implementation of possible prevention strategies is not a smooth one. Integrity of the pathway depends first upon the quality of response and then on whether there is any monitoring or follow-up if a response is unsatisfactory.

For example, the Victorian Guidelines for Responding to Coroners' Recommendations state that the response to the relevant recommendation may fall within one of five categories, including 'the coroner's recommendation is under consideration'.[140] There is no legislative requirement to follow up on this type of 'holding' response, and it is unclear whether staff capacity would allow this to be undertaken as standard practice.

As another illustration, the New South Wales Premier's memorandum encourages Ministers and agencies to provide updates to the Attorney General on any further action taken to implement recommendations following their initial advice.[141] However, it is not clear that any follow up is likely to occur if the Minister's or agency's response is to state that they have referred the issue to another entity or — again, a 'holding' response — that implementation is simply 'progressing'. A perusal of tables of responses also shows that the 'Future — Next response' row of the table is often blank.[142]

It is very difficult to assess the impact of coronial recommendations upon the prevention of deaths in Australia.

A further issue on the path from response to potential implementation concerns whether there is any monitoring to ensure that agencies put their stated strategies into practice. The question of whether there is any entity that actually takes responsibility for monitoring of implementation is a vexed one, even in those jurisdictions that mandate responses to coronial recommendations. In theory, the best approach involves a prevention team supporting the Coroners Court/Office 'in publishing, monitoring and evaluating responses to and implementation of coronial recommendations'.[143] Hence for exam-

[138] Watterson, Brown and McKenzie, 13.

[139] Watterson, Brown and McKenzie, 12.

[140] The Guidelines are not available as a separate entity on the Coroners Court of Victoria website, but are listed as part of Telstra Corporation Ltd, Response – Finding without Inquest into the Death of Andrew Campbell, 1 July 2010.

[141] <http://www.dpc.nsw.gov.au/announcements/ministerial_memoranda/2009/m2009-12_responding_to_coronial_recommendations>.

[142] <http://www.lsb.lawlink.nsw.gov.au/lsb/coronialrecommendations.html>.

[143] Law Reform Commission of Western Australia, *Review of Coronial Practice in Western Australia Discussion Paper* (June 2011), 164.

ple, the current Review of Coronial Practice in Western Australia takes Victoria as a model for improving WA approaches to coronial recommendations and death prevention.[144] In practice, however, much hinges on the interpretation of 'monitoring' and 'evaluating' the responses and implementation.

For example, the recent Victorian changes include as a function of the Coroners Prevention Unit (CPU), monitoring and collecting information on the response to and implementation of recommendations.[145] The Coroners Court of Victoria website also states that one of the central goals of the CPU is to increase the uptake and implementation rate of coronial recommendations, and that the CPU may contribute at any stage of the coronial process, including after recommendations have been made, 'by monitoring and collecting information on the response to and implementation of coronial recommendations'.[146]

The CPU is not a statutory body and so there is no legislative guidance concerning its role, but the Second Reading Speech for the Coroners Bill 2008 includes:

> '. . .there was a need to strengthen the prevention role of the coroner. . .The bill addresses this issue and is supported by the establishment of the first coroner's prevention unit, which will assist the coroner in relation to the formulation of appropriate prevention recommendations as well as help monitor and evaluate the effectiveness of those recommendations.'[147]

In practice, however, Victorian follow-up with respect to most recommendations consists of collecting responses and publishing them on the Internet. There does not usually appear to be capacity to follow up, as standard operating procedure, on insufficiently detailed responses or to monitor whether a response is put into practice, let alone to monitor how that subsequent implementation might be contributing to death prevention.

The AILR study, albeit undertaken before developments such as the establishment of Victoria's CPU, found that fewer than half of coroners' suggestions to prevent future deaths were implemented by governments across Australia, with the proportion in each jurisdiction of coronial recommendations that were implemented ranging from 27 per cent (Victoria) to 65–70 per cent (Northern Territory and ACT).[148] While responses from Commonwealth agencies to coronial recommendations (for example, concerning deaths in immigration detention) were not examined in the study, anecdotal evidence suggests that this implementation rate is also low.

The AILR study concluded that implementation of recommendations is an ad hoc process, with the chances of implementation of particular recommendations improved by factors such as media pressure, advocacy group intervention, and family and community action.[149]

Since the AILR study was published, it does not appear that the state of affairs concerning implementation has changed significantly. For example, the Report by the Standing Committee on Environment and Public Affairs of the WA Inquiry into the Transportation of Detained Persons noted in July 2011:

> 'A number of stakeholders advised the Committee that there had been a lack of transparency surrounding the practical implementation of the Coroner's recommendations. For example, [the Deaths in Custody Watch Committee] expressed the view that there is "scant information available publicly" from the Government regarding action taken to implement the Coroner's

[144] Law Reform Commission of Western Australia, *Review of Coronial Practice in Western Australia Final Report* (January 2012), 105–7.

[145] 'Coroners Prevention Unit', 2 <http://www.coronerscourt.vic.gov.au/home/investigations/brochure+-+coroners+prevention+unit>.

[146] Coroners Prevention Unit <http://www.coronerscourt.vic.gov.au/home/investigations/whos+involved/coroners+prevention+unit/>.

[147] Victoria, *Parliamentary Debates*, Legislative Assembly, 13 November 2008, 5029 (Justin Madden).

[148] Ray Watterson, Penny Brown and John McKenzie, 'Coronial Recommendations and the Prevention of Indigenous Death' (2008) 12 (6) *Australian Indigenous Law Review* 4, 4.

[149] Watterson, Brown and McKenzie, 19.

recommendations [concerning the death of Mr Ward] other than the Government's Response to the Recommendations made by the State Coroner following the investigation into the death of Mr Ward (September 2009), which is often superficial and lacks clear timelines for implementation.'[150]

The Committee went on:

'The Committee is dismayed about the lack of transparency regarding the implementation of the Coroner's recommendations in the case of Mr Ward. Government departments did not proactively communicate with family, stakeholders and the public regarding the progress of action to implement the Coroner's recommendations. Given the tragic nature of Mr Ward's death, a Parliamentary inquiry, questions in Parliament and stakeholders chasing up Ministers and Government departments should not be required to obtain this information.'[151]

Whether recommendations get implemented is generally an ad hoc process.

As discussed above, the way in which coroners frame and target their recommendations also influences whether a recommendation is likely to be implemented. Other significant factors found by the AILR study include:

- whether implementation accords with government policies and priorities; and
- whether a proactive system for review of recommendations exists within the targeted organisation.[152]

Coroners may therefore make potentially life-saving recommendations, only for them never to be responded to or implemented, with no follow-up and no public awareness of what has happened. The examples above demonstrate a need not only for mandatory responses, but also for coroners to be provided with the power to comment on the adequacy and timeliness of responses, and to be assisted by a well-resourced prevention unit to obtain progress reports on implementation of recommendations.

Coroners may make potentially life-saving recommendations, only for them never to be responded to or implemented, with no follow-up and no public awareness of what has happened.

Implications for prevention

As the AILR study found, within any particular jurisdiction, recommendations may never be implemented. Even if recommendations receive a response and are ultimately implemented, current approaches mean that this may not happen in time to prevent other similar deaths. The present patchwork system also means that even though coroners may be sharing information across Australia via the NCIS, government and other agencies in one jurisdiction are unlikely to learn effectively and in a timely way from a death, or even a pattern of deaths, in another jurisdiction.

Recommendations may not be implemented in time to prevent other similar deaths — or may never be implemented.

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[150] Legislative Council Standing Committee on Environment and Public Affairs, Parliament of Western Australia, *Inquiry into the Transportation of Detained Persons: The Implementation of the Coroner's Recommendations in Relation to the Death of Mr Ward and Related Matters* (July 2011), 43 [2.169].

[151] Legislative Council Standing Committee on Environment and Public Affairs, Parliament of Western Australia, *Inquiry into the Transportation of Detained Persons: The Implementation of the Coroner's Recommendations in Relation to the Death of Mr Ward and Related Matters* (July 2011), 43–4 [2.173].

[152] Ray Watterson, Penny Brown and John McKenzie, 'Coronial Recommendations and the Prevention of Indigenous Death' (2008) 12 (6) *Australian Indigenous Law Review* 4, 12.

Failure to bridge the gap between coronial recommendations and implementation, and to apply the lessons from recommendations concerning earlier deaths to similar subsequent situations, is evident even in contexts where there are clear national ramifications or where a national body is implicated in the recommendations.

> Government and other agencies in one jurisdiction are unlikely to learn effectively and in a timely way from a death in another jurisdiction.

This failure is best illustrated by the fate of many of the recommendations of the Royal Commission into Aboriginal Deaths in Custody.

Royal Commission into Aboriginal Deaths in Custody

The Royal Commission into Aboriginal Deaths in Custody was established in 1987 to address concerns about the high numbers of Aboriginal and Torres Strait Islander people dying in prisons, police custody, and juvenile detention institutions. The Royal Commission's 1991 *National Report* concluded that the high death rate was due to the gross over-representation of Aboriginal and Torres Strait Islander people in custody.[153] The Royal Commission therefore examined the underlying reasons for this, including profound social, economic and cultural disadvantage.

As part of its investigation, the Royal Commission observed that there was a

> 'pervasive and troubling failure of the coronial structure in every state and territory to supply the critical analysis needed to uncover the reasons for Aboriginal deaths in custody.'[154]

This was coupled with a failure of the coronial system as a whole to help prevent Aboriginal and Torres Strait Islander deaths.[155]

The *National Report* offered practical suggestions to reduce the risk of Aboriginal and Torres Strait Islander incarceration and deaths in custody. 34 of the 339 recommendations concerned reform of the state and territory coronial systems. In essence, they urged that the coronial system be strengthened so that coroners could be empowered to effectively address systemic prevention.[156]

This Paper has already discussed the failure in South Australia to implement the Commission's recommendation to broaden coroners' powers to make recommendations. Recommendation 13 addressed this issue:

> Recommendation 13
> That a Coroner inquiring into a death in custody be required to make findings as to the matters which the Coroner is required to investigate and to make such recommendations as are deemed appropriate with a view to preventing further custodial deaths. The Coroner should be empowered, further, to make such recommendations on other matters as he or she deems appropriate.[157]

Five of the Royal Commission's recommendations also specifically concerned the need for mandatory responses to coronial recommendations:

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[153] Royal Commission Into Aboriginal Deaths In Custody *National Report Vol 1* (1991) (RCIADIC National Report).

[154] Ray Watterson, Penny Brown and John McKenzie, 'Coronial Recommendations and the Prevention of Indigenous Death' (2008) 12 (6) *Australian Indigenous Law Review* 4, 6.

[155] Watterson, Brown and McKenzie, 6.

[156] Watterson, Brown and McKenzie, 6.

[157] RCIADIC National Report, 172.

Recommendation 14

That copies of the findings and recommendations of the Coroner be provided by the Coroners Office to all parties who appeared at the inquest, to the Attorney-General or Minister of Justice of the State or Territory in which the inquest was conducted, to the Minister of the Crown with responsibility for the relevant custodial agency or department and to such other persons as the Coroner deems appropriate.[158]

Recommendation 15

That within three calendar months of publication of the findings and recommendations of the Coroner as to any death in custody, any agency or department to which a copy of the findings and recommendations has been delivered by the Coroner shall provide, in writing, to the Minister of the Crown with responsibility for that agency or department, its response to the findings and recommendations, which should include a report as to whether any action has been taken or is proposed to be taken with respect to any person.[159]

Recommendation 16

That the relevant Ministers of the Crown to whom responses are delivered by agencies or departments, as provided for in Recommendation 15, provide copies of each such response to all parties who appeared before the Coroner at the inquest, to the Coroner who conducted the inquest and to the State Coroner. That the State Coroner be empowered to call for such further explanations or information as he or she considers necessary, including reports as to further action taken in relation to the recommendations.[160]

Recommendation 17

That the State Coroner be required to report annually in writing to the Attorney-General or Minister for Justice (such report to be tabled in Parliament), as to deaths in custody generally within the jurisdiction and, in particular, as to findings and recommendations made by Coroners pursuant to the terms of Recommendation 13 above and as to the responses to such findings and recommendations provided pursuant to the terms of Recommendation 16 above.[161]

Recommendation 18

That the State Coroner, in reporting to the Attorney-General or Minister for Justice, be empowered to make such recommendations as the State Coroner deems fit with respect to the prevention of deaths in custody.[162]

It is important to stress the Royal Commission's view that in some situations there might be 'substantial reasons' for an agency or department not to adopt the coroner's recommendations.[163] The *National Report* explained:

> 'It is not a question of compelling the government or public authorities to act on recommendations, but rather to ensure that they have received proper consideration.'[164]

While a number of the Royal Commission reforms have now been implemented, many have not. In relation to the coronial recommendation issues, the Commonwealth Government and all State and Territory governments supported Recommendations 14, 15, 17 and 18. Recommendation 16, essentially dealing with keeping the inquest parties 'in the loop' in relation to responses, and with coronial

[158] RCIADIC National Report, 172.

[159] RCIADIC National Report, 172.

[160] RCIADIC National Report, 173.

[161] RCIADIC National Report, 173.

[162] RCIADIC National Report, 173.

[163] RCIADIC National Report, [4.5.97]. For example, if the recommendation is not feasible in the circumstances or if the recommended changes have already been made.

[164] RCIADIC National Report, [4.5.97].

follow-up of responses, was not endorsed by South Australia, Tasmania or the Northern Territory.[165] Over 20 years later, none of these recommendations have been implemented in a systematic, nationwide manner.

In 2009, the Western Australian State Coroner, Alastair Hope, handing down his findings and recommendations in the inquest into the death of Western Australian Aboriginal Elder, Mr Ward, supported the continuing relevance of the Royal Commission's recommendations and drew upon them to underpin his view of best practice coronial investigation and death prevention.[166] Mr Hope said that in his view the correct approach to coronial inquiry was described by the AILR study (discussed above), which he quoted at length:

> 'The Royal Commission recommended an expansion of coronial inquiry from the traditional narrow and limited medico-legal determination of the cause of death to a more comprehensive, modern inquest; one that seeks to identify underlying factors, structures and practices contributing to avoidable deaths and to formulate constructive recommendations to reduce the incidence of further avoidable deaths. The Royal Commission provides a timeless reminder that every avoidable Indigenous death calls upon us to identify its underlying causes, consider Indigenous disadvantage, uncover the truth about the death and resolve upon practical steps to prevent others.'[167]

The remaining Royal Commission recommendations, particularly those concerned with coronial recommendations, need to be implemented, with one significant qualification: they should apply to all deaths where coronial recommendations are made, not only to deaths in custody. This extension is important, first, because Aboriginal and Torres Strait Islander deaths do not only occur in custody. For example, Aboriginal and Torres Strait Islander peoples are also over-represented in other deaths, such as deaths in care and after release from custody and care, and family violence deaths.[168] Second, encompassing all deaths where there has been an inquest and recommendations is in the interests of harmonising effective death prevention across Australia.

The Royal Commission into Aboriginal Deaths in Custody recommended reform of state and territory coronial systems. Over 20 years later, none of these recommendations have been implemented in a systematic, nationwide manner.

The need for joined up justice

The systemic failure that led to the death is therefore often perpetuated due to a second tier of systemic failure — an inability of governments and other entities to respond effectively. In these contexts, coronial recommendations concerning earlier deaths might have saved later lives if they had been implemented.

This second systemic failure is most clearly illustrated by those deaths that form a repeating pattern irrespective of state and territory boundaries, such as deaths associated with the transportation of detained persons, the presence of hanging points in prisons, police shootings, or institutional failure to effectively intervene in family violence.

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[165] For more detail, see Ray Watterson, Penny Brown and John McKenzie, 'Coronial Recommendations and the Prevention of Indigenous Death' (2008) 12 (6) *Australian Indigenous Law Review* 4, 22.

[166] State Coroner of Western Australia, Findings and Recommendations of the Inquest into the Death of Mr Ward, 12 June 2009.

[167] Ray Watterson, Penny Brown and John McKenzie, 'Coronial Recommendations and the Prevention of Indigenous Death' (2008) 12 (6) *Australian Indigenous Law Review* 4, 6, quoted in Findings and Recommendations of the Inquest into the Death of Mr Ward, 12 June 2009, 116–17.

[168] See also Law Reform Committee, Parliament of Victoria, *Coroners Act 1985 Final Report* (2006), 407.

For example, Northern Territory Coroner Greg Cavanagh observed in relation to the petrol sniffing deaths of Kumanjaya Presley, Kunmanara Coulthard and Kunmanara Brumby that 'the problems leading to the deaths are manifest, well known and well researched,'[169] and he referred to his own earlier findings, those of other coroners and various government inquiries.[170] Coroner Cavanagh continued:

> 'Sadly, as was revealed at this Inquest, witnesses (especially Aboriginal women) are getting tired of co-operating with inquiries about the problem including coronial Inquests with no result.'[171]

Mr Cavanagh's remarks demonstrate how

> 'some coroners are frustrated with what they identify as a relatively internal coronial dialogue about remedial action that finds little external traction. Coroner Cavanagh's [2005] findings illustrate that coroners are well aware of the issues facing Indigenous communities through both their own repeated investigations into preventable deaths and the investigations and insights of other coroners. That is, they are developing individual and collective expertise with respect to these deaths. And, in each instance, in investigating deaths, holding inquests and making findings, those coroners draw on the expertise and experience of witnesses. This is a devastating amount of expertise to be stockpiling without consequence throughout Australian States and Territories.'[172]

To highlight in detail the present piecemeal approach to death prevention where lessons have often failed to be learned both within and across state and territory jurisdictions, we turn to a different but equally tragic pattern, of child deaths due to accidental strangulation or hanging by blind or curtain cords.

Blind cord deaths perhaps best illustrate why reform of the broader system that analyses and responds to deaths is necessary. The blind cord cases clearly show the gaps in the system that can perpetuate the pattern of deaths when responses to coronial recommendations are not only not mandatory, but also are not part of a coordinated nationwide response.

Blind cord deaths — examples of double system failure

On 28 July 2004, the Victorian State Coroner, Graeme Johnstone, brought down his findings in relation to Infant M,[173] who died in November 2003 when his neck became entangled in a looped blind cord. Mr Johnstone commented:

> 'Safer design options would help to prevent future deaths of young children from blind and curtain cords. Had safe design solutions been implemented many years ago when these types of "accidental" deaths began to occur, it is likely that the death of [Infant M] would have been prevented. It should be noted that there are numerous examples of deaths in other areas of coronial investigation where historical approaches to manufacturing common products have not, in the past, taken account of information in coroner's files to learn lessons about potential improvements in safe design.
>
> Accidental child strangulations or hangings with blind and curtain cords are not unusual and have been happening for many years. Last year, prior to the death of [Infant M] an issue of concern was raised by a researcher. . .following a search of the NCIS. On receipt of the notice

[169] *Inquest into the Deaths of Kumanjaya Presley, Kunmanara Coulthard and Kunmanara Brumby* [2005] NTMC 034, [14].

[170] *Inquest into the Deaths of Kumanjaya Presley, Kunmanara Coulthard and Kunmanara Brumby* [2005] NTMC 034, [10]–[14], [38]–[39], [42]–[46], [60]–[66].

[171] *Inquest into the Deaths of Kumanjaya Presley, Kunmanara Coulthard and Kunmanara Brumby* [2005] NTMC 034, [30].

[172] Rebecca Scott Bray, '"Why This Law?" Vagaries of Jurisdiction in Coronial Reform and Indigenous Death Prevention' (2008) 12 (6) *Australian Indigenous Law Review* 27, 36.

[173] Where findings are not publicly available, infants who have died are referred to by their first initial, and the findings are referenced in the main text only.

advising of the issue of concern all State and Chief Coroners and the Victorian Attorney General were advised in early August 2003. [The researcher] also provided some information on developments with countermeasures and this information was given to the relevant authorities.'

Mr Johnstone examined similar deaths in some other Australian and overseas jurisdictions, and adopted the recommendations delivered on 19 December 2003 by Coroner Helen Wood in a Tasmanian inquest concerning the death of Infant Z in September 2002 in almost identical circumstances:

- a public education program should be implemented which highlights the risk and informs the community about methods to address the hazard;
- an effective approach should be adopted to render safe blinds and curtains which are already installed; and
- a mandatory safety standard should be implemented [in Victoria] with regard to the sale/supply of window coverings with new cords to address the risk of infant strangulation.

On 1 March 2007, 13-month-old Nicholas Esposito died in South Australia as a result of hanging.[174] As with similar deaths, the Deputy State Coroner, Anthony Schapel, said there was absolutely no suggestion that any neglect was involved in Nicholas' care, and concluded that his death was an accident. The post-mortem report from forensic pathologist Professor Roger Byard said that hanging from cords is a recognised risk when cots are placed next to blinds. In his findings, Mr Schapel noted that Professor Byard had also given evidence at a previous South Australian inquest into the death of 15-month-old Brayden Alsford in November 1999 by hanging involving a blind cord.[175]

As a result of Brayden's death in 1999, the then South Australian State Coroner, Wayne Chivell, had called for a public warning to be given to the parents of young children about the risks involved in allowing them to have access to ropes or cords which are long enough to go around the child's neck. He said that parents should ensure that curtain cords are kept out of the reach of small children and that they should be provided with advice and assistance about how to avoid these risks.

In Nicholas Esposito's inquest more than eight years later, Mr Schapel said that child blind cord deaths were preventable. However he pointed out that over 2000–2008 there had been eight coronial reports from other States or Territories of infant blind cord deaths. Two of these deaths were those of Infant Z (Tasmania) and Infant M (Victoria) described above. Mr Schapel noted that these two deaths were the subject of coronial findings and recommendations that were in the public domain and were very similar to those made in the present inquest into the death of Nicholas Esposito.

Mr Schapel also found that while the ACT, New South Wales, Queensland, Tasmania and Western Australia now had blind cord regulations in place, South Australia and Victoria did not. The difference between Tasmania and Victoria in relation to the legislation, despite two very similar deaths, appears largely due to the media coverage in Tasmania as a result of the activism of the mother of the child who died there.[176] Victoria introduced mandatory safety standards for internal window coverings on 30 December 2008.[177]

Mr Schapel noted in Nicholas Esposito's inquest that product safety regulators across Australia were undergoing a process of harmonising all applicable legislation, which had been agreed to by all State, Territory and Commonwealth Ministers and would include safety standards and bans. Mr Schapel's findings stated that the nationwide system was expected to be in place by mid 2009. Mandatory na-

[174] Deputy State Coroner Anthony Schapel, Findings into the Death of Nicholas Esposito, 15 December 2008.

[175] State Coroner Wayne Chivell, Findings into the Death of Brayden John Alsford, 20 October 2000.

[176] Ray Watterson, Penny Brown and John McKenzie, 'Coronial Recommendations and the Prevention of Indigenous Death' (2008) 12 (6) *Australian Indigenous Law Review* 4, 17–18. See also the discussion in *Implementation of responses to coronial recommendations* (p 31).

[177] Consumer Affairs Victoria, Response — Finding without Inquest into the Death of Lachlan McCann, 21 February 2011.

tional safety standards were in fact not put into place until 30 December 2010.[178] The nationwide regulatory mechanisms also apply only to new curtains and blinds.[179]

By October 2010 there had been six more blind cord deaths since Nicholas Esposito's inquest in 2008.[180] For example, in Victoria, two-year-old Lachlan McCann died on 6 August 2009 from strangulation after Lachlan and his brother removed the safety covers from the blind cord.[181] Two-year-old Rosie Smith died on 30 September 2009 from strangulation involving a blind cord pre-dating the Victorian safety standards.[182] Coroner Parkinson therefore recommended that Consumer Affairs Victoria (CAV) undertake continuing public safety campaigns, which appears to have been implemented by CAV after commencing their initial campaign following the deaths of Lachlan and Rosie.[183]

Nevertheless, it is unclear whether all states and territories have now implemented ongoing community campaigns and the other approach recommended by the Victorian State Coroner in 2004 — rendering safe those blinds and curtains that are already installed.

The blind cord deaths starkly demonstrate the lack of clear recommendation and implementation pathways across states and territories, together with, in most jurisdictions, few if any mechanisms to monitor the progress of recommendations, and consequently little in the way of public accountability. This situation creates a serious obstacle to consistent best practice in inquests, to attempts at systematic research, and ultimately to more effective death prevention across Australia.

> Blind cord cases show the gaps in the system that can perpetuate the pattern of deaths when responses to coronial recommendations are not only not mandatory, but also are not part of a coordinated nationwide response.

The piecemeal approach to recommendations is also at odds with Australia's obligations, across state and territory boundaries, to respect, protect and fulfil the human right to life. Simply put, if states and territories do not develop an effective response system and become able to learn from each other when similar deaths occur in different jurisdictions — whether those deaths occur in prison transport, are due to avoidable accidents, or take place in any other preventable context — people will continue to die unnecessarily.

> If states and territories do not develop an effective response system and become able to learn from each other when similar deaths occur in different jurisdictions, people will continue to die unnecessarily.

Beginning to join up justice

Progressive reform of coronial systems has taken place in recent years in Australia. Reforms implemented in Queensland (2003), the Northern Territory (2004), Victoria (2008), New South Wales (2009) and the ACT (2011) have included a greater statutory focus on death prevention. However, as this Paper has discussed, significant changes are still required in all jurisdictions.

As suggested by the Northern Territory example from the AILR study discussed above, mandatory responses would improve both the communication and implementation of coronial recommendations. The six jurisdictions that have yet to do so must statutorily mandate responses to all coronial recom-

[178] Coroner Kim Parkinson, Finding without Inquest into the Death of Lachlan McCann, 29 October 2010.
[179] Coroner Kim Parkinson, Finding without Inquest into the Death of Lachlan McCann, 29 October 2010.
[180] Coroner Kim Parkinson, Finding without Inquest into the Death of Lachlan McCann, 29 October 2010.
[181] Coroner Kim Parkinson, Finding without Inquest into the Death of Lachlan McCann, 29 October 2010.
[182] Coroner Kim Parkinson, Finding without Inquest into the Death of Rosalind Smith, 29 October 2009.
[183] Consumer Affairs Victoria, Response — Finding without Inquest into the Death of Lachlan McCann, 21 February 2011.

mendations, and all states and territories need an effective system for monitoring recommendations, responses and appropriate implementation. Government agencies and other relevant entities must be encouraged to develop their own internal systems for dealing with recommendations, with clear lines of responsibility.

Mandatory responses would improve both the communication and implementation of coronial recommendations.

Other necessary reforms include: making findings and responses to recommendations easily accessible to the public; improving the experiences of families via, for example, specifying the factors that coroners must consider when performing their role;[184] and broadening the categories of deaths that must be reported. The whole process would also function more effectively if coroners had access to more systematic training and resources to assist them with the formulation and distribution of recommendations,[185] supported by system-wide data and research able to be easily accessed across jurisdictions.

All states and territories need an effective system for monitoring recommendations, responses and implementation.

State and territory initiatives

At the individual state and territory level at present, there are some limited opportunities to contribute to joining up justice. There are no current reviews or reforms planned in the Northern Territory, South Australia or Tasmania, and as discussed above, Victoria, New South Wales and the ACT have recently reviewed their coronial legislation. However, in July 2011 in Western Australia, the Report by the Standing Committee on Environment and Public Affairs of the Inquiry into the Transportation of Detained Persons recommended that

> 'Government departments and agencies establish processes to appropriately inform family, stakeholders and the public of the progress of Government action taken to implement coronial recommendations on a regular basis.'[186]

The Committee also noted that submitters to the Inquiry had expressed strong support for mandating responses to coronial recommendations in Western Australia,[187] and the Committee recommended this course of action.[188] The Committee noted that submitters

> 'urged the Committee to recommend that this reform be implemented as a matter of urgency and not delayed until the Law Reform Commission of Western Australia reports on their reference.'[189]

The recent review of coronial practice in Western Australia has also recommended the mandating of responses, following strong support in submissions.[190]

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[184] See eg *Coroners Act* 2008 (Vic) s 8. For a broader discussion of the relevant Victorian provisions addressing family issues, see Ian Freckelton, 'Opening a New Page', *Law Institute Journal* June (2009) 29.

[185] See eg Law Reform Commission of Western Australia, *Review of Coronial Practice in Western Australia Background Paper* (September 2010), 51.

[186] Legislative Council Standing Committee on Environment and Public Affairs, Parliament of Western Australia, *Inquiry into the Transportation of Detained Persons: The Implementation of the Coroner's Recommendations in Relation to the Death of Mr Ward and Related Matters* (July 2011), 44 (Recommendation 9).

[187] *Inquiry into the Transportation of Detained Persons*, 65 [4.10].

[188] *Inquiry into the Transportation of Detained Persons*, 67 (Recommendation 16).

[189] *Inquiry into the Transportation of Detained* Persons, 65 [4.10].

[190] Law Reform Commission of Western Australia, *Review of Coronial Practice in Western Australia Final Report* (January 2012), 107 (Recommendation 87).

The Queensland Ombudsman's Coronial Recommendations Project contained a number of recommendations to improve the responses to coronial recommendations, including mandating responses.[191] With respect to improving and monitoring implementation of responses, the Ombudsman recommended that public sector agencies should appoint coronial liaison officers, whose responsibilities should include:

- liaising with the State Coroner and staff;
- responding to any recommendations made; and
- maintaining a suitable coronial database within the agency.[192]

Coronial liaison officers might help to avoid some of the difficulties along the recommendations–response pathway, where recommendations do not reach the appropriate people responsible in a timely manner. Appointment of officers would also improve the efficiency of any necessary follow-up where no response has been received or the response requires clarification.

The Queensland Project also addressed the issue of monitoring the implementation of coronial recommendations, by recommending that the Ombudsman undertake this role.[193] However, the Project Report notes that this was not supported by the Queensland Director-General of the Department of Justice, or by the Attorney-General, and that there are different views among commentators as to who should undertake monitoring.[194]

Nevertheless, the Project identified the key issue that at present there is no entity with the responsibility and resources to follow up on what happens once agencies have responded to recommendations, and that it is therefore necessary for the various jurisdictions to allocate this essential role to a body that, if it is not able not enforce implementation, at least can bring the issue to government and public notice.

A federal approach — the example of violence against women and children

Increasingly, there is more recognition from State, Territory and Commonwealth Governments that many legal and social issues in Australia require a federally coordinated, cross-border approach of some kind, so that they can be more effectively and consistently addressed.

Recent illustrations pertinent to coronial reform concern violence against women and children. For example, the then Commonwealth Attorney-General, Robert McClelland, in support of the Law and Justice (Cross Border and Other Amendments) Bill 2009, noted with respect to the Bill:

> 'The scheme responds to community concerns, including from the NPY Women's Council, that justice services are being hampered by state boundaries. In particular, there is concern that state boundaries are enabling perpetrators of violence against women and children to evade police and the justice system. . .The flexible arrangements established under the scheme will assist police, magistrates and other officials to deal with the high levels of family violence, sexual abuse and substance misuse in the remote regions more effectively.'[195]

As another example, the National Council to Reduce Violence Against Women and their Children stated in their *Background Paper to Time for Action*:

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[191] Queensland Ombudsman, *Report of the Queensland Ombudsman: The Coronial Recommendations Project* (2006). The strategy of mandating responses was supported by the State Coroner (at xiv, 31).

[192] *Coronial Recommendations Project*, 33 (Recommendation 1).

[193] *Coronial Recommendations Project*, 38 (Recommendation 3).

[194] *Coronial Recommendations Project*, 36–8.

[195] Commonwealth, *Parliamentary Debates*, House of Representatives, 25 May 2009, 4181 (Robert McClelland, Attorney-General). The *Law and Justice (Cross Border and Other Amendments) Act 2009* commenced on 7 September 2009.

> '[T]he analysis reveals many similarities between jurisdictions in the way they respond to violence against women and their children. This suggests that there is considerable scope for greater cooperation and collaboration between the Commonwealth, states and territories in developing a unified, national approach to one of Australia's most pressing social issues.'[196]

The resulting Federal Government's National Plan to Reduce Violence Against Women and their Children 2010–2022 (National Plan), together with the Australian Law Reform Commission and NSW Law Reform Commission, *Family Violence — A National Legal Response Final Report* (October 2010), both identified the need for harmonisation and collaboration across jurisdictions, so that women's right to be free from violence can be effectively realised.[197]

In response, in 2011, the Standing Committee of Attorneys-General (SCAG — since 17 September 2011, the Standing Council on Law and Justice (SCLJ)) noted that Ministers had agreed to a national domestic and family violence order (DVO) scheme involving:

> '(a) States and Territories introducing model provisions that provide automatic recognition across jurisdictional borders of court issued DVOs;
> (b) subject to Police Ministers' agreement, the establishment and funding of a national DVO information-sharing capability using CrimTrac's National Police Reference System.'[198]

SCAG also noted that Ministers had agreed to develop a national response to the Australian and NSW Law Reform Commissions' Final Report on family violence.[199]

Federal, State and Territory governments have now committed to start developing a National Data Collection and Reporting Framework on domestic violence and sexual assault.[200] They also agreed to work towards the development of a National Centre of Excellence to enhance the evidence base.[201] The Select Council on Women's Issues noted:

> 'The National Plan acknowledges that no government or group can address this problem alone. A unified approach to engagement is critical if we are to make real progress. Therefore, the National Plan is underpinned by the belief that involving all governments and the wider community is pivotal to reducing violence in the short and longer terms. Since many of the actions in the Time for Action report relate to state and territory responsibilities, the Commonwealth and state and territory governments have worked in partnership to develop the National Plan and build on the comprehensive work already being undertaken by all governments.'[202]

Impetus from other cross-jurisdictional issues

As we have discussed in this Paper, deaths in preventable circumstances also repeat across state and territory boundaries. Some individual deaths or joint inquests also raise complex cross-jurisdictional issues, and therefore particularly emphasise the need for joined up approaches similar to the Law and Justice (Cross Border and Other Amendments) Bill 2009 discussed above. For example, many of the

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[196] National Council to Reduce Violence Against Women and their Children, *Background Paper to Time for Action: The National Council's Plan for Australia to Reduce Violence against Women and their Children, 2009–2021* (March 2009), 7.

[197] The National Plan includes various initiatives to try to produce more effective and 'wrap around' service provision, such as a national domestic violence and sexual assault telephone and online crisis service.

[198] SCAG Communiqué, 4 & 5 March 2011, 3 <http://www.sclj.gov.au/agdbasev7wr/sclj/documents/pdf/scag_communique_4-5_march_2011_final.pdf>.

[199] SCAG Communiqué, 21 & 22 July 2011, 2 <http://www.sclj.gov.au/agdbasev7wr/sclj/documents/pdf/scag_communique_21-22_july_2011_final.pdf>. The SCLJ *Annual Report 2011–12* (at 4) notes that Ministers agreed to a national response in 2012–13 <http://www.sclj.gov.au/agdbasev7wr/sclj/documents/pdf/sclj%20annual%20report%202011-12.pdf>.

[200] Council of Australian Governments Select Council on Women's Issues, *National Implementation Plan 1st Action Plan 2010–2013 Building a Strong Foundation* (September 2012), 'Building the Evidence Base: New Ways of Working Together.'

[201] *National Implementation Plan 1st Action Plan 2010–2013*, 'Building the Evidence Base'. The Centre begins operations this year <http://awava.org.au/2013/02/16/weekly-round-up-15-february/>.

[202] *National Implementation Plan 1st Action Plan 2010–2013*, 'Background' (no page numbers).

recommendations from the former New South Wales Senior Deputy State Coroner, Magistrate Jacqueline Milledge, concerning the death of Dianne Brimble on a P&O Cruise Ship, were addressed to the Australian Federal Government.[203]

The recommendations included that the Australian Federal Government establish a special Parliamentary Committee which should have special regard to:

- cross jurisdictional issues that face the States, Territories and the Commonwealth; and
- the overlap of the various Coronial Jurisdictions with power to investigate the 'cause and manner' of death (even extending beyond the limits set by the Crimes at Sea Act) and those of the many State, Territory and Federal Police Forces and other investigative bodies.[204]

The Law Reform Commission of Western Australia has recently addressed similar themes, noting that in 2007, in the context of discussions on cross-border disaster inquests, the Standing Committee of Attorneys-General agreed to implement a model provision so that coroners may provide assistance to, or request assistance from, coroners in another Australian jurisdiction.[205] To date, only Queensland and New South Wales have implemented the provision.

In response to Magistrate Milledge's recommendations, the Federal Government agreed to refer some of these issues to the House Standing Committee on Social Policy and Legal Affairs (the Committee) for consideration.[206] While the Government believes that the inquest report did not identify any specific deficiencies in existing protocols and arrangements for determining cross-jurisdictional issues in response to the incident, and that accordingly the current arrangements are appropriate, 'there is value in the Committee considering whether these arrangements can be improved.'[207]

Magistrate Milledge had also commented:

> 'In recent years there have been a number of deaths reported to the New South Wales State Coroner under the provisions of Section 13C (now Section 18 new Act). The 2000 and 2002 Bali Bombing victims, the Tsunami Victims 2004, the murder of the "Balibo Five" journalists, the shooting of Private Jake Kovco and many others. Investigating the death of Dianne Brimble and the resulting inquest was resource poor but complex and challenging for the limits of the State jurisdiction. There is a real and pressing need for these "mega" inquests to be undertaken by a Federal Coroner who would have the investigative and administrative resources that are lacking at State level.'[208]

Magistrate Milledge accordingly recommended that the Commonwealth Attorney General establish a federal coronial jurisdiction, and that a Federal Court judge should be appointed as the Federal Coroner.[209]

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[203] Magistrate Jacqueline Milledge, The 'Brimble' Recommendations, 3 December 2010 <http://www.lawlink.nsw.gov.au/lawlink/Coroners_Court/ll_coroners.nsf/vwFiles/Brimblerecs2.pdf/$file/Brimblerecs2.pdf>.

[204] Magistrate Jacqueline Milledge, The 'Brimble' Recommendations, 3 December 2010, 3 <http://www.lawlink.nsw.gov.au/lawlink/Coroners_Court/ll_coroners.nsf/vwFiles/Brimblerecs2.pdf/$file/Brimblerecs2.pdf>.

[205] Law Reform Commission of Western Australia, *Review of Coronial Practice in Western Australia Discussion Paper* (June 2011), 103.

[206] Government Response to the Recommendations of the NSW Coroner Following the Inquest Into the Death of Ms Dianne Brimble, 22 June 2012, 5–6 <http://www.ag.gov.au/Organisationalstructure/Pages/21-June-2012---Government-Response-to-the-recommendations-of-the-NSW-Coroner-following-the-inquest-into-the-death-of-Ms-Dia.aspx>.

[207] Government Response to the Recommendations of the NSW Coroner Following the Inquest Into the Death of Ms Dianne Brimble, 22 June 2012, 5 <http://www.ag.gov.au/Organisationalstructure/Pages/21-June-2012---Government-Response-to-the-recommendations-of-the-NSW-Coroner-following-the-inquest-into-the-death-of-Ms-Dia.aspx>.

[208] Magistrate Jacqueline Milledge, The 'Brimble' Recommendations, 3 December 2010, 4 <http://www.lawlink.nsw.gov.au/lawlink/Coroners_Court/ll_coroners.nsf/vwFiles/Brimblerecs2.pdf/$file/Brimblerecs2.pdf>.

[209] Magistrate Jacqueline Milledge, The 'Brimble' Recommendations, 3 December 2010, 4 <http://www.lawlink.nsw.gov.au/lawlink/Coroners_Court/ll_coroners.nsf/vwFiles/Brimblerecs2.pdf/$file/Brimblerecs2.pdf>.

The Federal Government rejected this recommendation, because it considered that

> 'there is not a demonstrated need for a federal coronial jurisdiction at this time, due to the collaborative arrangements currently in place to facilitate a cross-jurisdictional approach. There is no evidence of a gap in the current coronial system in Australia. Collaboration amongst State and Territory coroners is well developed. For example, coroners regularly meet to discuss issues of a cross-jurisdictional nature and have an established practice of regular liaison and cooperation on operational issues. State and Territory coroners have collaborated in the past in conducting inquests, such as following the Bali Bombings.'[210]

However, the Federal Government responded that it will give consideration to establishing a federal coronial jurisdiction if a need is identified.[211] As this Paper has demonstrated, there are gaps in the current coronial system. Even apart from the issue of the effectiveness of cross-jurisdictional collaboration, examples such as infant blind cord deaths and widespread failures to implement, or monitor the impact of, many coronial recommendations, emphasise the need for a federal role in 'joining up justice'.

Examples like infant blind cord deaths and widespread failures to implement, or monitor the impact of, many coronial recommendations, emphasise the need for a federal role in 'joining up justice'.

Proposals to centrally record coronial recommendations

An effective, coordinated national preventative response to repeating patterns of deaths must include a central database of coronial recommendations that is easily accessed by coroners, researchers and the general public, irrespective of their particular state or territory location. There has been some government recognition of the need for this approach, via national efforts to prevent violence against women and children.

In 2009, *Time for Action*, the Plan developed by the National Council to Reduce Violence against Women and their Children, suggested establishing and building upon domestic/family homicide fatality review processes across Australia, because this would enhance our understanding of the primary risk factors leading to those deaths, improve system and service responses, and inform policy designed to reduce rates of domestic-related homicide.[212] Recommendation 4.3.2 listed for urgent implementation:

> Establish or build on emerging homicide/fatality review processes in all States and Territories to review deaths that result from domestic and family violence so as to identify factors leading to these deaths, improve system responses and respond to service gaps. As part of this process ensure all information is, or recommendations are, centrally recorded and available for information exchange.[213]

The Australian Government's response to *Time for Action* in April 2009 stated:

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[210] Government Response to the Recommendations of the NSW Coroner Following the Inquest Into the Death of Ms Dianne Brimble, 22 June 2012, 12 <http://www.ag.gov.au/Organisationalstructure/Pages/21-June-2012---Government-Response-to-the-recommendations-of-the-NSW-Coroner-following-the-inquest-into-the-death-of-Ms-Dia.aspx>.

[211] Government Response to the Recommendations of the NSW Coroner Following the Inquest Into the Death of Ms Dianne Brimble, 22 June 2012, 12 <http://www.ag.gov.au/Organisationalstructure/Pages/21-June-2012---Government-Response-to-the-recommendations-of-the-NSW-Coroner-following-the-inquest-into-the-death-of-Ms-Dia.aspx>.

[212] National Council to Reduce Violence against Women and their Children, *Time for Action: The National Council's Plan for Australia to Reduce Violence against Women and their Children, 2009–2021* (March 2009), 115.

[213] *Time for Action*, 120.

> 'Starting in 2009 the Government will. . .work with the States and Territories through the Standing Committee of Attorneys-General to. . .improve the uptake of relevant coronial recommendations.'[214]

> '[T]he Government, through the Standing Committee of Attorneys-General. . .Will work with the States and Territories to assess the impact of strategies to encourage responsiveness to Coroners' recommendations including on domestic violence related deaths.'[215]

The resulting Commonwealth National Plan to Reduce Violence Against Women and Their Children refers to, as one of the four high-level indicators of change that will be used to show progress, 'reduced deaths related to domestic violence and sexual assault'.[216] Strategy 5.2, 'Strengthen leadership across justice systems', includes

> 'Drive continuous improvement through sharing outcomes of reviews into deaths and homicides related to domestic violence.'[217]

The NSW *Report of the Domestic Violence Homicide Advisory Panel* (2009), which led to the establishment of the New South Wales Domestic Violence Death Review Team, proposed that a best practice model of data collection for such a review would include improving and strengthening the information currently captured by NCIS.[218]

While the NSW Domestic Violence Death Review is the only one of its type established by statute and therefore to expressly provide in legislation for prevention strategies,[219] several Australian States now have family/domestic violence death reviews, with New South Wales, Victoria, Queensland and South Australia reviews being hosted or convened by the State Coroner or supported by the State Coroner's Office. The various death reviews also share information via a national network. However, as this Paper has outlined, there is still no central publicly accessible repository of coronial recommendations.

With respect to preventable deaths more broadly, in 2008, the then Federal Minister for Home Affairs, the Honourable Bob Debus, expressed his hope that coronial recommendations and the prevention of avoidable deaths would be added to the SCAG agenda.[220] In 2010, the Federal Attorney-General, Robert McClelland, responded to a petition concerning the death of Mr Ward.[221] The petition asked the Commonwealth Government to lead the State and Territory Governments to enact reforms that create obligations on governments to respond to coronial recommendations. Mr McClelland stated:

> 'Through the Standing Committee of Attorneys-General, I have encouraged my State and Territory counterparts to take steps to monitor the progress of initiatives to promote responsiveness to coronial recommendations. The National Coroners Information Service is currently exploring options to record responses to coronial recommendations on the NCIS system. The outcomes of that work will be reported back to SCAG.'[222]

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[214] Commonwealth of Australia, *The National Plan to Reduce Violence against Women: Immediate Government Actions* (April 2009), 5.

[215] *Immediate Government Actions*, 12. The NSW *Report of the Domestic Violence Homicide Advisory Panel* (2009, 76) also notes that 'The Commonwealth Government, through [SCAG], has committed to working with the States and Territories to conduct a thorough review of current procedures to monitor the consideration, implementation and reporting of coronial recommendations in order to identify best practice approaches with respect to domestic violence homicides.'

[216] Commonwealth of Australia, *National Plan to Reduce Violence again Women and their Children 2010–2022*, 13.

[217] *National Plan*, 31.

[218] *Report of the Domestic Violence Homicide Advisory Panel* (NSW 2009), 47.

[219] *Coroners Act 2009* (NSW) Chapter 9A. See **Appendix 1** of this Paper.

[220] Hon Bob Debus, 'Foreword' (2008) 12 (6) *Australian Indigenous Law Review* 4, 1.

[221] State Coroner of Western Australia, Findings and Recommendations of the Inquest into the Death of Mr Ward, 12 June 2009. The petition was dated 19 November 2009.

[222] Commonwealth, *Parliamentary Debates*, House of Representatives, 24 May 2010, 3777 (Robert McClelland, Attorney-General).

As outlined earlier in this Paper, a process is being developed so that users can use the NCIS to track the progress of agency responses to coronial recommendations, but probably only in those jurisdictions where responses are mandatory. The issue of responsiveness to coronial recommendations appears to have been the subject of consideration by SCAG.[223] A 2009 document setting out legislation and administrative requirements in each Australian jurisdiction to respond to coronial recommendations is provided on the SCAG website,[224] but no further information concerning the work of SCAG or SCLJ on coronial recommendations is publicly available. The Report of the Standing Committee on Environment and Public Affairs of the Inquiry into the Transportation of Detained Persons states:

> 'The Committee understands that the Standing Committee of Attorneys General was of the view that a legislated approach to responding to coronial recommendations was not warranted or necessary.'[225]

An effective, coordinated national preventative response must include a central database of coronial recommendations that is easily accessed by coroners, researchers and the general public, irrespective of their particular state or territory location.

We need national leadership to achieve a prevention-focused coronial process, through co-operative federalism initiatives, that includes a national, publicly accessible system to report whether or not coronial recommendations have been implemented by responsible government agencies. Ian Freckelton's comment in the *Journal of Law of Medicine* in 2010 remains salient:

> 'For the present, the various jurisdictions in Australia continue to adjust their legislation in a disuniform way, albeit increasingly with similar objectives motivating the changes. It is to be hoped that before too much further time passes the Standing Committee of Attorneys-General will move toward nationally consistent coronial legislation in Australia.'[226]

We need national leadership, including a national, publicly accessible system to report whether or not coronial recommendations have been implemented by responsible government agencies.

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[223] Law Reform Commission of Western Australia, *Review of Coronial Practice in Western Australia Discussion Paper* (June 2011), 171.

[224] Summary requirements August 2009 <http://www.scag.gov.au/lawlink/SCAG/ll_scag.nsf/pages/scag_coronialrecommendations>.

[225] The Report footnotes Submission No 31 from Department of the Attorney General, 28 May 2010, p5 (Legislative Council Standing Committee on Environment and Public Affairs, Parliament of Western Australia, Inquiry into the Transportation of Detained Persons: The Implementation of the Coroner's Recommendations in Relation to the Death of Mr Ward and Related Matters (July 2011), 64 [4.7] fn 296).

[226] Ian Freckelton, 'Anglo-Australian Coronial Law Reform: The Widening Gap' (2010) 17 *Journal of Law and Medicine* 471, 479–80.

Recommendations (Part 1)

1. All State and Territory governments should act to adopt core best practice and guarantee that the preservation of life is central to their coronial systems, by introducing, as appropriate to the jurisdiction, prevention and reporting amendments to their coronial legislation.

These amendments should include or have the effect of:

- a preamble that expresses the role of the coronial system as involving the independent investigation of deaths, for the purpose of finding the causes of those deaths and to contribute to the prevention of avoidable deaths and the promotion of public health and safety and the administration of justice, across Australia;
- purpose and objects provisions that include the prevention of avoidable deaths through the findings of the investigation, and the making of findings, comments and recommendations, by coroners;
- a provision empowering coroners to make comments and recommendations on any matter connected with a death investigated at an inquest, including public health or safety and the administration of justice; and
- a provision empowering coroners to make recommendations to any Minister, public statutory authority or entity.

2. The Commonwealth Government should work with State and Territory governments to achieve a uniform national coronial public reporting and review scheme for coronial findings and recommendations which:

- guarantees that all coronial recommendations will be considered and meaningfully responded to by the government agencies or entities to whom they are directed (updates on progress towards implementation should be provided by the relevant agency or entity where the initial response was only a holding response);
- provides ready public access to all coronial findings, recommendations, responses and updates;
- records and makes publicly available (including via a Coroners Annual Report to the relevant State or Territory Parliament and on the Internet) whether or not coronial recommendations have been implemented by responsible government agencies or entities;
- enables evaluation of the impact of coronial recommendations upon the prevention of deaths;
- adheres to timeliness at every step of the recommendations process; and
- provides feedback to families (including a copy of recommendations and responses to families, other parties and legal representatives) at every step of the recommendations process.

3. As an important element of Recommendation 2, State and Territory Governments should:

- appoint coronial liaison officers to enable public sector agencies to respond to coronial recommendations in a timely and appropriate manner; and
- allocate, for each jurisdiction, the responsibility for monitoring the implementation of coronial recommendations to an independent statutory body adequately resourced for the task and with powers to alert government and public about any key implementation issues.

4. The Commonwealth Government should work with State and Territory governments to enable each jurisdiction to effectively recognise the international human rights obligation to respect, protect and fulfil the right to life by introducing, as appropriate, amendments to their coronial legislation so that coronial investigation is independent, appropriately and adequately resourced, and considers systemic issues.

In particular, in investigations into deaths in police custody or in the course of police operations, the agency conducting the primary investigation at the direction of the Coroner must have practical, institutional and hierarchical independence from the police.

5. Primary and secondary coronial legislation in the various jurisdictions should be amended or introduced in recognition of the principle that participation of families in the inquest process is a fundamental component of Australia's international human rights obligations.

Specifically, reforms must enable families and friends of the deceased to experience the coronial process in as sensitive, timely and fully informed a manner as possible, regardless of the circumstances of the death.

These reforms must include:

- provision of proper and timely notification of family members and proactive provision of accessible, timely and explanatory information, at every stage of investigation and inquest processes. This should include as comprehensive as possible access to police and coronial documents, and accessible material on families' legal rights;
- no unreasonable delays in investigations and inquests;
- resolution of any cultural or spiritual conflicts raised by the coronial process;
- recognition of the need to have Aboriginal and Torres Strait Islander legal and health services and communities involved in the coronial process; and
- provision of quality, accessible, and culturally and spiritually appropriate support and counselling services for families.

6. All States and Territories should establish or continue funding for their own Coroners Prevention Unit similar to the current Victorian model, including funding to facilitate an effective role for the Unit in the reforms in Recommendations 1–5.

7. State and Territory Governments should adequately fund their Coroners Courts with the aim of reducing delays in inquests, investigations and the delivery of findings, in order to at least conform to current national standards.

8. The remaining recommendations of the National Report of the Royal Commission into Aboriginal Deaths in Custody (1991) must be implemented.

Part 2 Why we need a National Inquest Clearing House

Overview

Discovering the truth of a person's death is vitally important for the family, friends and community of the deceased. The families of those whose lives are cut short by avoidable death want to spare others the same fate.

Modern coroners are expected to recognise these needs and to respond thoughtfully and compassionately to families and communities. As best practice, all Australian coronial jurisdictions should provide for the full and effective participation of families and advocates throughout the investigative and inquest processes.

In reality, however, the coronial process can be an exceptionally difficult and complicated experience, particularly for bereaved families. As **Part 1** discussed, families can endure long delays between the death and any inquest, and again between the inquest and when findings are released. Further, even if recommendations are made, in most jurisdictions they can disappear into the ether with no flow-on to accountable implementation.

Inquests also often take place in the public spotlight where the interests of government and other agencies are under scrutiny. Inevitably, these interests are legally represented at inquests. In contrast, families often lack legal representation and other support. It is therefore not uncommon for families to remain mystified about aspects of the investigation or inquest process, or to find out about their rights to participate when it is too late to try to exercise them meaningfully. Broader prevention issues may also go unaddressed or under-emphasised without the input of other advocates to assist the coroner.

This second part of the Paper first discusses the avenues for legal assistance that may be available for families involved in a coronial investigation or inquest. The reality for many families is that they may not even be aware that they have the right to a lawyer, let alone be able to obtain legal help throughout the process. We then outline the important role of public interest organisations in inquests. This suggests that a National Inquest Clearing House (NICH) is needed to enable the provision of adequate legal assistance funding for families, and so that public interest interveners can be represented at inquests as appropriate. The NICH will consolidate and share knowledge and understanding in order to achieve the best prevention-based outcomes from the coronial process.

Discovering the truth of a person's death is vitally important for the family, friends and community.

All Australian coronial jurisdictions should provide for the full and effective participation of families and advocates throughout the investigative and inquest processes.

Legal assistance for families in the coronial process

When might families need legal assistance?

As **Part 1** of this Paper discusses, there are many contexts in which a person dies where there must be a coronial investigation, and perhaps also an inquest. Families can find it helpful, even in the early stages following the death, to get legal advice about what to expect from the process, or in some cases so that they can be assisted to request an investigation and/or an inquest. However, families are most likely to confront the question of whether to get legal help when a decision has been made to

hold an inquest. An inquest is a formal court hearing, and the legislation of each state and territory provides certain individuals and groups with an opportunity to appear at an inquest.

Who has the right to appear in an inquest?

A 'party' with a 'sufficient interest' may apply for leave to appear or to be represented.[227] These are usually the deceased's family members, parties about whom adverse allegations may be made, and public interest groups.[228]

Some jurisdictions do not define what constitutes a 'sufficient interest' or provide any guidance as to how a coroner will interpret the requirement.[229] The right to appear at an inquest is 'generally liberally interpreted'[230] but highly discretionary,[231] meaning that whether specific persons are found to qualify as having a sufficient interest will vary according to the particular coroner and inquest.[232]

Why might families wish to be legally represented at an inquest?

Due to the fact that, unlike many other legal proceedings, inquests are formally inquisitorial rather than adversarial, strictly speaking there are no parties.[233] Nevertheless, many families find inquest proceedings highly formal and intimidating, especially when there are issues involving government departments or corporations, whose interests are often advanced in an adversarial manner via legal representation.[234] The legal issues can also be very complex and time-consuming, and the whole process may be the subject of intense media interest.[235] Unrepresented families tend to rely on the Counsel assisting the Coroner or the police informant for legal information, which raises conflicts of interest.[236]

For these reasons, 'a right to appear in the complex hearings that are the modern coronial process without the related [realised] right to representation is virtually meaningless.'[237] In order to realise

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[227] *Coroners Act 1997* (ACT) s 42; *Coroners Act 2009* (NSW) s 57(1); *Coroners Act 1993* (NT) s 40(3); *Coroners Act 2003* (Qld) s 36(1)(c); *Coroners Act 2003* (SA) s 20(1)(b); *Coroners Act 1995* (Tas) s 52(4); *Coroners Act 2008* (Vic) ss 56, 66(3) (s 56(b) further requires that it must be 'appropriate' for the interested party to appear); *Coroners Act 1996* (WA) s 44(1).

[228] Frances Gibson, 'Legal Aid for Coroners' Inquests' (2008) 15 *Journal of Law and Medicine* 587, 588.

[229] Exceptions include *Coroners Act 2009* (NSW) s 57(3), which presumes family members are interested parties unless there is exceptional evidence to the contrary. Reg 17 of the Coroner's Regulations 1997 (WA) provides an exhaustive list of 'interested persons', including spouse, de facto partner, child, parent or other personal representative, or next of kin under the Act; however this list is not conclusive: *Coroners Act 1996* (WA) s 44(3). *Coroners Act 2003* (Qld) s 36(1)(c) provides three examples of an interested party, including a family member, and the Queensland State Coroners Guidelines state that 'parties who will have sufficient interest include the family and any other individual or organisation which might be the subject of adverse findings or comment during the course of the inquest. Employers, treating doctors, supervisors, professional accreditation bodies, government welfare agencies and regulatory agencies are examples of parties that may not be directly implicated in the death but who may have sufficient interest to be given leave to appear', 8.9 <http://www.courts.qld.gov.au/__data/assets/pdf_file/0004/84919/m-osc-state-coroners-guidelines.pdf>. *Coroners Act 1993* (NT) s 46B(4)(c) implies that senior next of kin or their representative will have a sufficient interest.

[230] Ian Freckelton, 'Inquest Law' in Hugh Selby (ed), *The Inquest Handbook* (1998) 1, 9.

[231] Freckelton, 'Inquest Law', 10.

[232] Freckelton, 'Inquest Law', 10. There are certainly suggestions that not all potential public interest interveners (see **Public interest organisations** p 67) obtain leave. For example, the *Report on the Coroners Act 1985* (Law Reform Committee, Parliament of Victoria (2006), 4) recommended that the coroner be required to apply a public interest test 'which would allow a broader range of participants than is currently the case.'

[233] Ian Freckelton and David Ranson, *Death Investigation and the Coroner's Inquest* (2006), 566.

[234] Frances Gibson, 'Legal Aid for Coroners' Inquests' (2008) 15 *Journal of Law and Medicine* 587, 588–9; Law Reform Commission of Western Australia, *Review of Coronial Practice in Western Australia Discussion Paper* (June 2011), 146–9.

[235] Gibson, 589.

[236] Gibson, 590.

[237] Gibson, 590.

these interrelated rights, the family must therefore obtain legal representation. However the first barrier many families face is in becoming aware that they even have the right to a lawyer.

Families might want legal advice about what to expect from the coronial process. Inquest proceedings can be intimidating, complex and time-consuming, with intense media scrutiny.

If families rely on the coroner's assistant or police informant for legal information, there can be conflicts of interest.

How do families know that they have a right to a lawyer?

Because the issue of legal representation generally arises when an investigation or inquest is planned, families tend to rely on the information that is provided to them about the coronial process by the relevant Coroners Court. While many Coroners Court websites and other public information may acknowledge the right to a lawyer, it is not always framed in clear and encouraging language.

For example, the ACT Coroner's Court website states under the heading 'Legal representation':

> 'A person summoned to give evidence at a hearing, or a person with sufficient interest in the subject matter of the inquest or inquiry, may be given leave by the Coroner to appear in person at the hearing or to be represented by a lawyer.'[238]

Some families may not understand that the category of 'person with sufficient interest', and perhaps the 'person summoned to give evidence' category, apply to them.

The Northern Territory Coroners Office website describes 'What Happens at an Inquest?'

> 'An inquest is a formal court hearing.
> Witnesses at an inquest are usually asked questions by a Counsel assisting the Coroner. This is a legal practitioner experienced in coronial matters.
> People with an interest in the circumstances of a death may, at the Coroner's discretion, ask questions of a witness or a lawyer may ask questions on their behalf.
> Family members may raise issues with a Counsel assisting the Coroner who can then ask questions relevant to those issues, if appropriate.
> Family members may also raise issues in a letter addressed to the Coroner, preferably before the inquest, so the Coroner is aware of their concerns.'[239]

The brochure, *The NSW Coroners Court — A guide to services*, responds to the question 'Do I have to be represented by a solicitor at the inquest?' with:

> 'This is not usually necessary, but some people choose to have a lawyer. If you wish, the legal officer assisting the Coroner can help you by asking questions on your behalf.'[240]

The website of the Magistrates Court of Tasmania simply states:

> 'If you consider you need legal advice or indeed legal aid you should consult the telephone directory for assistance.'[241]

The website then provides the telephone numbers of the Law Society of Tasmania, Aboriginal Legal Aid and the Legal Aid Commission.

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238 <http://www.courts.act.gov.au/magistrates/courts/coroners_court>.

239 <http://www.nt.gov.au/justice/courtsupp/coroner/inquests.shtml>.

240 *The NSW Coroners Court — A guide to services*, 10 <http://www.lawlink.nsw.gov.au/lawlink/Coroners_Court/ll_coroners.nsf/vwFiles/Coroner'sCourtBrochure20100101.pdf/$file/Coroner'sCourtBrochure20100101.pdf>.

241 <http://www.magistratescourt.tas.gov.au/divisions/coronial/coronial_procedures>.

In contrast, the Queensland Coroners Court website takes a more helpful approach, answering 'Does the family need to be legally represented?' with:

> 'Anyone with a sufficient interest (including family members) can apply to the coroner to participate in the inquest. This means you can be given permission to ask questions of witnesses and make submissions at the inquest. Parties can act for themselves or they can be legally represented.
>
> Family members may choose to be legally represented and may wish to discuss this with the lawyer or police officer assisting the coroner at the inquest (called counsel assisting). The counsel assisting is an independent person who ensures that all relevant information is presented to the coroner. Counsel assisting does not act for the family but they will be able to explain the process and the issues to be explored during the inquest.'[242]

Families may not be aware that they even have the right to a lawyer, let alone how to find one.

How do families obtain a lawyer?

If a family knows they have the right to a lawyer and are determined to seek legal representation, they may still not be aware of how to obtain it. Some jurisdictions will refer parties to, or give them the contact details of, a relevant body such as the Law Institute of Victoria, the New South Wales Law Society, Legal Aid Queensland or the National Association of Community Legal Centres, who will then refer them to an appropriate legal practitioner for legal advice and/or representation at the inquest. In other jurisdictions, such as the ACT and the Northern Territory, it appears that at least from what is available on the Internet, the family has to rely on being given contact details if they request them, or perhaps on being supplied with written information that is not on the coroners website.

The next hurdle for many families is then the question of cost. Because the coronial jurisdiction is formally non-adversarial, costs are not usually awarded in inquests. This means that unlike in many other civil matters, families cannot use an inquest to prove that particular entities were implicated in the death, and then seek payment from them toward their legal fees. Family members seeking legal assistance must therefore either try to fund legal representation themselves or attempt to get help in some other way.

Privately funded legal assistance

Paying for a private lawyer is expensive. It is not unusual for legal fees in an inquest to total $40 000, once several hearing days and the services of a barrister and solicitor are included. When it is considered that often the circumstances in which people die involve social disadvantage, private legal representation is simply out of reach for most families. For example, the Commonwealth Government's Review of the Commonwealth Community Legal Services Program noted that 82% of community legal sector clients earned less than $26,000 per annum.[243] In other cases, family members go into serious debt in order to try to get justice for their loved one.

Legal Aid

Parties unable to fund private representation can apply for legal assistance from their state or territory Legal Aid service. Legal aid commissions are state and territory statutory agencies that typically have a

[242] Office of the State Coroner Queensland, What to expect at an inquest – A guide for family and friends <http://www.courts.qld.gov.au/__data/assets/pdf_file/0008/92870/m-osc-fs-what-to-expect-at-an-inquest.pdf>.

[243] Review of the Commonwealth Community Legal Services Program (March 2008) <http://www.ag.gov.au/www/agd/agd.nsf/Page/RWP6DE98B3437EEB6FDCA25742D007B0738>.

central head office and regional offices. If legal aid is granted, a family could be assisted by a lawyer employed by the relevant Legal Aid Commission, or by a private lawyer who receives legal aid funding for the work.

The conditions under which legal aid will be provided for representation vary across jurisdictions, but all states and territories except Western Australia grant legal aid if representation at an inquest is considered to be in the public interest.[244] The conditions under which legal aid assistance may be granted for an inquest are summarised in **Table 2**.

[244] Frances Gibson, 'Legal Aid for Coroners' Inquests' (2008) 15 *Journal of Law and Medicine* 587, 598.

Table 2 Conditions for granting legal aid for inquests

Jurisdiction	**Conditions under which legal aid assistance will be granted for inquest** (yellowed entries = additional considerations[245])	Source
Australian Capital Territory	• Where the inquest involves issues of substantial public interest. • Not if total cost likely to exceed $20 000, unless exceptional circumstances. • 'Substantial public interest' is determined 'on a case by case basis. . .in inquests that involve exposure to criminal prosecution for serious offences, involve disadvantaged people or highlight an issue that impacts on the community, we would be likely to grant legal assistance to an applicant who otherwise meets our financial criteria.'[246]	Legal Aid ACT, Legal Assistance Guidelines (October 2012) <http://www.legalaidact.org.au/pdf/la_act_guidelines_oct_2012.pdf>
New South Wales	• Where representation at the inquest is a preliminary step to civil proceedings for which aid is available; or • where the public interest would be advanced by representing the applicant. Regard will be had to: • whether applicant has reasonable prospects of being granted leave to appear at the inquest; • applicant's relationship to the deceased; • likelihood of deceased's family's interests being represented at inquest if legal aid not granted. • Where death occurs in police custody, prison, psychiatric hospital, child care centre, juvenile justice centre or community welfare centre, questions of public interest will generally be considered to have arisen.	Legal Aid New South Wales, Policies <http://www.legalaid.nsw.gov.au/for-law-yers/policyonline/policies/6.-civil-law-matters-when-legal-aid-is-available/6.12.-coronial-inquests-into-deaths>
Northern Territory	• Where it is considered that the applicant's claim for damages will be significantly advanced if representation is made available for coronial proceedings; or • where in the opinion of the Director there are strong reasons based on the public interest for providing representation to ensure a full airing of the facts; or • where there is a reasonable likelihood that the applicant will be charged with a criminal offence as a result of the inquest.	Northern Territory Legal Aid Commission, Guidelines <http://www.ntlac.nt.gov.au/left_menucontent/guidelines/Chapter05Guidelines.pdf>

[245] Adapted from Gibson, 595–7 (Table 1).

[246] Email from ACT Legal Aid Office to Frances Gibson, 25 May 2007, quoted in Gibson, 597.

Queensland	• Where the applicant has in some way been involved in the death or deaths and may be criminally charged; or • there is a substantial public interest element; or • the applicant for aid is a relative of an Aboriginal or Torres Strait Islander who died in custody. • Legal aid should be considered where the result of the inquest may affect the applicant's prospects of success in a potentially substantial civil claim. • Substantial public interest element = case will have a direct/indirect benefit on other claims in Qld and involves multiple claimants who reside in Qld.	Legal Aid Queensland, Grants Handbook <https://elo.legalaid.qld.gov.au/grantshandbook/default.asp>
South Australia	There is no reference to inquests. Generally, where there is a public interest.	Legal Services Commission of South Australia, Eligibility for Legal Aid <http://www.lsc.sa.gov.au/cb_pages/practitioners_eligibility.php#guidelines>
Tasmania	• Normally, only if there is a possibility that the applicant will be charged with a serious offence in relation to the death; or • in the opinion of the Director there are strong reasons based on the public interest for providing representation to ensure a full airing of the facts.	Legal Aid Commission of Tasmania, Inquest <http://www.legalaid.tas.gov.au/Guidelines/3%20Matter%20Type/3B%20State/Civil/Guideline%2020%20Inquest.htm>
Victoria	• If it is reasonably likely that the applicant will be charged with a serious offence eg murder, manslaughter or culpable driving; or • it is in the public interest that the person be legally represented.	Victoria Legal Aid, VLA Handbook for lawyers, Guideline 4 — coronial inquests <http://www.legalaid.vic.gov.au/handbook/205.htm>
Western Australia	• Where as a result of the inquest there is a realistic risk that serious criminal charges may arise against the applicant; or • where the outcome of the inquest can reasonably be seen to be likely to have a significant impact on civil proceedings involving the applicant; and • as a result of such representation, there is a real likelihood of some substantial benefit accruing to the applicant.	Legal Aid Western Australia, Chapter 6B State Eligibility Guidelines, Manual of Legal Aid <http://www.legalaid.wa.gov.au/InformationForLawyers/Documents/chapter_6b_July_06.pdf>

Legal Aid New South Wales differs from its state and territory counterparts in that it has a dedicated statewide specialist service, the Coronial Inquest Unit (CIU). The CIU provides free legal advice, assistance and representation to people at inquests where the matter involves some public interest.[247]

[247] The CIU website defines 'public interest' as 'something of serious concern common to the public at large or a significant section of the public, such as a disadvantaged or marginalised group', and gives as some examples of inquests likely to involve

Usually, legal aid is provided by the CIU to a family member or next of kin to the deceased person. In exceptional circumstances, aid might be granted to someone other than a family member. Legal advice may be provided to a 'person of interest' (a person who might face criminal charges as a result of the death), but representation is usually not available to such people.[248]

Whether family members can receive legal aid for help at an inquest is not only dependent on the particular conditions of the jurisdiction. Their case must also be deemed to have merit, and perhaps most importantly, the applicants must satisfy a means test. Due to funding shortages, means eligibility for legal representation is limited mainly to people with very low incomes and low assets.[249]

Aboriginal and Torres Strait Islander Legal Services (ATSILS)

Aboriginal or Torres Strait Islander families can seek representation from Aboriginal and Torres Strait Islander legal services, which are independent, non-profit bodies. The legal service then either seeks a grant of legal aid or applies to the Commonwealth Attorney-General's Department for special test case funding. Aboriginal and Torres Strait Islander legal services are provided in accordance with priorities laid down in the Commonwealth Attorney-General's service delivery directions for the delivery of legal assistance to Indigenous Australians.[250]

The service delivery directions stipulate that a priority client includes a family member of a person who died in custody, and who is seeking representation at an inquiry into the death, unless other appropriate assistance is readily available for that person.[251] As the Law Reform Commission of Western Australia observed in 2011:

> '[R]ecommendation 23 of the Royal Commission into Aboriginal Deaths in Custody, which states that the family of the deceased be entitled to government-funded legal representation for deaths in custody inquests does not appear to have been legislatively implemented, either in Western Australia or elsewhere.'[252]

A priority client is also defined as an eligible client who 'faces a real risk to his or her physical, cultural or personal well-being',[253] or who 'would be significantly disadvantaged were assistance not provided'.[254] This means that it is possible for family members to obtain legal representation for an inquest other than a death in custody, such as an inquest concerning a death in psychiatric care. However, this is far from automatic, and Aboriginal and Torres Strait Islander people often do not get legal assistance for inquests where the death did not occur in custody.[255]

The ability of ATSILS to represent families in inquests is also restricted due to funding shortages and the time-consuming and labour-intensive nature of such work:

> 'There's such urgent need for other legal work, so the inquest would need to be extremely significant, because we only have one civil law solicitor and he does everything. So he has to

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a public interest, a death in custody, a death of a child in care, a death in a psychiatric hospital and a death involving a matter of public safety. <http://www.legalaid.nsw.gov.au/what-we-do/civil-law/coronial-inquest-matters>. See also **Table 2** above.

248 <http://www.legalaid.nsw.gov.au/what-we-do/civil-law/coronial-inquest-matters>.

249 Community Law Australia, *Unaffordable and Out of Reach: The Problem of Access to the Australian Legal System*, 9-10 <http://www.communitylawaustralia.org.au/wp-content/uploads/2012/07/CLA_Report_Final.pdf>.

250 Australian Government Attorney-General's Department, *Service Delivery Directions for the Delivery of Legal Assistance to Indigenous Australians Indigenous Legal Assistance and Policy Reform Program*, effective from July 2011.

251 Australian Government Attorney-General's Department, *Service Delivery Directions*, 4.5c, 7.

252 Law Reform Commission of Western Australia, *Review of Coronial Practice in Western Australia Discussion Paper* (June 2011), 147, citing Frances Gibson, 'Legal Aid for Coroners' Inquests' (2008) 15 *Journal of Law and Medicine* 587, 600.

253 Australian Government Attorney-General's Department, *Service Delivery Directions for the Delivery of Legal Assistance to Indigenous Australians Indigenous Legal Assistance and Policy Reform Program*, 4.5b, 7.

254 Australian Government Attorney-General's Department, *Service Delivery Directions*, 4.5d, 7.

255 Frances Gibson, 'Legal Aid for Coroners' Inquests' (2008) 15 *Journal of Law and Medicine* 587, 599.

make really hard choices. It's a capacity issue because it's one man – the capacity's not there.' (ATSILS worker)

The following examples obtained in 2011–12 illustrate the kinds of legal assistance ATSILS provide to families in inquests and coronial investigations.

- ATSILS (Qld) Ltd has assisted approximately 40 families in relation to reportable deaths, and has appeared or briefed (usually in-house) counsel in 15 inquests, since 2008. 10 inquests have concerned deaths in custody, and two were about deaths in care. Other than one Deaths in Custody Officer position, the service is not funded for coronial-related work.
- Since 2007, the North Australian Aboriginal Justice Agency (NAAJA) has assisted about 40 people with inquiries relating to coronial matters, and has appeared for families in approximately eight inquests. NAAJA has also appeared in the Supreme Court in two matters in which the family objected to an autopsy being conducted, and has assisted families in three other cases to make representations to the Coroner objecting to an autopsy.
- Since 2009, Victorian Aboriginal Legal Service Co-operative Limited (VALS) has represented families in two inquests concerning deaths in care, acted for the family in a further four reportable deaths, and provided advice in other situations.

Community legal centres (CLCs)

Families and groups can receive advice and sometimes representation from community legal centres, which are independent non-profit organisations largely funded by State/Territory and Federal Governments to provide legal assistance at no cost to the public. CLCs aim to represent the family and to also address systemic issues that may be raised during the inquest. CLCs have a long history of advising and representing families, as well as of acting for public interest organisations, and acting as public interest interveners themselves (see **Public interest organisations** p 67).

As one lawyer explains:

> 'The scope of the investigation would have been more narrow without the help of our community legal service. Because it was about prison issues and we had been involved with prison issues for quite some time, there was already knowledge of a whole lot of systemic problems, so that informed what went into the preparation. And it was really important because it is about making change and making sure that the same problems don't happen again, and so looking broadly at all of the issues was really important from our perspective because we had a strong background in the systemic issues. Whereas private practitioners who don't have that systemic background in the prison system perhaps wouldn't have gone to some of the places that we were able to go to or had knowledge of.' (Community lawyer)

Some examples where CLCs have legally assisted families in inquests are:

- Inquest representation by Redfern Legal Centre (NSW), for the daughter of Sallie-Anne Huckstepp, in the coronial inquiry into her death (1987);
- Inquest representation by Redfern Legal Centre (NSW), for the brothers and sisters of David Gundy, shot by police in his home (1989);
- Appearance by Queensland Advocacy Inc in an inquest into the death of a person with an intellectual disability in supported accommodation (1998);
- Appearance of University of Newcastle Legal Centre (NSW) for the family of Roni Levi at the inquest into his shooting by police on Bondi Beach (1998);
- Inquest representation by Brimbank Melton Community Legal Centre (Victoria), for the wife and children of a prisoner, Garry Whyte, shot dead by a prison guard (2004);[256]
- Inquest representation by Public Interest Advocacy Centre (NSW) for the mother of Scott Simpson, who committed suicide while in custody as a forensic patient (2006);

[256] Above examples from Gibson, 599.

- Inquest representation by Fitzroy Legal Service (Victoria) for the daughter of Ian Westcott, who died from an asthma attack in prison when the alert button failed to work (2009); and
- Inquest representation by Public Interest Advocacy Centre (NSW) for the sisters and brother of Mark Holcroft, who suffered a heart attack in a prison van and was not able to attract guards' attention (2011).

> 'It is about making change and making sure that the same problems don't happen again, and so looking broadly at all of the issues was really important from our perspective because we had a strong background in the systemic issues.'
> Community lawyer

A significant limitation on inquest work by CLCs is the resource-intensive nature of the process, which can continue for years and is work which may fall outside the core and already under-funded activities of the centre undertaking it.[257] CLCs may still be committed to such work because the death has significant social justice implications, and the alternative could be that no one would assist the family because they do not qualify for legal aid.

As two inquest advocates explain:

> 'CLCs have a different approach to work on inquests. They work on the whole case with the family of the deceased involved. As a result the CLC lawyers are stretched and exhausted by the time it comes to writing the submissions and there is little money to pay legal counsel to do this. There is a heavy amount of research involved in this work. The real cost of the work would be huge.' (Community legal worker)

> 'At the centre that I was at I was the only lawyer, so basically we had to get money to employ somebody to do my job in that period of time and because it went on for quite a long period of time that was quite a lot of resources needed. It put a lot of strain on a small centre and it put a lot of strain on the other staff — it's huge administrative demands that it places on the centre. So it was great to get the philanthropic funding and that really helped, but in terms of comparing all the hours that we all put in and the strain that it put on the centre it was really not much.' (Community lawyer)

Because community legal centres also often do not receive funding to represent individuals and groups at inquests, they may rely on their volunteers to support the family, and may also work to locate other solicitors together with barristers who will provide further pro bono assistance in the inquest:

> 'We ended up getting philanthropic funding to be able to run the case and we did get some money, I believe, for counselling, and we did arrange some volunteers to be support people during the hearing as well because we were having to handle all aspects of running the case as well trying to be lawyers. So in trying to fulfil that role, I think we had a number of volunteers for the support of clients during the hearing which was really important.' (Community lawyer)

Pro bono assistance

There are various state and territory pro bono schemes that coordinate pro bono assistance for individuals seeking legal representation for coronial proceedings. These schemes refer potential clients to, among others, the relevant bar associations that may then arrange free private legal assistance or legal help at reduced rates, for family members.

[257] Community Law Australia, *Unaffordable and Out of Reach: The Problem of Access to the Australian Legal System* 9–10 <www.communitylawaustralia.org.au/wp-content/uploads/2012/07/CLA_Report_Final.pdf>.

How often are families represented and who appears for them?

Overview

It is not possible to quickly ascertain how many people are represented at inquests across Australia, or, when they are represented, what proportion of that representation is publicly funded.[258] To obtain this information, each inquest file would need to be viewed. As one Coroners Court official explained, this is a very time consuming and onerous task, and one that many officers of Coroners Courts may not be enthusiastic to undertake upon request.[259]

The following outline of inquest representation in the various states and territories is the result of intensive Internet research and personal email and telephone inquiries to a wide range of legal service providers in early 2012. Even so, the information is often simply not collected or not ascertainable from the category of data. For example, law societies are the most likely source of data on referrals to privately funded lawyers, but they rarely keep inquest-related statistics. Legal Aid Commissions do not always record data to that level of specificity, or may not make it publicly available. It is difficult to obtain national and state/territory figures on inquest assistance provided by ATSILS, and the national Community Legal Service Information System (CLSIS) does not separately record legal assistance for inquests provided by community legal centres. In many contexts, despite several inquiries and being referred on to other staff or other organisations, ultimately service providers were unable to assist.

Figures for each state and territory may also include some duplicate inquiries/referrals. For example, a person may contact a law society, then be referred to a Legal Aid office and have their application denied and so then seek pro bono assistance. As an approximate indicator of the low level of legal representation, the most recent figure for the number of inquests is also documented where available (from **Table 1** above).

Australian Capital Territory

The Pro Bono Clearinghouse only considered one application over 2010–11 with respect to a coronial inquiry.[260] No other data is available. There were 20 inquests in 2010–11.

New South Wales

The NSW Law Society was unable to provide any coronial data.

Over 2009–11, the Coronial Inquest Unit in Legal Aid NSW provided either representation at inquests or substantive submissions to the coroner in support of an inquest being held, in about 25 matters per year. Another 25 coronial matters per year entailed advice or other forms of minor assistance to family members and others.[261]

Legal Aid NSW also referred four inquiries to the NSW Public Interest Law Clearinghouse. Barristers will often do pro bono inquest work.[262]

The figures can be roughly compared to the 290 inquests in 2011.

[258] Frances Gibson, 'Legal Aid for Coroners' Inquests' (2008) 15 *Journal of Law and Medicine* 587, 594. The NCIS does not collect this data.

[259] Communication from Michell Heidtmann, ACT Coroners Court, to Courtney Guilliatt, 18 May 2009.

[260] Communication from Debbie Sims, Executive Secretary, ACT Law Society, to Beth King, 24 February 2012.

[261] Communication from William de Mars, Solicitor Advocate, Coronial Inquest Unit, Legal Aid Commission NSW, to Chris Atmore, 17 September 2012.

[262] Communication from Katrina Ironside, Principal Solicitor/Coordinator, PILCH NSW, to Beth King, 13 February 2012.

Northern Territory

The Northern Territory Law Society does not have a formal referral service and does not keep a list of inquiries, but only provides a list of Northern Territory law firms for callers.[263]

Northern Territory Legal Aid received two applications for coronial-related legal aid in 2010–11, and approved one of them. In 2009–10, six applications were received and six approved. Over 2008–11, NT Legal Aid provided an average of 19 legal advices and one duty lawyer assistance per year concerning coronial matters.[264]

Queensland

The Queensland Law Society does not keep statistics on coronial-related legal inquiries and referrals, but anecdotally, inquiries are very rare.[265]

Legal Aid Queensland declined to respond to inquiries.[266] In the absence of more recent available data, Frances Gibson's research on legal aid for inquests, published in 2008, gives some sense of the scope of under-representation: in 2005–6 there were 22 new approved applications for aid in Queensland inquests.[267]

Queensland Public Interest Law Clearinghouse records its information on CLSIS, so as noted above, inquest data is not available. Anecdotally, over the five years to 2011 there would have been no more than six coronial-related inquiries. Two of these were referred for pro bono help and the remainder to Legal Aid Queensland.[268]

The figures can be roughly compared to the 81 inquests in 2011–12.

South Australia

The Law Society of South Australia does not collect coronial-related data.

In 2010–11, the Legal Services Commission of South Australia provided 12 telephone advices concerning inquest matters, eight of which concerned deaths in custody. The Commission provided 10 advice interviews concerning inquest matters, one of which concerned a death in custody. A grant of legal aid, necessary if more substantial assistance is required, is not normally provided for coronial matters, and the last such legal aid application received, which was refused on guidelines, was in May 2009.[269]

JusticeNet SA, which coordinates pro bono assistance, had three inquiries from 2009 to early 2012, but does not record the areas of law precisely, so this could be an under-estimate. At the time of our query, two of the inquiries were in process, and in the third, a request for legal representation, was declined on the basis that there was insufficient evidence for the argument that authorities had acted improperly.[270]

The figures can be roughly compared to the 45 inquests in 2011–12.

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[263] Communication from Danielle Sawyer, Licensing Officer, NT Law Society, to Beth King, 13 February 2012.

[264] Communication from Fiona Hussin, Coordinator, Policy & Projects, NT Legal Aid Commission, to Beth King, 13 February 2012.

[265] Communication from Vicky Moore, Call Centre Operator, Queensland Law Society, to Beth King, 13 February 2012.

[266] 'LAQ would prefer not to participate in this project at this time. We do not currently have any serious issues with the Queensland Coroners' legislation' (Email from Mary Burgess, Director, Strategic Policy and Communication, Legal Aid Queensland, to Beth King, 16 February 2012).

[267] Frances Gibson, 'Legal Aid for Coroners' Inquests' (2008) 15 *Journal of Law and Medicine* 587, 596.

[268] Communication from Tony Woodyatt, Queensland PILCH, to Beth King, 13 February 2012.

[269] Communication from George Hatzirodos, Team Leader, Community Education, Legal Services Commission SA, to Sharee Macfarlane, 20 April 2012.

[270] Communication from Louise, Administration Assistant, JusticeNet SA, to Beth King, 13 February 2012.

Tasmania

No recent data is available. Frances Gibson's 2007 research notes that legal aid for inquests had not been granted in Tasmania for five years, although there had been two inquests funded prior to that.[271]

The figures can be roughly compared to the 9 inquests in 2011–12.

Victoria

In 2011, there were 10 referrals from the Law Institute concerning legal assistance related to inquests.[272]

During the 2010–11 financial year, Victoria Legal Aid provided grants of aid for legal assistance, including representation, in 13 inquest matters, with two refusals.[273]

In 2010–11 PILCH (VIC), which also administers the Law Institute of Victoria Legal Assistance Scheme and the Victorian Bar Pro Bono Scheme, received a total of 17 coronial inquiries.[274] Since July 2010, PILCH (VIC) has referred nine matters for legal assistance.[275]

The figures can be roughly compared to the 142 findings with inquest in 2010–11.

Western Australia

None of the legal assistance providers in Western Australia record specific data concerning requests and referrals for legal assistance relating to coronial inquiries or inquests. Research undertaken for the current Western Australian Review of Coronial Practice found that in 2009, of 33 inquests, 21 had counsel.[276] Most of the lawyers appearing did so for nurses, doctors and police officers called as witnesses, with families being legally represented in only six inquests.[277]

As the WA Law Reform Commission notes, given the absence of public interest criteria for legal aid funding for inquests in Western Australia, families will rarely, if ever, receive legal aid for representation.[278] Accordingly, the Commission has recommended that the Western Australian government fund Legal Aid WA, the Aboriginal Legal Service of Western Australia and community legal centres to provide legal representation and assistance to families for the purposes of an inquest where such representation is in the public interest.[279]

Implications for families

As discussed above, many families who have lost a loved one do not obtain effective, adequately funded legal representation. At a time when they are struggling to comprehend the death, they are also encountering a world of legal jargon and processes that is unfamiliar to most people.

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[271] Frances Gibson, 'Legal Aid for Coroners' Inquests' (2008) 15 *Journal of Law and Medicine* 587, 596.

[272] Communication from Susan Woodman, General Manager, Membership and Marketing, Law Institute of Victoria Legal Referral Service, to Beth King, 16 February 2012.

[273] Communication from Chris Ermacora, Business Information Coordinator, Victoria Legal Aid, to Chris Atmore, 7 February 2012. The 13 successful applicants included both family members and persons potentially facing criminal charges.

[274] Information supplied by PILCH (VIC).

[275] Reasons for rejection of inquiries included, in order of frequency: client withdrew application; no merit; did not meet means test; no legal issue; not the relevant jurisdiction; legal aid available (information supplied by PILCH (VIC)).

[276] Law Reform Commission of Western Australia, *Review of Coronial Practice in Western Australia Background Paper* (September 2010), 36.

[277] *Review of Coronial Practice in Western Australia Background Paper*, 36.

[278] Law Reform Commission of Western Australia, *Review of Coronial Practice in Western Australia Discussion Paper* (June 2011), 147.

[279] Law Reform Commission of Western Australia, *Review of Coronial Practice in Western Australia Final Report* (January 2012), 93.

One family, whose father and husband was killed in a car accident, were concerned about inconsistencies in the police investigation, and so wrote to the Coroner seeking an inquest.

> 'It took a year to get a (one-day) inquest, which I had to lobby for. Information was only given to me in dribs and drabs. I only got photos of the scene after several visits to the Coroners Office. No one told me what I was actually entitled to have.'

The family was not legally represented at the ensuing inquest.

> 'With hindsight, we would have got a lawyer, but we just thought "It's only an inquest." We were in close contact with coronial staff but no one really said you should get a solicitor and that if it didn't go our way you have to appeal it at the Supreme Court. At no point were we told that you only get one shot. We were probably a bit naïve as to what an inquest was, it being our first inquest.'

Many families who have lost a loved one do not obtain effective, adequately funded legal representation.

The lack of legal representation was a particularly critical issue because, as with a significant number of inquests, the family wanted to ask questions about the actions of police, and Counsel assisting the Coroner is most usually a police officer.

> 'We don't want sympathy – that's not what you want when you're wanting justice. We just want something to happen. . .I just wanted some justice, some form of comfort for us. I want someone independent to investigate the police. I just want my mother to have some peace, and know that his death was taken seriously.'

'Information was only given to me in dribs and drabs. . . No one told me what I was actually entitled to have.'
Family member

'We were probably a bit naïve as to what an inquest was, it being our first inquest.'
Family member

'I want someone independent to investigate the police.'
Family member

'We don't want sympathy – that's not what you want when you're wanting justice. We just want something to happen.'
Family member

A second experience also began with seeking an inquest.

> 'Because I did not have faith in the thoroughness of the police investigation, I gathered a lot of the evidence myself, and my solicitor also obtained documents under freedom of information law. This cost me just under $70,000. It cost me another $3000 to get legal help to apply for the inquest. I travelled from overseas to the directions hearing,[280] and it also cost me $1100 for a Barrister to represent me. He didn't fight very hard for all information to be revealed and wanted at least $7500 for the Inquest. As I could only spend one hour with him prior to the inquest starting, I decided to represent myself — I could then ask questions that would be on record. When you add my flights and accommodation costs, telephone calls, taxi fares, registered mail and so on, not to mention the fees of my independent expert, it amounts to well over $100,000.'

[280] A directions hearing is a preliminary hearing of the matter before the inquest date is set.

At the inquest where this parent represented herself, there were 10 barristers representing the other parties, including two senior counsel.

> ‘When you add my flights and accommodation costs, telephone calls, taxi fares, registered mail and so on, not to mention the fees of my independent expert, it amounts to well over $100,000.’
> Family member

> At the inquest where one parent represented herself, there were 10 barristers representing the other parties, including two senior counsel.

A third example, of a rural parent whose child was a victim of domestic homicide, demonstrates a lack of clear information and sometimes misinformation about the available options, along with gaps in legal referral pathways.

‘I got a letter from the Coroners Court and I also got pamphlets for counselling but I can’t remember getting any information about being able to get a lawyer. I spoke to the detective and he said there was no need to get one, but I had lost confidence in the police by then as I felt like nothing they told me had been right. It just didn’t feel like he was on my side. Because I was seeing a community support agency in the country for the victims compensation, they sent me to a local lawyer. Apparently he does all their stuff, but I don’t think he had very much experience with what happened with my child. The work he did was about sorting out the financial affairs like super and so on. That cost over $2000. I kept asking would he come to the court and give evidence but he said there wouldn’t be an inquest. I think he probably got told that by the detective.

Then we were told there was going to be an inquest and the directions hearing was coming up over the summer. I googled some lawyers on the Internet — there’s a site where you pay $80 to contact a lawyer by sending an email with a brief description of what you want. A lot had gone on holidays, but one rang me back and said she would represent us at the directions hearing. When we went there with her, the detective was a bit put out. I didn’t know how much it was going to cost until they told me after the directions hearing that it was over $4000. I had no idea it was going to cost that much.

The inquest was set for four days, so I contacted Legal Aid but they said because I was already in the system with the community support agency I should go back to them. The country office of the agency just told me there were no funds available and sent me to the city office who said I was entitled to legal representation but sent me back to the country office. They said we’d had the maximum because we got victims compensation divided among the different members of the family. The private lawyer that we’d had at the directions hearing said she’d approach Legal Aid for us but she never did.

We got a quote from her for the inquest which was $9000 a day, so almost $40 000. We couldn’t afford that. No one talked about trying to get pro bono help. The only time I even heard those words “pro bono” was on *Boston Legal*! You just don’t know. God forbid if it happened to me again — I’d be a lot more experienced. No one tells you anything. You’ve got to find out as you’re going along. You’re not even on the same planet at the start. That’s something that really needs to be addressed.’

> ‘I googled some lawyers on the Internet. . .I didn’t know how much it was going to cost until they told me after the directions hearing that it was over $4000. I had no idea it was going to cost that much.’
> Family member

‘The country office of the agency just told me there were no funds available and sent me to the city office who said I was entitled to legal representation but sent me back to the country office. . . The private lawyer that we’d had at the directions hearing said she’d approach Legal Aid for us but she never did.’

Family member

‘We got a quote from her for the inquest which was $9000 a day, so almost $40 000. We couldn’t afford that. No one talked about trying to get pro bono help. The only time I even heard those words “pro bono” was on *Boston Legal*!’

Family member

‘No one tells you anything. You’ve got to find out as you’re going along. You’re not even on the same planet at the start. That’s something that really needs to be addressed.’

Family member

A fourth situation is described by a worker who provided some assistance to ‘X’, the parent of a man who was pursued and later fatally shot by police in a public place. The worker explains how financial barriers to obtaining legal representation can compromise the family’s legal rights. The example also clearly documents the stress and problems families continue to experience in accessing both inquest briefs and legal representation before an inquest hearing date is set.

‘Because X’s son was killed by police, an inquest is mandatory. In 2011, three years after the death, a coroner set a date for a directions hearing. X approached us about four weeks before the directions hearing after being referred by a suburban law firm. X sought advice from us on how to go about getting legal aid in order to be represented at this hearing.

My observation was that X was almost completely overwhelmed and intimidated by the complexity of the investigation and coronial processes and was extremely anxious about the prospect of attending the direction hearing without any support. A complicating factor was that the Coroners Court had denied X access to the full brief of evidence, advising X that the unreleased parts could only given to X’s lawyer.

As an interim measure I drafted a formal request for the inquest brief, advising the court of the Catch 22 situation X was in: the court wouldn’t release the brief until X had retained a lawyer, but the pro bono lawyer scheme and Legal Aid wanted access to the brief in order to determine the merits of the application.

In response, the Coroner advised that they would not release the brief before the directions hearing and that the Coroner would provide the reasons at the hearing. This left us unable to fully prepare for the directions hearing at which X would potentially face complex legal argument with lawyers for the Commissioner for Police around the scope of the inquest, as well as needing to respond to arguments invoking public immunity grounds to resist disclosure of some of the brief.

Legal aid was refused two weeks before the directions hearing but we managed to obtain a pro bono law firm and barrister to represent X at that hearing. Because we were able to access pro bono lawyers for X, the Coroner released the brief to the legal team with non-disclosure undertakings. The Coroner noted the importance of legal representation in this case and emphasised the complexity of the issues involved in this inquest.

Following the directions hearing, our client appealed the decision to refuse legal aid. Legal aid was then granted, but for only two days of the inquest. To date, there have been four separate direction hearings and 10 inquest hearing days, with 4 more days to follow.

Fatal police shootings and their investigation are always matters of public interest. In this case, the circumstances of the death of X's son raise serious concerns about the safety of members of the public, who as innocent bystanders may be exposed to serious danger or death through what may be described as an unplanned, uncoordinated and uncontained police shoot-out. It is therefore a real concern that it was not possible to obtain a full grant of legal aid to effectively represent the family throughout the entire inquest.'

'Legal aid was refused two weeks before the directions hearing but we managed to obtain a pro bono law firm and barrister. . .Following the directions hearing, our client appealed the decision to refuse legal aid. Legal aid was then granted, but for only two days of the inquest. To date, there have been four separate direction hearings and 10 inquest hearing days, with 4 more days to follow.'

Community lawyer

The worker's comments above highlight a common issue facing families wishing to be legally represented through a grant of legal aid. Legal aid rates are below market rates, so some private lawyers avoid legally aided work. The longer the inquest, the less likely it is that a private lawyer will be willing to take on the work. If the family can't afford legal representation, or access it through legal aid, community legal centres or Aboriginal and Torres Strait Islander Legal Services, the only other option is to seek pro bono help:

'If it hadn't been for my wonderful kind-hearted lawyers, who are working on my behalf on a pro bono basis, I don't know where I'd be. . .In the event I might have had to represent myself, I resigned myself to reading the brief. I read 187 pages of the 481-page brief and the memory still lingers. No mother should have to read so many accounts of her son's last half hour on Earth.

I strongly believe however that everyone has the right to be heard and represented especially in situations like this where a coronial inquest is mandatory. . .The coronial process has been longer and more difficult than I could ever have imagined. I hate to think what it would have been like to go through this process alone. Had I not been represented I truly believe that I would not have uncovered the answers to many of my questions.'[281]

However, again, the longer the inquest, the less likely that any solicitor and barrister will be able to give unpaid time. Families are therefore often left to fend for themselves in complex and traumatic inquests. In contrast, many other interested parties, such as government departments, retain senior counsel, and in complex and lengthy inquests an entire legal team, throughout the process.

'If it hadn't been for my wonderful kind-hearted lawyers, who are working on my behalf on a pro bono basis, I don't know where I'd be. . . Had I not been represented I truly believe that I would not have uncovered the answers to many of my questions.'

Bobbi, mother of Samir Ograzden

One family advocate estimates that with respect to legal representation, families are outspent by other parties at a rate of 20 to 1. Another community advocate talks about the frustration of

'being there and seeing the masses of resources of all the powers that be, compared to our own. . .At the time it is not so much of an issue because you just get so focused on what you're doing and what you need to achieve — but you notice when one of the big law firms have their clerk wheel their trolleys into court every day with all these beautifully prepared documents that the lawyers haven't put their hands on and we were doing it all ourselves and trying to transport and cart things. And that sort of stuff, which at the time you don't think about. . .it's just really

[281] Bobbi, mother of Samir Ograzden who was shot by police, quoted in Adrian Lowe, 'Mother slams lack of help in son's coronial inquest', 19 March 2012 <http://www.theage.com.au/victoria/mother-slams-lack-of-help-in-sons-coronial-inquest-20120318-1vdld.html>.

exhausting and it all seems a little bit unfair — you think about it later and about the fact that it's unfair and that it shouldn't be the case. Why should the family of the person that's died, and the legal team, have to be in that position, while everybody else representing people who have some responsibility for what happened be massively well-resourced — it makes no sense, no sense whatsoever!' (Community lawyer)

Whether families will have to pay for legal help depends on the particular state or territory, and especially on whether the case is deemed to have merit, and on the means of the family. Due to funding shortages, legal aid is limited mainly to people with very low incomes and low assets. Families might get help from Aboriginal and Torres Strait Islander legal services or community legal centres, but both these are under-funded and may not have capacity. Pro bono help is sometimes provided, but many families who have lost a loved one do not obtain effective, adequately funded legal representation, and end up either without a lawyer or having to pay at least $40 000.

'Why should the family of the person that's died, and the legal team, have to be in that position, while everybody else representing people who have some responsibility for what happened be massively well-resourced?'
Community lawyer

Public interest organisations

Public interest organisations will generally seek to become involved in an inquest as public interest interveners, meaning that the organisation has interests that are different from those of the existing parties.[282] 'Public interest' is most commonly understood as referring to matters with systemic implications that 'affect the general community or a group in the community, especially those that involve significant harm' and which adversely affect 'disadvantaged sectors of the community'.[283]

The Coroners Court will grant leave for the organisation to intervene if it deems the organisation to have some qualification or expertise to put forward the public interest.[284] Via tendering evidence and making submissions, and perhaps, in some inquests, examining witnesses, public interest interveners will seek to raise matters harming the community or affecting a disadvantaged group, in such a way that the outcome of the proceeding will have a positive impact on those matters.[285]

Just as for the data on legal representation at inquests, it is difficult to assess the extent and range of public interveners in inquests in Australia. The Australian Human Rights Commission (formerly the Human Rights and Equal Opportunity Commission) has intervened in a number of inquests in different jurisdictions, including Aboriginal deaths in custody, deaths of asylum seekers, and petrol sniffing deaths.[286]

[282] George Williams, 'The Amicus Curiae and Intervener in the High Court of Australia: A Comparative Analysis' (2000) 28 *Federal Law Review* 365, 368.

[283] Public Interest Advocacy Centre (PIAC) in Penny Martin, 'Defining and Refining the Concept of Practising in "the Public Interest"' (2003) 28(1) *Alternative Law Journal* 3, 4. 'Disadvantage' has been defined as 'social and economic problems arising out of a differential and unequal distribution of opportunities and entitlements in society' (Rajeev Dhavan, 'Whose Law? Whose Interest?' in Jeremy Cooper and Rajeev Dhavan (ed), *Public Interest Law* (1986) 17, 21).

[284] Julie O'Brien, 'Intervention Powers of the Human Rights Commission' (2006) February *Law Society Journal* 39.

[285] See eg *Australian Conservation Foundation Inc v Commonwealth* (1980) 146 CLR 493; *Onus v Alcoa of Australia Ltd* (1981) 149 CLR 27.

[286] Submission to Court as Intervener and Amicus Curiae <http://www.humanrights.gov.au/legal/submissions_court/index.html>.

Other public interest interveners in inquests have included the Public Advocate, Aboriginal and Torres Strait Islander legal services (ATSILS), Aboriginal Justice Advisory Committees and community legal centres (CLCs).

Examples of community legal centre public interest intervention in inquests include:

- Flemington/Kensington Legal Service (Victoria) in a series of inquests into fatal shootings by police in the 1980s;
- Villamanta Legal Service (Victoria) at inquest into the deaths in Kew cottages of people with intellectual disabilities (1996);
- Tenants Union Victoria and PILCH Homeless Persons Legal Clinic at inquest into the deaths of Christopher Giorgi and Leigh Sinclair in a rooming house fire (2008–9);
- Mental Health Legal Centre (Victoria) at inquest into the death of James Bloomfield, a man with a mental illness who died of severe burns after police sprayed him with capsicum spray (2009–10); and
- Human Rights Law Centre at inquest into the death of 15-year-old Tyler Cassidy, who was fatally shot by police (2010–11).

Victoria Legal Aid also intervened in the Tyler Cassidy inquest.

Public interest interveners play an important role in inquests by raising matters of social justice, and through indirectly assisting the coroner to examine all of the relevant systemic issues and to make appropriate recommendations aimed at long-range prevention. Interveners are probably particularly important where the family is not legally represented, as at least they may be able to make submissions and perhaps examine witnesses about issues that the family would like to see investigated. As with the situation of ATSILS and CLCs providing legal representation to families, however, many of the organisations likely to be the most useful to the inquest process are those organisations that operate on scarce resources and therefore may not be in a position to intervene.

Public interest organisations are important in inquests because they draw attention to systemic issues that often involve questions of social justice. They can be especially important when the family is not legally represented. However, these organisations often have scarce resources and therefore may not be able to intervene.

A National Inquest Clearing House

As detailed above, CLCs, ATSILS, Legal Aid Commissions and other public legal assistance providers support, represent and otherwise help families through the inquest process. In addition, public interest organisations, often also CLCs or affiliated with ATSILS or the family's community, play a significant role in the prevention function of inquests. This work has continued for many years, and yet the knowledge and understanding gained by individual providers through countless individual inquests has not been effectively consolidated and shared among public legal assistance providers throughout Australia.

A new national non-government organisation, a National Inquest Clearing House (NICH),[287] founded by a coalition of public legal assistance providers and allied organisations, is needed to fulfil this role. The NICH would be committed to securing, in the public interest, the best outcomes from the coronial process for families, via access to specialist knowledge, expert opinion and other resources necessary to monitor and report on coronial processes and their outcomes.

[287] The acronym 'NICH' has been chosen because of its affiliation with the word 'niche', meaning a gap that is filled in a specialist manner. 'Niche' also evokes a place of support and safety.

The NICH would enhance inquest representation for families and community organisations, and improve the coronial process by:

- providing a specialist legal advice, referral and support service for families and community groups entering the coronial process;
- maintaining a register of legal practitioners willing and able to undertake casework for, and experts willing to assist, these parties;
- acting as a forum for the exchange of information and experience;
- undertaking specialist coronial advocacy and support training, and professional development programs;
- providing access to a 'bank' of standard operating procedures, policies, protocols and MOUs, together with legislation and case law from all jurisdictions;
- undertaking research and resource support for public legal assistance providers, including community legal centres, Aboriginal and Torres Strait Islander Legal Services and Legal Aid Commissions;
- facilitating access to coronial recommendations from all jurisdictions;
- monitoring and analysing coronial findings and recommendations and their implementation, in the interests of family and community wellbeing, public health and safety and the administration of justice;
- conducting community legal education; and
- developing policy proposals and engaging in law reform.

In many ways the roles proposed for the NICH are similar to those of the United Kingdom non-government organisation, INQUEST (see **Appendix 2**). Like INQUEST, the NICH would assist the development of expertise in the coronial jurisdiction, and provide greater capacity for policy development and systemic reform, together with media campaigns and community education. The two main anticipated differences are that the NICH would respond to all preventable deaths;[288] and at this stage at least it is not envisaged that the NICH would itself undertake casework. The policy and law reform work of the NICH would include advocating for the provision of adequate legal assistance funding so that all families could obtain legal representation for coronial investigations and inquests without financial hardship, and so that public interest interveners could be represented at inquests as appropriate.

A National Inquest Clearing House is needed to enhance inquest representation for families and public interest organisations, and to improve the coronial process by consolidating and sharing knowledge for the prevention of avoidable deaths.

[288] INQUEST's main focus is on deaths in custody.

Recommendations (Part 2)

9. As a fundamental component of Australia's international human rights obligations under the right to life, funding and availability of legal assistance providers must be sufficient to enable all families to obtain, without financial hardship, effective legal advice and representation for investigations and inquests, at a level that is consistent with the level of legal representation accorded to government and other institutional parties in the inquest. A specific pool of funds should be made available to enable community legal centres to provide legal representation for families at inquests.

10. Legal assistance services must be sufficient to enable all advocacy organisations with a sufficient interest to intervene in inquests, as a fundamental component of Australia's international human rights obligations under the right to life.

11. An independent National Inquest Clearing House, along the lines of INQUEST (UK), should be established and adequately funded.

Appendix 1 Provisions in State/Territory legislation relevant to death prevention and system accountability (as at 28 February 2013)

Legislation	Heading	Provision
Coroners Act 1997 (ACT)	Objects of Act	s 3BA(1)(d) [The main objects of this Act are to— [...]] allow a coroner, based on the coroner's findings in an inquest or inquiry, to make recommendations about the following: (i) the prevention of deaths; (ii) the promotion of general public health and safety including occupational health and safety; (iii) the administration of justice; (iv) the need for a matter to be investigated or reviewed by an entity. s 3BA(2)(c) [As far as practicable, the objects of this Act must be carried out in a way that— [...]] promotes the development of a systematic and comprehensive public record of findings made by a coroner and any associated recommendations made by the coroner; and s 3BA(2)(d) increases public awareness of a coroner's findings about— (i) violent or unusual deaths; and (ii) serious risks to public health and safety; and (iii) ways to protect public health and safety by reducing the risk of death, fire or disaster
	Coroner's findings	s 52(4) The coroner, in the coroner's findings— (a) must— (i) state whether a matter of public safety is found to arise in connection with the inquest or inquiry; and (ii) if a matter of public safety is found to arise—comment on the matter; and (b) may comment on any matter about the administration of justice connected with the inquest or inquiry.
	Report after inquest or inquiry	s 57(3) A report by a coroner to the Attorney-General— (a) must be in writing; and (b) must set out the coroner's findings about any serious risks to public safety that were revealed in the inquest or inquiry to which the report relates; and (c) may make recommendations about matters of public safety if the recommendations— (i) relate to the coroner's findings about a cause of death, fire or disaster; and (ii) would, in the coroner's opinion, improve public safety. s 57(4) If the Attorney-General receives a report under this section, the Attorney-General must— (a) present the report to the Legislative Assembly within 6 months after the day the Attorney-General receives the report; and (b) present a statement of the Executive's response to the report on the same day the report is presented to the Legislative Assembly.
	Findings about quality of care, treatment and supervision	s 74 The coroner holding an inquest into a death in custody must include in a record of the proceedings of the inquest findings about the quality of care, treatment and supervision of the deceased that, in

		the opinion of the coroner, contributed to the cause of death.
	Copies of reports of findings	s 75(1) After the coroner has completed an inquest into a death in custody, the coroner must, in writing, report the findings to— (a) the Attorney-General; and (b) the custodial agency in whose custody the death happened and to the Minister responsible for that agency; and (c) the Australian Institute of Criminology; and (d) if the deceased was an Aboriginal person or Torres Strait Islander—an appropriate local Aboriginal legal service; and (e) any other person whom the coroner considers appropriate. s 75(2) The coroner must make available a copy of a report of the findings into a death in custody to— (a) a member of the immediate family of the deceased or a representative of that member; and (b) a witness who appeared at an inquest into the death.
	Response to reports	s 76(1) The custodial agency to which a report is given under section 75 must, not later than 3 months after the date of receipt of the report, give to the Minister responsible for the custodial agency a written response to the findings contained in the report. s 76(2) A written response under subsection (1) must include a statement of the action (if any) that has been, or is being, taken in relation to any aspect of the findings contained in the report. s 76(3) The Minister to whom a copy of a response is given under subsection (2) must give a copy of the response to the coroner in relation to whose findings the report relates. s 76(4) The coroner must give a copy of the response to each person or agency to whom a copy of the report was given under section 75.
	Annual report of court	s 102(1) The Chief Coroner must give a report relating to the activities of the court during each financial year to the Attorney-General for presentation to the Legislative Assembly. s 102(2) The report must include particulars of— (a) reports prepared by coroners into deaths in custody and findings contained in those reports; and […] (c) recommendations made under section 57 (3); and (d) responses of agencies under section 76, including correspondence about the responses. s 102(3) The Chief Coroner must give the report to the Attorney-General as soon as practicable after the end of the financial year and, in any event, within 6 months after the end of the financial year. [s 102(4)-(7) = conditions for an extension of time] s 102(8) The Attorney-General must present a copy of a report under this section to the Legislative Assembly within 6 sitting days after the day the Attorney-General receives the report.

Coroners Act 2009 (NSW)	Objects of Act	s 3(e) to enable coroners to make recommendations in relation to matters in connection with an inquest or inquiry (including recommendations concerning public health and safety and the investigation or review of matters by persons or bodies)
	State Coroner to inform Ombudsman about certain child or disability deaths	s 36(1) The State Coroner is to provide the Ombudsman, in accordance with subsection (2), with all relevant material held by the State Coroner relating to: (a) any death or suspected death of a person in any of the circumstances referred to in section 24 (1) [specified children and disabled persons], or (b) any death of a person who is less than 18 years old in the circumstances referred to in section 23 (d) [in or temporarily absent from a detention centre, correctional centre or lock-up]. s 36(2) The relevant material referred to in subsection (1) is to be provided as soon as practicable after: (b) if an inquest is held—the conclusion or suspension of the inquest.
	State Coroner to report on deaths in custody	s 37(1) The State Coroner is to make a written report to the Minister containing a summary of the details of the deaths or suspected deaths that: (a) the State Coroner has been informed about under section 35 or 38 [reportable deaths or suspected reportable deaths], and (b) appear to the State Coroner to involve the death or suspected death of a person in circumstances referred to in section 23 [deaths in custody or as a result of police operations]. s 37(2) A report under subsection (1) is to be made for the period of 12 months commencing on 1 January of each year. A report is to be made within 2 months after the end of the period to which it relates. s 37(3) The Minister is to cause a copy of the report made to the Minister under subsection (1) to be tabled in each House of Parliament within 21 days after the report is made. s 37(4) If a House of Parliament is not sitting when the Minister seeks to cause a copy of the report to be tabled before it, the Minister is to cause a copy of the report to be presented to the Clerk of that House of Parliament. s 37(5) A copy of the report presented to the Clerk of a House of Parliament under this section: (a) is, on presentation and for all purposes, taken to have been laid before the House, and (b) may be printed by authority of the Clerk of the House, and (c) if so printed, is taken to be a document published by or under the authority of the House, and (d) is to be recorded: (i) in the case of the Legislative Council—in the Minutes of the Proceedings of the Legislative Council, and (ii) in the case of the Legislative Assembly—in the Votes and Proceedings of the Legislative Assembly, on the first sitting day of the House after receipt of the copy of the report by the Clerk.

	Coroner or jury may make recommendations	s 82(1) A coroner (whether or not there is a jury) or a jury may make such recommendations as the coroner or jury considers necessary or desirable to make in relation to any matter connected with the death, suspected death, fire or explosion with which an inquest or inquiry is concerned. s 82(2) Without limiting subsection (1), the following are matters that can be the subject of a recommendation: (a) public health and safety, (b) that a matter be investigated or reviewed by a specified person or body. s 82(4) The coroner is to ensure that a copy of a record that includes recommendations made under this section is provided, as soon as is reasonably practicable, to: (a) the State Coroner (unless the coroner is the State Coroner), and (b) any person or body to which a recommendation included in the record is directed, and (c) the Minister, and (d) any other Minister (if any) that administers legislation, or who is responsible for the person or body, to which a recommendation in the record relates.
	Domestic Violence Death Review Team	Chapter 9A
	Object of Chapter	s 101A The object of this Chapter is, through the constitution of the Domestic Violence Death Review Team, to provide for the investigation of the causes of domestic violence deaths in New South Wales, so as to: (a) reduce the incidence of domestic violence deaths, and (b) facilitate improvements in systems and services.
	Members of Team	s 101E(1) The Team is to consist of the Convenor of the Team and other persons appointed by the Minister. s 101E(2) The Minister is to appoint as Convenor of the Team the State Coroner, a Deputy State Coroner or a former State Coroner or Deputy State Coroner.
	Functions of Team	s 101F The Team has the following functions: (a) to review closed cases of domestic violence deaths occurring in New South Wales, (b) to analyse data to identify patterns and trends relating to such deaths, (c) to make recommendations as to legislation, policies, practices and services for implementation by government and non-government agencies and the community to prevent or reduce the likelihood of such deaths, (d) to establish and maintain a database (in accordance with the regulations) about such deaths, (e) to undertake, alone or with others, research that aims to help prevent or reduce the likelihood of such deaths.
	Matters to be considered in reviews	s 101G(1) In carrying out a review of closed cases of domestic violence deaths, the Team is to consider the following matters: (a) the events leading up to the death of the de-

		ceased persons, (b) any interaction with, and the effectiveness of, any support or other services provided for, or available to, victims and perpetrators of domestic violence, (c) the general availability of any such services, (d) any failures in systems or services that may have contributed to, or failed to prevent, the domestic violence deaths. s 101G(2) This section does not limit the matters that the Team may consider or examine in any review of closed cases of domestic violence deaths.
	Reports	s 101J(1) The Team must prepare, within the period of 4 months after 30 June in each year, and furnish to the Presiding Officer of each House of Parliament, a report on domestic violence deaths reviewed in the previous year. s 101J(2) Without limiting subsection (1), the report may include the following: (a) identification of systemic and procedural failures that may contribute to domestic violence deaths, (b) recommendations as to legislation, policies, practices and services for implementation by government and non-government agencies and the community to prevent or reduce the likelihood of such deaths, (c) details of the extent to which its previous recommendations have been accepted.
	Reporting to Parliament	s 101K(1) A copy of a report furnished to the Presiding Officer of a House of Parliament under this Part must be laid before that House on the next sitting day of that House after it is received by the Presiding Officer. s 101K(2) The Team may include in a report a recommendation that the report be made public forthwith. s 101K(3) If a report includes a recommendation that a report be made public forthwith, a Presiding Officer of a House of Parliament may make it public whether or not that House is in session and whether or not the report has been laid before that House.
Coroners Act 1993 (NT)	Report on additional matters by coroner	s 26(2) A coroner who holds an inquest into the death of a person held in custody or caused or contributed to by injuries sustained while being held in custody shall make such recommendations with respect to the prevention of future deaths in similar circumstances as the coroner considers to be relevant.
	Coroner to send report etc. to Attorney-General	s 27 The coroner must cause a copy of each report and recommendation made under section 26 to be sent without delay to the Attorney-General.
	Coroner's findings and comments	s 34(2) A coroner may comment on a matter, including public health or safety or the administration of justice, connected with the death or disaster being investigated.
	Coroner's reports	s 35(2) A coroner may report to the Attorney-General on a death or disaster investigated by the coroner. s 35(2) A coroner may make recommendations to the Attorney-General on a matter, including public health

		or safety or the administration of justice connected with a death or disaster investigated by the coroner.
	Reports etc. under section 27 or 35 to be forwarded to Agencies etc.	s 46A(1) If the Attorney-General receives a report or recommendation from a coroner under section 27 or 35 that contains comment relating to an Agency or the Police Force of the Northern Territory, the Attorney-General must, without delay, give a copy of the report or recommendation to the Chief Executive Officer of the Agency or the Commissioner of Police, as the case requires. s 46A(2) If the Attorney-General receives a report or recommendation from a coroner under section 27 or 35 that contains comment relating to a Commonwealth department or agency, the Attorney-General, must without delay, give a copy of the report or recommendation to the Commonwealth Minister responsible for the administration of the department or agency.
	Response to reports	s 46B (1) If a Chief Executive Officer or the Commissioner of Police receives a copy of a report or recommendation under section 46A(1), the Chief Executive Officer or Commissioner must, within 3 months after receiving the report or recommendation, give to the Attorney-General a written response to the findings in the report or to the recommendation. s 46B(2) The response of the Chief Executive Officer or the Commissioner of Police is to include a statement of the action that the Agency or the Police Force is taking, has taken or will take with respect to the coroner's report or recommendation. s 46B(3) On receiving the response of the Chief Executive Officer or the Commissioner of Police, the Attorney-General: (a) must, without delay, report on the coroner's report or recommendation and the response to the coroner's report or recommendation; and (b) may give a copy of his or her report to the coroner; and (c) must lay a copy of his or her report before the Legislative Assembly within 3 sitting days after completing the report. s 46B(4) The coroner may give a copy of the Attorney-General's report to: (a) the senior next of kin of a deceased person mentioned in the report (or a representative of the senior next of kin); and (b) a witness who appeared at the inquest the subject of the report; and (c) any other person who the coroner considers has sufficient interest in the inquest or investigation the subject of the report.
Coroners Act 2003(Qld)	Object of Act	s 3(d) to help to prevent deaths from similar causes happening in the future by allowing coroners at inquests to comment on matters connected with deaths, including matters related to – (i) public health or safety; or (ii) the administration of justice.
	When inquest may be held	s 28(2)(a) In deciding whether it is in the public interest to hold an inquest, the coroner may consider—

		(a) the extent to which drawing attention to the circumstances of the death may prevent deaths in similar circumstances happening in the future.
	Coroner's Comments	s 46(1) A coroner may, whenever appropriate, comment on anything connected with a death investigated at an inquest that relates to— (a) public health or safety; or (b) the administration of justice; or (c) ways to prevent deaths from happening in similar circumstances in the future. s 46(2) [The coroner must give a written copy of the comments to…] (d) if a government entity deals with the matters to which the comment relates— (i) the Attorney-General; and (ii) the Minister administering the entity; and (iii) the chief executive officer of the entity; and (e) if the comments relate to the death of a child—the children's commissioner.
	Coroner's comments and findings for particular deaths	s 47(1) This section applies to the findings, and any comments, of a coroner made in relation to the investigation of a death in care, death in custody or death that happened in the course of or as a result of police operations. s 47(2) The coroner must give a written copy of the findings and comments to— (a) the Attorney-General; and (b) the appropriate chief executive; and (c) the appropriate Minister.
	Annual report	s 77(1) As soon as practicable after the end of each financial year, the State Coroner must give the Attorney-General a report for the year on the operation of this Act. s 77(2) The report must also contain— (a) the State Coroner's guidelines that were operative in the year; and (b) a summary of the investigation, including the inquest, into each death in custody; and[…] s 77(3) The report may also contain a summary of any other investigation that the State Coroner considers should be brought to the Minister's attention. s 77(4) The Attorney-General must table a copy of the report in the Legislative Assembly within 14 sitting days after receiving the report.
Coroners Act 2003 (SA)	Findings on inquests	s 25(1) The Coroner's Court must, as soon as practicable after the completion of an inquest, give its findings in writing setting out as far as has been ascertained the cause and circumstances of the event that was the subject of the inquest. s 25(2) The Court may add to its findings any recommendation that might, in the opinion of the Court, prevent, or reduce the likelihood of, a recurrence of an event similar to the event that was the subject of the inquest. s 25(4) The Court must, as soon as practicable after the completion of the inquest, forward a copy of its

		findings and any recommendations— (a) to the Attorney-General; and (b) in the case of an inquest into a death in custody— (i) if the Court has added to its findings a recommendation directed to a Minister or other agency or instrumentality of the Crown— to each such Minister, agency or instrumentality of the Crown; and (ii) to each person who appeared personally or by counsel at the inquest; and (iii) to any other person who, in the opinion of the Court, has a sufficient interest in the matter. s 25(5) The Minister or the Minister responsible for the agency or other instrumentality of the Crown must, within 8 sitting days of the expiration of 6 months after receiving a copy of the findings and recommendations under subsection (4)(b)(i)— (a) 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 those recommendations; and (b) forward a copy of the report to the State Coroner.
	Annual report	s 39(1) The State Coroner must, on or before 31 October in each year, make a report to the Attorney-General on the administration of the Coroner's Court and the provision of coronial services under this Act during the previous financial year. s 39(2) The report must include all recommendations made by the Coroner's Court under section 25 during that financial year. s 39(3) The Attorney-General must, within 12 sitting days after receiving a report under this section, cause copies of the report to be laid before both Houses of Parliament.
Coroners Act 1995 (Tas)	Findings, &c., of coroner investigating a death	s 28(2) A coroner must, whenever appropriate, make recommendations with respect to ways of preventing further deaths and on any other matter that the coroner considers appropriate. s 28(3) A coroner may comment on any matter connected with the death including public health or safety or the administration of justice. s 28(5) If a coroner holds an inquest into the death of a person who died whilst that person was a person held in custody or a person held in care or whilst that person was escaping or attempting to escape from prison, a secure mental health unit, a detention centre or police custody, the coroner must report on the care, supervision or treatment of that person while that person was a person held in custody or a person held in care.
	Reports on deaths	s 30(1) A coroner may report to the Attorney-General on a death which the coroner investigated. s 30(2) A coroner may make recommendations to the Attorney-General on any matter connected with a death which the coroner investigated, including public health or safety or the administration of justice.

	Annual report	s 69(1) The Chief Magistrate must, on or before 30 November in each year, prepare and submit to the Attorney-General a report in relation to the operation of this Act during the financial year ending on the preceding 30 June. s 69(2) The report – (a) must include details of deaths of persons held in custody and findings and recommendations made by coroners; and (b) may include any other matter that the Chief Magistrate considers appropriate. s 69(3) The Attorney-General must cause a copy of the report to be laid on the table of each House of Parliament within 10 sitting days after receiving the report.
Coroners Act 2008 (Vic)	Preamble	The coronial system of Victoria plays an important role in Victorian society. That role involves the independent investigation of deaths and fires for the purpose of finding the causes of those deaths and fires and to contribute to the reduction of the number of preventable deaths and fires and the promotion of public health and safety and the administration of justice.
	Purposes	s 1(c) [The purposes of this Act are] to contribute to the reduction of the number of preventable deaths and fires through the findings of the investigation of deaths and fires, and the making of recommendations, by coroners.
	Factors to consider for the purposes of this Act	s 8(f) the desirability of promoting public health and safety and the administration of justice.
	Findings of coroner investigating a death	s 67(3) A coroner may comment on any matter connected with the death, including matters relating to public health and safety or the administration of justice.
	Reports and recommendations	s 72(1) A coroner may report to the Attorney-General on a death or fire which the coroner has investigated. s 72(2) A coroner may make recommendations to any Minister, public statutory authority or entity on any matter connected with a death or fire which the coroner has investigated, including recommendations relating to public health and safety or the administration of justice. s 72(3) If a public statutory authority or entity receives recommendations made by the coroner under subsection (2), the public statutory authority or entity must provide a written response, not later than 3 months after the date of receipt of the recommendations, in accordance with subsection (4). s 72(4) A written response to the coroner by a public statutory authority or entity must specify a statement of action (if any) that has, is or will be taken in relation to the recommendations made by the coroner. s 72(5) The coroner must— (a) publish the response of a public authority or entity on the Internet; and

		(b) provide a copy of the response to any person— (i) who has advised the principal registrar that they have an interest in the subject of the recommendations; and (ii) who the principal registrar considers to have a sufficient interest in the subject of the recommendations.
	Publication of findings and reports	s 73 (1) Unless otherwise ordered by a coroner, the findings, comments and recommendations made following an inquest must be published on the Internet in accordance with the rules.
	Assignment of magistrates and acting magistrates to be coroners	s 93(2) In assigning a magistrate or acting magistrate to be a coroner for the Coroners Court, the State Coroner and Chief Magistrate must have regard to the experience and knowledge of the magistrate or acting magistrate in relation to coronial investigations, investigations into deaths and fires and the identification of preventative measures following such investigations.
	Annual report	s 102(1) As soon as practicable in each year but not later than 31 October, the State Coroner must submit to the Attorney-General a report containing— (a) a review of the operation of the Coroners Court during the 12 months ending on the preceding 30 June; and (b) any other matters that are prescribed by the regulations. s 102(2) The Attorney-General must cause each annual report submitted to him or her under this section to be laid before each House of Parliament within 7 sitting days after receiving it.
	Function of the [Coronial] Council	s 110(1) The function of the Council is to provide advice, and make recommendations, to the Attorney-General either— (a) of its own motion; or (b) at the request of the Attorney-General. s 110(2) Advice and recommendations prepared under subsection (1) must be in respect of— (a) issues of importance to the coronial system in Victoria; (b) matters relating to the preventative role played by the Coroners Court; (c) the way in which the coronial system engages with families and respects the cultural diversity of families; (d) any other matters relating to the coronial system that are referred to the Council by the Attorney-General.
	Annual report [of the Coronial Council]	s 113(1) As soon as practicable each year but not later than 31 October, the Council must submit to the Attorney-General a report— a) of its operations for the year ending on 30 June that year; and (b) that includes any prescribed matter. s 113(2) The Attorney-General must cause each annual report submitted to him or her under this section to be presented to each House of Parliament within 7 sitting days of that House after receiving it.

Coroners Act 1996 (WA)	Functions of State Coroner	s 8(d) The functions of the State Coroner are to ensure that an inquest is held whenever there is a duty to do so under this Act or whenever it is desirable that an inquest be held.
	Findings and comments of coroner	s 25(2) A coroner may comment on any matter connected with the death including public health or safety or the administration of justice. s 25(3) Where the death is of a person held in care, a coroner must comment on the quality of the supervision, treatment and care of the person while in that care.
	Reports	s 27(1) The State Coroner must report annually to the Attorney General on the deaths which have been investigated in each year, including a specific report on the death of each person held in care. s 27(2) The Attorney General is to cause a report submitted under subsection (1) to be laid before each House of Parliament within 12 sitting days of such House after its receipt by him or her. s 27(3) The State Coroner may make recommendations to the Attorney General on any matter connected with a death which a coroner investigated, including public health or safety, the death of a person held in care or the administration of justice. s 27(4) Where a recommendation made under subsection (3) regarding a death of a person held in care is relevant to the operation of an agency, the State Coroner must inform that agency in writing of the recommendation.

Appendix 2 The model of INQUEST (UK)

Context

The national coronial jurisdiction in the United Kingdom is the responsibility of the Ministry of Justice. Although the system is local, with coroners overseeing 127 distinct jurisdictions, the Chief Coroner monitors coronial standards nationally. INQUEST is an independent specialist organisation that provides free and confidential services to bereaved families in England and Wales.[289]

Casework

Inquests into deaths in custody

The bulk of INQUEST's operations are casework, with priority given to deaths in custody, including prison or police custody and psychiatric or immigration detention. INQUEST provides a dedicated caseworker to each family as well as legal representation via a solicitor or barrister from their INQUEST lawyers group, which is a collection of legal practitioners who are willing to offer their legal services via INQUEST. INQUEST will also work with the client's existing practitioner and attend legal meetings with the client if the client has already sought legal advice, and assist families to access funding for legal representation if needed.

General advice

INQUEST also offers a general advice and information service to any bereaved person seeking help in relation to an inquest. They operate a unique telephone-based service providing free support, advice and information about the inquest process, and help callers contact more specialist services if necessary. In addition, INQUEST provides the *Inquest Handbook,* downloadable at no cost from their website.[290] It contains an overview of the UK coronial system and procedures, and a comprehensive list of professional and voluntary organisations that bereaved individuals can contact for specialist advice.

Policy and parliamentary work

INQUEST's casework informs its research, parliamentary and policy work. INQUEST campaigns for change to prevent future deaths and increase accountability, and to remedy deficiencies in the current system from the perspective of the bereaved. It focuses dually on reform of the inquest system and reduction in deaths in custody. This work includes submitting evidence to Parliament and European human rights committees, publishing a wide range of resources including press releases and narratives of bereaved families and their experience with the coronial investigation and inquest, and working with prisons and non-government organisations to raise concerns.

Education and training

Membership of the INQUEST Lawyer's Group promotes the circulation of knowledge and expertise among members. Regular meetings led by leaders in the field act as a forum for exchange of information and experience, and training courses have been provided for practitioners on current issues in inquest law. Members also receive a subscription to the Inquest Law Magazine, published three times

[289] Information in this Appendix was obtained from <http://www.inquest.org.uk>.

[290] INQUEST, *Inquest Handbook* (2011) <http://www.handbook.inquest.org.uk>.

a year, and have access to an email group in which ideas and questions are discussed and information on developments in inquest law is exchanged.

Public monitoring and support for bereaved families

INQUEST monitors the number of deaths in custody as well as the number of unlawful killing verdicts delivered at inquests. It also supports family campaigns that are independently run by individuals and groups and which aim to raise media awareness for their concerns. INQUEST also organises support groups for bereaved families, and can refer to pathologists if an independent post-mortem is required.

Funding and resources

A non-government organisation, INQUEST is funded by donations and grants. Funds are received from purchases of publications, subscription to the *Inquest Law* magazine, membership of the INQUEST Lawyers Group, and donations. Support of professionals and leaders in the field provides the organisation with credibility and expertise.