Submission to Productivity Commission Inquiry into Access to Justice Arrangements

Australian Inquest Alliance

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Introduction

The Australian Inquest Alliance

The Australian Inquest 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, advocates for imprisoned women and men, and academic researchers. Our current members are:

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);
Creative Ministries Network, UnitingCare;
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;
Community Legal Centres NSW 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 over many years. This knowledge encompasses coronial investigations, inquests, and broader coronial frameworks across jurisdictional boundaries.

The Alliance seeks systemic change in order to eliminate and reduce preventable deaths. We believe that this requires each State and Territory to effectively address the structural issues underpinning preventable deaths.

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, from investigations such as the Royal Commission into Aboriginal Deaths in Custody, such 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 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, 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.

This submission

The coronial jurisdiction occupies a unique place in the Australian legal landscape, and its processes do not neatly fit the description of 'civil *dispute* resolution'. However, we note that the Productivity Commission's Issues Paper (p2) includes in the scope of its Terms of Reference a broad understanding of potential routes for dealing with matters that parties cannot resolve themselves. We believe that current coronial systems across Australia are within this scope and epitomise how the cost of accessing justice services and securing legal representation prevents many Australians from gaining effective access to the justice system.

Our submission is probably most relevant to Sections 2–5, 12 and 14 of the questions posed by the Issues Paper. For more extensive discussion, associated recommendations and evidential support for our arguments below, we refer the Commission to our Issues Paper, *Saving Lives By Joining Up Justice: Why Australia Needs Coronial Reform and How to Achieve It* (March 2013).[1]

The coronial system

> '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.'[2]

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. 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 rather than adversarial, 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,

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[1] Available at www.fclc.org.au/cb_pages/currentprojects.php

[2] 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>.

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. However, many families who have lost loved ones experience the coronial process and its aftermath as traumatic, mystifying, frustrating and disempowering.

Experiences of families

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 for bereaved families. Family suffering is exacerbated if there is no clear information or regular follow-ups with the family by coronial or other official personnel. Other common difficulties for families include:

- 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;
- 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; and
- families not being able to view and touch the body of the deceased person while it is in the coroner's jurisdiction.[3]

[3] Law Reform Committee, Parliament of Victoria, *Coroners Act 1985 Final Report* (2006), 428–30; Law Reform Commission of Western Australia, *Review of Coronial Practice in Western Australia Background Paper* (September 2010), 55–7; Law Reform Commission of Western Australia, *Review of Coronial Practice in Western Australia Discussion Paper* (June 2011), 93-6,181–93.

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. The Law Reform Commission of Western Australia has 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.'[4]

The Victorian Parliament Law Reform Inquiry into the Coroners Act 1985 (Vic) and the Review of Coronial Practice in Western Australia have also highlighted 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; as well as a lack of adherence, when police are potentially implicated in a death, to the human rights standard that coronial investigations be independent.

Most profoundly, families can fail 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.

For example, 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.'

All of these issues are underpinned by a general failure across jurisdictions to fully implement into practice the right of families to participate in coronial

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

processes concerning their loved ones. In particular, states and territories often do not adequately inform families of their legal rights, including the right to representation, and fail to provide effective access to legal help.

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

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.

Due to the fact that inquests are formally inquisitorial, strictly speaking there are no parties.[5] 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.[6] The legal issues can also be very complex and time-consuming, and the whole process may be the subject of intense media interest. Unrepresented families tend to rely on the Counsel assisting the Coroner or the police informant for legal information, which raises conflicts of interest.[7]

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.'[8] In order to realise 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.

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

At a time when families are struggling to comprehend the death, they are also encountering a world of legal jargon and processes that is unfamiliar to most people. Because the issue of legal representation generally arises when an

[5] Ian Freckelton and David Ranson, *Death Investigation and the Coroner's Inquest* (2006), 566.
[6] 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.
[7] Gibson, 590.
[8] Gibson, 590.

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. However, 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.

The family bereaved by a car accident and referred to above 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.'

How do families obtain a lawyer?

If a family knows that 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 organisation such as a law society, legal aid commission or community legal centres peak body, 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.[9]

In other cases, family members go into serious debt in order to try to get justice for their loved one.

> '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, 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.'

Legal Aid

Parties unable to fund private representation can apply for legal assistance from their state or territory Legal Aid service. 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. 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.[10] 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

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

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

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.[11]

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.[12]

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.[13]

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.[14]

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',[15] or who 'would be significantly disadvantaged were assistance not provided'.[16] This means that it is possible for family members to obtain legal representation for an inquest

[11] <http://www.legalaid.nsw.gov.au/what-we-do/civil-law/coronial-inquest-matters>.
[12] 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>.
[13] 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.
[14] Australian Government Attorney-General's Department, *Service Delivery Directions*, 4.5c, 7.
[15] 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.
[16] Australian Government Attorney-General's Department, *Service Delivery Directions*, 4.5d, 7.

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.[17]

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 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

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

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.

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.'

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);[18]
- 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);
- 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).

[18] Above examples from Gibson, 599.

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.[19] 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.

How often do families receive legal assistance in coronial matters?

It is not easy to ascertain how many people have received legal help for coronial matters, or even how many have been legally represented at inquests across Australia, let alone what proportion of that representation is publicly funded.[20] To obtain this information, each inquest file would need to be viewed. As one Coroners Court official explained, this is a very time

[19] 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>.
[20] Frances Gibson, 'Legal Aid for Coroners' Inquests' (2008) 15 *Journal of Law and Medicine* 587, 594.

consuming and onerous task, and one that many officers of Coroners Courts may not be enthusiastic to undertake upon request.[21]

Research undertaken for the Alliance in 2012 provides very limited and approximate figures, which we compare with the number of inquests held in each jurisdiction in order to give a rough indication of the representation rate. Note that as data on CLC and ATSILS assistance is not available, and law societies rarely keep coronial-specific statistics, the figures largely reflect Legal Aid statistics.

State/Territory	**Representation or other legal assistance**	**Number of inquests held**	**Comments**
ACT	No data available	20 (2010-11)	1 pro bono application
NSW	25 substantive + 25 minor	290 (2011)	
Northern Territory	1 + 19 advices	Unavailable from Internet	Average over 2008-11
Queensland	Unavailable	81 (2011-12)	
South Australia	12 telephone advices + 10 advice interviews	45 (2011-12)	3 pro bono inquiries 2009-12: 2 in process, 1 declined
Tasmania	No recent data	9	
Victoria	13 + 10 Law Institute referrals + 9 pro bono referrals	142 (2010-11)	
Western Australia	No data available but see discussion below	98	Families rarely receive legal aid for representation due to absence of public interest criteria

[21] Communication from Michell Heidtmann, ACT Coroners Court, to Courtney Guilliatt, Federation of Community Legal Centres, 18 May 2009.

Implications for families

Although information is limited, the above table together with the anecdotal experience of families and advocates makes clear that many families who have lost a loved one do not obtain effective, adequately funded legal representation. This example of a rural parent, whose child was a victim of domestic homicide, demonstrates the lack of clear information and sometimes misinformation about the available options, along with various 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 victim’s 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.'

In contrast to the barriers faced by families, the fact that inquests often take place in the public spotlight where governments and other agencies are under scrutiny means that their interests tend to be legally represented at inquests. Research undertaken for the Western Australian Review of Coronial Practice found that in 2009, of 33 inquests, 21 had counsel.[22] 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.[23] At one Victorian inquest where a parent represented herself, there were 10 barristers representing the other parties, including two senior counsel.

Another 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 be given to X's lawyer.

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

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.'

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 is not able to 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.’[24]

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.

Public interest organisations

Families often need legal help not only to navigate the coronial process, but to seek answers to the questions they have about the death of their loved one. Without legal assistance, broader prevention issues may also be under-emphasised or remain unaddressed. Family counsel can therefore assist a coroner to perform his or her prevention function.

Public interest organisations can also play an important role in supporting and advocating on behalf of families, or raising prevention issues as public interest interveners. 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,

[24] 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>.

deaths of asylum seekers, and petrol sniffing deaths.[25] Other public interest interveners in inquests have included the Public Advocate, ATSILS, Aboriginal Justice Advisory Committees and 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.

Coronial recommendations

The content of coronial recommendations and their potential influence on death prevention are of particular concern to family members and advocates. However, only a small minority of cases produce recommendations. Although there have been recent reforms in several states and territories, the emphasis

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

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, and many require training in order for their recommendations to be at least potentially effective.[26] 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.'[27]

The only study to date of the implementation of coronial recommendations in all Australian jurisdictions, published in 2008 in the *Australian Indigenous Law Review*, found that there were

> 'recurring instances where coronial recommendations had not been communicated or had been miscommunicated, or were lost within bureaucratic processes.'[28]

Responses to and implementation of coronial 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

[26] See eg Law Reform Commission of Western Australia, *Review of Coronial Practice in Western Australia Background Paper* (September 2010), 51.
[27] *Review of Coronial Practice in Western Australia Background Paper*, 21–2.
[28] 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 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.[29]

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.

Concluding comments

The fact that so many families who have lost a loved one in circumstances requiring coronial investigation are unable to secure legal representation, especially when other 'parties' have legal assistance, is a fundamental inequality in access to justice. This injustice impacts not only on the families involved, but also on the preventative function of the coronial system.

Present trends in court management and government policy are to address growing demand by looking for 'efficiencies'. Recently in Victoria, in response to continued failure to reach Productivity Commission benchmarks (as with all Australian coronial jurisdictions) and a budget deficit, the Coroners Court was restructured to provide coroners with more solicitor assistance. In order to achieve this within financial constraints, family counselling services have been cut and some of the functions of the Coroners Prevention Unit (CPU)

[29] Watterson et al, 19.

downgraded and staffing reduced. As one of the primary functions of the CPU is to assist coroners in formulating recommendations, Victorian members of the Alliance are concerned that this can only have a negative impact on effective death prevention strategies.

We therefore believe that while it is important to try to address current delays in coronial processes, any strategies should not be at the expense of coroners' ability to thoroughly and independently investigate all of the relevant evidence, nor of resourced support for careful formulation of coronial recommendations.

It would be short sighted to consider only the costs of, for example, enabling sufficient legal aid funding for legal representation at inquests, or funding independent monitoring of responses to coronial recommendations, without weighing these against the greater social and economic costs of repeating avoidable deaths because prevention opportunities were not fully realised.