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

Report of the Queensland Ombudsman

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19 December 2006

The Hon John English MP
Acting Speaker
Parliament House
George Street
BRISBANE QLD 4000

Dear Mr English

In accordance with s.52 of the *Ombudsman Act 2001*, I hereby furnish to you my report titled *The Coronial Recommendations Project: An investigation into the administrative practice of Queensland public sector agencies in assisting coronial inquiries and responding to coronial recommendations*.

Yours faithfully

David Bevan
Queensland Ombudsman

Enc.

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Foreword

The Queensland Ombudsman has an important role in investigating administrative actions and decisions of public sector agencies. Since the Ombudsman Act commenced in 2001, the Ombudsman also has a statutory responsibility to make recommendations to agencies and provide them with other help to improve their administrative practices.

This report presents the findings of an investigation conducted by my Office into the administrative practice of a number of Queensland public sector agencies in assisting coronial inquiries and responding to coronial recommendations. The investigation involved an analysis of 72 inquest reports by Queensland coroners in 2002 and 2003 involving 23 agencies. I also considered the findings of a number of coronial inquests that were examined during my Office's Workplace Electrocution Project, on which I provided a report to the Speaker of the Queensland Parliament on 30 June 2005 for tabling in the Legislative Assembly.

My investigation has revealed systemic problems that reduce the effectiveness of the coronial system in Queensland. Currently, the procedures for notifying that an inquest is to be held do not ensure that a public sector agency that deals with matters to be considered at the inquest is notified of the inquest or, if notified, is notified in sufficient time to provide relevant information to a coroner. Furthermore, no person or entity has the responsibility of monitoring whether public sector agencies properly consider and, in appropriate cases, implement coronial recommendations. I have suggested that this role is one for my Office.

I have made certain observations for the consideration of the State Coroner about ways to improve the procedures followed by coroners in formulating coronial recommendations and I have identified a number of possible amendments to the *Coroners Act 2003* for consideration. I have also made recommendations to a number of key agencies that have frequent involvement in coronial inquiries.

As the issues dealt with in the report are of significant public interest, I have decided to present the report to the Speaker for tabling in the Legislative Assembly as provided for in s.52 of the *Ombudsman Act 2001*.

I place on record my appreciation of the cooperation and assistance of the State Coroner and his staff during the course of the investigation. I also thank Assistant Ombudsman, Peter Cantwell, and his team for their work on the project.

David Bevan
Queensland Ombudsman

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Abbreviations and Dictionary

Agency	A public sector agency
Coroner's comments	Comments authorised to be made by a coroner under s.46 of the *Coroners Act 2003* being comments made by a coroner "… on anything connected with a death investigated at an inquest that relates to — (a) public health and safety; or (b) the administration of justice; or (c) ways to prevent deaths from happening in similar circumstances in the future"
Coroner's findings	Findings made under s.45 of the *Coroners Act 2003*
Coroners Court	The court established as a court of record constituted by a coroner under the repealed Coroners Act or under the *Coroners Act 2003*
Coronial recommendations	Preventive recommendations made by a coroner, coronial riders, riders or coroner's comments
Inquest	Means an inquest under the repealed Coroners Act or the *Coroners Act 2003*
My Office	Office of the Queensland Ombudsman
Ombudsman Act	The *Ombudsman Act 2001*
Principal officer	The person identified in schedule 3 of the Ombudsman Act as the principal officer of a public sector agency
Public sector agency	An agency within the meaning of s.8 of the Ombudsman Act; that is, a Queensland government department, local government or public authority
Repealed Coroners Act	*Coroners Act 1958*
State Coroner	The person appointed as the State Coroner by the Governor in Council under s.70 of the *Coroners Act 2003*
State Coroner's Guidelines	The guidelines dated December 2003 issued by the State Coroner pursuant to s.14(1)(b) of the *Coroners Act 2003* to ensure best practice and consistency in the coronial system
Victorian Law Reform Committee Report	A report of the Parliament of Victoria Law Reform Committee in relation to the *Coroners Act 1985* dated September 2006, being Parliamentary Paper No 229 of Session 2003-06
WEP	The Workplace Electrocution Project
WEP Report	The Report of the Workplace Electrocution Project – a public report dated June 2005 on investigations into the adequacy of the responses of government agencies to nine fatal electrical incidents and an analysis of the effectiveness of changes made to Queensland's electrical safety framework since those incidents occurred

Executive Summary

Sir John Norris QC, in his 1980 review of Victoria's *Coroners Act 1958*, said[1] that:

> The office of the Coroner is a very ancient one; the functions exercised by the holders of the office have changed over the centuries as the needs of the social order have altered. The social order remains in a process of development. It is consistent with the adaptability characteristic of the office of coroner that the present and future needs of society should lead to a review of those functions and the conditions of their exercise in light of existing circumstances.

The current coronial system in Queensland commenced operation on 1 December 2003[2] following the enactment of the *Coroners Act 2003* (Qld)[3]. The new Act repealed the 1958 Coroners Act[4] and created an Office of State Coroner, heralding a change of approach in respect of coronial investigations in Queensland.

The Director-General of the Department of Justice and Attorney-General advised me by letter dated 31 October 2006 that the operation of the *Coroners Act 2003* is currently being reviewed by the department. I understand that the State Coroner has already identified a number of amendments that could be made to the legislation. I trust that my review of aspects of the coronial system will assist the department with its review.

Coroners in Queensland conduct approximately 300 inquests each year. At the conclusion of an inquest, a coroner is able to make recommendations, directed to relevant persons or entities (commonly government agencies), that certain action be taken with a view to preventing a recurrence of the circumstances that led to the fatal incident. In Queensland, these recommendations are now known as "coroner's comments"[5]. Prior to the enactment of the *Coroners Act 2003*, they were called "riders"[6]. They are commonly known as "coronial recommendations" and I have used that expression throughout this report.

This Project, which I have called the Coronial Recommendations Project, arose out of a detailed investigation my Office conducted into workplace electrocutions in Queensland, known as the Workplace Electrocution Project (WEP). The WEP Report[7] was provided to the Speaker of the Queensland Parliament and tabled in Parliament on 30 June 2005. It examined the adequacy of the responses of government agencies to nine fatal electrical incidents between 1995 and 1999. Each of those incidents was the subject of an inquest. The transcripts from those inquests were examined in detail by my officers and the administrative improvement possibilities arising from those inquests have been considered in formulating my opinions and recommendations in this report.

At the outset, it should be noted that the repealed Coroners Act did not require agencies to respond to recommendations that were made to them. That is still the case under the *Coroners Act 2003*. It became evident during the course of the WEP that, in many cases, little or nothing had been done by public sector agencies to assess and/or implement coronial recommendations designed to prevent deaths occurring in similar situations. Surprisingly, in a significant number of cases, it was apparent that the relevant agencies had neither sought nor received a copy of the recommendations in question from the coroner and, in some instances, were unaware that recommendations had been made that concerned legislation they administered.

---

[1] Norris, J The *Coroners Act 1958* – A General Review, Victorian Government Printer, 1980, page 1 cited in Parliament of Victoria Law Reform Committee (April 2005) *Coroners Act 1985: Discussion Paper*, Melbourne: Victorian Government Printer at page 1

[2] See Coroners Regulation 2003 (Qld)

[3] Hereafter *Coroners Act 2003*

[4] Hereafter the repealed Coroners Act

[5] Section 46 of the *Coroners Act 2003*

[6] Section 43(4) of the repealed Coroners Act

[7] Queensland Ombudsman (2005) *Report of the Queensland Ombudsman - The Workplace Electrocution Project*, Brisbane: Queensland Ombudsman

Furthermore, where agencies were aware of recommendations and had agreed to implement them, there was no formal monitoring of the implementation of those recommendations by any independent entity. Accordingly, on most occasions, coroners and the families of the deceased were provided with no information as to what was being done by agencies to prevent a recurrence of the circumstances that had led to the fatal incident.

I resolved to conduct an investigation to assess whether these problems evidenced the need for a coordinated system for ensuring that appropriate action was taken by public sector agencies in response to coronial recommendations. The Coronial Recommendations Project has involved the analysis of 72 inquest reports prepared by Queensland coroners in 2002 and 2003[8] involving 23 agencies. As indicated, I have also considered the coronial inquests that were examined during the WEP.

Inquests for this period were chosen for the purpose of my project because of my concern that coronial recommendations made under the repealed Coroners Act may not have been brought to the attention of public sector agencies to which they were directed as no official was given this responsibility under that Act. This situation has been remedied by the *Coroners Act 2003* by requiring a coroner who makes a coronial recommendation to notify the relevant public sector agency and Minister of the recommendation.

Other deficiencies identified in the sample in the way inquests were conducted were discussed with the State Coroner to ascertain whether those deficiencies had been addressed.

Under the *Ombudsman Act 2001*, I have power to investigate the administrative actions of "officers"[9] of an "agency"[10] as defined in the Act. I also have statutory power to make recommendations to the principal officer of a public sector agency[11] to rectify maladministration and/or improve public administration. I have made two recommendations in this report directed to a number of key agencies that have frequent involvement in coronial inquiries. I invited the relevant agencies to comment on these recommendations and have included or summarised their responses in this report.

I have no power to investigate the actions of the State Coroner, other coroners and magistrates, or to make formal recommendations to improve administrative practice directly to any of those judicial officers. However, I have made certain observations for the consideration of the State Coroner about ways to improve the procedures followed by coroners in formulating coronial recommendations with a view to ensuring that coroners have access to all relevant information (particularly information from public sector agencies) when formulating recommendations. A copy of my report in proposed form was provided to both the Director-General of the Department of Justice and Attorney-General and the State Coroner for their comments. Their responses are set out throughout the report.

Furthermore, in view of the current review of the *Coroners Act 2003*, I have identified possible amendments to the Act for consideration.

I have provided this report to the Speaker of the Queensland Legislative Assembly pursuant to s.52 of the Ombudsman Act for tabling in the Assembly[12].

[8] But before 1 December 2003
[9] See the definition of "officer" of an agency in schedule 3 of the *Ombudsman Act 2001*
[10] Section 8 of the *Ombudsman Act 2001*
[11] Section 50 of the *Ombudsman Act 2001*
[12] Section 52 of the *Ombudsman Act 2001* states that if I consider it appropriate, I may give to the Speaker at any time, for tabling in the Assembly, a report on a matter arising out of the performance of the Ombudsman's functions

I have taken this step because the matters raised are of considerable public interest and because my investigation has revealed systemic problems that reduce the effectiveness of the coronial system in Queensland, in that:

- the procedures for notifying that an inquest is to be held do not ensure that a public sector agency that deals with matters to be considered in the inquest:
    - is notified of the proposed inquest; or
    - if notified, is notified in sufficient time to obtain relevant information and provide it to the coroner.
- no person or entity has the responsibility of monitoring whether public sector agencies properly consider and, in appropriate cases, implement coronial recommendations.

While the *Coroners Act 2003* has satisfactorily addressed the communication of coronial recommendations to agencies[13], issues surrounding the formulation and implementation of recommendations remain, in my opinion, problematic.

In my report I have omitted or altered information that would identify the deceased or any of the members of the deceased's families. Although details of the coronial inquiries into these deaths are on the public record, the focus of my report is on the actions of public sector agencies in response to coronial recommendations, rather than the actions of private individuals.

Therefore, I have not reinvestigated the circumstances of any of these deaths and I have not considered whether any of the inquests should be reopened. It should also be noted that none of the inquests considered during my project related to missing persons.

Summary of opinions, proposed amendments and recommendations

Opinions

Opinion 1

The audit showed that relevant public sector agencies (and other relevant persons/entities) were not given sufficient notice of the holding of an inquest to enable them to provide appropriate input into the inquest.

Opinion 2

The audit showed that the coronial system does not ensure that relevant public sector agencies (and other relevant persons/entities) are sufficiently informed of the issues to be canvassed at the inquest, to enable them to provide appropriate input into the inquest.

Opinion 3

The audit showed that a significant reason for public sector agencies not implementing coronial recommendations is that the relevant agency considers that the recommendation is not soundly based or is not practicable.

Opinion 4

The audit showed that the effectiveness of the coronial system is reduced by the fact that public sector agencies to which coronial recommendations are directed are not required to respond to those recommendations.

---

[13] Section 46(2) of the *Coroners Act 2003*; see section 5.2.1

Opinion 5

The audit showed that the effectiveness of the coronial system is reduced by the failure of public sector agencies to have in place systems for ensuring they are aware of pending inquests and obtain and provide relevant information to assist the coroner.

Opinion 6

Officers who discharge regulatory functions in public sector agencies should ensure that their investigations of incidents resulting in a person's death are not focussed solely on whether a breach of legislation has occurred and should be prosecuted but also consider measures for preventing similar deaths occurring.

Opinion 7

The response of public sector agencies to coronial recommendations directed to them should be monitored. The Queensland Ombudsman is best placed to undertake this monitoring role.

Proposed amendments to the *Coroners Act 2003*

Proposed amendment 1 to *Coroners Act 2003*

The *Coroners Act 2003* should be amended to provide that:

(a) notice advising that a pre-inquest conference is to be held be published in a daily newspaper circulating generally in Queensland at least one month before the date of the conference; and
(b) notice advising that an inquest is to be held be published in a daily newspaper circulating generally in Queensland at least one month before the date of the inquest.

Proposed amendment 2 to *Coroners Act 2003*

The *Coroners Act 2003* should be amended to require that

(a) the notice advising that a pre-inquest conference is to be held contain, in general terms, a list of the issues (including preventive issues) expected to be considered at the inquest; and
(b) the notice advising that an inquest is to be held contain a list of the issues (including preventive issues) expected to be considered at the inquest.

Alternatively, the State Coroner could consider issuing guidelines under s.14(1)(b) of the *Coroners Act 2003* requiring that notices be issued as proposed above.

Proposed amendment 3 to *Coroners Act 2003*

Section 34 of the *Coroners Act 2003* should be amended to require that a pre-inquest conference be held for all inquests, unless the coroner is satisfied that such a conference is unnecessary in the particular case.

Proposed amendment 4 to *Coroners Act 2003*

The *Coroners Act 2003* should be amended to require that, where a coroner gives notice under s.46(2) of the Act of a coronial recommendation to a public sector agency that deals with matters to which the recommendation relates, the agency must, within six months of being so notified, advise the coroner of the action taken or proposed to be taken to implement the recommendation or, if the agency does not intend to take action, its reasons for not doing so.

Proposed amendment 5 to *Coroners Act 2003*

The *Coroners Act 2003* should be amended to require public sector agencies to provide details in their annual reports of coronial recommendations directed to the agency and the agency's response to those recommendations.

Proposed amendment 6 to *Coroners Act 2003*

The *Coroners Act 2003* should be amended to require the State Coroner to provide particulars of findings and coronial recommendations that relate to public sector agencies to the Office of the Queensland Ombudsman at the same time such information is provided to the agencies.

Recommendations

Recommendation 1

Public sector agencies (particularly those frequently involved in inquests) should appoint coronial liaison officers with responsibility for:

- liaising with the State Coroner and staff;
- ascertaining the existence of pending coronial inquests relevant to that agency;
- coordinating the agency's response;
- responding to the issues list;
- undertaking or arranging any investigations required to assist the coroner;
- participating in pre-inquest conferences;
- responding to any recommendations made;
- maintaining a suitable coronial database within the agency; and
- preparing material for the agency's annual report in relation to the agency's response to relevant coronial recommendations.

Recommendation 2

Public sector agencies with regulatory responsibilities for matters frequently relevant to coronial inquiries should provide training to relevant officers so that investigations conducted by those agencies extend beyond the circumstances of the death to identifying changes to law or practice that could prevent similar deaths occurring.

Recommendation 3

Pending the implementation of proposed amendment 6 to the *Coroners Act 2003*, a liaison agreement should be entered into between the State Coroner and the Queensland Ombudsman pursuant to which the State Coroner agrees to provide to the Ombudsman information about coronial recommendations made to public sector agencies within the Ombudsman's jurisdiction with a view to the Ombudsman monitoring the implementation by relevant public sector agencies of coronial recommendations.

Chapter 1: Background

1.1 Own initiative investigation

My Office undertook the Coronial Recommendations Project because of concerns identified during our investigation into the response of public sector agencies to workplace electrocutions in Queensland, known as the Workplace Electrocution Project (WEP). This project culminated in a public report to the Queensland Parliament[14].

It became evident during the course of the WEP that, for a number of reasons, there had been cases where, following an inquest into a death by electrocution, little or nothing had been done by public sector agencies to implement recommendations made by coroners with a view to preventing similar deaths occurring.

Furthermore, there appeared to be no adequate system or mechanism for:

- ensuring that a public sector agency was informed of a coronial recommendation bearing on that agency's responsibilities;
- monitoring the implementation of coronial recommendations;
- assessing the reasonableness of an agency's decision not to implement a coronial recommendation; or
- ensuring coroners, and families of the deceased, were kept informed of whether any action was being taken by agencies in response to coronial recommendations.

I decided that a broader investigation should be undertaken to assess whether the shortcomings evident from the sample of cases examined for the WEP were indicative of a more widespread systemic failure by public sector agencies to take appropriate action in response to coronial recommendations.

Section 18(1)(b) of the Ombudsman Act provides that "the ombudsman may investigate administrative action of an agency if the ombudsman otherwise considers the administrative action should be investigated". I am authorised to conduct what is commonly known as an "own motion" or "own initiative"[15] investigation without a specific complaint about a particular administrative action of a public sector agency.

The Coronial Recommendations Project was therefore conducted as an "own initiative" investigation.

1.2 Terms of reference and objects of investigation

The terms of reference for the Coronial Recommendations Project were to investigate the following issues in respect of public sector agencies:

- Were coronial recommendations being communicated to relevant agencies?
- Were relevant agencies providing information to coroners to assist them in making recommendations?
- Were coronial recommendations being properly assessed and implemented by agencies?
- If agencies were not implementing coronial recommendations, what were the reasons for those decisions?
- Was there any system for monitoring the implementation of coronial recommendations by agencies, and if not, should there be such a system and who should have that role? and
- What public reporting should there be about the implementation of coronial recommendations by agencies?

[14] Queensland Ombudsman (2005) *Report of the Queensland Ombudsman – The Workplace Electrocution Project*, Brisbane: Queensland Ombudsman
[15] Section 12(a)(iii) of the *Ombudsman Act 2001*

I have not undertaken an exhaustive review of the current coronial system. Improvements of an operational or technical nature are matters for the State Coroner. My investigation focuses on systemic issues surrounding the making, assessment and implementation of coronial recommendations and on identifying improvements to systems, with particular reference to public sector agencies.

1.3 Recommendation functions

I have statutory power to make recommendations to the principal officer of a public sector agency, as defined in s.8 of the Ombudsman Act, to rectify maladministration and/or improve public administration[16]. I also have power:

> to consider the administrative practices and procedures of agencies generally and to make recommendations or provide information or other help to the agencies for the improvement of the practices and procedures.[17]

However, I have no power to make recommendations to the State Coroner, other coroners or magistrates, who are judicial officers and are not by definition "officers" of an "agency".

1.4 Report to Parliament

Section 52 of the Ombudsman Act provides that I may, if I consider it appropriate, give the Speaker at any time for tabling in the Legislative Assembly, a report on any matter arising out of the performance of my functions.

I have prepared this report as a public report for tabling in accordance with s.52. I have taken this step because the matters raised are of considerable public interest and because my investigation has revealed systemic problems that reduce the effectiveness of the coronial system in Queensland, in that:

(a) the procedures for notifying that an inquest is to be held do not ensure that a public sector agency that deals with matters to be considered in the inquest:

- is notified of the proposed inquest; or
- if notified, is notified in sufficient time to obtain relevant information and provide it to the coroner.

(b) no person or entity has the responsibility of monitoring whether public sector agencies properly consider and, in appropriate cases, implement coronial recommendations.

The *Coroners Act 2003* has satisfactorily addressed the communication of recommendations to agencies[18]. However, the other problems identified by my investigation in the coronial system remain.

[16] Section 50(1) of the *Ombudsman Act 2001*
[17] Section 12(c) of the *Ombudsman Act 2001*
[18] See section 5.2.1

1.5 Procedure for gathering evidence

Section 25 of the Ombudsman Act provides as follows:

> 25 Procedure
>
> (1) Unless this Act otherwise provides, the ombudsman may regulate the procedure on an investigation in the way the ombudsman considers appropriate.
>
> (2) The ombudsman, when conducting an investigation—
>
> (a) must conduct the investigation in a way that maintains confidentiality; and
>
> (b) is not bound by the rules of evidence, but must comply with natural justice; and is not required to hold a hearing for the investigation; and
>
> (c) may obtain information from the persons, and in the way, the ombudsman considers appropriate; and
>
> (d) may make the inquiries the ombudsman considers appropriate.

I did not have to use any of my coercive powers under part 4 of the Ombudsman Act to obtain evidence as all agencies and persons from whom information and and/or documents were sought willingly assisted my officers.

I provided a copy of this report in proposed form to the Director-General of the Department of Justice and Attorney-General and to the State Coroner for comment. Their responses to particular opinions, suggestions and recommendations are set out in the report.

I also provided a copy of chapter 6 of this report in proposed form to the Directors-General of a number of key public sector agencies that are frequently involved in inquests to comment on recommendations relevant to their organisations. Two agencies did not respond. Only one agency did not support all of the proposed recommendations referred to them for comment. Any particular comments are set out in the report.

1.6 Focus of report

Although details of the coronial inquiries into these deaths are on the public record, the focus of my report is on the actions of public sector agencies in response to coronial recommendations, rather than the actions of private individuals. In my report I have omitted or altered information that would identify the deceased or any of the members of the deceased's families.

Nor have I reinvestigated the circumstances of any of these deaths or considered whether any of the inquests should be reopened. It should also be noted that none of the inquests considered during my project related to missing persons.

1.7 The Victorian Law Reform Committee Report

The Law Reform Committee of the Parliament of Victoria has recently published a review of the Victorian *Coroners Act 1985*[19]. That detailed review made 138 recommendations[20] to improve coronial practice in Victoria. I have referred to the Committee's report on several occasions throughout my report.

1.8 Possible amendments to Coroners Act

I have been advised that the operation of the *Coroners Act 2003* is presently being reviewed and that my report will be considered prior to a possible Coroners Act Amendment Bill proposed for introduction in the first half of 2007[21]. I have therefore identified possible amendments to the Act for consideration during the course of the review.

[19] Parliament of Victoria Law Reform Committee (September 2006) *Coroners Act 1985: Parliamentary Paper No 229 of Session 2003-06*, Melbourne: Victorian Government Printer
[20] Parliament of Victoria Law Reform Committee (September 2006) *Coroners Act 1985: Parliamentary Paper No 229 of Session 2003-06*, Melbourne: Victorian Government Printer at page xvii
[21] Letter of Director-General, Department of Justice and Attorney-General to Queensland Ombudsman dated 31 October 2006

Chapter 2: Coroners and coronial recommendations

2.1 The role of coroners

Most commentators agree that the fundamental role of a coroner is to investigate unexpected or unusual death. In May 2004, the Victorian Attorney-General made the following remarks[22] about the role of a coroner:

> The Coroner's Court is a unique jurisdiction that uses an inquisitorial process rather than an adversarial procedure to establish the causes of unusual deaths. Unlike other judicial officers, the State Coroner's role goes beyond making findings on the relevant law and facts of the case to include making recommendations that would prevent the recurrence of similar deaths or accidents in the future. This role is an important and valuable one for improving the safety of the community.
>
> The Coroner's roles must be tempered with appropriate and sensitive consideration of the needs of families and others affected by the necessary investigation of sudden, unexpected and tragic events by the Coroner.

These comments also accurately describe the current coronial system in Queensland. The "inquisitorial process" referred to by the Attorney-General generally involves, but not always, a coronial investigation and a subsequent inquest or hearing[23].

2.2 The focus of inquests

Schedule 2 of the *Coroners Act 2003* defines an inquest to mean "a coronial inquest". A coronial inquest is an administrative inquiry or hearing presided over by a coroner. The focus of an inquest in Queensland is to determine who the deceased was, how, when and where that person died and what caused that person to die[24]. A coroner can also, whenever appropriate, comment on anything connected with a death investigated at an inquest that relates to certain matters[25]. These are commonly known as coronial recommendations.

2.3 Coronial recommendations

The desirability of coroners making recommendations for remedial action to prevent the occurrence of similar deaths to the one under investigation has not always commanded universal acceptance, even in the comparatively recent history of the office of coroner in common law jurisdictions[26]. From time to time, those charged with considering and implementing particular recommendations by coroners have expressed frustration on the grounds that the recommendations were based on inadequate research into costs and practicality[27].

[22] Attorney-General of Victoria, Rob Hull, Justice Statement, *New Directions for the Victorian Justice System 2004-2014* (2004) 46 cited in Parliament of Victoria Law Reform Committee (September 2006) *Coroners Act 1985: Parliamentary Paper No 229 of Session 2003-06*, Melbourne: Victorian Government Printer at page 1
[23] Part 3, division 1, section 27 and section 28 of the *Coroners Act 2003*
[24] Section 45(2) of the *Coroners Act 2003*
[25] Section 46(1) of the *Coroners Act 2003*; see also Cranny, G (June 2006) *Coronial inquests: some recent lessons*, Proctor, 26 (5), 24-26
[26] See for example Jarred, W (2003) *The Coroners Bill 2002 (Qld): Highlighting the important role of coroners in accident prevention: Research Brief No 2003/04*, Brisbane: Queensland Parliamentary Library; Law Commission (August 1999) *Preliminary Paper 36: Coroners A Review: A discussion paper,* Wellington: Law Commission (New Zealand); and Law Commission (August 2000) *Report 62: Coroners*, Wellington: Law Commission (New Zealand)
[27] See for example Law Commission (August 2000) *Report 62: Coroners*, Wellington: Law Commission (New Zealand)

The issue is discussed in the following passage from the work of Boronia Halstead in *Coroners' Recommendations and the Prevention of Deaths in Custody: A Victorian case study*[28]:

> The heart of the coronial process has been to gather facts about the who, what, when, where and why of unexpected deaths. Some commentators have viewed with suspicion any deviation from the realm of fact into the realm of opinion …
>
> …
>
> … it was considered that the "decision whether any further action is required may depend on many factors of which the coroner will know nothing and we think these matters would be best left to the expert authorities concerned" (Law Reform Commission [England] 1971, para 16.52, p.193).
>
> Thus, there has been vigorous debate about the authority of coroners to make recommendations and their appropriate status. Jervis, in the 8th edition of On the Office and Duties of Coroners, was clear about his view of the significance of recommendations (which are sometimes known as riders):
>
>> the addition is no part of the verdict, but is mere surplusage. A recommendation is no part of the verdict and the coroner may refrain from recording it, or, he may allow it to be written in the margin of the inquisition, of which it is not part (Jervis 1946, p. 110 cited in Johnstone 1992, p. 153).
>
> These comments were echoed in Pilling's review of the Brodrick Report, endorsing the proposed removal of "the irritation of riders and animadversions" (Pilling 1972, p. 75).
>
> In summary, there were fears that the coroner might inadvertently make suggestions which could have the potential to make a bad situation worse. The Brodrick Committee recommended that the right to attach a recommendation should be abolished and that, in order to prevent recurrence of the fatality, the coroner should have "the right to refer the matter to the appropriate body or public authority, and he should announce he is doing so" (Law Reform Commission [England] paras. 16.52 and 16.53, p. 193). Following the release of the Brodrick Report, the power of the coroner to attach a recommendation to the verdict was abolished in England and Wales in 1980.
>
> Waller, in his text on Coronial Law and Practice in New South Wales, echoes a similar concern when he cautions that "there are dangers that coroners will make definite recommendations without being fully aware of the ramifications, or of competing priorities in a Government department" (Waller 1994, p.95).
>
> As Johnstone points out, however, these arguments do not take account of the fact that the coroner can call experts to provide testimony on the details of any relevant matter; that coroners' suggestions are frequently very general in nature; and that, most importantly, "there is never likely to be a better time" to make a recommendation (Johnstone 1992, p. 156). Moreover, the coroner has no power to require formally that any suggested action be carried out. It is always open to the agency to ignore or reject coronial recommendations, either explicitly or implicitly, and with or without communicating the reason for choosing such a course of action.
>
> Johnstone (1992, p. 140) points out that as far back as 1907, the potential role of the coroner in the prevention of deaths and injury was acknowledged. He cites the early writings of William Brend, who argued that the Coroners' Court was poorly adapted for the detection of crime; that claims for compensation were settled in other courts and that the only valuable role left to the coroner was a preventive role.

[28] Halstead, B (November 1995) *Australian Deaths in Custody: No. 10: Coroners' Recommendations and the Prevention of Deaths in Custody: A Victorian Case Study*, Australian Institute of Criminology at page 3

This potentially preventive role has been marginalised in some coronial practices through the emphasis on unpacking the facts of individual cases, rather than the systematic identification of patterns of death and injury. This emphasis reflects the over-riding modus operandi of the legal profession as a whole, which has concerned itself solely with dealing with events on a case-by-case basis, closing the file at the conclusion of each. A preventive focus requires additional steps; identifying patterns; identifying remedial responses; making recommendations to implement the response; ensuring that problematic situations are remedied.

The tension between the fact finding/warning provision role and the active initiation of remedial action role is highlighted in the subtle, yet highly significant differences of emphasis between the Brodrick Committee which reviewed the coronial system in England and Wales and the Ontario Law Reform Commission (OLRC 1971) Report on the role of the coroner in Ontario, Canada. According to the Brodrick Committee Report, the public interest served by a coronial enquiry requires the coroner to:

> draw attention to a possible fatal hazard so that an adequate warning can be given to the public and precautions taken, whether by individuals or by a responsible authority, against any new fatality (Ontario Law Reform Commission 1971, para. 14.22, p. 161).

The Ontario Law Reform Commission went further, and stated that the coronial inquest should not only focus community attention on preventable deaths, but should also have the function of "initiating community response to preventable deaths" (OLRC 1971, p. xi). The Norris Review of the Victorian *Coroners Act 1958* drew attention to the capacity of the Ontario coronial system to take "direct action to implement jury recommendations when possible" by sending a copy of the verdict and recommendations "with a covering letter asking how it is intended to remedy the situation" (Norris 1980, p. 135). It also acknowledged the importance of the data generated by the coronial process for the prevention of future deaths and the need to make recommendations (Norris 1980, recommendation 30).

In Australia, following the importance attached to the role of coroners in making preventive recommendations by the 1991 *National Report of the Royal Commission into Aboriginal Deaths in Custody*, the issue has been settled in favour of coroners making preventive recommendations. As stated in the *Inquest Handbook*[29]:

> Coronial recommendations represent the distillation of the preventive potential of the coronial process. The action taken in response to such recommendations carries the promise of lives saved and injury averted. It should be noted that every single death represents the tip of the iceberg of injuries and other high risk circumstances. A proactive strategy has the potential to avert not only deaths but alleviate risks to health and safety more generally.

2.4 Repealed Coroners Act

Section 43(5) of the repealed Coroners Act provided that:

> (5) The coroner shall not express any opinion on any matter outside the scope of the inquest except in a rider which, in the opinion of the coroner, is designed to prevent the recurrence of similar occurrences.

The Oxford Dictionary definition of "rider" includes:

> "expression of opinion, recommendation etc, added to verdict".

[29] Selby, H (ed) (1998) *The Inquest Handbook*, Sydney: The Federation Press at page 187

In the context of s.43(5), a "rider" is a preventive recommendation that is made by a coroner at the conclusion of an inquest.

2.5 *Coroners Act 2003*

The *Coroners Act 2003* governs inquests into deaths that occurred in Queensland after 1 December 2003.

The term "rider" is no longer used in the *Coroners Act 2003.* The word now used is "comment".

Section 46 provides that:

> 46 Coroner's comments
>
> (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.

A coronial comment is therefore a recommendation made by a coroner, supplementary to the findings of an inquest, for remedial action to eliminate or reduce a risk or hazard that has caused, or contributed to, the death investigated in the inquest.

Importantly, s.46 continues:

> (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 Minister administering the entity; and
> (ii) the chief executive officer of the entity.
>
> …

There is also specific provision made in s.47 of the *Coroners Act 2003* obliging a coroner to provide to the Attorney-General, the appropriate chief executive and the appropriate Minister, a written copy of the findings, and any recommendations made, in relation to the investigation of a death in care or a death in custody.

2.6 When recommendations made and to whom

Coroners in Queensland conduct approximately 300 inquests each year, not all of which result in the coroner making a recommendation.

Currently there is no restriction on the range of persons or entities to whom or to which a coroner can address a recommendation[30]. For example, in the coronial reports examined by my officers for the purpose of selecting the sample, there were recommendations directed to public sector agencies, Commonwealth government agencies, exporters and importers, vehicle and other manufacturers, peak representative bodies and private sector employers of deceased workers.

My investigation has only considered recommendations made to public sector agencies.

[30] See section 46 of the *Coroners Act 2003*

Chapter 3: Investigative approach

3.1 Representative sample

A representative sample of inquest reports was obtained from the archive of the Department of Justice and Attorney-General. The inquest reports selected contained coronial recommendations that related to the responsibilities of public sector agencies.

The sample comprised a total of 72 reports prepared by coroners – 34 reports from the 2002 calendar year and 38 reports from the 2003 calendar year. Some inquests involved multiple deaths, so the reports related to a total of 79 deaths, 35 in 2002 and 44 in 2003. All inquests were conducted under the repealed Coroners Act.

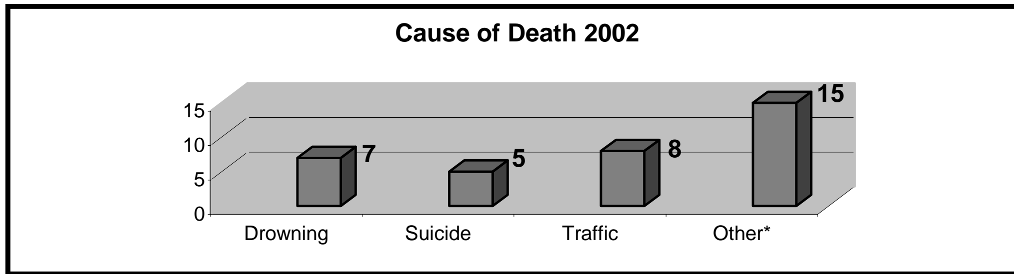
The 72 reports contained coronial recommendations that were directed to, or related to, matters within the administrative responsibilities of the 23 public sector agencies shown in Table 1.

Table 1: Agencies sampled

Agencies sampled	
Belyando Shire Council	
Brisbane City Council	
Broadsound Shire Council	
Communities & Child Safety	
Corrective Services	
Disability Services Queensland	
Education and the Arts	
Emergency Services	
Environmental Protection Agency	
Gold Coast City Council	
Industrial Relations	
Local Government, Planning, Sport and Recreation	
Mackay City Council	
Main Roads	
Port of Brisbane Corporation	
Queensland Health	
Queensland Law Society	
Queensland Nursing Council	
Queensland Police Service	
Queensland Rail	
Queensland Transport	
Redland Shire Council	
Tourism, Fair Trading and Wine Industry Development	
Total	**23**

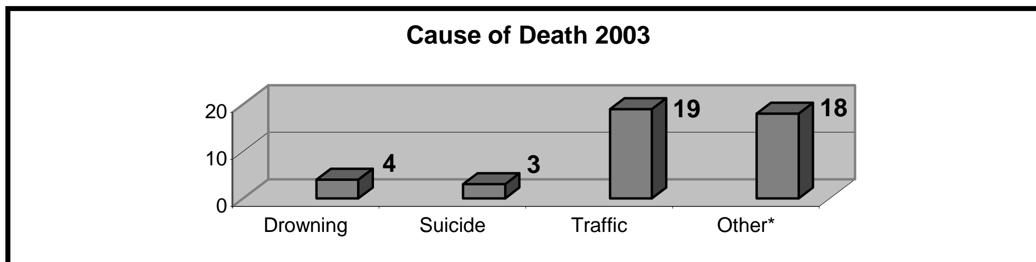
Charts 1 and 2 indicate the range of circumstances in which the deaths occurred in the sample of 72 reports where coroners recorded coronial recommendations aimed at reducing the risk of similar deaths.

Chart 1: Causes of 35 deaths in 2002



* Includes hit by object, not established, substance ingestion, aircraft accident, fall, electrocution and others.

Chart 2: Causes of 44 deaths in 2003



* Includes hit by object, not established, substance ingestion, aircraft accident, fall, electrocution and others.

Chart 3 shows the mode of travel for the eight traffic related deaths in the investigation sample for 2002. The "driver" and "passenger" categories relate to motor vehicles.

Chart 3: Traffic related deaths 2002

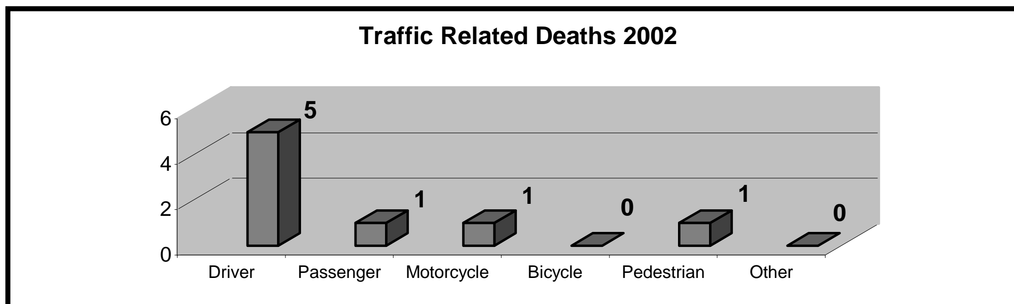
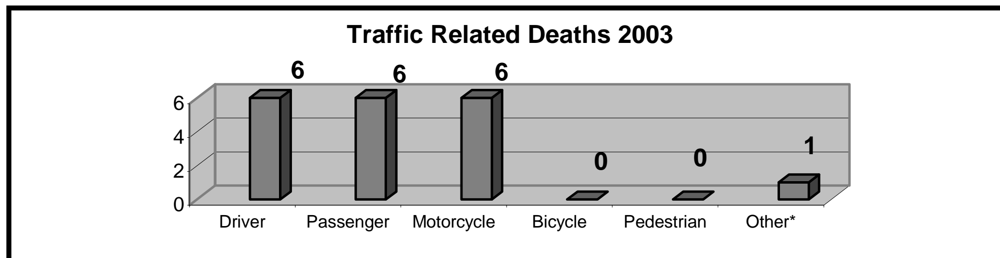


Chart 4 shows the mode of travel for the 19 traffic related deaths for 2003. The “driver” and “passenger” categories relate to motor vehicles.

Chart 4: Traffic related deaths 2003



*Fell from motor vehicle

3.2 Questionnaire

I wrote to the principal officer[31] of each public sector agency listed in Table 1, enclosing a copy of the inquest report that contained a coronial recommendation or recommendations directed to that agency or relating to its responsibilities, and requested the following information:

- whether anyone in the agency was aware of the coronial recommendations and, if so, by what means;
- if the agency was aware of the recommendations, whether they were considered and, if they were not considered, the reasons for that decision;
- whether the agency took any action to implement the recommendations and, if so, what action was taken;
- if the action taken involved developing or amending policies or procedures, a copy of those documents with an indication as to whether the document was still applicable;
- if the agency decided not to implement the recommendations, the reasons for that decision;
- if the agency was not aware of the recommendations until the receipt of my letter, the agency’s assessment of the recommendation and:
    - o if the agency intended to take any action to implement the recommendations, details of the proposed action; or
    - o if the agency did not intend to implement the recommendations, the reasons for that decision; and
- any other information the agency considered relevant.

3.3 Responses

Every public sector agency in Table 1 responded to my questionnaire.

All agencies cooperated with requests by my officers for additional information.

In a single inquest report, the coroner may make recommendations directed to, or relating to, one or more agencies. Thus, although there were 79 inquest reports in the sample, the total number of responses received from agencies was 105, as detailed in Table 2.

[31] See definition in schedule 3 of the *Ombudsman Act 2001*

Table 2: Responses received

Responses received	
Agency	**Number of responses assessed**
Belyando Shire Council	1
Brisbane City Council	13
Broadsound Shire Council	1
Communities & Child Safety	1
Corrective Services	5
Disability Services Queensland	2
Education and the Arts	1
Emergency Services	5
Environmental Protection Agency	1
Gold Coast City Council	1
Industrial Relations	14
Local Government, Planning, Sport and Recreation	4
Mackay City Council	1
Main Roads	10
Port of Brisbane Corporation	1
Queensland Health	15
Queensland Law Society	1
Queensland Nursing Council	2
Queensland Police Service	11
Queensland Rail	1
Queensland Transport	10
Redland Shire Council	1
Tourism, Fair Trading and Wine Industry Development	3
Total	**105**

3.4 Analysis of responses

The public sector agency responses have been analysed and discussions held with agency officers and with the State Coroner. On the basis of my analysis of the information gathered, I have made the recommendations contained in Chapter 5 and Chapter 6.

3.5 Conduct and outcome of inquests not within scope

I have not examined the subject matter and conduct of any of the inquests that resulted in the 72 reports that comprise the sample chosen for investigation.

It was not within the scope of my investigation to express any opinion about responsibility for the deaths of any of those persons.

I do not suggest, nor should any comment made in this report be taken to suggest, that any public sector agency or agency officer contributed in any way to the deaths of any person the subject of an inquest considered for the purposes of my investigation.

Chapter 4: Analysis of responses

4.1 Introduction

The responses of the public sector agencies contained answers to the following questions:

1. Did the agency have the opportunity to provide relevant input before a recommendation was made by the coroner?
2. Did the agency receive from the coroner the relevant recommendation directed to it, or relating to its responsibilities? and
3. Did the agency take steps to implement the recommendation?

The responses to each of these three questions are set out in the Public Sector Agency Response Summary in Table 3.

Table 3: Public Sector Agency Response Summary

Public Sector Agency Response Summary								
Agency	**Question 1: Did the agency have the opportunity of input before the recommendations were made?**			**Question 2: Did the agency receive recommendations from the coroner?**		**Question 3: Were recommendations implemented by the agency?**		
	Yes	No	Not known	Yes	No	Yes	No	Partially
Belyando Shire Council		1		1			1	
Brisbane City Council	4	9		7	6	6	7	
Broadsound Shire Council		1		1		1		
Communities & Child Safety		1			1	1		
Corrective Services	5			5		2	1	2
Disability Services Qld	1	1		1	1	1	1	
Education and the Arts		1		1		1		
Emergency Services	2	3		3	2	1	3	1
Environmental Protection Agency	1				1			1
Gold Coast City Council		1		1		1		
Industrial Relations	7	7		12	2	7	5	2
Local Government, Planning, Sport and Recreation	1	3		4			3	1
Mackay City Council		1			1		1	
Main Roads	2	8		8	2	3	6	1
Port of Brisbane Corporation	1			1			1	
Queensland Health	2	13		13	2	7	6	2
Queensland Law Society		1			1		1	
Queensland Nursing Council		2		2		1	1	
Queensland Police Service	1	10		9	2	5	3	3
Queensland Rail	1			1		1		
Queensland Transport	1	7	2	7	3	8		2
Redland Shire Council	1			1				1
Tourism, Fair Trading and Wine Industry Development		3		3			2	1
Totals	**30**	**73**	**2**	**81**	**24**	**46**	**42**	**17**

4.2 Question 1 – Opportunity for input before recommendation

As shown in Table 4, the responses from public sector agencies indicate that in 69% of the inquests sampled, the agencies believed that they were **not provided** with an opportunity for input into the formulation of coronial recommendations. Only 29% of agency responses indicated that they had had an opportunity to provide input to assist the coroner. It was unclear from 2% of responses whether an opportunity had been provided and what input, if any, had been given.

Table 4: Public sector agency input rate

Public Sector Agency Input Rate		
Input	**No input**	**Unknown**
28.6%	69.5%	1.9%

4.3 Question 2 – Whether public sector agency received recommendation

About 77% of public sector agencies advised that they had received from the coroner copies of recommendations that related to their administrative responsibility.

Of the 23% that reported they had not received a copy of relevant recommendations from the coroner, 4% said they had received information about a relevant recommendation in other ways, for example, from another public sector agency or by requesting it directly from the coroner once they had become aware of the inquest. In the other 19% of cases, the relevant public sector agencies did not become aware of the recommendations until they received the letters I sent to them for the purposes of this investigation.

Case Study 1

In 2002, a coroner in regional Queensland was considering the death of a person as a result of a motor vehicle accident. The coroner made a recommendation "that the speed limit at the location of the accident be reduced to 80kms". The recommendation was directed to the relevant local government where the accident occurred.

When contacted by my Office, the local government advised that it had not received the recommendation from the Coroner's Court and was unaware of it until supplied with a copy by my Office. Upon reviewing the recommendation, the local government took appropriate action to improve sight distance at the relevant intersection, but declined to implement the recommendation because it was thought to "be inappropriate and inconsistent with the theory and process for setting speed limits on Queensland roads".

The local government also advised me that there had been at least two other fatalities, the subject of inquests, which had occurred on council roads in recent years where council had also not received copies of the findings and recommendations.

Case Study 2

In 2003, a coroner was considering the death of a person involving "snatch straps", which are used to assist the removal of vehicles (normally four wheel drives) that have become bogged. The coroner made a recommendation that the Australian Standard for webbing products, including items commonly marketed as "snatch straps", be reviewed.

Although the recommendation was directed to the Commonwealth Department of Transport, the Compliance Division of the Office of Fair Trading (OFT), within the Department of Tourism, Fair Trading and Wine Industry Development, also had an interest in the matter.

When contacted by my Office, the OFT advised that it had been unaware of the issue until it received my letter and that it had immediately "initiated an investigation in regard to the representations made about the accuracy of the load bearing capacity of snatch straps and the warnings/instructions that are supplied with these products".

This issue has been addressed in the *Coroners Act 2003* by imposing an obligation on a coroner to advise agencies about recommendations that relate to legislation it administers[32].

4.4 Question 3 – Public sector agency implementation of recommendation

As shown in Table 5, only about 44% of all coronial recommendations made by coroners had been fully implemented by the public sector agencies to which they were directed. A further 16% had been partially implemented to varying degrees.

Public sector agencies gave a variety of reasons to my Office for not having implemented the remaining 40%. Some advised that they had simply not been made aware of the recommendations. Other reasons offered, in descending order of frequency, were:

- recommendation had not been made on an informed basis;
- consideration had been given to the recommendation and it was determined that implementation was inappropriate and/or unrealistic;
- additional training/policies (as recommended by the coroner) would not have prevented the death;
- successful implementation was impracticable/unlikely because of cost or lack of qualified staff;
- implementation of the recommendation may breach legislation;
- other more appropriate action had already been taken by the agency before the recommendation was made; and
- the recommendation was the responsibility of another public sector agency or of a Commonwealth agency.

Table 5: Recommendation implementation rate

Recommendation Implementation Rate		
Fully implemented	**Partial implementation**	**Not implemented**
43.8%	16.2%	40%

[32] Section 46(2)(d) of the *Coroners Act 2003*

4.5 Average age of coronial report

The average time taken for finalisation of the coronial reports in the audit sample, calculated from the date of death, was approximately 21.5 months. The shortest time taken was 4 months. The longest time taken was 4 years and 10 months.

I understand that the current average time for the finalisation of coronial reports remains 20 to 24 months.

Chapter 5: Proposals for improving coronial practice

Throughout chapters 5 and 6 of this report, I have formed a number of opinions and recommendations and suggested amendments to the *Coroners Act 2003*. As I have already stated, I provided a copy of this report in proposed form to the Director-General of the Department of Justice and Attorney-General for his comment. In his response to my proposed report he said:

> The Department is currently reviewing the operation of the Coroners Act, with a view to progressing any necessary amendments in the first half of 2007. The issues you have identified and the amendments proposed to address them will be examined closely in the context of that review.

5.1 System under repealed Coroners Act

It is evident from my investigation that, under the repealed Coroners Act:

- there was no coordinated system for the making of coronial recommendations;
- coroners did not follow any consistent practice of asking public sector agencies (and other entities with sufficient interest) for their input and advice in order to formulate recommendations;
- coroners were not required to communicate their recommendations to agencies (and other relevant entities) and no other person/entity performed that role;
- there was no system in place to monitor the implementation of recommendations; and
- there was no system in place to communicate with the family of a deceased person about action taken to implement recommendations with a view to preventing similar deaths in future.

In relation to the issue of communication of recommendations to public sector agencies, the then Director-General of the Department of Justice and Attorney-General stated[33]:

> You have specifically asked whether this department had any procedures for:
>
> …
>
> - assessing whether any riders made under the *Coroners Act 1958* (now repealed) were relevant to State or local government agencies, and, if so, communicating those riders to those agencies.
>
> This department did not have any procedures to … assess [coronial recommendations'] relevance to government agencies and communicate them to the relevant agencies. The department's role in the coronial process is statutorily defined and the *Coroners Act 1958* placed no such obligation on the department to do this.
>
> …
>
> I understand that some Coroners have directed in particular cases that their findings and riders be forwarded to a particular government agency or department. If such a direction was made, it should have been carried out by Court staff in accordance with general principles on implementation of Court orders. I am unable to indicate how many Coroners adopted this practice because the coronial system under the *Coroners Act 1958* was not coordinated.
>
> Also, in some situations, government agencies would have obtained copies of transcripts and findings as they were actively involved in the inquest.

[33] In a response dated 9 February 2004 to the correspondence I described at section 3.3

5.2 System under *Coroners Act 2003*

5.2.1 Some deficiencies of previous system not addressed

The *Coroners Act 2003* requires a coroner to give a copy of a recommendation to the Minister and the chief executive officer of a public sector agency that "deals with the matters to which the comment relates"[34].

However, the Act is silent on:

- whether public sector agencies ought to be consulted about proposed coronial recommendations that relate to their administrative responsibilities; and
- what happens after recommendations have been communicated to the agency.

My proposals for improvement to the coronial system follow. I have set out in Appendix A, a suggested flowchart for improving the coronial system in Queensland.

5.2.2 Notice of inquest

Section 32 of the *Coroners Act 2003* provides that:

> (1) The Coroners Court must publish, in a daily newspaper circulating generally in the State, a notice of—
>
> (a) the matter to be investigated at the inquest; and
> (b) the date, time and place of the inquest set by the Coroner.
>
> (2) The notice must be published at least 14 days before the inquest is to be held.

The State Coroner's Guidelines provide[35] that "all people with a legitimate interest in the inquest must be notified of the date, time and place it will commence. There must also be a general public notice of the commencement date published in the newspaper."

My investigation revealed that public sector agencies and other entities with a legitimate interest in an inquest often said they were unaware that an inquest was to be held. Others said they became aware that an inquest was pending at too late a stage for them to meaningfully participate, especially if a pre-inquest conference had already been held.

In my opinion, the current coronial system could be improved if there were better procedures for identifying, early in the inquest process, who should participate and providing those persons and entities with reasonable notice of the inquest and particulars of the issues to be investigated so that they can attend any pre-inquest conferences and, if necessary, seek leave to appear at the inquest.

Under the *Coroners Act 2003*, notices are required to be published "at least 14 days before the inquest is to be held"[36]. In my view, this does not provide sufficient opportunity for all relevant persons/entities to participate.

At the present time, notices state the matter that is "to be investigated at the inquest" as well as the date, time and place of the inquest[37]. In my opinion, notices should also particularise the issues to be investigated.

[34] Section 46(2)(d)
[35] State Coroner (Queensland) (December 2003) *State Coroner's Guidelines-Version 0*, Brisbane: Office of the State Coroner at paragraph 8.4
[36] Section 32(2) of the *Coroners Act 2003*
[37] Section 32(1)(a) and section 32(1)(b) of the *Coroners Act 2003*

Many inquests are preceded by a pre-inquest conference. In my opinion the intention to hold such a conference should also be publicly notified. The notice should provide information about the conference and, at least in general terms, include a list of the issues the inquest is expected to consider.

I have set out in Appendix B, a template notice that could be suitable for advising relevant persons/entities of information relevant to a pending pre-inquest conference.

In order to assist and improve the coronial system, "coronial liaison officers" could be appointed in public sector agencies that have administrative responsibilities for issues frequently considered at inquests (for example, the Department of Employment and Industrial Relations, the Department of Tourism, Fair Trading and Wine Industry Development, the Department of Child Safety, the Department of Corrective Services, the Department of Emergency Services, the Department of Main Roads, the Department of Transport and the Department of Health). This issue is dealt with later in the report[38].

Opinion 1

> The audit showed that relevant public sector agencies (and other relevant persons/entities) were not given sufficient notice of the holding of an inquest to enable them to provide appropriate input into the inquest.

Response by State Coroner

In response to this opinion, the State Coroner advised:

> "The current practice is for the coroner in consultation with counsel assisting to identify individuals, organisations and public sector agencies that may have an interest in the issues to be investigated at inquest. Those individuals/organisations are advised of the date for the pre-inquest conference. At the pre-inquest conference the matter is listed for hearing, generally some months in the future. Thereafter usually at least one month before the inquest a public notice of the holding of the inquest is published. I am of the view that this provides for interested parties to be given sufficient notice of inquests."

Comment

Notwithstanding the State Coroner's comments, he agreed with my suggestions for ensuring relevant persons/entities are advised of the holding of an inquest in sufficient time to enable them to prepare submissions for the coroner's assistance.

In my proposed report, I suggested that the *Coroners Act 2003* should be amended to require that:

(a) notices advising of an inquest be published in a daily newspaper circulating generally in Queensland at least two months before an inquest is to be held unless the coroner decides in a particular case that the notice should be published closer to the date of the inquest but, in any event, at least 14 days before the inquest is to be held.

(b) Such notices should:

- particularise the issues for investigation in sufficient detail to allow persons/entities with relevant information to provide that information to the coroner; and
- invite submissions from relevant persons/entities about how similar deaths can be prevented from occurring.

[38] See my recommendations at section 6.1 and section 6.3

Response by State Coroner

In response to this suggested amendment to the *Coroners Act 2003*, the State Coroner advised:

> "I am inclined to the view that it would be more beneficial to require notification to be given of the pre-inquest conference and subsequently the inquest. That is rather than making the requirement two months advance notice of the inquest, give one month's notice of the pre-inquest conference and one month's notice of the inquest.
>
> Were this adopted the amendments set out in paragraph (b) could then be followed in relation to the inquest after those who sought leave to appear were provided with an opportunity to have input into identifying the issues at the pre-inquest conference.
>
> However, I do not consider it to be appropriate to invite submissions about prevention prior to the evidence being heard as suggested in the second dot point. The appropriate time for that contribution is at the end of the inquest when the proposals can be better informed by the facts."

Comment

The suggestion by the State Coroner that two notices be published has merit and should address the notification problem that was raised by agencies during my investigation. I agree with the suggestion which is reflected in proposed amendment 1 to the *Coroners Act 2003* (see below). The appointment of coronial liaison officers (see recommendation 1 in chapter 6) should also help to ensure relevant agencies are aware of both pre-inquest conferences and pending inquests.

I understand the coroner's argument that the appropriate time for making submissions about ways of preventing a recurrence of an incident is at the end of an inquest once all of the facts have been gathered. I suggest that, to ensure parties have sufficient time to prepare their submissions, they be advised at the pre-inquest conference of issues relevant to prevention in respect of which submissions will be sought at the inquest.

I expect these issues will be considered further during the review of the *Coroners Act 2003*.

Having considered the State Coroner's comments, I propose the following amendment to the *Coroners Act 2003*.

Proposed amendment 1 to *Coroners Act 2003*

The *Coroners Act 2003* should be amended to provide that:

(a) notice advising that a pre-inquest conference is to be held be published in a daily newspaper circulating generally in Queensland at least one month before the date of the conference; and
(b) notice advising that an inquest is to be held be published in a daily newspaper circulating generally in Queensland at least one month before the date of the inquest.

5.2.3 The case for an issues list

The *State Coroner's Guidelines* provide that, when making recommendations, coroners are required to act judicially, not perversely or capriciously, when determining the level of satisfaction required to support conclusions on which the recommendations are based[39].

The preparation of an issues list should assist coroners to formulate appropriate recommendations.

[39] State Coroner (Queensland) (December 2003) *State Coroner's Guidelines – Version 0*, Brisbane: Office of the State Coroner at section 8.8

In my proposed report, I used the term "issues paper" which led to the State Coroner disagreeing with my proposal in the belief that I was referring to a formal paper discussing the merits of issues. I have since clarified the matter with the State Coroner who generally supports the opinions and proposed amendments that follow.

Obviously, the more information available to a coroner in formulating a recommendation, the greater the likelihood that the recommendation will be soundly based. Any recommendations made by a coroner need to provide practicable and appropriate solutions for addressing an adverse event, particularly if an underlying systemic problem has been identified. Recommendations need to be quite specific rather than broad directions[40].

When making a recommendation, it would be useful if the coroner provided a rationale or explanation for the recommendation. Otherwise, a recommendation directed to a public sector agency to, for example, review a policy, could encourage the agency merely to conduct a cursory review and change nothing of significance, leaving the underlying problem in place[41].

From time to time, public sector agencies (especially regulatory agencies) will have a particular view about what remedial action should be taken in response to an adverse event, the subject of an inquest. Coroners should be vigilant in that they obtain information about potential recommendations from a number of viewpoints, not just that of the public sector agency that will be requested to implement the recommendation[42].

Groups such as peak representative bodies (for example, the RACQ[43]), employer organisations and unions, private workplace health and safety consultants, and other community or interest groups may have valuable information to contribute that will assist a coroner to formulate a soundly based preventive recommendation.

One way the provision of such input could be encouraged is by publishing an issues list that would alert relevant persons/entities to issues an inquest is likely to consider. The publication of an issues list at an early stage (once the investigation report has been completed) should ensure the participation of relevant persons/entities and that they participate on an informed basis.

During the course of my investigation, I was advised by a significant number of public sector agencies that they were willing to become more involved in the coronial process if provided with a better opportunity to do so. One Director-General stated:

> I fully support the undertaking of the Coronial [*Recommendations*] Project and recognise the importance of coronial recommendations being referred to the appropriate authority for consideration as soon as possible, as they can bring issues of concern to the forefront and have the possibility of preventing future deaths from the same causes. In this regard, the [*relevant unit of the Department*] will liaise with the Coroner's Office to offer assistance during the course of their investigations to ensure that [*relevant*] issues are brought to its attention as soon as possible and to provide advice in relation to the referral of issues to the appropriate authority.
>
> You may wish to consider whether there is benefit in recommending that other government agencies take similar action so as to expedite relevant agencies involvement in the consideration of Coronial riders.

[40] See Parliament of Victoria Law Reform Committee (September 2006) *Coroners Act 1985: Parliamentary Paper No 229 of Session 2003-06*, Melbourne: Victorian Government Printer at pages 370 to 375
[41] Parliament of Victoria Law Reform Committee (September 2006) *Coroners Act 1985: Parliamentary Paper No 229 of Session 2003-06*, Melbourne: Victorian Government Printer at page 377
[42] See Parliament of Victoria Law Reform Committee (September 2006) *Coroners Act 1985: Parliamentary Paper No 229 of Session 2003-06*, Melbourne: Victorian Government Printer at pages 375 to 377
[43] Royal Automobile Club of Queensland

Opinion 2

The audit showed that the coronial system does not ensure that relevant public sector agencies (and other relevant persons/entities) are sufficiently informed of the issues to be canvassed at the inquest, to enable them to provide appropriate input into the inquest.

Response by State Coroner

In response to this opinion, the State Coroner advised:

"The current practice is for counsel assisting to read out at the pre-inquest conference the issues he/she considers warrant investigation at the inquest. All those who have attended and obtained leave to appear are then invited to make submissions if they consider any of the proposed issues are outside the proper scope of the inquest, or if they consider other issues warrant investigation. Such submissions are usually required within fourteen days. Provided the appropriate parties have been identified and invited to attend the pre-inquest conference I am of the view that this process provides them with sufficient opportunity to have input into the issues to be canvassed at the inquest."

Comment

The practice, as described by the coroner, should be effective provided the appropriate parties have been identified and invited to attend the pre-inquest conference.

I have already suggested, following consultation with the coroner, a proposed amendment to the *Coroners Act 2003* to require that notices of both the pre-inquest conference and the inquest be published. This recommendation should ensure that relevant persons are notified of coronial proceedings.

Again, the appointment of coronial liaison officers should assist agency participation and consequently the quality of coronial recommendations. (see recommendation 1 in chapter 6)

As mentioned, in my proposed report, I suggested that the *Coroners Act 2003* should be amended to require that an Issues Paper be prepared in respect of each inquest and be publicly available at the time the notice of inquest is published. I also suggested that alternatively, the State Coroner could consider issuing guidelines under s.14(1)(b) of the *Coroners Act 2003* encouraging coroners to cause Issue Papers to be prepared and made publicly available at the time the notice of inquest is published.

Response by State Coroner

In response to my suggested amendment to the *Coroners Act 2003*, the State Coroner advised:

"I am of the view that the requirement to publish an Issues Paper before each inquest is flawed for two reasons. First, in many cases not sufficient would be known about the issues that are yet to be explored at the inquest. A primary purpose of an inquest is to obtain information and opinions about issues that may subsequently be the subject of recommendations. Second, such a proposal would impose very significant burdens on coroners and have significant resource implications. Many inquests are undertaken by magistrates who spend only a small proportion of their time in the coronial jurisdiction. They have no administrative support. It would be unreasonable to expect those coroners to have sufficient time or expertise to draft an Issues Paper. Even in investigations undertaken by the State Coroner or Deputy State Coroner the publishing of an Issues Paper prior to the inquest would be unduly burdensome. I would strongly resist this recommendation."

Comment

I acknowledge that my use of the words “issues paper” in my proposed report misled the State Coroner about the nature of the document I was proposing. After considering the State Coroner’s comments, I am now proposing that the notice advising an inquest is to be held should also contain a list of issues expected to be considered.

Furthermore, the notice advising a pre-inquest conference is to be held should also contain a list of issues expected to be considered at the inquest, in a more general form.

I have discussed these proposals with the State Coroner who indicated his support for them.

I expect that the issue will be considered during the current review of the *Coroners Act 2003*.

Proposed amendment 2 to *Coroners Act 2003*

The *Coroners Act 2003* should be amended to require that

(a) the notice advising that a pre-inquest conference is to be held contain, in general terms, a list of the issues (including preventive issues) expected to be considered at the inquest; and
(b) the notice advising that an inquest is to be held contain a list of the issues (including preventive issues) expected to be considered at the inquest.

Alternatively, the State Coroner could consider issuing guidelines under s.14(1)(b) of the *Coroners Act 2003* requiring that notices be issued as proposed above.

5.2.4 Pre-inquest conferences

Section 34 of the *Coroners Act 2003* provides that:

(1) The Coroners Court investigating a death may hold a conference before holding an inquest—
 (a) to decide—
  (i) what issues are to be investigated at the inquest; or
  (ii) who may appear at the inquest; or
  (iii) which witnesses will be required at the inquest; or
 (b) to work out how long the inquest will take; or
 (c) to hear any application under section 17; or
 (d) to otherwise ensure the orderly conduct of the inquest.

(2) The Coroners Court may order a person concerned with the investigation to attend the conference.

The State Coroner's Guidelines state[44] that, in principle, pre-inquest conferences "should usually be convened before inquests unless there is a reason not to do so". I strongly endorse this guideline. During the WEP, my Office reviewed the transcripts of nine inquests. These reviews led me to conclude that pre-inquest conferences greatly assist the orderly conduct of an inquest and that inquests where pre-inquest conferences are not held are more likely to be adjourned or take longer to complete because issues are poorly defined and witnesses in relation to specific issues have not been arranged.

The State Coroner's Guidelines contain the following explanation of the value of convening pre-inquest conferences[45]:

- It is preferable that applications for leave to appear and challenges to the scope of the inquiry etc be determined prior to the hearing commencing so that if any party wishes to challenge that ruling or persuades the court that more time is needed to consider matters the witnesses will not have needlessly been summoned to attend a hearing that will then not proceed.

- At a pre-inquest conference, counsel assisting can outline the issues he/she submits [that] warrant investigation at the hearing and the witnesses that will, in his/her submission, need to be called. The other parties that have been given leave to appear can reflect on those submissions and raise other issues there and then, or at least at some stipulated time. This assists with estimations as to the likely duration of the proceedings and the settling of the witness list.

[44] State Coroner (Queensland) (December 2003) *State Coroner's Guidelines – Version 0*, Brisbane: Office of the State Coroner at paragraph 8.5
[45] State Coroner (Queensland) (December 2003) *State Coroner's Guidelines – Version 0*, Brisbane: Office of the State Coroner at paragraph 8.5

- If the inquest is to proceed on the day it is set to commence it will be necessary for the parties to have access to the investigation report prior to that time. A pre-inquest conference enables a coroner to authorise the release of the documents to parties granted leave to appear and to impose conditions on access and stress with the parties the seriousness of any breach of such an order.

- Although not bound by the rules of evidence, coroners are obliged to ensure that the principles of procedural fairness are applied. One consequence of this is that if evidence adverse to any party is led, that party must be given an opportunity to respond. If the leading of such evidence has not been anticipated and the party whose conduct is criticised has not been involved from the outset of the inquest it will be necessary to adjourn the inquest and allow that party time to obtain representation and familiarise him/herself with all of the evidence that has been given. At a pre-inquest conference counsel assisting can outline the issues that will arise during the hearing and if any party affected by that evidence has not sought leave to appear a direction can be given by the coroner that they be contacted and invited to seek such leave from the outset or for so much of the proceedings as may be relevant to their interests.

I agree with the views expressed by the State Coroner, which are consistent with the experience of my Office in the WEP.

The responses from the audit sample indicated a high proportion of cases in which public sector agencies did not implement coronial recommendations. A significant reason agencies gave for not implementing recommendations was that they did not believe the recommendations had been made on an informed basis. It was apparent that these same agencies had not participated in any pre-inquest conferences and felt largely excluded from the process. Accordingly, a view was formed that the recommendations were of little value and should not be implemented.

The question that needs to be asked is whether the convening of a pre-inquest conference should be mandatory. A pre-inquest conference is essentially a form of investigative planning. My experience is that investigative planning is critical to the success of any investigation including a coronial inquest, which is essentially an administrative investigation into a death. Even less complex inquests would be likely to benefit from a pre-inquest conference even if the conference was straightforward and brief.

Opinion 3

> The audit showed that a significant reason for public sector agencies not implementing coronial recommendations is that the relevant agency considers that the recommendation is not soundly based or is not practicable.

Response by State Coroner

In response to this opinion, the State Coroner advised:

> "I accept that some recommendations have been made that are not able to be implemented because the coroner has not sought sufficient input from those with responsibly for administrating the area of activity in question and as a result the recommendations may not be soundly based. The State Coroner's Guidelines could be strengthened to make this a less likely outcome."

Comment

> I agree with the State Coroner's comment and suggest that he amend the guidelines accordingly.
>
> In my proposed report, I suggested that s.34 of the *Coroners Act 2003* should be amended to require that a pre-inquest conference be held for all inquests, unless the coroner is satisfied that such a conference is unnecessary in the particular case.

Response by State Coroner

In response to my suggested amendment to the *Coroners Act 2003*, the State Coroner advised:

> "The Act currently gives a coroner a discretion in this regard. The State Coroner's Guidelines recommend that a PIC be convened in most cases. I don't consider a change is necessary."

Comment

> I have considered the State Coroner's comments. Nonetheless, I put forward the proposed amendment for consideration as it is difficult to envisage circumstances in which a pre-inquest conference would not assist the smooth function of the inquest.

Proposed amendment 3 to *Coroners Act 2003*

> Section 34 of the *Coroners Act 2003* should be amended to require that a pre-inquest conference be held for all inquests, unless the coroner is satisfied that such a conference is unnecessary in the particular case.

5.2.5 Response to coronial recommendations

In Queensland, the *Coroners Act 2003* does not impose a legal obligation upon the principal officer of a public sector agency, or any other person or entity, to respond to recommendations that concern that agency, person or entity. As I have mentioned, the Act has corrected the deficiency in the repealed Coroners Act by requiring that recommendations be communicated to the Minister and public sector agency to whom they are directed. The repealed Coroners Act required neither communication nor a response.

A significant issue for modern coronial practice is whether public sector agencies to which recommendations are directed should have a legal obligation to respond to the coroner who made those recommendations[46]. A further issue is whether, in the absence of a legal obligation, good administrative practice requires that public sector agencies formally assess relevant recommendations and provide the coroner, and perhaps other persons, with advice as to whether a recommendation will be accepted and implemented, what actually will be done and by when[47]. Another significant issue is whether the response should be subject to general or limited publication[48]. There are a variety of views and a number of practices across a range of coronial systems[49].

The following remarks, made by a coroner at an inquest in Queensland in 2001 and among the sample of cases considered in my audit, reflect the level of frustration experienced by coroners under the repealed Coroners Act:

> Presumably that recommendation has suffered the same fate as other recommendations I have made. I do not know if it has been acted upon, or, if not, why not. As best I can recall, I have never been given the courtesy of a reply or acknowledgement by any relevant authority or department to any recommendation I have made in the eight years that I have acted as coroner. **That, of course, will change when the Office of the State Coroner is established and a proper system put in place to ensure that follow-up action does, in fact, occur, or that parties that do not respond are subject to stringent criticism.** [emphasis added]

[46] See Parliament of Victoria Law Reform Committee (September 2006) *Coroners Act 1985: Parliamentary Paper No 229 of Session 2003-06*, Melbourne: Victorian Government Printer at page 397 to 402

[47] See generally Bugeja, L & Ranson, D (2005) 'Coroners' recommendations: a lost opportunity', *Journal of Law and Medicine*, 13(2), 173-175

[48] See Parliament of Victoria Law Reform Committee (September 2006) *Coroners Act 1985: Parliamentary Paper No 229 of Session 2003-06*, Melbourne: Victorian Government Printer at pages 397 to 402

[49] These are summarised at pages 388 to 396 of Parliament of Victoria Law Reform Committee (September 2006) *Coroners Act 1985: Parliamentary Paper No 229 of Session 2003-06*, Melbourne: Victorian Government Printer. I have summarised these practices by reference to that information throughout section 5.2.5

The *Coroners Act 2003* did not address the issue complained about, and the "follow-up" action referred to by the coroner in this quote remains a topic for debate.

Case Study 3

In 2002, a Queensland coroner was considering the death of a young child who had drowned in a swimming pool. During the course of the proceedings, the coroner had stated:

> Issues of cost, inconvenience, private rights to enjoy property, and the principle against retrospective legislation, must also be secondary to the community's value of children's safety.

The coroner made a number of recommendations concerning the inspection and certification of domestic swimming pools. One of those recommendations was that swimming pools be inspected every two years to ensure continuing compliance and maintenance.

Although this recommendation was assessed by the relevant public sector agencies, no action has been taken to give effect to the particular inspection recommendation that was formulated by the coroner.

There is presently no legal obligation on a public sector agency to respond to any recommendation directed to it.

A review of the position in other states and territories of Australia and in New Zealand and Ontario, Canada (one of the alternative coronial models) reflects the divergence of views that are held as to whether agencies should have a positive obligation to respond to coronial recommendations.

5.2.5.1 General

The Royal Commission into Aboriginal Deaths in Custody made certain recommendations in relation to the reporting of and responses to findings and recommendations following inquests into deaths in custody[50]. Some Australian jurisdictions have taken up various recommendations in their coronial legislation. Others have included various reporting and response obligations for deaths other than deaths in custody.

5.2.5.2 Australian Capital Territory

Under the *Coroners Act 1997* (ACT), after completing an inquest into a death in custody, a coroner must report his or her findings to the custodial agency in whose custody the death occurred and the Minister responsible for that agency[51]. Section 76 provides that any custodial agency to which a report is given must provide a written response to the Minister responsible for the custodial agency within three months of receiving the report[52]. The response is to include a statement of the action (if any) that is being or will be taken on any of the findings contained in the report[53]. The Minister must then forward a copy of the response to the coroner[54].

The mandatory response measures contained in the *Coroners Act 1997* (ACT) were described as marking “the beginning of a new direction for coronial legislation in Australia in terms of increasing accountability”[55].

5.2.5.3 Northern Territory

Recent amendments to the *Coroners Act 1993* (NT) have introduced mandatory response obligations for non-custodial agencies “in what could be regarded as a pioneering step towards greater accountability”[56].

If the recommendation relates to a Northern Territory public sector agency or the Northern Territory police, the Attorney-General must give a copy of the recommendation to the chief executive officer of the relevant agency or the Commissioner of Police[57].

A chief executive officer and the Commissioner of Police must respond to the Attorney-General within three months. The Attorney-General must then report the response to Parliament[58] and may give a copy of his or her report on the response to the coroner[59].

The Deputy Coroner of the Northern Territory has reported that “the system has worked extremely well since the above provisions were enacted, and that the coroner now receives responses in relation to all coronial recommendations made in relation to government agencies”[60].

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[50] Summarised in Appendix 1 of Parliament of Victoria Law Reform Committee (April 2005) *Coroners Act 1985: Discussion Paper*, Melbourne: Victorian Government Printer starting at page 105
[51] Section 72(1) of *Coroners Act 1997* (ACT)
[52] Section 76(1) of *Coroners Act 1997* (ACT)
[53] Section 76(2) of *Coroners Act 1997* (ACT)
[54] Section 76(3) of *Coroners Act 1997* (ACT)
[55] Parliament of Victoria Law Reform Committee (September 2006) *Coroners Act 1985: Parliamentary Paper No 229 of Session 2003-06*, Melbourne: Victorian Government Printer at page 389; see also Freckelton, I (June 1999) ‘Coronial law: the evolving institution of coroner’, *Alternative Law Journal* 24(3), 156-157
[56] Parliament of Victoria Law Reform Committee (September 2006) *Coroners Act 1985: Parliamentary Paper No 229 of Session 2003-06*, Melbourne: Victorian Government Printer at page 387
[57] Section 46A(1) of the *Coroners Act 1993* (NT)
[58] Section 46B(3) of the *Coroners Act 1993* (NT)
[59] Section 46B of the of the *Coroners Act 1993* (NT)
[60] Email, Helen Roberts, Deputy Coroner, Northern Territory, to Parliament of Victoria Law Reform Committee Research Officer, 1 August 2006, cited in Parliament of Victoria Law Reform Committee (September 2006) *Coroners Act 1985: Parliamentary Paper No 229 of Session 2003-06*, Melbourne, Victorian Government Printer at page 390

5.2.5.4 South Australia

In the case of an inquest into a death in custody, if the Coroner's Court has made a recommendation directed to a Minister or a public sector agency, it must forward a copy of the report and recommendations to that Minister or agency[61]. The Minister responsible for the agency must, within eight sitting days of the expiry of six months after receipt of findings and recommendations, cause a report to be laid before each House of Parliament giving details of any action taken or proposed to be taken in consequence of those recommendations[62] and forward a copy of the report to the State Coroner[63].

5.2.5.5 New South Wales, Victoria, Tasmania and Western Australia

The legislation in these jurisdictions does not require Ministers or public sector agencies to report on their responses to coronial recommendations.

5.2.5.6 Victorian Law Reform Committee Report

In 2000, the Victorian State Coroner recommended in a finding that the Attorney-General consider the issue of mandatory reporting on the implementation (or otherwise) of coronial recommendations in relation to deaths in custody[64].

In September 2006, the *Victorian Law Reform Committee Report* recommended that agencies[65] be required to respond to a coronial recommendation within six months. It also recommended that the Victorian State Coroner include agencies'[66] responses to recommendations in its report to Parliament. The Committee considered that the publication would enhance transparency and encourage implementation of coronial recommendations.

5.2.5.7 New Zealand

The New Zealand Law Commission, in its 2000 report on coroners, recommended:

> "The agency [to which a recommendation relates] must, within three months, report to its Minister the steps it intends to take in relation to the coronial recommendation and a copy of that report must be provided to the Chief Coroner"[67].

However, the recent *Coroners Act 2006* (NZ) does not include such a requirement in relation to government agencies.

5.2.5.8 Ontario

In Ontario:

- in cases where the factual circumstances surrounding the death appear relatively clear; and
- the case is one where the coroner has a discretion as to whether to hold an inquest or not;
- the coroner may invite parties with a sufficient interest in the case to an informal conference.

At the informal conference, a party may agree with the coroner upon the measures to be taken by that party to prevent further deaths occurring in similar circumstances.

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[61] Section 25(4)(b) of *Coroners Act 2003* (SA)
[62] Section 25(5)(a) of *Coroners Act 2003* (SA); see also Chivell, W (April 2005) 'Coroner's act: refined', *Bulletin* (Law Society of SA), 27(3), 10-11
[63] Section 25(5)(b) of *Coroners Act 2003* (SA)
[64] Deaths in Custody at Port Phillip Prison (State Coroner's Office, Victoria), Part 1, 208 cited in Parliament of Victoria Law Reform Committee (September 2006) *Coroners Act 1985: Parliamentary Paper No 229 of Session 2003-06*, Melbourne: Victorian Government Printer at page 395
[65] And specified private bodies
[66] And specified private bodies
[67] Law Commission (August 2000) *Report 62: Coroners*, Wellington: Law Commission (New Zealand) at page 60 cited in Parliament of Victoria Law Reform Committee (September 2006) *Coroners Act 1985: Parliamentary Paper No 229 of Session 2003-06*, Melbourne: Victorian Government Printer at page 395

I understand that parties often prefer to reach such an agreement rather than face the prospect of adducing evidence at an inquest before a coroner's jury[68]. This is not a concern in Queensland where the coronial system does not involve juries.

5.2.5.9 The arguments for and against mandatory responses

The arguments for mandatory responses

There are several compelling reasons for requiring public sector agencies to respond to recommendations directed to them. These reasons are equally applicable to both custodial and non-custodial deaths[69]:

- The recommendations are made in an open public forum and therefore warrant transparent and public responses.

- Considerable public resources are expended in the process of investigating deaths and formulating recommendations - an inquest may be a wasteful exercise if the recommendations can be ignored by the agency to which they are directed.

- Agencies exist for a public purpose and should act in the public interest. Agencies must determine the public interest as it applies to them by reference to the purposes for which the agency has been established and the functions it is required or permitted to perform as expressed through enabling legislation or any objectives set out in government policy. There is a high level of community interest in whether recommendations are accepted by agencies and how implementation will occur, if at all, and if not, why not.

- Placing agency responses on the public record ensures data required for proper assessment of implementation rates is captured.

- Coroners are more likely to develop effective recommendations if an agency is required to respond and explain how implementation will be carried out and give coroners constructive feedback including advice on any implementation difficulties.

- An agency response enhances accountability, particularly in the eyes of the grieving families, who rightly expect that any systemic changes recommended by the coroner to avoid further deaths in similar circumstances are implemented by the relevant public sector agency.

The arguments against mandatory responses

Proponents of the no mandatory response position generally use the following arguments[70]:

- Recommendations are only one source of information available to a public sector agency and should be accorded no higher priority than other information the agency may wish to consider.

- The preparation of responses is resource intensive and generally unwarranted.

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[68] See detailed discussion of informal conferences in Ontario in Ontario Law Reform Commission (1995) *Report on the Law of Coroners*, Toronto: Ontario Law Reform Commission (via Publications Ontario); Law Commission (August 2000) *Report 62: Coroners*, Wellington: Law Commission (New Zealand); and Parliament of Victoria Law Reform Committee (September 2006) *Coroners Act 1985: Parliamentary Paper No 229 of Session 2003-06*, Melbourne: Victorian Government Printer

[69] ibid

[70] See detailed discussion in Ontario Law Reform Commission (1995) *Report on the Law of Coroners*, Toronto: Ontario Law Reform Commission (via Publications Ontario); Law Commission (August 2000) *Report 62: Coroners*, Wellington: Law Commission (New Zealand); and Parliament of Victoria Law Reform Committee (September 2006) *Coroners Act 1985: Parliamentary Paper No 229 of Session 2003-06*, Melbourne: Victorian Government Printer

- Historically, the quality of recommendations has been poor and no purpose would be served by a response in cases where the recommendations are incapable of implementation.

- The coroner is neither resourced, nor sufficiently familiar with the activities of an agency (other priorities and unintended ramifications of implementation), to engage in informed and extensive debate about the recommendations, and, therefore, providing a response serves no useful purpose.

5.2.5.10 Discussion and conclusion

In my view, the ability of the Queensland coronial system to prevent death and injury would be substantially improved by a requirement that public sector agencies respond to coronial recommendations that relate to legislation they administer. The arguments for this position are highly persuasive, while the arguments against are not consistent with a best practice accountability framework.

In my opinion, public sector agencies should be required to report on their responses to relevant coronial recommendations within a reasonable period of time. A period of three to six months would seem appropriate.

To promote transparency, details of the responses of public sector agencies should appear in their annual reports and in the annual report of the State Coroner.

A number of public sector agencies advised me during the course of my investigation that they believed, as an aspect of good administrative practice, that they should respond to a coronial recommendation directed to them.

Opinion 4

> The audit showed that the effectiveness of the coronial system is reduced by the fact that public sector agencies to which coronial recommendations are directed are not required to respond to those recommendations.

Response by State Coroner

> The State Coroner agreed with the opinion.

Proposed amendment 4 to *Coroners Act 2003*

> The *Coroners Act 2003* should be amended to require that, where a coroner gives notice under s.46(2) of the Act of a coronial recommendation to a public sector agency that deals with matters to which the recommendation relates, the agency must, within six months of being so notified, advise the coroner of the action taken or proposed to be taken to implement the recommendation or, if the agency does not intend to take action, its reasons for not doing so.

Response by State Coroner

> The State Coroner agreed with the proposed amendment.

Proposed amendment 5 to *Coroners Act 2003*

> The *Coroners Act 2003* should be amended to require public sector agencies to provide details in their annual reports of coronial recommendations directed to the agency and the agency's response to those recommendations.

Response by State Coroner

> The State Coroner agreed with the proposed amendment.

Chapter 6: Complementary administrative improvements

6.1 Appointment of public sector agency coronial liaison officers

It became apparent to my officers early in this investigation that the current coronial system in Queensland would benefit significantly from the appointment of officers within key public sector agencies who had specific responsibility for coronial matters affecting that agency. The preparation of many of the inquests in the audit sample reviewed by my officers were adversely affected by the failure of agencies to allocate to a particular officer the responsibility for preparing the agency's response.

It also appeared that coroners, and persons assisting coroners, had difficulty contacting relevant persons within public sector agencies, particularly large agencies, to obtain information, access documents, identify appropriate witnesses (including experts) and generally prepare for the inquest. Coroners did not have ready access to current information about public sector agency personnel who could assist them and, on many occasions, it appeared that communication between the coroner and agencies was ineffective and poorly focussed. Unfortunately, it appeared that some public sector agencies did not accord a sufficiently high priority to coronial work.

In my opinion, while it may not be necessary for all public sector agencies to appoint officers for the purposes of coronial liaison, agencies that have substantial involvement in coronial inquiries (for example, the Department of Employment and Industrial Relations, the Department of Tourism, Fair Trading and Wine Industry Development, the Department of Child Safety, Queensland Corrective Services, the Department of Emergency Services, the Department of Main Roads, Queensland Transport and Queensland Health) should nominate an officer (or officers) to perform the role of coronial liaison officer as and when required.

Other public sector agencies that have less involvement in inquests should appoint a coronial liaison officer as soon as they become aware that an inquest is to be held that is likely to deal with issues of relevance to the public sector agency's administrative responsibilities.

Relevant tasks for coronial liaison officers would include overall responsibility for liaison with the State Coroner and his staff including identifying pending coronial inquests relevant to that agency, coordinating the agency's response, responding to the issues list, undertaking or arranging any investigations that may assist the coroner, participating in pre-inquest conferences, responding to any recommendations made, maintaining records within the agency and being responsible for the preparation of annual report material in relation to the agency's response to any relevant coronial recommendations.

A significant number of public sector agencies advised me during my investigation that they would fully support the appointment of coronial liaison officers within their agencies. One large local government advised:

> It does not appear that the Council receives a copy of the coroner's decision in all cases in matters that may affect it. On some occasions when a copy of the coroner's decision has been forwarded to the Council, it has been simply addressed to, 'The Manager …' One of the suggestions from this review would be for a copy of the coroner's decision to be forwarded to a nominated officer in the…Council.

Opinion 5

> The audit showed that the effectiveness of the coronial system is reduced by the failure of public sector agencies to have in place systems for ensuring they are aware of pending inquests and obtain and provide relevant information to assist the coroner.

Response by State Coroner

The State Coroner advised that he agreed with the opinion and noted that some of the larger agencies which are frequently involved in inquests such as Queensland Health and Queensland Police Service have instituted such procedures.

Recommendation 1

Public sector agencies (particularly those frequently involved in inquests) should appoint coronial liaison officers with responsibility for:

- liaising with the State Coroner and staff;
- ascertaining the existence of pending coronial inquests relevant to that agency;
- coordinating the agency's response;
- responding to the issues list;
- undertaking or arranging any investigations required to assist the coroner;
- participating in pre-inquest conferences;
- responding to any recommendations made;
- maintaining a suitable coronial database within the agency; and
- preparing material for the agency's annual report in relation to the agency's response to relevant coronial recommendations.

Response by State Coroner

The State Coroner agreed with the recommendation.

Response by public sector agencies

I provided this recommendation in proposed form to a number of key public sector agencies that were frequently involved in inquests. All agencies that responded to my invitation to comment supported this recommendation.

6.2 A National Coroners Information System

Section 93 of the *Coroners Act 2003* provides:

(1) This section applies if an entity, including a government entity, maintains a database about coronial investigations.

(2) The Minister may, for the State, enter into an arrangement with the entity for stated information obtained under this Act to be included in the database.

(3) The Minister may enter into the arrangement only if satisfied—

(a) the entity has a legitimate interest in storing the information in the database;
(b) the entity will make the information available only to persons with a legitimate interest in obtaining it; and
(c) the conditions for making the information available to database users are reasonable.

The Australian National Coroners Information System or NCIS was developed in 2000[71]. NCIS has been described as a "world-first national database for coronial information"[72]. It is an initiative of the Australian Coroners Society and is based at and operated by the Victorian Institute of Forensic Medicine in Melbourne[73]. Queensland began contributing information to the database in 2001[74].

The *Victorian Law Reform Committee Report* summarised the current position as follows:

> Before the NCIS there was no systematic national data storage system for Australia's eight coronial jurisdictions. The advent of the NCIS has made the identification of similar cases on a national basis quicker and simpler[75].
>
> The NCIS is a valuable tool for death and injury research, as it permits users to conduct national searches on coronial data to identify the frequency and circumstances surrounding particular forms of death. The primary role of the NCIS is to assist coroners in their role as death investigators, by providing them with the ability to review previous coronial cases that may be similar in nature to current investigations, thus ensuring their ability to identify systemic hazards within the community[76]. In addition, researchers and government agencies have access to the data for research and prevention purposes[77]. Thus the NCIS also provides valuable information to the agencies responsible for developing community health and safety strategies to reduce the incidence of unnatural death and injury in Australia.[78]

The *Victorian Law Reform Committee Report* also suggested[79] possible improvements in relation to the use of, and access to, NCIS.

I have previously stated my view (in section 5.2.5.10) that public sector agencies should be compelled to respond to coronial recommendations. In my opinion, a summary of these responses prepared by or on behalf of the State Coroner should also form part of the data that is captured by NCIS[80]. Obviously, this development is dependent upon an amendment to the *Coroners Act 2003* that would compel agencies to respond to coronial recommendations.

[71] Parliament of Victoria Law Reform Committee (September 2006) *Coroners Act 1985: Parliamentary Paper No 229 of Session 2003-06*, Melbourne: Victorian Government Printer at page 338

[72] Lightfoot, J (November 2000) *The National Coroners Information System:* 'A Death and Injury Prevention Tool', *Journal of Law and Medicine*, 8, 155

[73] It was previously managed by the Monash University National Centre for coronial information, cited in Parliament of Victoria Law Reform Committee (September 2006) *Coroners Act 1985: Parliamentary Paper No 229 of Session 2003-06*, Melbourne: Victorian Government Printer at page 338

[74] Lightfoot, J (November 2000) 'The National Coroners Information System: A Death and Injury Prevention Tool', *Journal of Law and Medicine*, 8, 155

[75] National Coroners Information System brochure, National Coroners Information System, undated – available at http://www.vifp.monash.edu.au/ncis/web_pages/publications; brochure cited in Parliament of Victoria Law Reform Committee (September 2006) *Coroners Act 1985: Parliamentary Paper No 229 of Session 2003-06*, Melbourne: Victorian Government Printer at page 338

[76] See http://www.vifp.monash.edu.au/ncis/index.htm cited in Parliament of Victoria Law Reform Committee (September 2006) *Coroners Act 1985: Parliamentary Paper No 229 of Session 2003-06*, Melbourne: Victorian Government Printer at page 339

[77] State Coroner's Office submission to Victorian Parliament Law Reform Committee cited in Parliament of Victoria Law Reform Committee (September 2006) *Coroners Act 1985: Parliamentary Paper No 229 of Session 2003-06*, Melbourne: Victorian Government Printer at page 339

[78] National Coroners Information System brochure, National Coroners Information System, undated – available at http://www.vifp.monash.edu.au/ncis/web_pages/publications; brochure cited in Parliament of Victoria Law Reform Committee (September 2006) *Coroners Act 1985: Parliamentary Paper No 229 of Session 2003-06*, Melbourne: Victorian Government Printer at page 339

[79] Parliament of Victoria Law Reform Committee (September 2006) *Coroners Act 1985: Parliamentary Paper No 229 of Session 2003-06*, Melbourne: Victorian Government Printer at pages 357 to 360 and recommendation 86 at page 410

[80] As was recommended in recommendation 86 at page 410 of Parliament of Victoria Law Reform Committee (September 2006) *Coroners Act 1985: Parliamentary Paper No 229 of Session 2003-06*, Melbourne: Victorian Government Printer

6.3 Training for public sector agency officers

During the course of the WEP, it became apparent that regulatory public sector agencies primarily focussed their investigations on whether there had been a breach of any legislation administered by that agency and whether a prosecution was warranted or not. Rarely would an agency identify changes to law or practice that could prevent similar deaths occurring. My officers' review of the audit sample reinforced this impression.

Public sector agencies, particularly regulatory agencies, are public bodies that exist for public purposes. One of those purposes should be, whenever possible, to assist coroners by identifying systemic problems arising from the legislation they administer. Officers must be vigilant in ensuring that their investigations are not solely focussed on matters of breach and prosecution but also on the preventive measures. Investigation reports that are likely to be provided to the coroner should be prepared with this objective in mind.

Officers of public sector agencies should also be made aware of the power under the *Coroners Act 2003* to require witnesses at an inquest to answer questions, including questions that may incriminate the witness.

Coronial liaison officers should receive appropriate training on coronial practice and how best they can assist the coroner.

Opinion 6

> Officers who discharge regulatory functions in public sector agencies should ensure that their investigations of incidents resulting in a person's death are not focussed solely on whether a breach of legislation has occurred and should be prosecuted but also consider measures for preventing similar deaths occurring.

Response by State Coroner

> The State Coroner advised that he agreed with the opinion and noted that some agencies, for example, the Mines Inspectorate and the Ethical Standard Command of the Queensland Police Service, are already doing this.

Recommendation 2

> Public sector agencies with regulatory responsibilities for matters frequently relevant to coronial inquiries should provide training to relevant officers so that investigations conducted by those agencies extend beyond the circumstances of the death to identifying changes to law or practice that could prevent similar deaths occurring.

Response by State Coroner

> The State Coroner agreed with the recommendation.

Response by public sector agencies

I provided this recommendation in proposed form to a number of key public sector agencies that are frequently involved in inquests. All agencies that responded to my invitation to comment, except one, supported the recommendation made.

That Director-General, while agreeing that the public service should do better at identifying and, if possible, addressing systemic issues did not support the recommendation "as it was cast". He considered that the role should not be undertaken by individual investigators but "at an agency or even a whole-of-government level". He submitted that:

> "In my view, the recommendation would be better cast to urge public sector agencies to do better at identifying changes to law or practice that might prevent future deaths. If there is to be training in this analysis, it would be better provided at a whole-of-government level."

Comment

I do not see how such a system could operate effectively. My concern is that officers of agencies (often discharging a regulatory role) investigate the circumstances of a fatality without giving sufficient attention to ways to stop similar deaths occurring in that their investigation narrowly focuses on whether any breach has occurred of the legislation they enforce. These officers are in the best position to identify preventive recommendations and it is difficult to see how this function could be performed on a whole-of-government basis. However, responsibility for the function could also be taken at the agency level, by the chief executive officer signing the relevant report to the coroner.

6.4 Liaison agreement between State Coroner and Queensland Ombudsman

Monitoring the implementation of coronial recommendations is another difficult issue for coronial systems.

Some commentators suggest that the person who makes the recommendation, that is, the coroner, is best placed because of their familiarity with the case and general experience to assess whether the recommendation has been implemented and, if so, how effectively. Other commentators have suggested that the role lies with the Attorney-General as the chief law officer of each of the states and territories. Others have suggested that the role lies with a variety of other government ministers[81].

I am not aware of any commentators who have suggested that the role is one for an Ombudsman.

Section 5 of the Ombudsman Act provides that one of the Ombudsman's roles is "to improve the quality of decision-making and administrative practice in agencies". Clearly, monitoring the implementation of coronial recommendations is an aspect of administrative action within my jurisdiction. I have already examined this issue in some detail in the WEP and have assessed allegations in the past that the failure of a public sector agency to respond to a coronial recommendation was in itself indicative of maladministration on the part of that agency.

There are approximately 300 coronial inquests in Queensland every year. Not all of those inquests result in recommendations to public sector agencies, but a significant portion do.

The *Coroners Act 2003* does not contain any mechanism by which the State Coroner can advise me, in any formal way, of what inquests have been conducted during the year, and what coronial recommendations have been made that relate to public sector agencies within my jurisdiction.

[81] See discussion in Law Commission (August 2000) *Report 62: Coroners*, Wellington: Law Commission (New Zealand)

However, I see no reason why the State Coroner could not provide this information to my Office in accordance with an appropriate protocol or liaison agreement. I have already discussed this issue with the State Coroner, who indicated his support for such an arrangement with a view to my Office monitoring the implementation of recommendations made to such agencies.

Ideally, a legislative amendment to the *Coroners Act 2003* could be sought to specifically authorise the sharing of relevant information between our respective offices. At present, the only legislative provision relevant to the sharing of information is s.57A of the Ombudsman Act, which authorises the Ombudsman to give a copy of a report relating to certain deaths to the State Coroner.

Opinion 7

The response of public sector agencies to coronial recommendations directed to them should be monitored. The Queensland Ombudsman is best placed to undertake this monitoring role.

Response by State Coroner

The State Coroner agreed with the opinion.

Response by public sector agencies

Although the State Coroner supported this recommendation, the Director-General of the Department of Justice and Attorney-General commented that he:

> …did not consider that monitoring the response of public sector agencies to coronial recommendations is an appropriate role for the Ombudsman, as the issue of whether and if so, how public sector agencies implement coronial recommendations is a matter for Government policy.

Another Director-General made a comment in similar terms.

Comment

These comments are based on a misunderstanding of the recommendation and/or my jurisdiction.

The purpose of the recommendation is to ensure that State agencies appropriately consider implementing coronial recommendations directed to them. An agency's consideration of such a coronial recommendation constitutes administrative action of the agency and, therefore, I clearly have jurisdiction to investigate the agency's action or failure to act in response to the recommendation.

I have not suggested that I should investigate a policy decision made by a Minister or Cabinet that a coronial recommendation will not be implemented, as I do not have jurisdiction to question the merits of these policy decisions[82].

The distinction is an important one because I do have jurisdiction to investigate:

- A recommendation an agency makes to a Minister[83]
- An action taken by an agency because of a recommendation to a Minister[84].

I also have power to investigate administrative action of an agency if I consider the action should be investigated. In other words, I do not have to receive a complaint about the action before commencing an investigation[85].

[82] Section 16(1) of the *Ombudsman Act 2001*
[83] Section 7(1)(d) of the *Ombudsman Act 2001*
[84] Section 7(1)(e) of the *Ombudsman Act 2001*
[85] Section 18(1)(b) of the *Ombudsman Act 2001*

Proposed amendment 6 to *Coroners Act 2003*

The *Coroners Act 2003* should be amended to require the State Coroner to provide particulars of findings and coronial recommendations that relate to public sector agencies to the Office of the Queensland Ombudsman at the same time such information is provided to the agencies.

Response by State Coroner

The State Coroner agreed with the proposed amendment.

Recommendation 3

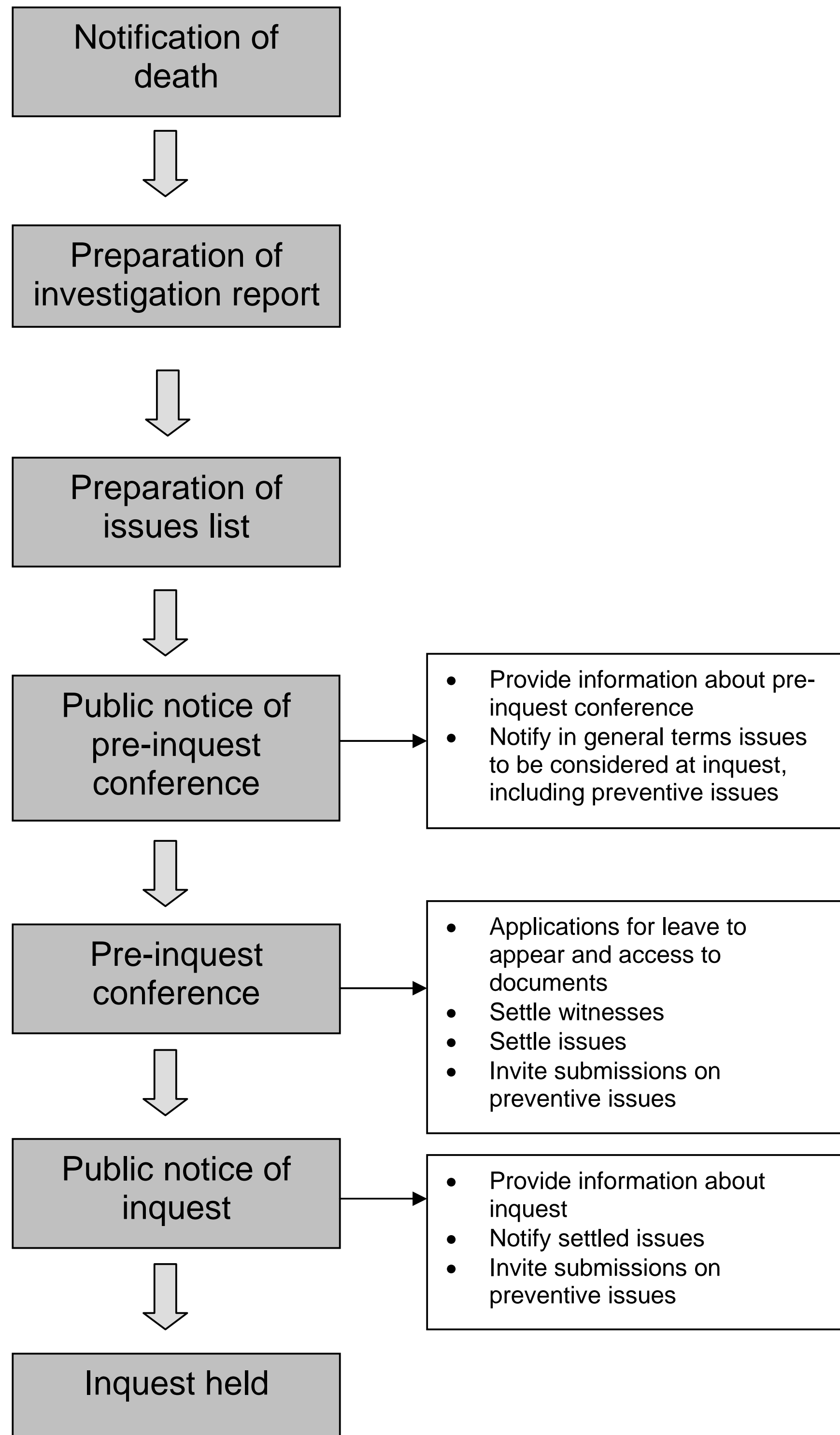
Pending the implementation of proposed amendment 6 to the *Coroners Act 2003*, a liaison agreement should be entered into between the State Coroner and the Queensland Ombudsman pursuant to which the State Coroner agrees to provide to the Ombudsman information about coronial recommendations made to public sector agencies within the Ombudsman's jurisdiction with a view to the Ombudsman monitoring the implementation by relevant public sector agencies of coronial recommendations.

Response by State Coroner

The State Coroner agreed with the recommendation.

Appendix A

Proposed Coronial System



Appendix B

Scenario

Assume that the coroner is investigating the death of a young person who has died as the result of a fall from a horse at a horse riding school. The following notice would be published at least one month before the date of the pre-inquest conference set by the coroner. A similar notice advising of the inquest (with necessary modifications as described at section 5.2.3 and Appendix A) would be published at least one month prior to the inquest.

Notice of pre-inquest conference

Coroners Act 2003

- Advise subject matter of the inquest
- Advise date, time and place of the pre-inquest conference set by the coroner
- Notify in general terms issues to be considered at inquest, including preventive issues
- Advise that coroner has the ability to make comments on measures to reduce the health and safety risks to clients at horse riding schools
- Provide information about:
    - intended pre-inquest conference,
    - application for leave to appear, and
    - access to documents
- Provide contact details for Coroner's Court.

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