

# LAW REFORM

## Coronial law reform

REBECCA SCOTT BRAY takes stock of some key issues in Australian coronial law reform

A significant wave of contemporary coronial law reform in Australia in recent years has sought to more effectively define the coronial role and its valuable function in the aftermath of death. Queensland overhauled its coronial legislation with the implementation and recent review of the *Coroners Act 2003* (Qld), and coronial reform has taken place in other States, with recent commencements of the *Coroners Act 2008* (Vic) and the *Coroners Act 2009* (NSW). This interesting and intense period of reform is not over yet; in 2008 the Law Reform Commission of Western Australia ('LRCWA') began its review of the jurisdiction and practices of the coronial system in that State, including the operation of the *Coroners Act 1996* (WA), and has recently released its Background Paper (see DUAO, this issue).<sup>1</sup>

This period of reform is marked by some key concerns, including the rights and role of families in the coronial process, post mortem practices, the place of prevention in the legislative framework, and targeted coronial recommendations and responses to them. Many of these issues are interrelated and therefore have multiple points of influence and expression, such as family concerns around autopsy, and the nexus between preventive principles and coronial recommendations and any requirements to respond. Yet despite similar coronial issues emerging throughout Australian States and Territories, jurisdictions have exercised these concerns differently in revising legislation and altering policy. For example, Victoria has incorporated the recognition of families into the objectives of the new *Coroners Act 2008* (Vic) (s 8), and outlined provisions allowing for preliminary examinations (s 23), which have reduced autopsy rates from 85 per cent of deaths reported to the coroner to 50 per cent.<sup>2</sup> The *Coroners Act 2003* (Qld) provides for autopsies that are not restricted to a full internal examination of the body (s 19(3)), and requires that before ordering an internal examination of the body the coroner must, where practicable, consider that in some cases the deceased's family may be distressed by such an order (s 19(5)(a)) and consider any concerns raised by the family in relation to the type of examination to be conducted (s 19(5)(b)). These provisions are augmented with coronial guidelines that stipulate the principle of the least intrusive examination being ordered.<sup>3</sup> In the same spirit but contained in the legislative provisions alone, the *Coroners Act 2009* (NSW) provides that if more than one procedure is available to establish cause and manner of death, the person conducting the examination is to endeavour to use the least invasive procedures that are appropriate in the circumstances (s 88(2)); the Act also provides examples of less invasive procedures such as an external examination, and blood and tissue sampling

(s 88(3)). These distinctions are sketching a new landscape for autopsy around Australia.

On the subject of coronial recommendations, key differences have emerged around the issue of legislating for mandatory responses.<sup>4</sup> With the *Coroners Act 2008* (Vic), Victoria legislated for responses to recommendations (s 72) in addition to greater visibility of coronial decisions with the systematic internet publication of coronial findings (s 73) and responses to them (s 72(5)(a)). In league with these changes, the (now) Victorian Coroner's Court has a revamped website, which further realises the legislative aspirations of accessibility and visibility provisions. In distinction to a legislated stance on responses to coronial recommendations, NSW adopted a policy decision in respect of responses issued via a memorandum from the NSW Premier to Ministers and agencies in June 2009, with the Attorney General to maintain a record of all recommendations made and responses received, and to summarise this information in a report to be posted on the Attorney General's website twice a year.<sup>5</sup> Queensland similarly adopted a policy decision despite the 2006 review of the *Coroners Act 2003* (Qld) and a report by the Qld Ombudsman recommending amendments to the Act including legislating for mandatory responses from relevant public sector agencies.<sup>6</sup> In August 2009 the Qld Attorney-General and Minister for Industrial Relations produced the first report under this new administrative regime, with the Qld government's response to those coronial recommendations handed down in 2008.<sup>7</sup> In its review, the LRCWA has similarly flagged the issue of coronial recommendations as constituting a key area of concern in consultations, a matter that will be further canvassed in its Discussion Paper.<sup>8</sup>

The attention towards coronial recommendations in a prevention-inspired coronial climate, and the differing approaches employed throughout jurisdictions, illustrate how the subject of mandatory responses raises a number of issues that go to the very heart of the jurisdiction. These issues include the scope of inquest, the development of relevant, targeted recommendations and the role of the coroner vis-à-vis prevention by way of recommendations and any potential trespassing on government policy. While recognising the importance of coronial recommendations, in June 2009 the NSW Attorney General noted that they are 'not directives', adding that '[a]ny system which enabled a coroner, who is a judicial officer, to direct or determine government policy would not only be a serious breach of the separation of powers, but would also be contrary to the principles of democratic governance'.<sup>9</sup> This rather serious caution demonstrates the fine line walked in relation to recommendations — a line that is

### REFERENCES

1. Law Reform Commission of WA, *Review of Coronial Practice in Western Australia*, Background Paper Project No 100 (2010).
2. David Ranson, 'The Coroners Act 2008 (Vic): A Medical investigator's perspective' (2010) 17 *Journal of Law and Medicine* 487, 488.
3. Qld *State Coroner's Guidelines*, December (2003) 5.5; see also Belinda Carpenter et al. 'Increasing the information available to coroners: the effect on autopsy decision-making' (2009) 49(2) *Medicine, Science and the Law* 101.
4. Some jurisdictions have legislatively mandated a response to coronial recommendations (in SA and ACT in relation to deaths in custody): *Coroners Act 2003* (SA) s 25; *Coroners Act 1997* (ACT) ss 75, 76; *Coroners Act* (NT) ss 26, 27, 46A, 46B. See also Ray Watterson, Penny Brown and John McKenzie, 'Coronial Recommendations and the Prevention of Indigenous Death' (2008) 12(2) *Australian Indigenous Law Review* 4.
5. NSW Premier, Memorandum, *M2009-12 Responding to Coronial Recommendations* <dpc.nsw.gov.au/publications/memos\_and\_circulars/ministerial\_memoranda/2009/m2009-12\_responding\_to\_coronial\_recommendations> at 8 November 2010. To view summaries of responses go to <lawlink.nsw.gov.au/lawlink/LSB/II\_lsb.nsf/pages/lrb\_coronialrecommendations> at 8 November 2010.
6. Qld Ombudsman, *Coronial Recommendations Project* (2006), 31.
7. Qld Dept of Justice and Attorney-General, *Queensland Government's response to coronial recommendations 2008* (2009).
8. LRCWA, above n 1, 45-46.
9. NSW, *Parliamentary Debates*, Legislative Assembly, 4 June 2009, 15781 (John Hatzistergos, Attorney General, and Minister for Industrial Relations).

managed with reference to the aforementioned issue of relevance, and liable to become increasingly negotiated by appeals to the development of coronial expertise.<sup>10</sup> Echoing this, in August 2010 the Brisbane press cited Queensland State Coroner Barnes's introductory comments in the Office of the State Coroner's recently tabled 2008–2009 Annual Report.<sup>11</sup> In his comments, State Coroner Barnes notes the non-implementation of recommendations made by Commissioner Davies following the Commission of Inquiry into Queensland Public Hospitals; recommendations that related to the provision of medical expertise to the coroner as regards medical deaths.<sup>12</sup> Victoria has sought to mitigate against these issues with the establishment of a Coroner's Prevention Unit;<sup>13</sup> a policy initiative to enhance coronial expertise to ensure that recommendations are relevant by assisting in their development and evaluation, and to enable research to augment the death prevention capacities of Victorian coroners, a move that may well benefit other Australian jurisdictions.<sup>14</sup>

Clearly, whether legislatively enshrined or a policy directive, the focus on the importance of recommendations highlights the social value of the coroner who has a unique and capacious socio-legal role in improving health, safety and the administration of justice, and contributing to the avoidance of preventable deaths.<sup>15</sup> Concern with the scope of inquest, circumstances of death and the nexus between these matters and coronial recommendations have long been issues arising in judicial review of coronial decisions; coronial jurisprudence warns of the important relevant nexus between deaths being investigated and comments or recommendations.<sup>16</sup> Correspondingly, in conducting its current review of coronial law and practice in Western Australia, the LRCWA has noted concerns raised in consultations about the scope of WA inquests. The LRCWA's recently released Background Paper notes the 2007 'Kimberley Inquest' as one 'widely cited example' that reached beyond the 'acceptable scope of an inquest'.<sup>17</sup> WA State Coroner Alastair Hope

investigated the deaths of 22 Aboriginal people who died between 2000 and 2007 in the Kimberley, holding an inquest to explore the reasons for a high death rate amongst Aboriginal people in the Kimberley 'whose deaths appeared to have been caused or contributed to by alcohol abuse or cannabis use and also, if possible, to identify reasons for an alarming increase in suicide rates'.<sup>18</sup> Concerned with both the underlying reasons for the deaths and the appropriateness of any comments to assist in 'reducing the number of avoidable deaths',<sup>19</sup> the State Coroner produced his statutory findings and a broader exegesis of issues in the Kimberley, including living conditions, education, housing, alcohol and drug use, health, policing and child protection.

That the LRCWA's consultations reveal concerns about 'wide-ranging' inquests with 'broad' recommendations 'tenuously connected' to deaths,<sup>20</sup> highlights that, notwithstanding the valuable role the coroner plays in drawing attention to the social context of death, the boundaries of the coronial purview (and thus power to comment) are not unfettered. Precisely how this balance is achieved continues to be an interesting area of coronial law and practice. With recent reforms strongly connected to preventive principles, and an increasing emphasis on the place of coronial recommendations and the accessibility and visibility of coronial decisions, these questions will receive more attention. Certainly, WA has witnessed significant coronial findings in recent years,<sup>21</sup> and so how such matters are tackled in this latest review, with its anticipated forthcoming Discussion Paper, will provide further insight into the productive refinement and contemporary evolution of this ancient office.

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10. See also LRCWA, above n 1, 45; see also Law Reform Committee, Parliament of Victoria, *Coroners Act 1985: Final Report* (2006) 330–360.

11. Daniel Hurst, 'Coroner complains of death probe "difficulties"', *Brisbane Times* (Brisbane), 10 August 2010 <brisbanetimes.com.au/queensland/coroner-complains-of-death-probe-difficulties-20100809-11tss.html> at 8 November 2010.

12. Qld Office of the State Coroner, *Annual Report 2008–2009* (2009) 4.

13. See <coronerscourt.vic.gov.au/wps/wcm/connect/justlib/Coroners+Court/Home/Investigations/Who\_s+Involved/Coroners+Prevention+Unit/> at 8 November 2010.

14. For a succinct yet comprehensive breakdown of the Victorian changes see Ian Freckelton, 'Opening a new page' (2010) 83(6) *Law Institute Journal* 28.

15. Watterson, Brown and McKenzie, above n 4.

16. *Harmsworth v State Coroner* [1989] VR 989; *Chief Commissioner of Police v Hallenstein* [1996] 2 VR 1; *R v Coroner Doogan; Ex parte Lucas-Smith* (2005) 158 ACTR 1. For comment see Ian Freckelton, 'Reforming Coronership: International perspectives and contemporary developments' (2008) 16 *Journal of Law and Medicine* 379, 389–390; and for discussion see Law Reform Committee, above n 10, ch 7.

17. LRCWA, above n 1, 45.

18. *WA Inquest* (Unreported, WA Coroner's Court, State Coroner Hope, 25 February 2008) 37/07, Executive Summary.

19. *Ibid* 9.

20. LRCWA, above n 1, 45.

21. See, eg, inquest into the 2008 death in custody, *WA Inquest into the death of Ian Ward* (Unreported, WA Coroner's Court, State Coroner Hope, 12 June 2009) 9/09, which led to various points of inquiry and response such as the WA Standing Committee on Environment and Public Affairs, *Inquiry into the Transportation of Detained Persons* (2010); and Dept of Attorney-General, *Review of WA's system of Justices of the Peace* (2010).

## ACCESS TO JUSTICE

# Remembering the Rule of Law

MELISSA CASTAN considers the significance, once again, of 11 November

Remembrance Day is commemorated on 11 November; on that day, we recall those who fell in the Great War fighting for their country. Some also recall it as 'Dismissal Day,' marking one of the most turbulent political events in Australian history. In Australia this year we celebrated a 'Rule of Law' day on 11 November, as the High Court handed down decisions in three important cases that reflected the fundamentals of fairness, natural justice and equality before the law.

The first case (*Plaintiff M61/2010E v Commonwealth*, and *Plaintiff M69/2010 v Commonwealth* [2010] HCA

41) centered on the laws and policies regarding visas for asylum seekers. The Justices unanimously found that it was an error of law for the government, when reviewing a refugee status assessment as part of an 'offshore processing regime', to treat provisions of the *Migration Act 1958* (Cth) and the decisions of Australian courts as not binding. It held that two Sri Lankan (Tamil) citizens who arrived at Christmas Island claiming refugee status were also denied procedural fairness in the review of the assessment of their claims. This came about because the Australian policy has been that, when refugees are processed as 'offshore entry