

# **LAW REFORM COMMITTEE**

## **Coroners Act 1985**

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#### Warning

Aboriginal and Torres Strait Islander readers be aware that this Report may contain names and/or references to deceased Indigenous persons which may be distressing and cause sorrow.

#### **Parliament of Victoria**

**Law Reform Committee** 

Coroners Act 1985

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## FUNCTIONS OF THE COMMITTEE

#### Parliamentary Committees Act 2003

- 12. Law Reform Committee
- (1) The functions of the Law Reform Committee are, if so required or permitted under this Act, to inquire into, consider and report to the Parliament on any proposal, matter or thing concerned with—
  - (a) legal, constitutional or parliamentary reform;
  - (b) the administration of justice;
  - (c) law reform.

## TERMS OF REFERENCE

Referred by the Governor in Council on 7 December 2004

To inquire into and report to Parliament on the effectiveness of the *Coroners Act 1985* (the Act) and to consider whether the Act (excluding Part 9) provides an appropriate legislative framework for:

- (a) the independent investigation of deaths and fires in Victoria;
- (b) the making of recommendations to:
  - (i) prevent deaths and fires in Victoria; and
  - (ii) improve the safety of Victorians; and
- (c) the provision of support for the families, friends and others associated with a deceased person who is the subject of a coronial inquiry.

In particular, the Committee is required to recommend any areas where the Act should be amended or modernised to better meet the needs of the Community.

In making its inquiry the Committee should examine equivalent legislation and its operation in other jurisdictions.

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It is more than twenty years since coronial legislation in Victoria has been systematically reviewed and updated. The Hon Sir John Norris QC completed his review of the previous Act (Coroners Act 1958) in 1980. The Coroners Act 1985 substantially implemented the recommendations of that review, establishing an Office of the State Coroner and creating a co-coordinated and centralised coronial system in Victoria for the first time.

The 1985 Act has served the community well, allowing the development of a coronial system which is highly regarded world wide and which has been the basis for the enactment of similar legislation in a number of other Australian jurisdictions. The Committee heard evidence from a number of sources that the work of the two State Coroners who have filled this role in the intervening years, Mr Hal Hallenstein and Mr Graeme Johnstone, has been instrumental in creating a system which focuses the coroners work on community safety through the prevention of injury and death.

It is now timely to review the 1985 Act in light of developments in coronial law in Australia and internationally. It is also appropriate given the now broadly accepted view among professional bodies and agencies, and the general community that the coronial system can play a critical role in injury and death prevention. This has been accompanied by an increasing understanding of the important role that the family and others associated with a death investigated by the coroner, have to play in the investigation. This includes ensuring that the rights and needs of family members are properly acknowledged and accommodated.

The Committee has undertaken a substantial and complex task in reviewing the current legislation. The inquiry generated considerable public interest and coincided with a heightened media awareness of coronial matters. The large number of written submissions received, in conjunction with the evidence of witnesses heard over five days of public hearings, provided a large volume of material to work with. The Committee wishes to thank all those who contributed in this way to making our report a thorough and well informed document. In particular the Committee wishes to thank those family members of a person whose death was the subject of a coronial investigation, who gave evidence to the Committee. The Committee recognises the value of this input and the emotional cost often involved in providing it.

In the latter stages of our inquiry some substantial changes to the State Coroner's Office were announced by the Attorney-General and these are noted throughout the Report. These changes focus on improving the outcomes for bereaved families who come into contact with the Coroner's Office, and establishing better administrative and management structures within the Office. The Committee welcomes these initiatives which address a number of issues raised in the inquiry as matters for concern.

The Report has made a large number of recommendations for reform which build upon the basic structure of the 1985 Act to bring it up to date with advances and improvements in other jurisdictions. The Report proposes a significantly increased medical input at the front end of the coronial process, and more medical, including psychiatric, expertise available throughout the investigation process. Under our proposals the under-reporting of deaths which should be the subject of a coronial investigation, will be addressed and the coroner will have the power to investigate a death where s/he considers it necessary, even where the death has not been reported. The deaths of vulnerable people in the care of the State will be the subject of a mandatory inquest.

The Committee has identified the prevention of death and injury as the overriding purpose of the coronial jurisdiction and has recommended that this be made explicit in the Act. To achieve this objective the Committee makes recommendations to enhance the capacity of the coroner to make effective recommendations and to require mandatory responses from agencies and individuals.

We have also identified the rights and needs of families and others affected by a death, as central to the improved coronial process and recommended the introduction of a number of additional rights as well as improved support services.

The Committee records its appreciation to Dr Ian Freckelton and Associate Professor David Ransom for making an advance copy of their book Death Investigation and the Coroner's Inquest available, which proved to be very useful. The Committee also thanks the coroners and staff of the State Coroner's Office and the staff of VIFM for providing responses to our requests for information throughout the inquiry.

I would like to thank my colleagues on the Committee for their considerable contribution over the course of the inquiry.

The lead Research Officer for this report, Michelle McDonnell, deserves particular thanks for the high quality of her work and for the dedication she has brought to the task of producing a comprehensive and meticulously researched report. Research Officer, Justin Ford has also made a valuable and substantial contribution, joining the research team in the second half of the inquiry.

The Executive Officer, Merrin Mason has managed the complex strands of this inquiry with great skill and also contributed to the writing of the Report. The Office Manager Jaime Cook has provided vital administrative backup to the staff team and to the Committee working on this challenging inquiry.

The Committee believes that the changes recommended in this Report will allow Victoria to maintain its status as a leader and innovator in coronial law and practice, in the next twenty years and beyond.

#### **Rob Hudson MP**

#### Chair

# RECOMMENDATIONS

Recommendation 132
That legislation be enacted which requires a doctor, nurse, paramedic or other suitably qualified person to provide a certificate which verifies the fact that a person has died. Such certification must only occur following a clinical assessment of the body (which would include an examination of the body) to establish that death has occurred and must include information in the certificate which details the circumstances of death including a record or any injuries observed on the body and any information about the death which should be referred to the coroner.
Recommendation 2
That the Australian Bureau of Statistics in conjunction with the Registrar of Births, Deaths and Marriages consider including, along with the mortality data it currently collects, statistical information which indicates the type of place where deaths occur.
Recommendation 338
That s 13(3)(d) of the Coroners Act 1985 be amended so that the maximum penalty for doctors who fail to report a notifiable death to the coroner be increased to five years imprisonment and a fine of 600 penalty units.
Recommendation 448
That the State Government resource a research project to further investigate incidences of under-reporting of deaths to the coroner and that an analytical report on the data be prepared and published.
Recommendation 557
Recommendation 5
That the Victorian Institute of Forensic Medicine in consultation with the State Coroner's Office review the level of training currently provided to students, interns and overseas trained doctors with a view to developing a consistent training programme that could be used by the

Recommendation 782
That a medical review process for death certification be introduced so that all medical certificates of cause of death are reviewed by medical specialists at the Victorian Institute of Forensic Medicine, following the release of the body to the family, to establish whether further review of the death is required.
Recommendation 883
That where further review is necessary, this is to include the review of the medical case file, discussions with the doctor who certified the death and other medical personnel who were involved in treating the person before s/he died, along with consultation with family members and carers.
Recommendation 983
That the medical review process incorporate a triage approach to the review in which medical specialists at the Victorian Institute of Forensic Medicine would recommend which reported cases require further death investigation and which can be completed by a medical death investigation report
Recommendation 1083
That legislation be enacted which requires the Registrar of Births, Deaths and Marriages to transmit a copy of the medical cause of death certificate to the Victorian Institute of Forensic Medicine within 24 hours of lodgement of the certificate at the Registry
Recommendation 1183
That, in the event that a system is developed which allows doctors to submit certificates online, legislation be enacted which permits the Victorian Institute of Forensic Medicine to access the live data in that system.
Recommendation 1283
That the Victorian Institute of Forensic Medicine establish a computerised auditing system which enables patterns of unusual death rates to be identified and then further investigated, and that the Victorian Institute of Forensic Medicine provide regular reports on auditing outcomes to the State Coroner.
Recommendation 1383
That the medical specialists at the Victorian Institute of Forensic Medicine be required to promptly report to the State Coroner all incidences in which doctors have failed to notify the coroner of a reportable death

systen	the State Government resource the proposed medical review process and auditing in so that the Victorian Institute of Forensic Medicine is able to recruit, fund and manage ie of general and specialist medical practitioners and to train them in medicolegal work.
Recor	nmendation 1584
an and not repaction referre	the Coroners Act 1985 be amended to require the State Coroner to submit to Parliament nual report which includes information on the number of reportable deaths which were ported to the coroner during that year. The report must also include a summary of the the State Coroner took in relation to each incident, including whether the State Coroner at the Medical Practitioners Board of Victoria for possible investigation into lical practitioner's professional conduct.
Recor	nmendation 1693
	he Coroners Act 1985 be amended to remove the word 'unexpected' from the definition term 'reportable death'.
Recor	mmendation 17114
	he Coroners Act 1985 be amended to include, within the definition of reportable death procedure deaths which doctors should report to the coroner. The provision should:
(a)	be modelled on the Queensland provision and guidelines; and
(b)	have an additional requirement that the category also include deaths 'where the death from the particular cause was potentially avoidable or preventable had the clinical management been different'
Recor	nmendation 18.   114
anaes	the Coroners Act 1985 be amended to remove the words 'that occurs during ar thetic' and 'that occurs as a result of an anaesthetic and is not due to natural causes he definition of the term 'reportable death'.
Recor	mmendation 19122
	he Coroners Act 1985 be amended to extend the definition of a death in custody to e the death wherever occurring of a person:
(a)	who is in prison custody or police custody or detention as a juvenile or detention under a Commonwealth law;
(b)	whose death is caused, or contributed to, by traumatic injuries sustained, or by lack or proper care while in such custody or detention;
(c)	who dies or is fatally injured in the process of police or prison officers attempting to detain that person; and

Recommendation 14. ......83

(d)

	escape from prison custody or police custody or juvenile detention or detention under a Commonwealth law
Recon	nmendation 20127
	ne Coroners Act 1985 be amended to extend the definition of 'in care' to include the ng persons:
(a)	all children in the custody or guardianship of the state under the Children and Young Persons Act 1989 (or the Children, Youth and Families Act 2005 when this is proclaimed);
(b)	children on interim accommodation orders;
(c)	children whose care was temporarily delegated to a child care facility or educational institution such as a crèche, kindergarten or school; and
(d)	children who at the time of death were residing at a youth refuge or women's refuge which was operated with funding provided by the State or Federal Government for the purposes of providing a refuge.
Recon	nmendation 21129
	ne Coroners Act 1985 be amended to extend the definition of 'in care' to include a subject to a community treatment order.
Recon	nmendation 22130
persor	ne Coroners Act 1985 be amended to extend the definition of 'in care' to include a who at the time of death was undergoing treatment as a mental health patient at a hospital.
Recon	nmendation 23132
	ne Coroners Act 1985 be amended to extend the definition of 'in care' to include a with a disability as defined under section 3 of the Disability Act 2006, who:
(a)	was living in a residential care service or a supported residential service as defined under section 3 of the <i>Health Services Act 1988</i> ; or
(b)	was receiving residential services operated, or wholly or partly funded, by the Department of Human Services.
Recon	nmendation 24135
Comm hours Correct	he Coroner's Office, in conjunction with the Office of the Correctional Services issioner, implement and develop guidelines to govern a system whereby, within 72 of a death being reported to the coroner, a request is made to the Office of the tional Services Commissioner to establish whether that person has been released from y within the preceding 12 months, and where this is the case, that the coroner provide

who dies or is fatally injured in the process of that person escaping or attempting to

a copy of the findings in the case to the Office of the Correctional Services Commissioner at the completion of the inquiry or inquest.

Recommendat	ion 25143
	Deaths and Marriages Registration Act 1996 be amended so that, as part of cation requirements:
comple	or is required to undertake an external examination of the body when ing the medical certificate of the cause of death (MCCD), wherever this is ble; and
(b) where a	doctor has not examined the body, the doctor is required to:
` '	on the MCCD why s/he is satisfied that s/he can certify the death accurately out examining the body; and
` '	ate on the form that s/he is satisfied that the care and attention afforded to the on who died was reasonable and had no bearing on the death.
Recommendat	ion 26145
the death cer	Deaths and Marriages Registration Act 1996 be amended so that, as part of tification requirements, an independent doctor undertakes an external he deceased's body if the person, prior to his or her death, had resided at:
` '	care residential aged care service or accommodation under the nwealth Residential Aged Care Programme; or
` ,	are residential aged care service where the person was receiving approved re services under the Commonwealth Residential Aged Care Programme; or
. ,	e care service where the person was receiving approved high care services ne Commonwealth Residential Aged Care Programme; or
(d) support Service	ed accommodation provided on a private basis such as Supported Residential s.
Recommendat	ion 27145
and cremation	Government raise with the Commonwealth Government the need for death certificates to be recognised under the Medicare Benefits Schedule as ng Medicare benefits.
Recommendat	ion 28155
	to reviewable deaths, the Coroners Act 1985 be amended so that it specifies on of the Victorian Institute of Forensic Medicine to investigate, assess and

- (a) the health or safety of a living sibling of a child who has died; and
- (b) the health of a parent of a child who has died

instigate responses in relation to:

ceases when the Victorian Institute of Forensic Medicine provides a report to the State Coroner on the action taken by it in relation to a reviewable death, unless the State Coroner requests that the Victorian Institute of Forensic Medicine undertake further investigations or assessments in relation to the death.

Recon	nmendation 29155
That s	ection 22A of the Coroners Act 1985 be amended to replace the word 'may' with 'shall'.
Recon	nmendation 30156
	ne State Coroner and the Victorian Institute of Forensic Medicine establish standards investigation of reviewable deaths.
Recon	nmendation 31159
in which	ne Coroner's Office and the Victorian Institute of Forensic Medicine implement a system of the directors of certain aged care facilities are required to notify the coroner of the of all residents, and that an appropriate agreed number of these notified deaths, but is than 10 percent, be investigated by the State Coroner.
The ca	stegory of institutions required to notify the coroner include:
(a)	high care residential aged care services or accommodation under the Commonwealth Residential Aged Care Programme;
(b)	low care residential aged care services where the person was receiving approved high care services under the Commonwealth Residential Aged Care Programme;
(c)	respite care services where the person was receiving approved high care services under the Commonwealth Residential Aged Care Programme; and
(d)	supported accommodation provided on a private basis such as Supported Residential Services.
Recon	nmendation 32165
That th	ne proposed coronial council consider the following issues:
(a)	whether particular workplace deaths, such as deaths from industrial diseases or deaths where employment or previous employment may have been connected with the death, should be reported to the coroner; and
(b)	how such deaths should be reported and investigated.
Recon	nmendation 33170
That th	ne Coroners Act 1985 be amended to include, as a function of the State Coroner, the

responsibility to provide ongoing education of the medical profession and the public, to

increase awareness of the obligation to report reviewable and reportable deaths.

Recom	mendation 34170
That th	e State Government provide ongoing funds to resource this function
Recom	mendation 35176
	ictoria Police and the Coroner's Office formally develop guidelines for the reporting of g persons to the coroner.
Recom	nmendation 36177
	onsideration be given to amending section 59A of the Coroners Act 1985 to apply the on retrospectively.
Recom	mendation 37187
Paedia	tillbirths continue to be investigated by the Consultative Council on Obstetric and tric Mortality and Morbidity and not the coroner, and that this be clarified in the ers Act 1985.
Recom	nmendation 38187
Counci	ne Department of Health review the role, functions and powers of the Consultative I on Obstetric and Paediatric Mortality and Morbidity to determine whether they are ate to undertake a comprehensive investigation of stillbirths.
Recom	nmendation 39187
or reco	ection 17(3) of the Coroners Act 1985 which gives a coroner the discretion not to hold mmence an inquest where a person has been charged with and convicted or acquitted ain offences, be amended by removing the words 'child destruction' from the section.
Recom	mendation 40188
That th	e Coroners Act 1985 be amended to provide that:
(a)	where it appears to a coroner that a death may be a reportable death, a coroner may undertake a preliminary investigation of the death to establish whether the death is a reportable death;
(b)	a person may apply to the State Coroner for a review of a coroner's decision, following preliminary investigation, that a death is or is not a reportable death; and
(c)	a person may apply to the Supreme Court for a review of the State Coroner's decision reviewing a coroner's decision that, following preliminary investigation, a death is or is not a reportable death.
Recom	mendation 41194
That th	e Coroners Act 1985 be amended to provide that

- (a) the Coroner's Office is required to create and maintain a search warrants register and to record the information set out in recommendation 18 of the Victorian Parliament Law Reform Committee report *Warrant Powers and Procedures: Final Report;*
- (b) the Coroner's Office is required to provide information about search warrants and warrant-like powers to persons in the place to be searched, as set out in recommendation 47 of the Victorian Parliament Law Reform Committee report Warrant Powers and Procedures: Final Report, and
- (c) on the completion of an inquest or inquiry, a coroner must take all reasonable steps to give anything taken or seized, to the person whom the coroner reasonably believes to be legally entitled to it.

Recommendation 42.	204
That the Coroners Act 1985 be amended to provide that a coro	oner may give a police officer
directions concerning investigations to be carried out for the pure	naces of an inquest or inquiry

directions concerning investigations to be carried out for the purposes of an inquest or inquiry into a death or suspected death, whether or not the inquest or inquiry has commenced.

#### Recommendation 43. ......210

That the Coroners Act 1985 be amended to provide that a coroner holding an investigation into a death in custody, a police-related death or a death of an on-duty police officer, must appoint a lawyer or other appropriately qualified person to assist the coroner at an early stage of the investigation and at an inquest, and that the State Government provide funding to the Coroner's Office to enable these appointments.

#### Recommendation 44. ......210

That the duties of the investigator, subject to the direction of the coroner are to:

- (a) ensure that a full and adequate investigation is conducted into the cause and circumstances of the death; and
- (b) ensure that at the inquest all relevant evidence is brought to the coroner and tested.

#### Recommendation 45. ......212

That the Coroners Act 1985 be amended to provide that a coroner may appoint a specialist investigator to assist with an investigation into a death. The duties of the investigator, subject to the direction of the coroner, are to:

- (a) ensure that a full and adequate investigation is conducted into the cause and circumstances of the death; and
- (b) identify any possible measures which may have prevented the death or similar deaths.

#### 

That the Coroners Act 1985 be amended to provide that:

(a)	in order to	ens	ure	best prac	ctice in	the	coronial sy	/stem,	the S	State Cor	oner	must	issu	ıe
	guidelines	to a	all	coroners	about	the	performan	ice of	their	function	s in	relati	on 1	tc
	investigation	ons g	gen	erally;										

- (b) when preparing the guidelines, the State Coroner must have regard to the recommendations of the Royal Commission into Aboriginal Deaths in Custody that relate to the investigation of deaths in custody;
- (c) when investigating a death, a coroner must comply with the guidelines issued to the coroner to the greatest extent practicable.

Recommendation 47225
That the guidelines outlined in Recommendation 12 be made available to the public and be available on the Coroner's Office website.
Recommendation 48225
That the State Coroner's annual report contain all guidelines which were in operation during that year.
Recommendation 49225
That the proposed Coroner's Advisory Council assist the State Coroner to develop guidelines and standards.

Recommendation 50. .....227

That the Coroners Act 1985 be amended to provide that:

- (a) it is a statutory function of the State Coroner to provide training to coroners.
- (b) as part of the State Coroner's annual report, the State Coroner must provide a report indicating the training that coroners have attended during that year.

#### Recommendation 51. .....227

That the State Coroner and the Chief Magistrate work together to support and encourage coroners, and magistrates who act as coroners, to take advantage of the training opportunities available to them.

#### Recommendation 52. ......230

That the Coroners Act 1985 be amended to provide that the purposes of an inquest are:

- (a) to conduct a public investigation into a death which occurred in contentious circumstances in order to provide public accountability for the death;
- (b) to provide an effective mechanism for eliciting and challenging evidence; and
- (c) to provide a forum for interested persons to contribute to the development of coronial recommendations for the prevention of similar deaths

Recon	nmendation 53232
Corone	e Coroners Act 1985 be amended to include a provision modelled on the Queensland ers Act 2003, section 34, which allows a coroner to hold, and require attendance at, a uest conference.
Recon	nmendation 54241
	ne present categories of death investigations which attract mandatory inquests under roners Act 1985 be retained.
Recon	nmendation 55246
	ection 17(2) of the Coroners Act 1985 be amended to provide that, when determining er an inquest is desirable, a coroner must have regard to the purposes of an inquest.
Recon	nmendation 56250
That th	e Coroners Act 1985 be amended to provide:
(a)	a set of broad criteria which outline the circumstances in which a multiple-death inquest may be held;
(b)	that a person may ask the State Coroner to hold an inquest into a number of deaths that happened at different times and places but that appear to have happened in similar circumstances;
(c)	that the State Coroner may investigate, or direct a coroner to investigate, at an inquest, a number of deaths that happened at different times and places but that appear to have happened in similar circumstances; and
(d)	that, before deciding whether to convene a multiple-death inquest, the State Coroner must consider the views of persons with a sufficient interest regarding the merits of a multiple-death inquest.
Recon	nmendation 57254
to com	ne Coroner's Office undertake a research project examining the length of time it takes plete a coronial death investigation when the investigation is suspended pending the ne of related criminal proceedings, with a view to taking up this issue with Victorian
Recon	nmendation 58256
	ne State Coroner issue guidelines to coroners regarding the circumstances in which a r should consider holding an inquest following the completion of related criminal dings.

Recommendation 59257
That section 17(3) of the Coroners Act 1985 be amended to provide that if, in relation to the investigation of a death, a coroner is satisfied that one or more persons have been charged before a court with:
(a) dangerous driving causing death; or
(b) arson causing death;
and one or more of those persons has been found guilty of the offence or acquitted or found not guilty of the offence the coroner may—
(i) determine not to hold an inquest; or
(ii) adjourn the holding of an inquest which has already commenced; or
(iii) if an inquest has been adjourned, determine not to recommence the inquest.
Recommendation 60263
That the Coroners Act 1985 be amended to provide that, in determining whether a person has a sufficient interest for the purposes of section 45 of the Act, a coroner must conside whether:
(a) it is in the public interest; and
(b) it is consistent with the purposes of the Act;
for the person to call, examine and cross-examine witnesses and make submissions at an inquest.
Recommendation 61288
That the Coroners Act 1985 be amended to include a provision modelled on section 128 of the uniform Evidence Act, incorporating recommendation 15-7 of the Uniform Evidence Law Report 2005, which requires that section 128 of the uniform Evidence Act should apply where—
(a) a witness objects to giving evidence either to a particular question, or
(b) a class of questions;
on the grounds that the evidence may tend to prove that the witness has committed at offence against or arising under an Australian law or a law of a foreign country or is liable to a civil penalty under such law.
Recommendation 62288

That the section referred to in recommendation 61 is to provide that:

- (a) the coroner is to determine whether or not that claim is based on reasonable grounds;
- (b) if the coroner is so satisfied, the coroner must inform the witness that the witness may choose to give the evidence or the coroner will consider whether the interests of justice require that the evidence be given;

(c)	the coroner may require that the witness give the evidence if the interests of justice
	so require, but the coroner must not do so if the evidence would tend to prove that the
	witness has committed an offence against or arising under a law of a foreign country
	or is liable to a civil penalty under a law of a foreign country; and

(d)	if the evidence is given, either voluntarily or under compulsion, a certificate is to be
	granted preventing the use of that evidence against the person.

Recommendation 63.	 289
Recommendation 63.	 2

That the Coroners Act 1985 be amended to include a provision which provides that, in considering whether the interests of justice require that the evidence be given, a coroner must consider whether there is a compelling argument that the information is necessary to prevent further harm from occurring.

#### 

That the Coroners Act 1985 be amended to provide that, where it appears to the coroner that a witness has been asked a question which tends to incriminate the witness, the coroner is required to inform the witness of:

- (a) the right to object to answering the question because the evidence would tend to incriminate the witness but that the coroner may overrule the objection if the coroner considers that it is in the interests of justice for the witness to give evidence;
- (b) the right to obtain independent legal advice; and
- (c) the right to make an application to the coroner that the evidence be heard in camera or that the coroner place a restriction on the reporting of that evidence.

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That the Coroners Act 1985 be amended to include a provision requiring the State Coroner to issue standard written directions for coroners and witnesses advising witnesses of their rights in relation to giving evidence at an inquest, the section to provide that:

- (a) the directions are to be used by coroners when an issue of self-incrimination arises at an inquest; and
- (b) a copy of the directions is to be provided to all persons who are summoned to give evidence at an inquest at the same time as the summons is served on the person.

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That section 59A of the Coroners Act 1985 be amended to provide that a person may apply to the State Coroner for an order that some or all of the findings made without inquest are void.

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That section 18(3) of the Coroners Act 1985 be amended so that it states with a greater degree of clarity that, if a coroner refuses a request to hold an inquest and gives reasons in

Recommendation 68319
That the jurisdiction of coroners under the Coroners Act 1985 to investigate non-fatal fires be retained.
Recommendation 69319
That section 36(1)(c) of the Coroners Act 1985 be repealed.
Recommendation 70
That section 1 of the Coroners Act 1985 be amended to provide that a purpose of the Act is to help to prevent deaths or fires in similar circumstances happening in the future by allowing coroners to comment and make recommendations on matters connected with deaths or fires including matters related to public health and safety or the administration of justice.
Recommendation 71360
That the Coroners Act 1985 be amended to recognise the existence of, and authorise the provision of data to and retrieval of data from, the National Coroners Information System using section 93 of the Coroners Act 2003 (Qld) as a model.
Recommendation 72360
That increased funding be made available for the National Coroners Information System to enable the search interface and data fields of the database to be improved, and to enable further training initiatives for coroners and other agencies.
Recommendation 73360
That the State Coroner, in conjunction with other Australian State and Chief Coroners, review the rules governing access to the National Coroners Information System database and consider whether access to the database can be made more widely available, in a way that is however consistent with applicable privacy considerations.
Recommendation 74
That a research unit be established within the Coronial Services Centre with the capacity to

properly utilise the National Coroners Information System database, to conduct research relevant to individual cases on behalf of coroners, and to identify trends and clusters of

deaths requiring further investigation.

writing for the refusal, a person may apply to the Supreme Court for an order that an inquest

be held.

Recommendation 75
That the Coroners Act 1985 be amended to provide, using section 5 of the Coroners Act 2006 (NZ) as a model, that one of the functions of the State Coroner is to help avoid unnecessary duplication and expedite investigation of deaths by liaison and encouragement of coordination (for example, through development of protocols) with other investigating authorities, official bodies or statutory officers.
Recommendation 76
That as a high priority funds be provided to the Clinical Liaison Service to extend its operation to include psychiatric expertise.
Recommendation 77
That section 19 of the Coroners Act 1985 be amended to include a requirement that a coroner must, whenever appropriate, make recommendations with respect to ways of preventing further deaths in similar circumstances and on any matter connected with the death including public health and safety or the administration of justice.
Recommendation 78
That the State Coroner prepare detailed guidelines for coroners in relation to the formulation of recommendations.
Recommendation 79
That the State Coroner's Office provide further training for coroners in relation to the formulation of recommendations.
Recommendation 80
That the Coroners Act 1985 be amended to include a requirement, modelled on section 55 of the Coroners Act 1997 (ACT), that a coroner shall not include in a finding or report under the Act a comment adverse to a person identifiable from the finding or report unless the coroner has, prior to the making of the finding or report, taken all reasonable steps to give to the person a copy of the proposed comment and a written notice advising the person that, within a specified period (being not more than 28 days and not less than 14 days after the date of the notice), the person may:
(a) make a submission to the coroner in relation to the proposed comment; or
(b) give to the coroner a written statement in relation to it.
Recommendation 81
That the Coroners Act 1985 be amended to require that all coronial recommendations be approved by the State Coroner and be made publicly available.

Recor	nmendation 82409
That th	ne Coroners Act 1985 be amended to:
(a)	empower a coroner to refer findings and/or recommendations to any individual or agency and require that individual or agency to provide, within six calendar months, a written response including a report as to whether any action has been taken or is proposed to be taken in response to the recommendation
(b)	identify those agencies and individuals to which this section applies, which at a minimum will include government departments or agencies and incorporated companies
Recor	mmendation 83409
	he Coroners Act 1985 be amended to require the coroner to provide a copy of the use referred to in recommendation # above to:
(a)	the senior next of kin of the person whose death is mentioned in the coroner's findings or their representative;
(b)	a witness who appeared at an inquest into the death the subject of the findings; and
(c)	any other person who the coroner considers has sufficient interest in the inquest or investigation the subject of the findings.
Recor	mmendation 84409
further	he Coroners Act 1985 be amended to empower the State Coroner to call for such explanations or information as he or she considers necessary, in relation to the nentation of recommendations.
Recor	mmendation 85409
That th	ne Coroners Act 1985 be amended to require:
(a)	the State Coroner to include in the Coroner's annual report to Parliament:
	(i) a summary of all coronial investigations in which recommendations have been made; and
	(ii) a summary of responses to the recommendations made in the previous year, including a list of those recommendations which are still awaiting implementation or responses.
(b)	that the State Coroner's annual report be tabled in Parliament
(c)	that the State Coroner's annual report be published on the website of the State Coroner's Office
Recor	nmendation 86410
consid	the National Coroners Information System, in conjunction with the State Coroner, ler the development a comprehensive, categorised and readily searchable online ase of all recommendations by State and Territory coroners.

Recon	nmendation 87420
Ontario	ne State Coroner's Office undertake a trial of informal conferencing modelled on the pregional coroners' review system for cases which the State Coroner considers could priately be dealt with in this way.
Dagan	ann an dation 00
	nmendation 88
	e features of the informal conferencing model to be trialled include the following:
(a)	any agreement reached in relation to implementing recommendations should be published (with the consent of the organisation and the family) on the State Coroner's Office website and in the State Coroner's annual report
(b)	where consensus is not forthcoming but the coroner considers his or her recommendations to be feasible, the coroner is to submit draft recommendations to the State Coroner for review prior to their release to the organisation.
Recom	nmendation 89420
That th	ne trial of informal conferencing be formally evaluated and that this evaluation be
reporte	ed in the State Coroner's annual report.
Recon	nmendation 90434
accom	ection 1 of the Coroners Act 1985 be amended to include, as a purpose of the Act: to modate the needs of and provide support for families, friends and others associated death which is the subject of a coronial investigation.
Recom	nmendation 91445
	e Coroners Act 1985 be amended to define 'senior next of kin' as the first person who able from the following persons in the order of priority listed:
(a)	a person who, immediately before the death, was living with the person and was either –
	(i) legally married to the person;
	(ii) a domestic partner of the person;
(b)	a person, who, immediately before the death, was legally married to the person;
(c)	a son or daughter, who is of or over the age of 18 years, of the person;
(d)	a parent of the person;
(e)	a brother or sister, who is of or over the age of 18 years, of the person;
(f)	a person who had, in accordance with the customs or traditions of the community of which the person was part, responsibility for, or an interest in, the welfare of the person who has died.
(g)	an executor named in the will of the person or a person who, immediately before the

death, was a personal representative of the person; or

- (h) any person nominated by the person to be contacted in an emergency;
- (i) where paragraphs (a) to (h) do not apply or a person who would be the senior next of kin under those paragraphs is not available a person who immediately before the death had a relationship with the person who died that, in the opinion of the coroner, is sufficient for the purpose of being the senior next of kin.

#### Recommendation 92. ......446

That the definition of 'domestic partner' in the Act be amended to 'a person to whom the person is not married but with whom the person is living as a couple on a genuine domestic basis (irrespective of gender)

#### Recommendation 93. ......446

That the Coroners Act 1985 be amended to include a definition of 'immediate family' that includes all of the categories of people referred to in the definition of senior next of kin.

#### Recommendation 94. ......454

That the Coroners Act 1985 be amended to include a requirement that, wherever practicable, the coroner permit the immediate family of the person who has died to view and touch the body while the body is under the coroner's control. If the coroner determines not to grant the requested authorisation, the person who made the request should be given written reasons for the refusal.

#### Recommendation 95. ......457

That the Coroners Act 1985 be amended to include a provision that, wherever practicable, the coroner must authorise a member of the immediate family of the person who has died, or a representative of that family member, to access the place where the death has occurred and that, if the coroner refuses the request, the person making the request should be given written reasons for the refusal.

### Recommendation 96. ......467

That the Coroners Act 1985 be amended to:

- (a) give family members the right to access witness statements, reports and other evidence and information concerning the death investigation as soon as they become available unless the coroner considers that releasing the material has the potential to compromise a criminal investigation
- (b) require coroners to inform family members of their right to access such information and, if a request for such information is refused, to provide written reasons for the refusal
- (c) clarify the scope of 'persons with sufficient interest' in an inquest and the coroner's discretion to determine that question, following the model used in section 40(2) of the *Coroners Act 1993* (NT) and section 52 of the *Coroners Act 1995* (Tas);

- (d) state the timing for release of the statements or other information, if the discretion to release them is exercised;
- (e) establish an avenue for appealing a decision made by the coroner in relation to releasing statements; and
- (f) clarify the extent and nature of the information that can be accessed, following the approach used in section 51 of the *Coroners Act 1997* (ACT); in this regard the *Coroners Act 1985* and the *Coroners Regulations 1996* should be consistent.

Recommendation 97.	47	4
ZACOMMANDATION 4/	41	1

That the State Coroner's Office investigate the applicability of case management systems used in other jurisdictions and implement an appropriate state-wide case management system.

#### Recommendation 98. ......471

That the Coroners Act 1985 be amended to include requirements that:

- (a) coroners provide regular updates to family members on the progress of investigations;
- (b) coroners review the progress of each case every six months, commencing from the date that the case is referred to the coroner:
- (c) where an investigation has not been concluded after 12 months have elapsed since the case was referred to a coroner, the investigating coroner give written reasons for the delays to the family of the person who died, along with an estimate of the time required to complete the investigation;
- (d) the State Coroner supervise and monitor the progress of cases under consideration by other coroners in Victoria; and
- (e) every coroner must, so far as it is consistent with justice and practicable to do so, perform or exercise his or her functions, powers and duties without delay.

#### Recommendation 99. ......479

That the Coroners Act 1985 be amended to include a provision modelled on section 20 of the Coroners Act 1996 (WA), which requires:

- (1) A coroner who has jurisdiction to investigate a death, as soon as practicable after a death, to provide to any of the immediate family of the person who died the following information:
  - (a) that the body is under the control of the coroner investigating the death;
  - (b) that an autopsy is likely to be performed;
  - (c) that any of the dead person's immediate family may touch the body, where practicable;
  - (d) that there is a right to have a representative chosen by the senior next of kin attend the autopsy;

- (e) that if tissue is to be removed from the body in accordance with the written permission of the person who died, there is a right to view such written permission;
- (f) that there is a right to view the body;
- (g) that there is a right to object to the autopsy, and a right to request that an autopsy be performed;
- that tissue may be retained after the completion of the autopsy where it is necessary to do so in order to investigate the death;
- (i) a brief summary stating the manner in which an objection to autopsy may be made; and
- (j) that a free counselling and support service is available
- (2) The information provided to be in writing, where practicable, and in a language and form likely to be understood by the person to whom it is provided.

The Committee also recommends that, in addition to the matters covered in the WA legislation, provisions be included which require that the following information must also be provided to the immediate family:

- (a) whether an investigation or inquest will take place, and that there is a right to request that an inquest be held;
- (b) before conducting an inquest, the time and place of the hearing, where practicable;
- (c) that there is a right to access or request information such as new evidence, witness statements and expert reports in advance of an inquest or finding, as this material becomes available:
- (d) that they are entitled to obtain independent legal advice or representation in relation to the investigation and, if one exists, that there is a free telephone service that provides advice about objections to autopsies;
- (e) reasons for delays in the investigation or inquest;
- (f) findings made by the coroner and explanations of those findings where requested; and
- (g) details of responses to recommendations received from agencies.

#### Recommendation 100. ......499

That the Coroners Act 1985 be amended to require that, before ordering an internal examination of the body, coroners have regard to a list of factors modelled on section 30 of the Coroners Act 2006 (NZ), including:

- (a) the extent to which matters required by the Act to be established by an investigation are not already disclosed in respect of the death concerned, by information available directly to the coroner or from information arising from investigations or examinations the coroner has made or caused to be made but are likely to be disclosed by an autopsy;
- (b) whether the death appears to have been unnatural or violent;

- (c) if the death appears to have been unnatural or violent, whether it appears to have been due to the action or inaction of other persons;
- (d) the existence and extent of any allegations, rumours, suspicions or public concern about the cause of death;
- (e) the desirability of minimising distress to persons who, by reason of their ethnic origins, social attitudes or customs, or spiritual beliefs, customarily require bodies to be available to family members as soon as possible after death;
- (f) the desirability of minimising distress to persons who, by reason of their ethnic origins, social attitudes or customs, or spiritual beliefs, find the post-mortem examination of bodies offensive:
- (g) the desire of any member of the immediate family of the person concerned that a post-mortem examination should be performed; and
- (h) any other matters the coroner thinks relevant.

#### Recommendation 101. ......500

That the Coroners Act 1985 be amended to give immediate family members other than the senior next of kin the right to object to autopsies but not the right to appeal the coroner's decision, as is the case under the Coroners Act 1980 (NSW).

#### Recommendation 102. ......500

That the Coroner's Office initiate a formal consultation process with the Victorian Aboriginal Legal Service to develop a protocol for the resolution of questions involving the conduct of inquiries and autopsies, the removal and burial of organs, and the removal and return of the body of the deceased.

#### Recommendation 103. ......500

That a staff member of the Coroner's Office be designated to act as a cultural liaison officer for the purpose of developing knowledge of the cultural requirements of different groups in the community regarding coronial procedures and facilitating effective communication with such groups.

#### Recommendation 104. ...... 500

That consideration be given to exempting the senior next of kin from the requirement to pay Supreme Court filing fees when lodging an objection to the decision of a coroner ordering that an autopsy be performed.

#### Recommendation 105. ......500

That the current delegation of powers and duties under section 10 of the Coroners Act 1985 to coroner's clerks be reconsidered by the State Coroner.

Rec	ommendation 106508
nece	the Act be amended to require a coroner, when determining whether an autopsy is essary, to consider whether alternatives to internal examination, or whether partial rather full internal examination, may be appropriate in a particular case.
Rec	ommendation 107515
of ki post	the Coroners Act 1985 be amended to contain the following provision: If the senior next n asks a coroner to allow a doctor chosen by the senior next of kin to be present at a mortem examination, the coroner is to allow that doctor to be present and is to ensure the doctor is informed as to the time and place of the examination.
Rec	ommendation 108526
That	the Coroners Act 1985 be amended to:
(a)	require a coroner, where practicable, to inform the family of the person who died that tissue will be retained, specify the tissue to be retained, give reasons for its retention and indicate how long the tissue will need to be retained;
(b)	provide that, prior to the retention of any tissue other than minute samples, the written consent of the coroner must be obtained;
(c)	require a coroner to consider the necessity of the retention for the purposes of the investigation despite any concerns raised;
(d)	require a coroner to review at six-monthly intervals the necessity of retaining such tissue; and
(e)	provide for the disposal of the tissue at the end of the retention period, by release to the family or by other arrangements for respectful disposal by the entity that has the tissue.
Rec	ommendation 109527
auto of th spec scier	the Coroners Act 1985 be amended to permit the removal of tissue from a body at an psy for purposes other than investigating the death only with the prior written permission he person who died, or with the written informed consent of the senior next of kin cifying the tissue which may be removed and the purpose (therapeutic, medical or ntific) for which the tissue may be removed. Consent forms used for this purpose should expressed in plain English, and a copy should be provided to the senior next of kin.
Rec	ommendation 110527
That	the Human Tissue Act 1982 be amended to ensure its consistency with
(a)	the recommendations in this report in relation to organ and tissue retention; and
(b)	the National Code of Ethical Autopsy Practice
Rec	ommendation 111529
That	the Coroners Act 1985 be amended to:

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(a)	provide that, if a coroner orders an exhumation, the immediate family of a person whose body is to be exhumed or their representative has the right to attend the exhumation; and
(b)	require a coroner who orders an exhumation to direct a person by order to re-inter the body or return the ashes to the person entitled to them, with the costs to be met by the Coroner's Office.
Reco	ommendation 112536
exist subje	the Coroners Act 1985 be amended to incorporate the procedures contained in the ing State Coroner's protocol in relation to the management of Indigenous burial remains, ect to any amendments necessary to achieve consistency with the provisions of Part 2, ion 2, of the Aboriginal Heritage Act 2006.
Reco	ommendation 113538
	the existing Victorian Civil and Administrative Appeals Tribunal telephone service be nded to provide after-hours legal advice for next of kin on how to object to an autopsy.
Reco	ommendation 114538
That Medi	the State Coroner's Office, in conjunction with the Victorian Institute of Forensic cine:
(a)	develop, in addition to the booklet The Coroners Process: Information for Family and Friends, a separate legal information kit which explains the legal requirements for objections to autopsies, the rights of families in relation to coronial investigations, the rules and procedures relating to inquests, and other legal and practical information relevant to persons affected by a coronial death investigation;
(b)	publish the legal information kit on its website;
(c)	distribute the legal information kit to a wide range of relevant agencies and persons, including police stations, funeral homes, hospitals, nursing homes, hospices, community legal centres and religious institutions;
(d)	ensure that the legal information kit includes a hard copy and a downloadable form which can be used by people who wish to object to an autopsy; and
(e)	make the information available in languages other than English.
Reco	ommendation 115546
	the Government investigate the feasibility of providing legal advice and assistance to
famil	ies affected by a coronial investigation where this is necessary to enable them to tively participate in the investigation.
Reco	ommendation 116560
That	section 10 of the Information Privacy Act 2000 and section 14 of the Health Records Act
2001	be amended so as to clarify the application of the exemptions in those sections to such

coronial functions that relate to the conduct of inquests and inquiries under the Coroners Act 1985.

Rec	ommendation 117560
be re a co of ar	section 45 of the Coroners Act 1985 and regulation 24 of the Coroners Regulations 1996 epealed and that principles be inserted into the Act which regulate the kind of information roner may release and to whom s/he may release it, both before and after the completion investigation, modelled on the principles contained in Part 3, Division 4, of the Coroners 2003 (Qld).
Rec	ommendation 118560
Com	a formal consultation process be established between the State Coroner, the Privacy missioner and the Health Services Commissioner to design privacy protocols in relation e management of sensitive information by coroners and coronial staff.
Rec	ommendation 119560
That must	the Coroners Act 1985 be amended to require that medical files delivered to a coroner t:
(a)	be kept physically apart from the coroner's file in a secure place; and
(b)	be accessed only by persons with a sufficient interest and their legal representatives, unless the consent of the senior next of kin is given to other persons to access the medical information.
Rec	ommendation 120560
to co	the Coroners Act 1985 be amended to impose on coronial staff who allow public access onfidential information penalties similar to those which apply to hospitals and staff under Health Services Act 1988.
Rec	ommendation 121560
othe seal	autopsy reports, graphic photographs, videos, suicide notes, diary excerpts, letters and r material that is sensitive or likely to cause distress to family members be placed in ed envelopes within the coronial file to enable its removal prior to the file's being essed by members of the public in appropriate circumstances.
Rec	ommendation 122563
That	provision be made in the Coroners Act 1985 for the development of clear protocols

dealing with the management of coronial inquest data which incorporate privacy safeguards, including notice to persons whose privacy may be affected by the release of records and an opportunity to object to such release. Guiding principles should be included in the Act and

more detailed instructions in the protocols.

Rec	commendation 123566
in th	t the National Coroners Information System (NCIS) be recognised by detailed provisions ne Coroners Act 1985 that are drafted so that the Information Privacy Act 2000 applies to NCIS.
Rec	commendation 124
	t, following the implementation of recommendation # above, a code of practice under Part the Information Privacy Act 2000 be developed for the NCIS.
Rec	commendation 125572
	t section 58(1) of the Coroners Act 1985 be amended to include a new sub-section (c), as pted in Tasmania and the Northern Territory, that reads:
(1)	A coroner must order that no report of an inquest or of any evidence given at an inquest be published if the coroner reasonably believes that it would –
(c)	involve the disclosure of details of sensitive matters including, where the senior next of kin of the deceased has so requested, the name of the deceased.
Rec	commendation 126583
	t increased funding be provided to enhance the operation of the short-term counselling support program in Melbourne and to enable its implementation across regional Victoria.
Rec	commendation 127583
Cord	t the Coroners Act 1985 be amended to include a provision similar to section 16 of the oners Act 1996 (WA) requiring the State Coroner to ensure that a counselling service is ched to the jurisdiction.
Rec	commendation 128583
distr hom	t the information booklet The Coroner's Process: Information for Family and Friends be ributed to a wide range of relevant agencies or persons, including police stations, funeral nes, hospitals, nursing homes, hospices, community legal centres and religious tutions.
Rec	commendation 129592
Tha	t the Law Institute of Victoria:
(a)	consider making coronial law an area of accredited specialisation for its members; and
(h)	continue to provide legal education courses in coronial law

Recommendation 130595
That references to the 'Coroner's Court' be removed from the building, website and publications of the Coroner's Office, and from the website and publications of the Departmen of Justice.
Recommendation 131601
That the Coroners Act 1985 be amended to provide that the State Coroner be appointed for a term of five years, and may be reappointed for one further period of five years.
Recommendation 132601
That the Department of Justice determine how the status of the State Coroner and the Deputy State Coroner can be enhanced, whether by equivalent judicial status, salary or other means to better recognise the complexity and breadth of these roles.
Recommendation 133602
That the Coroner's Office prioritise the improvement of the delivery of coronial services to rural areas.
Recommendation 134605
That the State Coroner more actively monitor and supervise the coronial investigations of the state's coroners.
Recommendation 135605
That the State Coroner set up a formal process for dealing with requests for review of a coronial investigation process, and that the availability of this review process be publicised widely.
Recommendation 136605
That section 16 of the Coroners Act 1985 be amended to remove the words '(other than an inquest)'.
Recommendation 137607
That the Coroners Act 1985 be amended to include as a function of the State Coroner: to help, by education, publicity and liaison with the public, to promote understanding of, and co operation with, the coronial system provided for by this Act.
Recommendation 138609
That the Department of Justice establish a coronial council

In this inquiry the Committee was asked to inquire into the effectiveness of the Coroner's Act 1985 and to consider whether it provided an appropriate framework for the making of recommendations for the prevention of death and injury, and the provision of support to families and others affected by a death subject to a coronial investigation.

The Coroners Act 1985 (the Act) was an innovative piece of legislation when introduced which centralised coronial services in Victoria by creating the Office of the State Coroner, and established the Victorian Institute of Forensic Medicine (as it is now called). The Act established the Coroner's Office as an administrative rather than a judicial body, and, by specifying that the rules of evidence do not apply to an inquest, it also determined the coronial process as inquisitorial rather than adversarial. The Act does not give a coroner the power to commit for trial or make a statement that a person is or may be guilty of an offence, both powers previously held by coroners.

Major amendments to the Act since 1985 have included extending the power of a coroner to make recommendations to not only the Attorney-General but also ministers and public authorities, removing the obligation on a coroner to find contribution by individuals to a death, and the introduction of reviewable deaths which relate to situations where more than one child in a family has died.

## The system for reporting deaths to the Coroner

The Committee heard that the present system of death certification in Victoria is in need of strengthening to reduce the risks brought to light by recent events in other jurisdictions. The Committee identified a number of specific concerns with Victoria's death certification system.

The effectiveness of the Coroners Act 1985 depends on the existence of an effective death certification system, in which all deaths which should be reported to the coroner are indeed reported. The Committee received evidence from a large number of stakeholders that suggests there is currently an under-reporting of deaths to the coroner in Victoria — that is, a failure to report deaths which fall within the reportable categories.

A fundamental flaw of the current system is that the certification process does not occur in a team setting and is not subject to effective professional oversight. The Committee found that the reliance on a single doctor for certification exposes the system to the risk that some notifiable deaths will not be reported to the coroner.

The Committee recommends a number of measures which focus on increased medical involvement by the Victorian Institute of Forensic Medicine (VIFM) in assessing and auditing both reported deaths and those dealt with by the Registry of Births, Deaths and Marriages. The Committee has proposed a new death certification system in which notifiable deaths will continue to be reported to the Coroner's Office but will initially be dealt with by VIFM, which has the medical expertise to assess whether an autopsy is required. In addition, the Committee proposes that all deaths be subject to scrutiny by VIFM through online access to the deaths registered with the Registry of Births, Deaths and Marriages. These measures would allow VIFM to audit Medical Cause of Death Certificates to identify deaths which should have been reported but weren't and to analyse trends and patterns in deaths and death reporting. The Committee found that there is a need for research and data to assist in investigating incidences of under-reporting of deaths to the coroner.

The Committee believes that this system would be further strengthened by giving the coroner the power to undertake a preliminary investigation into unreported deaths, where concern has been expressed regarding the circumstances of the death, to determine whether the death is reportable.

As ancillary measures the Committee recommends improved training for doctors with regard to their responsibilities for death certification, and increased penalties for failure to report deaths to the coroner.

Verification of the fact of death is an important element of the system and the Committee has suggested it become a requirement of the Births, Deaths and Marriages Registration Act 1996.

## Reportable deaths

The Act sets out which deaths are 'reportable deaths', which in general terms currently include: unexpected, unnatural, violent and accidental deaths; deaths involving anaesthetics; deaths of persons in care and custody; and deaths where the identity of the person or the cause of death has not been established. A significant focus for the Committee in this inquiry was the question of whether the criteria and definitions in the Act remain appropriate, comprehensive and sufficiently clear to assist individuals in understanding what is meant by a 'reportable death'.

The Committee found a number of areas where action can be taken to improve the accurate reporting of deaths to the coroner. Many stakeholders informed the Committee that the term 'unexpected death' is unnecessary and confusing, and the Committee agreed that it should be removed. Confusion also exists with regard to anaesthetic related deaths. The Committee believes that removing this specific category and replacing it with a broader category of medical procedure related deaths would provide greater clarity and also partly address concerns related to the underreporting of deaths which occur following medical treatment.

Based on the evidence received during its investigations, the Committee believes that, wherever practicable, a doctor should be required to undertake an external examination of the body as part of the death certification process. This should be a mandatory requirement for deaths occurring in nursing homes, hostels, supported residential care arrangements and other aged-care facilities. There is a need for a closer level of medical scrutiny of such deaths to address under-reporting and ensure that deaths involving elder abuse do not go unnoticed. To that end, the Committee has recommended that the coroner be notified of all such deaths, regardless of whether they fall within a reportable category, and that at least 10 percent of these cases (cases not otherwise reportable) be investigated by the coroner.

The definitions of 'deaths in custody' and 'deaths in care' were examined in detail by the Committee. The Committee has proposed an amendment to the definition of 'deaths in custody' in line with that previously proposed by the Royal Commission into Aboriginal Deaths in Custody. The Committee has also recommended that the term 'deaths in care' be expanded to include the deaths of children in the following circumstances: in the care and custody of the state (already included in the Act to a large extent); on interim accommodation orders; in temporarily delegated care such as a child-care facility, creche or school; and residing in a women's or youth refuge. In addition, persons subject to community treatment orders, mental health patients in private hospitals and people with disabilities living in residential care facilities will be included in the definition of 'in care'.

Recently released prisoners will be the subject of a new provision which will require their status as 'recently released' (to be defined as released within the preceding 12 months) to be established and a report of any such death investigation to be forwarded to the Office of the Corrective Services Commissioner.

More generally, the Committee believes that the overall effectiveness of the Act would be improved with efforts by the State Coroner to raise the profile of the office and enhance the public's understanding of their responsibility to report certain deaths, and of the role of the Coroner's Office.

## **Death investigation**

Evidence received during the inquiry highlighted several areas where death investigation procedures can be enhanced and the Act clarified and improved.

The Committee was made aware of serious deficiencies in the systems at both Victoria Police and the Coroner's Office for dealing with missing person reports and unidentified bodies, and it recommends better coordination between the two agencies to be achieved by the development of formal guidelines for reporting missing persons to the coroner.

Conflicting evidence was received on the question of whether coroners currently have and should have the power to direct a police investigation for a coronial inquiry. While there are many instances in which police have conducted appropriate and timely coronial investigations, the Committee believes it is vital for coroners to have the power to direct police – this is particularly so in relation to deaths in police custody and deaths resulting from police actions. The Committee also recommends that the coroner be given the power to appoint an investigator to assist in an investigation and it recommends that this be mandatory for police-related deaths and the deaths of onduty police officers.

A number of participants noted the absence of comprehensive guidelines for coroners conducting death investigations. The Committee found this to be an issue of some concern, as achieving consistency in a state-wide death investigation system depends on coroners having access to best practice standards and practical guidance on how to manage different kinds of death investigations. Here the Committee recommends that the Act require the State Coroner to issue guidelines relating to investigations and also recommends improved training for coroners, noting that this is particularly relevant to magistrates in rural areas acting as coroners on an infrequent basis.

An inquest is a public hearing into the death of a person. On the evidence received, the Committee has concluded that inquests should continue to be mandatory for all deaths occurring 'in care', for suspected homicides and for deaths involving unidentified persons. The practice of suspending inquests while criminal proceedings advance has led to lengthy and stressful delays for families. Research is needed to look for ways to deal with this issue.

The Committee has also made a number of recommendations concerning the rules of evidence at an inquest, including the difficult question of a person's right to claim the privilege against self-incrimination at inquests. There was a division of opinion among witnesses on this issue and there were sound arguments on both sides. The Committee has examined practices in other jurisdictions, and it has recommended amendments to the Act to provide criteria for determining whether a statutory abrogation of the privilege against self-incrimination is justified and to ensure that a witness is encouraged to give a full and frank disclosure of the circumstances surrounding a death. The Committee has also recommended that, in relation to a person's standing to appear at an inquest, the coroner be required to apply a public interest test, which would allow a broader range of participants than is currently the case.

In the final section of chapter five the Committee has examined the legislative framework governing the appeals process for coronial decisions, findings and recommendations. The Committee recommends that the Act be amended to allow a person to appeal to the Supreme Court against a coroner's decision not to hold an inquest.

## Independent investigation of fires

Chapter six focuses on the circumstances in which a coroner may investigate and hold inquests into fires, and it pays particular attention to the non-fatal fire jurisdiction.

There are certain legislative requirements with regard to the circumstances which require such investigations; in practice, Victorian coroners will investigate non-fatal fires where there are significant public health and safety concerns.

In Victoria, fires are routinely investigated by a number of separate authorities working cooperatively according to the Victorian Fire Investigation Policies and Procedures. Evidence received by the Committee endorsed these policies and procedures as permitting thorough and effective investigations which contributed substantively to public health and safety. The leadership of the coroner in coordinating fire investigation teams, the important role that the coroner's powers of entry, search and seizure play in such investigations, the independence of the coroner, and the coroner's ability to publicise safety issues were noted by expert witnesses.

In summary, the Committee recommended the retention of this aspect of the coroner's power.

## The coroner's role in death and injury prevention

The Committee found strong support among the witnesses for the preventative role that the Coroner's Office can play. In making their findings, comments or recommendations, coroners may choose to highlight the preventable aspects of a death under investigation, including public health and safety concerns. This role is not currently recognised in the Act, and the Committee has recommended that the purposes of the Act be amended to include the prevention of deaths from similar circumstances occurring in future.

The particular category of suicide deaths of people involved in the mental health system was considered by the Committee. From the confidential and public evidence provided to the Committee, criticisms emerged with regard to a number of issues, including lack of epidemiological research, an apparent unwillingness by coroners to criticise the mental health system, inadequate investigations, inequality in legal representation of the parties, and the lack of follow-up by agencies in response to coronial recommendations. The need for data and its effective collation and analysis was highlighted by the Committee, as was the issue of the effectiveness of recommendations. These were further considered by the Committee as aspects of the coronial role of death and injury prevention.

The Committee considered in detail the following four aspects of the prevention of death and injury: the role of the National Coroners Information System (NCIS), research and investigation expertise, coroner's comments and recommendations, and the implementation and monitoring of recommendations. With regard to the NCIS and the research and investigation expertise available to the Coroner's Office, the Committee is concerned that much valuable information about reported and investigated deaths is not being properly used. Recognition of the NCIS in the Act and increased funding would enable its more extensive use. The Committee has also recommended the establishment of a research unit within the Coronial Services Centre with sufficient resources to utilise the NCIS database, to identify trends and

clusters of deaths requiring further investigation and to enable the development of death and injury prevention measures based on epidemiological research. Additionally, the Committee was concerned by the lack of psychiatric expertise available to the Coroner's Office and recommended that the Coroner's Liaison Service be funded to include such expertise.

There has been much debate regarding the extent to which coroners may make recommendations and comments as a consequence of a death investigation. This is a means by which coroners may exercise their preventative role, commenting on the context or system within which the death occurred or developing recommendations to prevent such deaths. Issues have arisen in relation to the fact that coronial comments may extend the inquiry beyond reasonable limits and the principle of causation. A number of concerns about the practice of making recommendations also arose, including the lack of empirical studies on their effectiveness; lack of rigour and guidelines in decisions; the practicality and feasibility of recommendations; inconsistency; infrequent use of recommendations, particularly by rural magistrates; delays between a death and the making of recommendations; and that recommendations only arise from death investigations.

In considering these matters, the Committee concluded that the preventative role of coroners should be recognised in legislation, albeit with some care. This includes, in addition to recognising this role in the purposes of the Act, a provision to place a positive duty on coroners to make recommendations in appropriate cases. The Committee believes that it is essential for coroners to receive adequate guidance and training if they are to make effective recommendations; further, such recommendations should be approved by the State Coroner and issued from the State Coroner's Office as a media release.

A large majority of witnesses supported the introduction of mandatory responses to coronial recommendations. Family members who had been involved in the coronial system tended to feel very strongly about the reporting of recommendations and requiring agencies to respond to recommendations. Many other witnesses also supported mandatory responses while recognising the difficulties inherent in such a proposition. One witness submitted that the State Coroner may lack sufficient information to assess such responses and may be embarrassed in the event of a further death whose precise circumstances had not be foreseen by a specific recommendation. However, most witnesses were of the view that coronial investigations may be a wasteful exercise if the resulting recommendations can be ignored by those to whom they are directed. The Committee has recommended in favour of a mandatory response regime.

This regime would require that government departments and agencies, and other groups and individuals to whom a coroner directs a recommendation, respond within six months to those recommendations. The State Coroner would then be required to include both the recommendations and the responses in an annual report tabled in Parliament, thus ensuring transparency and encouraging implementation.

The Committee reviewed the coronial system in Ontario, Canada, and a variation on that system proposed in the review of Queensland coronial law. In what is known as the regional coroner review system, the coroner may hold informal meetings with organisations and independent experts to discuss the circumstances surrounding a particular death and to discuss recommendations with a view to preventing similar deaths. Agreements with the coroner regarding these recommendations may be entered into, with a public inquest ensuing should a similar death occur. Informal meetings are also held with the families of the person who died in order to gain their views of effective preventative measures. In Ontario's case this informal conferencing strategy has proven to be an effective means of securing compliance with recommendations in appropriate cases.

The Committee considers that there are important differences between the Ontario and Victorian coronial systems which make direct translation of the system less straightforward. Coroners in Ontario are medical practitioners, not lawyers, and coronial inquests occur before a jury; both of these factors provide strong motivations for all parties to attend informal conferencing. The Committee is also aware that conferences held in camera interfere with the principle of open justice and diminish public confidence in the integrity of coronial inquiries. Nonetheless, the Committee's view is that, in appropriate cases, less formal proceedings may offer a number of advantages: feasible recommendations, increasing the likelihood of implementation; time and expense savings by avoiding the need for an inquest in the instance of the first such case; and the creation of a more flexible, efficient and effective coronial system. In conclusion, the Committee felt that it could not assess definitively the gains of such a system, based on the evidence before it. However, it recommends that the State Coroner's Office undertake a trial of informal conferencing in appropriate cases. Such trials should be formally evaluated and this evaluation included in the State Coroner's annual report.

## The needs, rights and support of families and others in the coronial system

The evidence gathered by the Committee found that families involved in the coronial process can be deeply affected by its procedures and investigations. Many submissions received by the Committee highlighted areas where coronial services may be improved with regard to the involvement in coronial processes of the family of the person who died. These referred particularly to the provision of information to families, explanation of the coronial process, rights of the family to object to autopsy, retention of records and evidence, and access to that information.

The Committee acknowledges that coronial staff have made many improvements to current practices and procedures, but it has concluded that such changes need to be augmented by legislative change. Such changes include amending the purpose of the Act to include accommodation of and support for families, friends and others associated with a death subject to coronial investigation.

A significant issue in the discussion of the rights of families is the definition of family itself. Having regard to the testimony given on this subject, the Committee sees the need for definitions of 'senior next of kin' and 'immediate family' which take into account contemporary family structures. While recognising the practical value of a hierarchical list of senior next of kin in relation to urgent autopsy decisions, the Committee recommends that coroners be given a degree of discretion to recognise other significant relationships. The Committee recommends an inclusive definition of immediate family for other purposes in the Act. Such changes would also accommodate the cultural practices and spiritual beliefs of sections of the community.

The Committee considered the adequacy of family rights under the current Act and rights that could be introduced. This discussion covered the rights to touch or view the body, inspect the scene of death, access information considered by the coroner, be kept informed during the coronial investigation and notified of certain events, and object to or request an autopsy. Also noted were rights considered appropriate by some witnesses but which are not available under the current Act: to request a second, independent autopsy; to request the attendance of an independent pathologist or religious representative at an autopsy; and to be informed of the fact of organ and tissue retention and the period for which these will be retained.

As a result of these considerations and the evidence received, the Committee recommends a number of changes to the Act, creating substantive additional rights. In particular, it recommended that a new provision be inserted into the Act clearly identifying the rights of family and next of kin with regard to the above matters and requiring notification of such rights.

Three other significant issues were also considered by the Committee – legal representation of families during coronial inquests, privacy, and counselling and support services. The Committee heard evidence of the disparity in legal representation in some inquests and the concern on the part of a number of organisations that, without such representation, families may not be able to pursue the full weight of evidence relevant to the inquest. This is of significant consequence in those instances where the conduct of a well-funded organisation is at issue; for example, in the case of deaths occurring in the care of a health organisation or in custody. The Committee recommends that the Government investigate the feasibility of providing legal advice and assistance to families affected by a coronial investigation where this is necessary to enable them to effectively participate in the investigation. The Committee also recommends that a self-help legal kit be developed and made available to families.

Privacy of medical records and the evidence gathered during a coronial investigation is a matter of serious concern. Doubts were raised by expert witnesses as to the applicability of the provisions of the Information Privacy Act 2000 to the Coroner's Office; it was also unclear how the provisions of the Health Regulations Act 2001 related to the Coroner's Office. The Committee was concerned at the broad and unregulated powers to release personal and health information, and it made

recommendations with regard to the management of sensitive coronial information and its release to the public.

Finally, and importantly, the Committee considered counselling and support services. The current Act does not prescribe the provision of counselling and support for families, nor does it require that families be notified of the availability of counselling at the Coroner's Office. In practice, the Coroner's Office has a Counselling and Support Service which provides counselling and information and conducts the Family Contact Program. In addition to this service is the volunteer non-legal court support service operated by Court Network. The Committee regards as essential the provision of appropriate support and counselling for families, and it recommends that funding for such services be increased and that provision of counselling be legislated.

#### The Coroner's Office and the State Coroner

Having looked in detail at the present system and made recommendations for changes in many areas, the Committee considered in its final chapter whether these changes to the system required a corresponding change to the way the Coroner's Office functions, its legal status and the status of the State Coroner.

The Committee found that coroners in Victoria exercise administrative rather than curial power and that this was an intended consequence of the 1985 Act. The Committee considered whether a change of status to establish the Office as a court would be beneficial but concluded that it would not. The Committee found that the status of the Coroner's Office in terms of its administrative or judicial character needs to be considered in conjunction with the way in which its hearings, which in the coronial system means inquests, are held.

A defining feature of the Victorian coronial jurisdiction since the 1985 Act was introduced has been its inquisitorial rather than adversarial approach. However, the Committee heard from many witnesses that, in reality, inquests are often highly adversarial. These can be intimidating experiences, particularly for the families of a person who has died, and they are not conducive to establishing the full circumstances surrounding a death. The Committee recommended that better training for coroners and legal practitioners would partly address this problem and also considered that better public awareness of the role of the coroner should be fostered through making public education a recognised function of the State Coroner.

The Committee considered that the State Coroner's current status does not adequately reflect the complexity and breadth of the role and it recommends that consideration be given to enhancing this status. The coordinating role of the State Coroner was considered, and the Committee concluded that more needed to be done in this regard, particularly in relation to improving service delivery in rural areas. The Committee also found that the case management system used by the Coroner's Office is inadequate and exacerbates many of the coordination problems. In addition, the ability of the Coroner's Office to respond to families in a timely fashion is

adversely affected. The Committee recommends that a significantly improved system be developed.

Finally, the Committee recommends the establishment of a Coronial Council to provide policy guidance and stakeholder input to the operations of the Coroner's Office.

## CHAPTER ONE — INTRODUCTION

## **Background to the inquiry**

On 7 December 2004 the Victorian Parliament Law Reform Committee (the Committee) received terms of reference from the Governor-in-Council to review the *Coroners Act 1985* (the Act). This followed the release of the Justice Statement by the Attorney-General in May 2004, which identified ways in which the Victorian justice system could be modernised and the rights of individuals protected. The Justice Statement makes the following remarks on the coronial jurisdiction:

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 re-occurrence 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 role 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.

The Government believes that a review of the Coroner's Act is timely. It will undertake such a review to improve the Court's capacity to contribute to accident prevention and safety strategies, and meet the needs of families of deceased persons and others who may be affected by a sudden, unexpected and tragic incident.<sup>1</sup>

Victoria's coronial legislation was last the subject of substantial review in 1985, when the State Government commissioned the first major review of the *Coroners Act 1958*, conducted by the Hon Sir John Norris QC. That review resulted in a substantial overhaul of the legislative and administrative framework of Victoria's coronial system. The changes included the establishment of a coordinated coronial service under the leadership of the State Coroner. The Act also established and provided for the operation of the Victorian Institute of Forensic Pathology, since renamed the Victorian Institute of Forensic Medicine (VIFM), under a governing council which includes the State Coroner.<sup>2</sup> Following the review the State Coroner's Office was relocated to new premises in South Melbourne, which is also where VIFM is located. The major feature

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<sup>&</sup>lt;sup>1</sup> Attorney-General Rob Hulls, Justice Statement, 'New Directions for the Victorian Justice System 2004–2014' (2004) 46.

<sup>&</sup>lt;sup>2</sup> Coroners Act 1985 s 67(2)(a).

of the 1985 reforms was a shift away from the traditional role of a coroner to hold an inquest towards that of a fully-fledged investigative authority.<sup>3</sup>

Over the intervening years the State Coroner's Office has interpreted this investigative role as requiring an increased emphasis on the prevention of death and injury. The State Coroner, Graeme Johnstone, and his predecessor, Hal Hallenstein, have played a substantial part in actively developing this preventative function in a way that has led to the recognition of Victoria's coronial system as one of the world's leading jurisdictions in the field of injury prevention.

An example of initiatives in this area is the development (in conjunction with the Monash University National Centre for Coronial Information) of the National Coroners Information System (NCIS), which records coronial data from all coronial jurisdictions in Australia. This database, the first of its kind in the world, stores information that is becoming 'an invaluable source of material for analysing trends and patterns in identifiable deaths'.<sup>4</sup>

A major review of the UK coronial system has also been of considerable significance to this inquiry. The discovery in 1998 of the activities of Dr Harold Shipman led coronial jurisdictions around the world to reflect on their own systems and consider whether sufficient safeguards existed to prevent a similar tragedy from occurring. While not the major focus of the present inquiry, the current international climate of review and reform, prompted by the Shipman Inquiry, has certainly assisted the Committee's consideration of issues by generating a considerable amount of debate and inquiry.

The Coroners Act 1985 was used as a model for reforms of the coronial legislation in a number of other Australian jurisdictions. However, the Norris review took place more than 20 years ago. Since then there have been changes in community expectations of the coronial system, which during the past decade have been reflected in a series of reforms of the legislation in other States and Territories.<sup>5</sup> In many areas the Coroners Act 1985, once a model for other jurisdictions and ahead of its time, is now amenable to reform that not only incorporates the worthwhile elements of changes introduced elsewhere but also takes a progressive approach in seeking to address the weaknesses of the current system and capitalise on its strengths. While

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<sup>&</sup>lt;sup>3</sup> Michael Hogan, 'Let Sleeping Watchdogs Lie – The NSW Coronial System and Deaths Involving State Agencies', in Michael Hogan, Dave Brown, Russell Hogg (eds), *Death in the Hands of the State* (1988), 115.

<sup>&</sup>lt;sup>4</sup> Attorney-General Rob Hulls, Justice Statement, 'New Directions for the Victorian Justice System 2004–2014' (2004) 46.

<sup>&</sup>lt;sup>5</sup> For example, the *Coroners Act 1997* (ACT) introduced mandatory responses to certain kinds of coronial reports, 'constructive responses' to the *National Report* of the Royal Commission into Aboriginal Deaths in Custody, clear natural justice entitlements and expanded powers of inquiry and improved recognition of the needs of bereaved family members: Ian Freckelton, 'Glimpses of the Coroner's Future: The Coroners Act 1997 (ACT)' (1998) 6 *Journal of Law and Medicine* 26.

relying on the sound foundations of the 1985 Act, the Committee's recommendations in this report for both legislative and administrative changes constitute more than a second wave of reform. Instead, the Committee proposes a significant restructure of the Victorian coronial system in order to establish an appropriate framework for the jurisdiction in the early 21st century.

## The coronial process

As an aid to readers, the Committee has set out below the summary of the coronial process which appears on the Department of Justice website.<sup>6</sup>

#### **Coronial Process**

#### **The Coroner**

The primary role of the Victorian State Coroner's Office is to investigate unexpected death and fire.

In Victoria, the State Coroner has the responsibility to ensure that the coronial system is administered and operated efficiently and to oversee and coordinate coronial services.

The State Coroner's Office (with the assistance of the Victoria Police - State Coroner's Investigation Unit) provides some of the legal, administrative and investigatory services necessary to investigate all forms of unnatural death.

This may include, in some cases, a court function in the form of a public inquest hearing.

- It is the coroner's job to find out:
- the identity of the deceased
- how the death occurred
- the cause of death
- the particulars needed to register the death.

#### Identification

The deceased will be taken to the Coronial Services Centre if they died in Melbourne or to a regional hospital if they died in the regional or rural Victoria.

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<sup>&</sup>lt;sup>6</sup> Available at http://www.justice.vic.gov.au.

The deceased must be formally identified by someone who knew them well such as a relative or friend. The identification process varies for each investigation. Only one person is needed to do the identification but it is a good idea to take someone with you, as identifying someone you know can be upsetting.

An identification form will be completed, giving the name, address, age, and occupation of the deceased, how long you knew them and your relationship to them. Once you have identified the person you will be asked to sign a statement of identification.

#### The investigation

It is up to the coroner to decide what investigation is necessary in each case. This can involve:

- a review of the person's medical history and the circumstances of the death
- an autopsy and pathology tests
- specialist reports from experts and external investigators including the police, doctors, engineers, fire and emergency officers and air safety officers, as well as statements from witnesses
- an inquest this is a court hearing to test all the evidence relating to the person's death.

#### An Inquest

An inquest is a public hearing conducted by the coroner.

In Melbourne, inquests are held at the Coronial Services Centre. Further information on this process can be found on the State Coroner's Office website. In regional Victoria, inquests are held at the local Magistrates' Court. An inquest is not a trial and it is conducted in a more informal way than some court hearings.

Very few coronial investigations end with an inquest. There is always an inquest if:

- homicide is suspected the coroner usually waits until the outcome of any criminal proceedings and can decide not to have an inquest if someone has been charged and convicted of a crime in relation to the death
- the person was 'held in care'
- the person's identity is not known.

There may be an inquest in other cases if the coroner believes it is necessary. This will usually be because the facts are unclear or if there is some issue of public importance, for example a matter of public health and safety.

You can find out more about the coronial process and the coroner's court by visiting the State Coroner's Office website.

## Scope of the inquiry

The terms of reference required the Committee to inquire into and report to Parliament on the effectiveness of the Act. The Committee was asked to consider whether the Act provides an appropriate legislative framework for investigating deaths and fires in Victoria and the making of recommendations to prevent these events and improve safety. The Committee was also asked to consider the appropriateness of the legislative framework in the Act for the provision of support to families, friends and others associated with a person whose death is the subject of a coronial inquiry. The Committee was required to recommend any areas where the Act should be amended or modernised to better meet the needs of the community. The terms of reference required the Committee to examine coronial legislation and its operation in other jurisdictions. Part 9 of the Act, which deals with the operation of VIFM, was excluded from the review.

## Conduct of the inquiry

#### Discussion paper

In April 2005 the Committee released the *Coroners Act 1985 Discussion Paper* (the discussion paper) inviting submissions to the inquiry. The purpose of the discussion paper was to provide an outline of the scope of the inquiry and to provide questions for discussion for relevant stakeholders and members of the public wishing to make a submission to the inquiry.

The outline considered the effectiveness of:

- The system in which notifiable deaths are brought to the attention of the coroner
- The legislation, case law and procedures which currently govern a coroner's investigation and inquiries
- The existing mechanisms which allow a coroner to make recommendations to prevent death and injury
- The framework of the Act in providing support for the family and friends of the person who has died

The outline also compared equivalent laws and alternative systems in other jurisdictions, along with the recommendations of various law reform agencies.

The questions for discussion asked readers:

 For their views on the effectiveness of specific aspects of the current coronial system

- For their views on the alternatives to the current system discussed in the outline
- Whether there were any other issues or concerns about aspects of the current system
- About their experiences in the current system
- While the Committee particularly welcomed submissions which directly addressed the questions identified, it also encouraged comments on other issues relevant to the terms of reference.

#### Evidence gathering

Before the Committee received written submissions and held public hearings, it attended the State Coroner's Office and VIFM at the Coronial Services Centre in South Melbourne on 12 April 2005, meeting with the State Coroner and a number of other coroners. During this visit several staff members made presentations to the Committee, including representatives from VIFM, the NCIS, the Clinical Liaison Service and the Counselling and Support Service.

In response to the discussion paper the Committee received 83 written submissions, which are listed in Appendix 1 of this report. The submissions came from a wide range of stakeholders, including family members, legal and medical stakeholders, government departments and ministers, fire and emergency services, industry groups, community legal services, community action groups, and other individuals and agencies. The majority of these submissions were placed on the Committee's website.<sup>7</sup>

The Committee also held public hearings in Melbourne on 22 August 2005, 19 September 2005, 20 September 2005, 28 November 2005 and 5 December 2005. In total, the Committee heard evidence from 68 witnesses. A list of witnesses and their affiliations is contained in Appendix 2. The transcripts of almost all of the hearings were placed on the Committee's website.<sup>8</sup>

Because the terms of reference for this inquiry require the Committee to have particular regard to other jurisdictions, during June and July 2005 members of the Committee and the Executive Officer travelled to several international jurisdictions and held meetings with justice department ministers, coroners, medical examiners, forensic pathologists, lawyers — including Dame Janet Smith, Chair of the Shipman Inquiry in the UK — and others with expertise relevant to coronial law and practice. The Committee selected these jurisdictions on the basis of their relevance to this inquiry. Some of the jurisdictions, for example Ontario, are recognised as international

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<sup>&</sup>lt;sup>7</sup> See http://www.parliament.vic.gov.au/lawreform/.

<sup>&</sup>lt;sup>8</sup> Ibid. The transcripts do not include the evidence of three witnesses who appeared in camera.

<sup>&</sup>lt;sup>9</sup> A list of meetings held during the course of this inquiry is set out in Appendix 3.

leaders in the coronial field, while others were selected because of their major recent or ongoing law reform inquiries.<sup>10</sup>

This review of the *Coroners Act 1985* involves a complex area of the law, and the Committee has found the submissions it has received and the evidence it has heard to be of invaluable assistance in helping it to reach conclusions and formulate recommendations for reform.

#### Consultant's research study

An important aspect of the terms of reference was the requirement to consider the appropriateness of the legislative framework in the Act for the provision of support for families and others associated with a person whose death is the subject of a coronial inquiry. Accordingly, the Committee invited a wide range of affected people to make submissions and attend the public hearings, as noted earlier. The Committee determined however in the early stages of its research that there were few available research studies on the effect of coronial proceedings on families and others. The most well-known studies had emerged from the UK. The Committee considered that, while the Australian and UK coronial systems' jurisdictions have many common features, there was a need for evidence relevant to Victoria in addition to research from overseas jurisdictions. Therefore the Committee engaged a consulting firm with psychological expertise to conduct research involving interviews with family members of people whose deaths had been the subject of a coronial inquiry. The results of this research and its ethical considerations, methodology and constraints are discussed in chapter eight. While the scale of the study was subject to certain restrictions, the results provided additional and useful evidence concerning the experiences of family members and others affected by coronial inquiries.

### Report

This report will be tabled in the Victorian Parliament in September 2006. The Government is required to respond to the Committee's recommendations within six months of the tabling date.<sup>11</sup>

## Constraints on the conduct of the inquiry

## Confidential reports and evidence

The Committee received a number of reports from government departments and agencies on the condition that the reports be kept confidential. While it has considered such material in forming its conclusions, the Committee believes that, had it been able to refer to and quote from these documents directly, its final report would have presented a more complete picture to the reader.

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<sup>&</sup>lt;sup>10</sup> The Committee visited the following jurisdictions: Toronto (Ontario), Halifax (Nova Scotia), Dublin (Ireland), London (UK – here the Committee also took evidence in relation to Northern Ireland) and Helsinki (Finland).

<sup>&</sup>lt;sup>11</sup> Parliamentary Committees Act 2003 s 36.

Another constraint on the content of the Committee's report was that several witnesses were reluctant to permit their evidence to be made publicly available. This included several written submissions as well as parts of the evidence given during public hearings. The Committee did not publish this material on its website and has not been able to present or comment on the evidence in this report. However, again the Committee has considered the evidence of all of the stakeholders in forming its conclusions.

#### Timeliness of information and lack of data

Delays in responses to the Committee's requests for information from certain government departments and agencies also affected the progress of the inquiry. While most information was provided within a timeframe which enabled the Committee to consider it, the Committee had not received responses to a small number of queries at the time the report was completed.

A further limitation on the inquiry was that in some cases there was insufficient statistical data to enable particular issues in relation to the current coronial system to be considered on the basis of a satisfactory amount of empirical evidence. In many cases the Committee was unable to obtain the statistics it needed from the Coronial Services Centre, largely as a result of the lack of an adequate case management system. Similar problems existed in relation to obtaining data from the Registry of Births, Deaths and Marriages. The Committee has identified these gaps in available data where relevant in the report.

## Distinctions between different death investigation systems

There are different types of death investigation systems around the world, some of which do not involve coronial investigations but are nonetheless comparable jurisdictions. In reviewing the Victorian death investigation system it is worthwhile to consider the operation of such alternative models.

First, however, the Committee notes that there are other processes set up to investigate the causes of unexpected deaths. Most deaths are subject to some level of investigation by police, workplaces, hospitals, regulatory agencies and others. Ordinarily, death investigation is a simple administrative process based on common sense that involves recording the fact of death on a register and noting details about the death, particularly the cause of death. In Victoria this process is handled by the medical practitioner of the person who died in over 90 percent of deaths and is overseen by the Registrar of Births, Deaths and Marriages. The remaining deaths are reported to the Coroner's Office for independent, external investigation.

In broad terms, the main alternative to the coronial system used in countries such as England and Wales, Ireland, Australia, New Zealand, Canada, Hong Kong, Singapore and Malaysia is found in the systems of death examiners which exist in many parts of

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<sup>&</sup>lt;sup>12</sup> Freckelton, Ian and Ranson, David, *Death Investigation and the Coroner's Inquest* (2006) 69.

Europe and in the US (including the medical examiner system in the US, the procurator fiscal system in Scotland, and the various continental systems). However, within these two broad categories there is considerable variation in the structure and processes of the death investigation systems of each jurisdiction.<sup>13</sup>

The primary focus of a medical examiner's investigation is potential criminal causes of deaths; once criminal conduct has been excluded the inquiry is relatively perfunctory in comparison with a coronial investigation. Due to the predominantly medical bias in medical examiners' training, the medical examiner's investigation of the circumstances surrounding a death is sometimes not regarded as sufficiently thorough in removing public doubts and suspicions. By contrast, the coronial systems in countries such as England, Australia and Canada investigate a wide range of deaths which have occurred in unexpected circumstances which may not involve criminal conduct but instead may have resulted 'from negligent, defective or poorly co-ordinated public health and safety practices'. This allows a greater focus on the prevention of deaths in similar circumstances.

The English coronial system was exported to the United States during settlement. However, a variety of factors led to the discrediting of the role of the coroner and its replacement in a number of states by a system of medical examiners. One of the main reasons that the role was discredited was that coroners tended also to be holders of a local political office, which had the potential to cause conflicts of interest. Corruption and misdiagnosis of cause of death became endemic, and lobbying by the medical profession and the anti-corruption movement led to the medical examiner system replacing the office of coroner in most United States jurisdictions. Medical examiner systems now exist in around 38 states, although some jurisdictions operate with a state medical examiner but also with coroners at the county level. Where they exist these coroners tend to be elected officials; many of them are funeral directors, and most are not medical practitioners.<sup>16</sup>

In New York, for example, the chief medical examiner is a medical practitioner and a specialist pathologist appointed by the health department. The medical examiner investigates deaths that may be criminal, suicide, sudden or unexpected, accidental, or in circumstances where the medical attendant is unable to certify that the cause of death is natural. Unlike coroners in countries such as England, Canada and Australia, the medical examiner does not have the power to hold a hearing or inquest. Instead, the investigation records are treated as documents that may be discovered and used in evidence in criminal and civil proceedings. Deaths are reported to the medical examiner by police, doctors, public officials and members of the community. The medical examiner decides whether an autopsy needs to be performed and what other

<sup>14</sup> United Kingdom, Report of the Committee on Death Certification and Coroners, Cm 4810 (1971).

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<sup>&</sup>lt;sup>13</sup> Ibid, 69-96.

<sup>&</sup>lt;sup>15</sup> Freckelton, Ian and Ranson, David, Death Investigation and the Coroner's Inquest (2006) 94.

<sup>&</sup>lt;sup>16</sup> Ibid, 72-3.

investigations should be conducted. The medical examiner will often attend and supervise the death scene and seize evidence to assist in the investigation.<sup>17</sup>

Dr Ian Freckelton and Associate Professor David Ranson observe that little use can be made of debate in the United States about the relative merits of medical examiner and coronial investigations:

Interestingly, the debate in the United States as to which system is more appropriate for death investigation does not translate into other coronial systems around the world. Outside the United States many coroners are judicial figures appointed by government or senior judicial officers. Such judicial appointees have an important independent public role to play, which separates them clearly from the more pragmatic operational approach of medical examiners to death investigation. Where coroners are medical practitioners, they appear to have a more clearly defined public health role, as in Ontario, Canada. In the United States, medical practitioners, including specialist forensic pathologists, make up the profession of medical examiners. By contrast, as noted above, a wide range of individuals may hold the office of coroner, and some of these will hold other official positions that raise or could raise significant conflicts of interest with their role as coroner.18

In European death investigation systems the inquiry into the circumstances and cause of death is conducted mostly by police in combination with criminal investigation personnel. A number of death investigation systems exist in Europe, but they have similar features. They do not involve coroners but often involve judicial officers (public prosecutors), although the jurisdiction may be controlled by police. These judicial/police systems are usually combined with a forensic medicine or pathology system. Police officers or public prosecutors are responsible for investigating deaths and for instructing that a medicolegal autopsy be performed. The result is often a focus on criminal issues rather than on death prevention or social or health-related issues.19

In Canada, in contrast to the structures in England and Wales, Australia, New Zealand, Papua New Guinea and Hong Kong, most coroners are medical practitioners. This means that they have a less legalistic or policy-oriented focus than coroners with legal training; however, they are able to bring to the task their medical expertise while also being able to conduct inquests into deaths. Further, this means that they are experienced in dealing with families and illnesses and are particularly well suited to investigating deaths which occur in medical settings. In Ontario, all coroners are medically qualified. The Ontario coronial jurisdiction has received international recognition for the innovative approaches it has taken with respect to

<sup>&</sup>lt;sup>17</sup> Ibid.

<sup>&</sup>lt;sup>18</sup> Ibid 74.

<sup>&</sup>lt;sup>19</sup> This is not always the case; for example, in Finland there is a strong emphasis on accurately determining cause of death (involving a high autopsy rate), even in the case of natural deaths, with a view to generating well-informed public health policy.

death prevention, and coroners' recommendations there have been particularly effective.<sup>20</sup>

Dr Freckelton and Associate Professor Ranson observe that 'those jurisdictions using medical examiners or coroners who are forensic pathologists usually operate in a similar way, with the medical practitioner being administratively and physically responsible for the death investigation'.<sup>21</sup> The advantage of this is that the investigator is independent of law enforcement agencies, the judiciary and the government; however, a medical examiner is usually unable to use the legal process of investigation that is made possible by an inquest or other fatal-accident inquiry.<sup>22</sup> Also, investigations of deaths in hospitals and other medical treatment contexts may cause community concern where the investigator is a medical practitioner.<sup>23</sup>

In jurisdictions where law enforcement officials are responsible for administering death investigations, they are able to rely on police officers and other employees to assist in gathering evidence but must rely on medical practitioners for any autopsy service.<sup>24</sup> They are also unable to use the legal investigative process of an inquest unless a separate structure is in place for the use of this in cases of public interest.<sup>25</sup> These systems are viewed as being potentially flawed with respect to investigations of deaths in custody or as a result of police action.<sup>26</sup>

Where a judicial officer is responsible for administering death investigations, as is the case in Victoria, s/he is able to use the legal investigative process of a formal hearing most effectively.<sup>27</sup> However, judicial officers require the expertise of a number of different specialist agencies to carry out the physical processes of an investigation, including police and medical practitioners. As a result, although this kind of system allows an apparently independent approach to death investigation, in certain cases the agents of investigation will come from the same professional group as those being investigated.<sup>28</sup> The strengths and weaknesses of the Victorian jurisdiction are discussed further throughout the report.

The various death investigation systems referred to above have advantages and disadvantages that are generally well recognised.<sup>29</sup> In each jurisdiction the range of

<sup>&</sup>lt;sup>20</sup> Freckelton, Ian and Ranson, David, *Death Investigation and the Coroner's Inquest* (2006) 75-79.

<sup>&</sup>lt;sup>21</sup> Ibid 94.

<sup>&</sup>lt;sup>22</sup> Ibid.

<sup>&</sup>lt;sup>23</sup> Ibid.

<sup>&</sup>lt;sup>24</sup> Ibid.

<sup>&</sup>lt;sup>25</sup> Ibid.

<sup>&</sup>lt;sup>26</sup> Ibid.

<sup>&</sup>lt;sup>27</sup> Ibid 95.

<sup>&</sup>lt;sup>28</sup> Ibid 95.

<sup>&</sup>lt;sup>29</sup> Ibid.

skills available from forensic pathologists, legal practitioners, police officers and other officials, and the investigative processes on offer, must be balanced in a way that ensures effective death investigations and minimises the disadvantages of the particular structure.<sup>30</sup> The focus of each system also depends on the priorities and concerns of the particular community with respect to death investigation.<sup>31</sup> Dr Freckleton and Associate Professor Ranson comment that in many cases the structure of a jurisdiction's death investigation system has arisen through accidents of history and politics rather than an attempt to articulate clearly what the system aims to achieve.<sup>32</sup> However, some jurisdictions are recognised in international reviews as having done this well, including Victoria, and Ontario, Canada.<sup>33</sup>

# Distinctions between metropolitan and regional coronial investigations

The Committee wishes to highlight the fact that there are significant differences between coronial investigations conducted in Melbourne and those conducted in regional Victoria. The State Coroner's Office has identified the standard of coronial services available to communities in regional Victoria as one of the areas in which there is scope for substantial improvement.<sup>34</sup>

In Melbourne, inquests are held at the Coronial Services Centre. In regional Victoria, inquests are held at the local Magistrates' Court. While in Melbourne there are a number of full-time coroners, in rural Victoria coronial matters are dealt with by magistrates as a small proportion of their overall workload. Similarly, in Melbourne coronial investigations are conducted by the State Coroner's Assistants' Unit, while in regional Victoria investigations are conducted by local police officers in addition to their other duties.

Former coroner Ms Jacinta Heffey informed the Committee during the public hearings that very few country magistrates have had significant experience or training in coronial investigation or have been trained in the use of the NCIS.<sup>35</sup> Ms Heffey added that there is no system of review by the State Coroner of coroners' findings, let alone the quality of their investigations. According to Ms Heffey, the Melbourne Magistrates' Court supplies relief magistrates to the country courts on a regular basis and these magistrates may be required to conduct inquests without any training. Ms Heffey expressed concern that there is a wide discrepancy between the standard of coronial

<sup>31</sup> Ibid 96.

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<sup>30</sup> Ibid

<sup>&</sup>lt;sup>32</sup> Ibid 96.

<sup>&</sup>lt;sup>33</sup> See for example United Kingdom, *Death Certification and Investigation in England, Wales and Northern Ireland: The Report of a Fundamental Review*, Cm 5831 (2003) ('the Luce Report') 27. Available at http://www.official-documents.co.uk/document/cm58/5831/5831.htmp.

<sup>&</sup>lt;sup>34</sup> State Coroner's Office, Submission no. 70, 11.

<sup>&</sup>lt;sup>35</sup> Jacinta Heffey, Submission no. 33, 14.

investigations in Melbourne and the standard of those in rural areas. She also referred to a lack of adequate guidelines for investigations, although the Committee notes that the State Coroner's Office has developed, in conjunction with the Judicial College of Victoria, the *State Coroner's Practice Manual*.<sup>36</sup>

The Committee notes that at present there is no state-wide case management system for coronial investigations, which means that there are limitations on the scope for monitoring and supervising the standard and progress of regional cases by the State Coroner's Office.

Another factor affecting the standard of coronial investigations in regional Victoria is that coroners do not have access to the specialist investigative expertise that is available to Melbourne coroners. This can be problematic in complex cases which require specialist knowledge, particularly those involving medical treatment issues. In these cases Melbourne coroners have the advantage of Clinical Liaison Service support, which Ms Heffey describes as critical for investigative processes such as being able to read and interpret medical files.<sup>37</sup>

The State Coroner's Office has also stated that there is significant under-reporting of reportable deaths in regional Victoria, particularly by doctors in hospitals and nursing homes, which suggests that they are not always aware of the reporting criteria or are in some cases reluctant to report cases because of the burden on the family of an investigation.<sup>38</sup>

Another difference between the regional and metropolitan coronial services is that there is a problematic shortage of forensic pathology services in regional Victoria.<sup>39</sup> In Melbourne forensic autopsies are carried out at VIFM within the Coronial Services Centre, while in regional Victoria forensic autopsies are usually contracted to local forensic pathologists and performed at local hospitals, or carried out by VIFM following the transportation of bodies to Melbourne.<sup>40</sup> This last process can cause significant delays for families wishing to arrange a funeral and it also has resource implications.<sup>41</sup>

Further, the State Coroner's Office provides a Counselling and Support Service, but this is only available in metropolitan Melbourne, largely due to resource constraints. However, the State Coroner's Office has continued to develop links to community

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<sup>&</sup>lt;sup>36</sup> State Coroner Victoria, State Coroner's Practice Manual (2005).

<sup>&</sup>lt;sup>37</sup> Jacinta Heffey, Submission no. 33, 15.

<sup>&</sup>lt;sup>38</sup> State Coroner's Office, Submission no. 70, 11.

<sup>&</sup>lt;sup>39</sup> The Department of Justice commissioned a review of these services in 2004, but the draft report has not been released. See State Coroner's Office, *Submission no. 70*, 153, where there is a brief reference to the findings of the report.

<sup>&</sup>lt;sup>40</sup> State Coroner's Office, Submission no. 70, 11, 152, 153.

<sup>&</sup>lt;sup>41</sup> Ibid 26.

support services in rural Victoria in order to enable an improved response to the needs of the bereaved.<sup>42</sup> The Committee discusses the need for extending the availability of the Counselling and Support Service to regional Victoria in chapter eight. It also discusses a recent pilot implementation in Moe of the Family Contact Program, an initiative of the State Coroner's Office and VIFM involving early communication with families about the coronial process.<sup>43</sup> A related difficulty in regional areas is that the magistrate's clerks have little training in relation to the handling of sensitive coronial matters.

The Committee has noted above that at the outset of this inquiry it was concerned to ensure that the evidence it received in relation to the experiences of the coronial system by families and others affected by a death was reflective of cases in both Melbourne and regional Victoria. While some of the witnesses to the inquiry were from regional areas, the majority were from metropolitan Melbourne. Accordingly, the Committee made a conscious decision to seek input from rural families and took measures to ensure that the majority of people interviewed in the study by its consultants were from non-metropolitan areas.

## **Outline of the report**

The Committee begins the substantive part of this report in chapter two by reviewing the history of coronial systems generally and the Victorian system in particular.

Chapter three reviews the system for reporting deaths to the coroner. A fundamental question for this inquiry is whether all notifiable deaths are brought to the attention of the coroner for further examination, since under the Act the coroner only investigates deaths which have been reported to the Coroner's Office. Therefore in chapter three the Committee examines the issue of under-reporting. This issue has been brought into focus by events in other jurisdictions, including the multiple-murder conviction of Dr Harold Shipman in England in 2000 and the events in Queensland in 2005 in relation to the alleged conduct of Dr Jayant Patel. A large number of stakeholders to the Committee's inquiry identified that there is evidence to show that some reportable deaths have not been reported to the coroner. The Committee considers the reasons for such under-reporting and reviews the effectiveness of the system for reporting deaths to the coroner, in particular the system by which deaths are registered and certified – the death certification process. The Committee considers whether there is a need to reform the death certification process in Victoria.

The Committee considers the kinds of deaths which should be reported to the coroner under the Act in chapter four. As part of this analysis, the Committee examines what a 'reportable' and a 'reviewable' death is, as under the Act there is a general obligation to notify the coroner of these kinds of deaths. The Committee considers whether these categories of notifiable deaths are stated with sufficient clarity. This is an

<sup>&</sup>lt;sup>42</sup> Magistrates' Court of Victoria, 2004–05 Annual Report (2004).

<sup>&</sup>lt;sup>43</sup> State Coroner's Office, *Submission no. 70*, 110–11.

important aspect of the inquiry because it is one of the reasons cited for underreporting of deaths to the coroner. The Committee also considers whether there are any kinds of deaths which ought to be included as reportable deaths but which are not currently within this category. In the final part of chapter four the Committee considers whether there is sufficient awareness within the community and the medical profession of the general obligation to report notifiable deaths to the coroner.

In chapter five the Committee reviews the processes and procedures by which Victorian coroners investigate and inquire into deaths. The Committee examines the effectiveness of the existing powers available to a coroner to investigate deaths. This includes discussion of a coroner's powers of search and seizure, a coroner's powers to direct police investigations, the roles of lawyers and specialist investigators assisting inquiries, and the need for guidelines and training to be provided to coroners in relation to their investigative functions. Next, the Committee reviews the criteria which determine when a coroner is required to hold an inquest, including the circumstances in which it is mandatory under the Act to hold an inquest, those in which a coroner has discretion to decide whether to hold an inquest and those in which a coroner may hold an inquest into multiple deaths. The Committee considers the relationship between inquests and criminal trials and the various rights and privileges available to people with standing in relation to an inquest, despite the fact that a coroner is not bound by the rules of evidence. This includes consideration of the difficult question of whether the abrogation of the privilege against selfincrimination at inquests is justified. Finally, the Committee examines the legislative framework which governs the way in which a person may appeal certain decisions made by a coroner, including the refusal of a coroner to grant a request for an inquest, and coroners' inquest findings, comments and recommendations.

In chapter six the Committee reviews the jurisdiction of Victorian coroners to investigate fires. In addition to investigating notifiable deaths, a coroner has the authority to investigate fires in certain circumstances. Where a fire has fatal consequences a coroner would also have jurisdiction to conduct a death investigation, which would include investigating the fire as part of the causative events leading to the death. Accordingly, the focus of chapter six is on the jurisdiction to investigate non-fatal fires and whether this additional element of coronial jurisdiction should be retained.

The Committee reviews the role of coroners in preventing death and injury in chapter seven. As noted earlier, the current State Coroner and his predecessor have developed this role significantly. However, many witnesses to the inquiry considered that this aspect of the jurisdiction is not sufficiently provided for in the Act, and that it is not effective in some areas such as patient safety. The Committee therefore considers whether prevention should be identified as a purpose of the Act. It also reviews the existing system for identifying similar kinds of death, including the NCIS database and the research expertise available for this purpose. The Committee then considers the effectiveness of coroners' recommendations arising from death investigations with a view to preventing similar events from occurring in the future.

The Committee also discusses barriers to the implementation of such recommendations and whether there should be obligations on the part of recipients of the recommendations to respond to them.

In chapter eight the Committee considers the appropriateness of the Act's framework for the provision of support for the families, friends and others associated with a person whose death is the subject of a coronial inquiry. Early in the inquiry the Committee identified a number of areas in which the Act could be amended or modernised to better meet the needs of people affected by a coronial inquiry. The Committee decided to dedicate a separate chapter to a discussion of these areas, given that this subject was such an important aspect of the terms of reference and also because the evidence demonstrated a strong need for the coronial system to minimise family trauma. Chapter eight begins with a discussion of the needs of families, friends and others in the coronial system. The Committee then considers whether accommodating the needs of families should be recognised as a purpose of the Act. After examining how family members and others are to be defined for the purposes of the Act, the chapter is then largely taken up with discussion of a number of substantive rights which the Committee considers should be provided to family members and others under the Act. The chapter also considers whether the legislation adequately respects cultural sensitivities, such as those of Indigenous Australians, particularly in relation to autopsies. The Committee also discusses the need for and role of counselling and support services within the coronial system, and it reviews the currently available services.

Finally, the Committee reviews the function and legal status of the Coroner's Office and the status of the State Coroner in chapter nine. The Committee then considers the administrative and inquisitorial nature of the coronial jurisdiction and the functions of the State Coroner as the coordinator of a state-wide coronial system. The public perception of the Coroner's Office is also discussed.

# CHAPTER TWO — HISTORY OF CORONIAL LAW IN VICTORIA

The office of Coroner or 'Crowner'<sup>44</sup> can be traced at least as far back as the 12th century.<sup>45</sup> The role 'incorporated a wide range of duties, just one of which was the investigation of unnatural or suspicious death'.<sup>46</sup> A number of commentators date the first reliable reference to a coroner to the Articles of Eyre in 1194.<sup>47</sup> For a very comprehensive history, the reader is referred to *Death Investigation and the Coroner's Inquest* by Ian Freckelton and David Ranson.<sup>48</sup>

For the purposes of this report we need only note that the origin of all current Australian coronial systems was the English system, which was received by Australia at the time of English settlement.<sup>49</sup>

## The Victorian coronial system

The first Victorian Act which referred to coroners was the *Coroners Statute 1865*. This Act gave coroners powers in respect of inquests, and based these on the existing powers of a coroner under common law.<sup>50</sup> This Act was followed by the Coroners Acts of 1890, 1911 and 1915; it is not proposed to provide any analysis of the content of these very early acts. The next piece of legislation, the *Coroners Act 1958*, was the subject of the first major reviews of the coronial system in Victoria.

<sup>&</sup>lt;sup>44</sup> The full title was originally 'keepers of the pleas of the Crown' — in Latin, *custodes placitorum coronae* — but this was shortened over time to 'coronarius' or 'coronator', anglicised to 'crowner' and then to 'coroner'. See Ian Freckelton and David Ranson, *Death Investigation and the Coroner's Inquest* (2006) 6.

<sup>&</sup>lt;sup>45</sup> Some historians have found references to the office dating to the time of Alfred the Great, who ruled from AD 871. See for example Department of Justice, Equality and Law Reform (Ireland), *Review of the Coroner Service* — *Report of the Working Group* (2004) 2.

<sup>&</sup>lt;sup>46</sup> Ian Freckelton and David Ranson, *Death Investigation and the Coroner's Inquest* (2006) 6.

<sup>&</sup>lt;sup>47</sup> See Jill McKeough, 'Origins of the Coronial Jurisdiction' (1983) 6 *University of New South Wales Law Journal* 191; Ian Freckelton and David Ranson, *Death Investigation and the Coroner's Inquest* (2006) 5.

<sup>&</sup>lt;sup>48</sup> Ian Freckelton and David Ranson, *Death Investigation and the Coroner's Inquest*, Oxford University Press, Melbourne, 2006.

<sup>&</sup>lt;sup>49</sup> Ibid 35.

<sup>&</sup>lt;sup>50</sup> Coroners Statute 1865 s 4.

#### **Coroner Court Review Committee**

The Coroner Court Review Committee was set up in 1975,<sup>51</sup> essentially to consider whether the existing facilities at the Melbourne City Mortuary and Coroners Court, particularly those for body identification, storage and autopsy, were adequate. Clearly, they were not. Professor Vernon Plueckhahn described the situation as follows:

The foyer of the building was often filled with bereaved relatives, witnesses, lawyers and police waiting for an inquest to start. Odours from the mortuary usually permeated through the crowded foyer. Distressed relatives called to make formal identifications had to find their way through the crowd to the identification room. No dignity existed for either the living or the dead.<sup>52</sup>

The Review Committee's report included in its recommendations:

- 7.2 Removal of the actual Court Room and associated public areas from the sight, sound and smell of the mortuary are essential ...
- 7.4 We wish to stress that conditions for the storage of bodies are a disgrace to the state of Victoria, that there as an urgent need for new facilities for the Coroners Court and mortuary.

Following this review an interdepartmental committee was established in 1978 to advise the Government on the implementation of the Review Committee's recommendations.<sup>53</sup> This committee's report was completed in 1981 and, although it agreed that a new facility was urgently needed, work did not commence on the new building until 1985. The building which currently houses both the Coroner's Office and the Victorian Institute of Forensic Medicine (VIFM), referred to as the Coronial Services Centre in Kavanagh Street, Southbank, was completed in 1988.

This co-location of the legal and medical arms of the coronial service was an innovation at the time, and it remains a central feature of the co-ordinated coronial system in Victoria.

#### Norris review

The Coroners Act 1958 — A General Review was commenced in 1979 by Saul Richard Mullaly QC, who at that time was Crown Counsel. Following his appointment to the bench the review was taken over by John Gerald Norris QC. It was completed in 1981 and became commonly known as the Norris Report. As the official title of the report suggests, the review focussed on the Act and was essentially a review of the role of the coroner. The report traced the role of coroner from one originally intended to protect royal revenue to one which:

<sup>&</sup>lt;sup>51</sup> V Plueckhahn, A Vision and the Reality — The Victorian Institute of Forensic Medicine 1975–1995, 15.

<sup>&</sup>lt;sup>52</sup> Ibid 13.

<sup>&</sup>lt;sup>53</sup> Ibid 19.

is principally concerned with enquiry into what may be described compendiously as sudden or unexpected deaths, the committal for trial of persons whom evidence suggests may have caused such death by criminal conduct and the deaths of persons in certain institutions.<sup>54</sup>

The report then identified its purpose as looking to the appropriate future role of the coroner:

The advance of medical science and certain aspects of modern industrial developments prompt some examination of the nature of the office, the justification for its existence and the purpose which it serves or should serve in the society of today. Further it is necessary to consider what improvements might be made in the practices and procedures of the coroner in the performance of his present functions, and whether these should in fact be varied.<sup>55</sup>

The report identified and supported a focus by coronial jurisdictions internationally on the recognition and further development of the preventative role of the coroner. While it noted that in practice the coroner's role was no longer primarily concerned with suspicious deaths, it also recognised that the public understanding of the coroner's role was not well informed. The report quotes from a significant UK review (the Brodrick Report), which was undertaken in 1971:

There is still a tendency to regard the coroner's role as being primarily directed to the investigation of suspicious deaths and in particular homicides. This belief had some basis in fact a hundred years ago but is now completely outmoded. ... We cannot too strongly emphasise our own conclusions that the coroner's primary function at the present is to help establish the cause of death in a wide variety of situations few of which have any criminal or even suspicious overtones.<sup>56</sup>

The Brodrick Report listed the 'many different objectives served by the present law' as:

- The recording of causes of death for statistical or research purposes
- · The investigation of an unusual or accidental death
- The identification of new hazards to life
- The provision of a safeguard against secret homicide.<sup>57</sup>

And continued:

<sup>56</sup> Brodrick Committee, *Report of the Committee on Death Certification and Coroners*, Cm 4810 (1971) para 13.

<sup>&</sup>lt;sup>54</sup> John Norris, *The Coroners Act 1958 — A General Review*, 1981, 2.

<sup>55</sup> Ibid.

<sup>&</sup>lt;sup>57</sup> Ibid para 11.

Moreover it is through a procedure aimed at determining the cause of every death accurately that those kinds of death which may be preventable can be identified and the appropriate action taken. <sup>58</sup>

In Ontario, Canada, also in 1971, the Ontario Law Reform Commission (OLRC) produced the *Report on the Coroner System in the Province of Ontario*. The Norris Report agreed with the OLRC findings that the primary justification for retaining a coronial system was the role it played in preserving and protecting human life.<sup>59</sup>

A further important finding of the report was that the law at that time was based not only on the 1958 Act but also substantially on common law.<sup>60</sup> In addition, the report noted that many practices had been adopted by coroners which apparently had no basis in statute or common law.<sup>61</sup> The report found that this situation created some difficulties and recommended a codification of the law.

These considerations point to the desirability of codifying the law relating to coroners. Many practices have been adopted which practical necessity has forced on the coroner. Much of the existing legislation, for example, apparently proceeds on the assumption that in the case of every death reported to the coroner an inquest will be held, which is very far indeed from the fact. Pragmatic solutions are in practice found, but they may well lack not only statutory but also common law authority. There is the danger that, by abrogating the whole of the relevant common law and failing in a statutory code to provide for some matter the subject of a common law rule, that matter may be left unregulated. It is thought that despite this possibility, having regard to the difficulties to which reference to the common law may give rise, it is worth taking the risk involved in endeavouring to deal with the whole subject by statute. The Report of the Coroners Court Review Committee (paras.11.1 to11.8) expressed the opinion for various reasons that this would be an advantage. Accordingly I recommend that the law relating to coroners be codified. 62

#### Coroners Act 1985

The Norris Report recommendations were the basis of the current act, the *Coroners Act 1985* (the Act). By the time the Act was passed the government of the day had already commenced planning for a new building to house both VIFM and the Coroner's Office, thus addressing most of the concerns raised by the earlier Coroner Court Review Committee.

The Coroners Act 1985 established for the first time an Office of the State Coroner, and also established the Victorian Institute of Forensic Pathology (now VIFM<sup>63</sup>). It

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<sup>&</sup>lt;sup>58</sup> Ibid.

<sup>&</sup>lt;sup>59</sup> John Norris, *The Coroners Act 1958 — A General Review* (1981) 4.

<sup>&</sup>lt;sup>60</sup> Ibid 15.

<sup>&</sup>lt;sup>61</sup> Ibid 19.

<sup>62</sup> Ibid.

<sup>&</sup>lt;sup>63</sup> The name change, brought about by amendment to the Act in 1995, reflected the taking over by the Institute of responsibility for clinical forensic medicine, which had formerly been the work of the Police Surgeon.

modernised the coronial system and established its ongoing relevance as a public institution. In addition, by establishing VIFM it recognised the essential partnership between the coroner and the provider of forensic services.

Whilst recent reviews of the coroners jurisdictions in England and Wales reveal an outdated system which is in need of radical reform there, the 1985 Act in Victoria arrested any decline of the coroners jurisdiction into irrelevance by empowering the coroner to make recommendations ... (In parallel, the establishment of VIFM recognised legislatively the essential partnership between medicine and law for a vibrant coronial system to function properly. This recognition of forensic pathology in the 1985 Act is unique in coroners' legislation as far as we are aware.)<sup>64</sup>

The Act codified the law and, in section 4, provided that common law ceased to apply:

A rule of the common law that, immediately before the commencement of this section, conferred a power or imposed a duty on a coroner or a coroner's court ceases to have effect.<sup>65</sup>

This resulted in the establishment of the Coroner's Office as an administrative rather than a judicial body.<sup>66</sup>

A further significant change was brought about by part seven of the Act, which set out the procedures for holding inquests. Section 44 specified that a coroner holding an inquest was not bound by the rules of evidence, and could be informed and conduct an inquiry, in any manner that s/he reasonably thought fit. These provisions established the inquest as an inquisitorial jurisdiction, moving it away from the previous adversarial court process.

The Act specified the functions of the State Coroner<sup>67</sup> which give him or her significant coordinating and administrative responsibility, aimed at centralising and standardising coronial services.

The types of deaths which were reportable were listed, 68 and the general powers and duties of the coroner were specified in part five in relation to death investigation and in part six for fire investigations. Significantly, the powers did not include the power previously held by coroners to commit for trial and the Act precluded a coroner from making any statement that a person is or may be guilty of an offence. These exclusions further facilitated the replacement of an adversarial system with an inquisitorial process.

<sup>&</sup>lt;sup>64</sup> Victorian Institute of Forensic Medicine, Submission no. 40, 3.

<sup>&</sup>lt;sup>65</sup> Coroners Act 1985 s 4.

<sup>&</sup>lt;sup>66</sup> Harmsworth v The State Coroner (1989) VR 989, 992.

<sup>&</sup>lt;sup>67</sup> Coroners Act 1985 s 7.

<sup>&</sup>lt;sup>68</sup> Coroners Act 1985 s 3.

# Major amendments

There have been some major amendments to the 1985 Act in recent years.

Coroners (Amendment) Act 1995:

- extended the functions of the Victorian Institute of Forensic Pathology to cover forensic medicine and changed the name to the Victorian Institute of Forensic Medicine (VIFM). These changes enabled the integration into VIFM of the Office of Forensic Medicine, which had previously existed within Victoria Police. The office's function was to provide clinical forensic services to support operational police.
- gave the coroner a discretion to decide whether an inquest should commence or continue after criminal proceedings have been concluded and a person has either been acquitted or found guilty of homicide.
- required a coroner to give written reasons for such a decision not to commence or continue an inquest and provided a right of appeal to the Supreme Court.

Coroners (Amendment) Act 1999:

- extended the power of coroners to make recommendations to ministers and public authorities. Previously, these could be made only to the Attorney-General.
- removed the obligation on coroners to make a finding about the identity of a
  person contributing to the death of another person, although coroners were not
  precluded from making such a finding. This was to avoid situations where a finding
  of contribution could be misconstrued as carrying a connotation of legal
  responsibility for the death.
- gave coroners the power to reopen inquests in certain circumstances.
- made discretionary some inquests which had previously been mandatory.
- repealed provisions relating to the holding of inquests with a jury.
- gave coroners the power to order costs.
- amended the objects and functions of VIFM to enable the storage of tissue for therapeutic purposes under the Human Tissue Act 1982.

Death Notification Legislation (Amendment) Act 2004:

- created the new category of reviewable death which must be reported to the Coroner. This relates to the death of a child where this is the second or subsequent death of a child of a particular parent.
- conferred additional responsibilities onto VIFM, including assessing whether the family of a person whose death is reviewable requires referral to specialised

health or support services, considering whether to make a child protection notification in relation to any surviving children, and educating professionals and supporting agencies about the issues concerning multiple child deaths in a family

Amendments to the 1985 Act have been aimed at addressing particular recently emerging issues or identified shortcomings in the Act.

The aim of the current inquiry is to look at the Act in a systematic way to establish, much as the Norris Report did over 20 years ago, how effectively the Act is fulfilling its purposes and whether these purposes remain relevant and sufficient.

# Purposes in the Act

Although the Norris Report identified prevention and public safety as the primary purpose of the coronial system, it did not recommend that this be included as a purpose in the Act. While the Act facilitated the carrying out of this role by allowing coroners to report to the Attorney-General<sup>69</sup> (and, by later amendment, to make recommendations to any minister or public authority, including in relation to public health or safety),<sup>70</sup> it does not currently specifically identify this role as a purpose of the Act.

Nevertheless the coroner's role in prevention has certainly been a feature of the State Coroner's Office since its establishment by the *Coroners Act 1985*, as is discussed in detail in chapter seven. As a number of commentators<sup>71</sup> have noted, this is due in large part to the work of the two individuals who have held the position of State Coroner since the Act commenced, Mr Hal Hallenstein and Mr Graeme Johnstone.

A further significant issue not currently identified as a purpose in the Act but clearly a matter of great concern to the Coroners Court Review Committee was the needs of family, friends and others associated with a death. The Committee deals with this matter in considerable detail in chapter eight. Again it can be said that, while the 1985 Act — in conjunction with the new Coroner's Office and VIFM facility which was opened in 1988<sup>72</sup> — facilitated the better accommodation of family needs, the Act itself did not specifically articulate this role as a purpose of the Act.

Given the importance of these two issues, the Committee concluded that they both needed to be more specifically recognised in the legislation. This conclusion has guided specific recommendations in chapters seven and eight.

<sup>70</sup> Coroners Act 1985 s 21(2).

<sup>71</sup> Victorian Institute of Forensic Medicine, *Submission no. 40*, 3; David Ranson, *Submission no. 19*, 82; Ian Freckelton, *Minutes of Evidence, 20 September 2005*, 201.

<sup>&</sup>lt;sup>69</sup> Coroners Act 1985 s 21(1).

<sup>&</sup>lt;sup>72</sup> V Plueckhahn, A Vision and the Reality — The Victorian Institute of Forensic Medicine 1975–1995, 31.

# CHAPTER THREE — SYSTEM FOR REPORTING DEATHS TO THE CORONER

A fundamental question for this inquiry is whether all notifiable deaths are reported to the coroner for further examination. This is important because, under the *Coroners Act 1985*, the coroner only investigates deaths which are actually reported to the Coroner's Office. The Act does not require the coroner to investigate deaths which have not been reported. The Committee identified this issue in its discussion paper in 2005 and invited stakeholders to make submissions. A large number of stakeholders, including the State Coroner, have accepted that there is evidence to show that some reportable deaths have not been reported to the coroner. This chapter therefore examines the incidence of under-reporting in detail in an attempt to understand the reasons for this under-reporting.

In order to more fully understand the under-reporting issue, the Committee has examined the current system in which deaths are registered and reported to the coroner — the death certification process. The death certification system in Victoria has not been reviewed for 25 years. During that time, the efficacy of the system has been questioned and has been brought more sharply into focus following the multiple murder conviction of Dr Harold Shipman in England in 2000 and, more recently, the events in Queensland in 2005 in relation to the alleged conduct of Dr Jayant Patel.

The Committee also examined the overall effectiveness of the death certification process in Victoria. A system is considered effective when it is able to fulfil the purpose for which it was established. In this chapter the Committee will therefore also examine the purposes of the death certification system and establish whether the current system is able to give effect to that purpose.

In the final part of this chapter, the Committee considers whether there is a need to reform the death certification process in Victoria. The Committee evaluates currently operational systems and models recommended in other jurisdictions, and it considers the systems which have been proposed by stakeholders to ensure that reform options are relevant to Victoria.

# Scope of the inquiry — connection between death certification and death investigation

The terms of reference require the Committee to review the effectiveness of the Coroners Act 1985. In its discussion paper, the Committee concluded that the effectiveness of the Act was dependent on having an effective death certification system in place in which relevant deaths are reported to the coroner. As noted above, in the current system the coroner only investigates deaths which have been reported.

The Committee is therefore of the view that an inquiry into reform of the coronial system cannot be meaningfully undertaken without also examining the system in which deaths are referred to the coroner.

This view is consistent with the approach taken in a number of previous inquiries in other jurisdictions.<sup>73</sup> It was also the approach adopted in the last review of coronial legislation in Victoria in 1981. In that review, the Hon Sir John Norris QC noted the need to examine and make recommendations for change to provisions of the *Registration of Births, Deaths and Marriages Act 1958.* He concluded that these provisions were of some importance to the effective exercise by the coroner of his or her proper functions.<sup>74</sup>

# The current system for reporting deaths to the coroner

# Purpose of death registration and certification

A system of registering and certifying the cause of death was first established in the United Kingdom in 1837.<sup>75</sup> The Act which established this system had two main purposes — to provide legal proof of death and to collect accurate mortality statistics.<sup>76</sup>

Deaths in Victoria are now registered under the *Births, Deaths and Marriages Registration Act 1996.* Under this Act, doctors are required to provide a Medical Certificate of Cause of Death (MCCD) to the Registrar of Births, Deaths and Marriages (the Registrar) for every death which is not reportable to the coroner. Approximately 86 percent<sup>77</sup> of all deaths are registered in this manner after being certified by GPs or hospital doctors. The remaining deaths, which are reportable deaths, are certified by the coroner following an investigation into the cause of the death. The diagram below sets out this process.

<sup>&</sup>lt;sup>73</sup> See for example: United Kingdom, *Report of the Committee on Death Certification and Coroners*, Cm 4810 (1971); United Kingdom, *Death Certification and Investigation in England, Wales and Northern Ireland: The Report of a Fundamental Review*, Cm 5831 (2003); United Kingdom, *Death Certification and the Investigation of Death by Coroners* (The third report), Cm 5854 (2003).

<sup>&</sup>lt;sup>74</sup> John Norris, *The Coroners Act 1958 — A General Review* (1981) 27.

<sup>&</sup>lt;sup>75</sup> Births and Deaths Registration Act 1836 (UK).

<sup>&</sup>lt;sup>76</sup> United Kingdom, Report of the Committee on Death Certification and Coroners, Cm 4810 (1971) 9.

<sup>&</sup>lt;sup>77</sup> Graeme Johnstone, State Coroner's Office, Submission no. 70, 177.

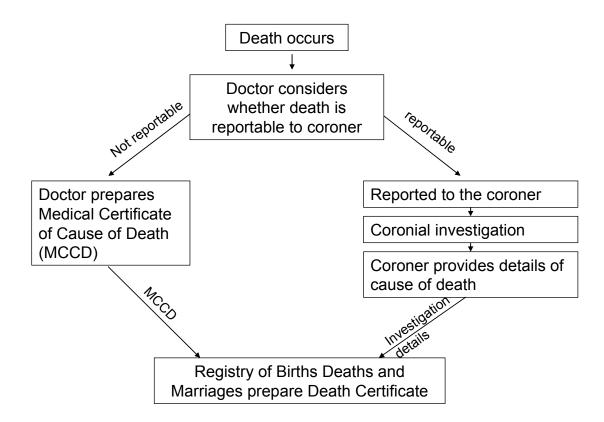


Figure 1 - Registration of Deaths in Victoria

One of the main purposes of the *Births, Deaths and Marriages Registration Act 1996* as stated in the legislation is to provide for the registration of deaths in Victoria.<sup>78</sup> While not expressly stated in legislation either in Victoria or in the UK, another purpose of death certification which was noted in a recent UK inquiry is that it acts as a safeguard against the disposal of bodies without professional scrutiny of the possible need for further investigation to establish the cause of death.<sup>79</sup>

### Medical certification of death

#### Certification of fact of death

Before a doctor certifies the cause of death, s/he must of course establish the 'fact' of death. In Victoria, there is no formal legal process requiring a doctor or other person with medical training to make a clinical assessment and written verification acknowledging that a person is dead. This may cause problems in relation to deaths occurring in public places if a doctor is not readily available to certify the death because most funeral directors are, obviously, reluctant to move a body from the scene of death until a doctor has determined whether the death should be reported to

<sup>79</sup> United Kingdom, *Death Certification and Investigation in England, Wales and Northern Ireland: The Report of a Fundamental Review*, Cm 5831 (2003) 40.

<sup>&</sup>lt;sup>78</sup> Births, Deaths and Marriages Registration Act 1996 s 1.

the coroner. Family members of a person who has died as well as bystanders may however become distressed when it is not possible to promptly remove the body from the scene of the death.

The lack of a formal legal process for certifying the fact of death also has implications for the Coroner's Office and the Victorian Institute of Forensic Medicine (VIFM). In the absence of a standard certificate to record the fact of death, it is the practice of the Coroner's Office and VIFM not to accept a body at the coronial morgue unless a doctor has provided a handwritten note which indicates that s/he has examined the body and that the person is dead.<sup>80</sup>

# Law reform agencies

In 1971, following a comprehensive six-year review of the death certification system in the UK, the Brodrick Committee recommended that doctors should be required to formally certify the fact as well as the cause of death.<sup>81</sup> However, recommendations from this inquiry were never implemented, because successive governments of the day did not make clear decisions on policy.<sup>82</sup>

Further review of the UK death certification system did not occur until 30 years later, following the murder conviction of Dr Shipman in 2000. Two separate UK inquiries reexamined the death certification system and also recommended that a formal process be established for the certification of the fact of death. The first inquiry, referred to as the Luce Inquiry, noted that there was general support for a clear and specific process to verify that a death had occurred and that the verification could be performed by medically trained persons such as nurses and paramedics. According to the inquiry, this formal process was particularly important in relation to deaths occurring in public places where there was a delay in securing the services of a doctor to certify that the person had died. The inquiry noted that delays in removing a body from a public place may cause distress to family members and bystanders. The inquiry recommended that all deaths should be subject to professional verification that the life

<sup>&</sup>lt;sup>80</sup> Transcript of proceedings, *The Shipman Inquiry Third Report — Death and Cremation Certification*, Professor Stephen Cordner, 16 January 2003, 21. Available at <a href="www.the-shipman-inquiry.org.uk">www.the-shipman-inquiry.org.uk</a>. Hospitals such as the Royal Melbourne Hospital use internal forms which are signed by a doctor to certify that life is extinct. The form accompanies the body to the morgue.

<sup>&</sup>lt;sup>81</sup> United Kingdom, Report of the Committee on Death Certification and Coroners, Cm 4810 (1971) 39.

<sup>&</sup>lt;sup>82</sup> United Kingdom, *Death Certification and the Investigation of Death by Coroners* (The third report), Cm 5854 (2003) i.

<sup>&</sup>lt;sup>83</sup> United Kingdom, *Death Certification and Investigation in England, Wales and Northern Ireland: The Report of a Fundamental Review*, Cm 5831 (2003) 47. Available at <a href="https://www.official-documents.co.uk">www.official-documents.co.uk</a>.

<sup>84</sup> Ibid.

had ended and that this verification should be statutorily defined as a separate requirement in the death certification process.85

Another inquiry, the Shipman Inquiry, considered that it was a shortcoming of the UK system that it did not require formal certification of the fact that a person has died. In the inquiry's third report, Dame Janet Smith recommended that doctors, nurses and paramedics should be authorised to officially record the fact of death for deaths occurring in the community in accordance with Proposed Form 1.87 This form would require the certifier to record the following information:

- the time and date that death was confirmed;
- a brief description of the position of the body and features which may be relevant to the cause of death;
- where an examination of the head, neck and arms had taken place, a brief description of wounds, bruising or other injuries such as injection marks or haemorrhages to the skin;
- a brief description of the circumstances of the death;
- a brief outline of the state of health preceding death; and
- any information that should be brought to the attention of the coroner.

The Shipman Inquiry also considered that the form would assist in the professional scrutiny of the circumstances of the death and would act as a valuable safeguard against any attempt to provide false information.88

In response to both inquiries the UK Government recently endorsed these recommendations. While the final form of the system is yet to be determined, the UK will commence significant reforms to its coronial system in the later half of 2006. This new system will require that the fact of death be verified as a separate step from the certification of the cause of death.<sup>89</sup>

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<sup>&</sup>lt;sup>85</sup> Ibid 49.

<sup>&</sup>lt;sup>86</sup> United Kingdom, *Death Certification and the Investigation of Death by Coroners*, (The third report), Cm 5854, (2003) 126.

<sup>&</sup>lt;sup>87</sup> Ibid 'Form 1: Certificate of Fact of Death and Statement of Circumstances of Death', Appendix G.

<sup>&</sup>lt;sup>88</sup> Ibid 127.

<sup>&</sup>lt;sup>89</sup> United Kingdom, Reforming the Coroner and Death Certification Service: A Position Paper, Cm 6159 (2004) 13.

# Other Australian jurisdictions

A formal determination that a death has occurred is now required by law in Tasmania<sup>90</sup> and in a number of other Australian jurisdictions.<sup>91</sup> The change to the law in Tasmania was a result of difficulties experienced by funeral directors who were sometimes requested to collect a body from the place of death before a doctor was able to attend to make a clinical assessment of the fact that the person had died.<sup>92</sup> Significant delays in securing the attendance of a doctor had arisen when a death occurred in a remote or rural place or where a person had died during the night in a private home or nursing home.<sup>93</sup> The new certification process alleviates these difficulties, as the regulations permit nurses, paramedics and other qualified persons to certify the fact of death when a doctor is unable to attend, so that funeral directors can then transport the body from the place of death.

# Evidence received by the Committee

The Victorian branch of the Australian Funeral Directors Association (AFDA) has advocated for a change to the law in Victoria for over five years. <sup>94</sup> The Association wants to establish a system which will allow paramedics in certain circumstances to complete an interim certificate of the fact of death at the scene of the death. This will then enable funeral directors to convey the body to a mortuary where a doctor can complete the MCCD. AFDA is concerned by the fact that on a number of occasions a funeral director has not been able to promptly locate a doctor who is able to attend the place of death in order to certify the death. This sometimes puts funeral directors in a difficult position in situations where a person dies in a public place. Sometimes funeral directors have had to make the decision to transport a body to the nearest hospital to request that an emergency department doctor certify the fact of death.

A draft industry protocol for pronouncing life extinct was prepared by DHS in 2003 and the Department conducted a consultation process with the medical and nursing professions, Ambulance, Victoria Police, the State Coroner's Office and funeral associations. DHS sought legal advice in relation to the protocol and there were some subsequent amendments. This now needs to be reviewed by each of the key

<sup>&</sup>lt;sup>90</sup> Burial and Cremation (Handling of Human Remains) Regulations 2005 (Tas), which requires a medical practitioner, nurse, paramedic or other 'responsible person' to determine the fact that a person is dead. Reg 3 provides the definition of 'responsible person'.

<sup>&</sup>lt;sup>91</sup> Births, Deaths and Marriages Registration Act 1996 (SA), s36; Births, Deaths and Marriages Registration Act 2003 (QLD), s26;

<sup>&</sup>lt;sup>92</sup> Tasmania, *Report on the Draft Burial and Cremation (Handling of Human Remains) Regulations 2004,* Department of Premier and Cabinet, Local Government Division, July 2004, 4.

<sup>&</sup>lt;sup>93</sup> Family and Community Development Committee, Parliament of Victoria, *Inquiry into the Regulation of the Funeral Industry*, (2005), 77.

<sup>&</sup>lt;sup>94</sup> Email, Kate Bell, Administration Officer, Australian Funeral Directors Association, to Committee Legal Research Officer, 28 March 2006.

stakeholder groups to ensure that the protocol does not conflict with their legislative obligations.95

As well as being a concern for funeral directors, the practice of funeral directors attending hospitals to find a doctor to declare a death is also an issue for some hospitals. Dr Mark Garwood, Chief Medical Officer at Austin Health, told the Committee that Austin Health's emergency department doctors currently have to deal with requests to examine bodies and declare deaths which have not occurred at the hospital. Ms Margaret Way, Director, Strategy, Risk and Clinical Governance, at Austin Health outlined the problems this causes for hospital emergency departments:

the only point of entrance is the ambulance bay which is used to transport patients to and from the hospital. It is an open area with no privacy and inappropriate for bodies to be brought to any Emergency Department.<sup>97</sup>

Dr Garwood advised the Committee that Austin Health considers that it should be a requirement of the death certification process that a qualified person view a body to confirm and document that a death has occurred before a doctor certifies the cause of death or reports the death to the coroner. In response to the Committee's question as to Austin Health's opinion on who would be qualified to undertake this role, Ms Way informed the Committee that:

At Austin, certification of death is seen as a medical responsibility. It is unlikely that this approach would need changing in the acute setting but in satellite community based locations it may be appropriate to consider nursing staff declaring death. However, this would involve approval from the relevant professional bodies.<sup>99</sup>

### Discussion and conclusion

The Committee agrees with the conclusions of the Brodrick, Luce and Shipman Inquiries that there should be some legal process recording the fact that a person has died. Verifying the fact that a person has died is an important step in the death certification process and the Committee considers that it should therefore be documented by a doctor or other medically qualified person such as a nurse or paramedic following an examination of the body near or at the place of the death.

Research Officer, 22 May 2006.

<sup>&</sup>lt;sup>95</sup> Advice provided by Mr Brian Crampton, Public Health Branch, Department of Human Services, to Committee Executive Officer, 6 September 2006.

<sup>&</sup>lt;sup>96</sup> Austin Health, Submission no. 45, 3.

<sup>&</sup>lt;sup>97</sup> Email, Margaret Way, Director, Strategy, Risk and Clinical Governance, Austin Health, to Committee Legal Research Officer 22 May 2006.

<sup>98</sup> Austin Health, Submission no. 45, 3.

<sup>&</sup>lt;sup>99</sup> Email, Margaret Way, Director, Strategy, Risk and Clinical Governance, Austin Health, to Committee Legal

The current arrangement in which doctors must certify the fact of death is unsatisfactory because it may cause problems for funeral directors and hospitals when a doctor cannot promptly attend the scene of a death. Delays in moving bodies from the death scene may also cause distress for members of the family of the person who has died. The lack of a standard form for verifying a death has also resulted in some doctors being required to write notes to explain that an examination revealed that a person is dead before the body will be accepted at a coronial morgue.

The Committee understands that DHS has been endeavouring to finalise a protocol referred to as the Industry Protocol for the Movement of Corpses since 2003. The Committee however considers that it is more appropriate that verification of the fact of death be regulated by legislation as in other Australian jurisdictions, as it is an important part of the death certification process. The Committee also considers that the information requested in the Shipman Inquiry's Proposed Form 1 could act as a useful model for a future certification of fact of death form for Victoria, as the form would provide further information about the death which could later be used to consider whether a death needs further investigation.

Recommendation 1. That legislation be enacted which requires a doctor, nurse, paramedic or other suitably qualified person to provide a certificate which verifies the fact that a person has died. Such certification must only occur following a clinical assessment of the body (which would include an examination of the body) to establish that death has occurred and must include information in the certificate which details the circumstances of death including a record of any injuries observed on the body and any information about the death which should be referred to the coroner.

## Certification of the cause of death

# Doctors' obligations

Whenever a person dies, a doctor is required to notify the coroner if the death is categorised as a notifiable death and must therefore be reported to the coroner; where this is not the case doctors are required to notify the Registrar. For non-coroner cases, the doctor who was responsible for a person's medical care immediately before his or her death, or a doctor who examined the body after the death, is required to notify the Registrar of the cause of the death within 48 hours of the death.<sup>100</sup> This process is known as 'death certification'.<sup>101</sup>

<sup>&</sup>lt;sup>100</sup> Births, Deaths and Marriages Registration Act 1996 s 37. The legal obligation to certify the death is on the doctor who was 'responsible for the person's medical care immediately before the death' or the doctor who examines the body of the person after death.

<sup>&</sup>lt;sup>101</sup> The form is called Medical Certificate of Cause of Death of a person aged 28 days or over, version 2, June 2005; it is issued by the Department for Victorian Communities. Available to doctors at www.dvc.vic.gov.au.

The paper form on which doctors certify the cause of death is known as the 'Medical Certificate of Cause of Death of a person aged 28 days or over' (the MCCD) and is issued to doctors by the Registry of Births, Deaths and Marriages (see appendix 4). The MCCD is produced on carbonless copy paper; the certifying doctor retains the green copy, lodges the white copy with the Registry and gives the blue copy to either the funeral director or the person arranging the burial or cremation.

The MCCD requires the doctor to state the name and date of birth of the person who has died, how this person was identified to the doctor (personal knowledge, medical records or relative's identification) and whether the doctor viewed the body after the death. The form also requires the doctor to list the place of death and to indicate whether an autopsy has been or will be held.

The doctor must then complete question 9, which involves stating the cause of death and listing diseases or conditions which directly led to the death (part 1(a)). The doctor is then required to list antecedent causes which gave rise to the actual cause of death. Up to three antecedent causes may be listed, ((b) to (d)), with the underlying condition stated last. Part 2 requires the doctor to list other significant conditions which contributed to the cause of death but were not related to the disease or condition causing it.

Question 11 requires the doctor to indicate whether the person who died had an operation within four weeks of the death and specify the type of operation, as well as any diseases and conditions. If the person who died was under 18 years old, the doctor is also required to list the names of siblings and their date(s) and place(s) of birth, and the names of the parents (question 13).

The doctor is required to certify that s/he believes that the death need not be reported to the coroner and that s/he either was responsible for the medical care of the person who died immediately before death or had examined the body after death (question 15). A doctor must not complete the MCCD if s/he believes that the death should be referred to the coroner.<sup>102</sup> It is an offence under the *Births, Deaths and Marriages Registration Act 1996* for a doctor to notify the Registrar of a death if the death is reportable to the coroner.<sup>103</sup> The current maximum penalty is a fine of 12 penalty units. After the doctor has forwarded the MCCD to the Registrar indicating that the death is not reportable to the coroner, the Registrar registers the death and later issues a death certificate.<sup>104</sup>

<sup>&</sup>lt;sup>102</sup> Births, Deaths and Marriages Registration Act 1996 s 37(4).

<sup>&</sup>lt;sup>103</sup> Births, Deaths and Marriages Registration Act 1996 s 37(4).

<sup>&</sup>lt;sup>104</sup> Births, Deaths and Marriages Registration Act 1996 s 40 and s 46.

For coronial cases<sup>105</sup>, the *Coroners Act 1985* requires doctors who are 'present at or after' certain kinds of deaths to report those deaths to a coroner.<sup>106</sup> In brief, the Act currently requires doctors to notify a coroner if:

- the death is 'reportable';107 or
- the doctor does not view the body of the person who has died;<sup>108</sup> or
- the doctor is unable to determine the cause of death: <sup>109</sup> or
- no doctor attended the person within 14 days before the death and the doctor is unable to determine the cause of death from the immediate medical history;<sup>110</sup> or
- the death is 'reviewable'.<sup>111</sup>

In coronial cases, the doctor does not certify the cause of the death, as this is the coroner's responsibility. After a coroner has conducted an investigation to establish the cause of death, the coroner must then give these details to the Registrar so that the cause of death can be registered under the *Births, Deaths and Marriages Registration Act 1996* and a complete death certificate can then be issued.<sup>112</sup>

Although there is a legal requirement for doctors to notify the coroner of reportable deaths, the Act does not prescribe the form in which doctors are required to notify the Coroner's Office. In practice, doctors usually inform the coroner's clerks of the death by phone. In relation to hospital deaths, the Coroner's Office requests the doctor referring the death to the coroner to complete the Medical Practitioner's Deposition form. The form requires the doctor to give his or her opinion as to the cause of the

<sup>&</sup>lt;sup>105</sup> Coroners Act 1985, s 13(3). Under the Births, Deaths and Marriages Registration Act 1996 s 37(4), a fine may be imposed on a doctor who notifies the Registrar of a death where the death should be reported to a coroner under the Coroners Act 1985.

<sup>&</sup>lt;sup>106</sup> If one or more doctors are present, only one doctor is required to report to the Coroner: s 13(4).

<sup>&</sup>lt;sup>107</sup> Coroners Act 1985 s 13(3)(a). 'Reportable death' is defined in s 3(1). This will be discussed in detail in the later part of this chapter.

<sup>&</sup>lt;sup>108</sup> Coroners Act 1985 s 13(3)(b).

<sup>&</sup>lt;sup>109</sup> Coroners Act 1985 s 13(3)(c).

<sup>&</sup>lt;sup>110</sup> Coroners Act 1985 s 13(3)(d).

<sup>&</sup>lt;sup>111</sup> Coroners Act 1985 s 13A(2). 'Reviewable death' is defined in s 3(1) as the death of a second or subsequent child of a 'parent'. The Act requires doctors to notify the State Coroner if the death is a reviewable death. The categories of reportable and reviewable deaths are examined in detail in chapter four.

<sup>&</sup>lt;sup>112</sup> Coroners Act 1985 s 22.

<sup>&</sup>lt;sup>113</sup> Conversation, Rick Roberts, Principal Registrar, State Coroner's Office, and Committee Legal Research Officer, 23 February 2006.

<sup>&</sup>lt;sup>114</sup> Graeme Johnstone, State Coroner's Office, Submission no. 70, 62.

death and the reason for reporting the death to the coroner.<sup>115</sup> A question on the form asks the doctor to consider whether the death was expected as a consequence of the illness or injury and also whether s/he is aware of any person who has expressed concerns regarding the cause of death or the medical treatment.

## Police obligations

The Act also requires police officers to report notifiable deaths to the coroner. This is likely to occur when the police attend an incident where there has been a death. The Victoria Police Manual requires the police officer to arrange for the removal and identification of the body of the person who has died and also to collect evidence. Under the *Coroners Regulations 1996* (the Regulations), a police officer may inform the coroner of a reportable death by phone. Although not a requirement under the Act, the Coroner's Office also requires the reporting police officer to complete a police report of death for the coroner which is then faxed by the police officer to the Coroner's Office. The form requires the police officer to consider whether the death was expected and the apparent cause of death. For deaths occurring outside Melbourne, the police officer will also lodge this form with the local Coroner's Office or the regional coroner's clerk.

# Certification of deaths by GPs and hospital doctors

To certify the cause of death under the *Births, Deaths and Marriages Registration Act* 1996, a doctor must be a registered medical practitioner within the meaning of the *Medical Practice Act* 1994.<sup>121</sup> General Practitioners (GPs) and hospital doctors, from the most junior to a specialist, may certify the cause of death. The Act only requires the opinion of one doctor as to the cause of death.<sup>122</sup>

Deaths which occur in the community (non-hospital deaths) will in most circumstances be certified by a local GP. However, when a person dies in a hospital, the death will usually be certified by one of the doctors at the hospital. Often this responsibility will be assigned to junior doctors who may have only observed or assisted with the medical treatment given to the person who has died. Where there

<sup>&</sup>lt;sup>115</sup> Doctors are required to tick a box to indicate one of the following reasons for reporting the death: unexpected; unnatural or violent; directly/indirectly from accident or injury; during anaesthetic; as a result of anaesthetic; other.

<sup>&</sup>lt;sup>116</sup> Coroners Act 1985 s 14(2).

<sup>&</sup>lt;sup>117</sup> Victoria Police Manual, Instruction 118-1, Police attendance and investigation of deaths.

<sup>&</sup>lt;sup>118</sup> Coroners Regulations 1996 r 6.

<sup>&</sup>lt;sup>119</sup> Victoria Police: Police report of death for the Coroner, VP Form 83, revised October 2000.

<sup>&</sup>lt;sup>120</sup> Victoria Police Manual, *VPM Instruction 118–2 Notification of the Coroner*, updated 2 August 2004, section 4.2.1.

<sup>&</sup>lt;sup>121</sup> Births, Deaths and Marriages Registration Act 1996 s 3; definition of 'doctor'.

<sup>&</sup>lt;sup>122</sup> There are additional legal requirements in relation to cremations. This is discussed in the next section of the chapter.

has been a death in a nursing home, the local visiting GP who provides in-house consultations at the nursing home will usually complete the medical certificate of the cause of death.

There are no statistics available to indicate the percentage of certificates which are completed by GPs, junior doctors in hospitals and specialist hospital doctors. Despite collecting a considerable amount of mortality data, the Australian Bureau of Statistics (ABS) does not collect statistics on the percentage of deaths which are certified by GPs or even statistics on the types of places where deaths occur. This is in contrast to the detailed data which is routinely collected in other countries such as England and Wales. For example, in 2003, National Statistics (the ABS equivalent) reported that 18 percent of deaths in England and Wales in that year occurred at home, 2 percent occurred in public places or other persons' homes, 75 percent occurred in hospitals, nursing homes and other communal establishments, and 4 percent occurred in hospices.<sup>123</sup>

The Committee conducted its own research, analysing non-ABS data to establish statistics which may indicate the percentage of deaths which occur in hospitals as well as the percentage of non-hospital deaths. The Committee analysed data collected by a number of Commonwealth Government departments for the 2004–05 financial year. In that year, 9950 Victorians died in nursing homes (30.5 percent of deaths). <sup>124</sup> In the same period 15,022 people in Victoria died in public hospitals while 3407 people died in private hospitals (a combined total of 56.6 percent of deaths). <sup>125</sup> The remaining 13 percent of people who died in this period would therefore have died either at home or in a public place.

These statistics varied from the results of a study which examined the records at the Fawkner Crematorium for 1999 and 2000. The sample data from that study indicated that around 56 percent of Victorians die in hospitals and 18 percent die at home. Another 22 percent of deaths in the sample occurred in nursing homes and hospices, while the remaining 4 percent occurred in public places.

The comprehensiveness of the official mortality statistics in Australia is an issue of concern for the Committee. In the absence of detailed statistics which record the type of place where deaths occur, researchers are unable to establish whether GPs or hospital doctors are responsible for issuing the majority of medical cause of death

<sup>&</sup>lt;sup>123</sup> Office of National Statistics, *Mortality statistics: General; Review of the Registrar General on Deaths in England and Wales, 2003,* Series DH1 no. 36, Table 18, 64. Available at www.statistics.gov.uk.

<sup>&</sup>lt;sup>124</sup> Australian Institute of Health and Welfare, Aged Care Statistics Series, Number 20, *Residential Aged Care in Australia 2003–04: A Statistical Overview*, AIHW cat no. AGE 43. Available at www.aihw.gov.au.

<sup>&</sup>lt;sup>125</sup> Australian Institute of Health and Welfare, Australian hospital statistics 2003–04, Table 7.15. Available at www.aih.gov.au.

<sup>&</sup>lt;sup>126</sup> Philip Bachelor, 'Contemporary Death in Australia', Australasian Cemeteries and Cremetoria Association News, Autumn 2002, 8-10.

certificates. This limits the ability to establish a proper understanding of the underreporting issue because researchers are unable to determine the source of the problem — whether it is the case that reporting issues relate mostly to hospital deaths or deaths in the community which are certified by GPs.

The Committee therefore recommends that the ABS give consideration to including, along with the mortality data it currently collects, statistical information which indicates the type of place where deaths in Australia occur.

Recommendation 2. That the Australian Bureau of Statistics in conjunction with the Registrar of Births, Deaths and Marriages consider including, along with the mortality data it currently collects, statistical information which indicates the type of place where deaths occur.

## Additional certification requirements for cremation

In Victoria, approximately 50 percent of bodies are cremated. <sup>127</sup> Before a body may be cremated, further legal requirements must be met. Under the *Cemeteries and Crematoria Act 2003*, two doctors are required to certify the cause of death before the body may be cremated. A second doctor who did not attend the person before s/he died is required to review the medical cause of death certificate completed by the first doctor. <sup>128</sup> The form requires the second doctor to certify that s/he:

- has carefully read the statements in the application for cremation;
- has examined the body;
- has sighted the completed medical certificate of cause of death and agrees with the cause of death;
- has made a careful and independent inquiry into the circumstances surrounding the death;
- has formed the opinion that the death is not reportable or reviewable under the Coroners Act 1985 and that there are no circumstances concerning the death that might require further examination of the body before it is cremated;
- is not in partnership with, nor will s/he derive any professional remuneration from, any registered medical practitioner who professionally attended the person before the death; and

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<sup>&</sup>lt;sup>127</sup> Email, Robyn Smith, Chief Executive Officer, Cemeteries and Crematoria Association of Victoria, to Committee Legal Research Officer, 10 April 2005. The association advises that, in areas where there are crematoria, the proportion of cremations performed is up to 65 percent. DHS does not record official statistics regarding the number of cremations performed.

<sup>&</sup>lt;sup>128</sup> Cemeteries and Crematoria Regulations 2005 r 9.

 will not acquire property or money or any other benefit from the person who died.<sup>129</sup>

The Cemeteries and Crematoria Act 2003 imposes penalties on doctors for making false statements on the certificate authorising cremation. The current maximum penalty is a fine of 600 penalty units and five years imprisonment. This is in contrast to the lower penalties which may be imposed on doctors for failing to notify the coroner of a reportable death. As noted earlier in the chapter, it is an offence under the Births, Deaths and Marriages Registration Act 1996 for a doctor to notify the Registrar of a death if the death is reportable to the coroner. The current maximum penalty is a fine of 12 penalty units. Penalties are also imposed under the Coroners Act 1985. Under s 13(3) of the Act, a doctor who is present at or after a death must report the death if it is a reportable death or if the circumstances of the death meet any of the other criteria in the subsection. The maximum penalty is a fine of 10 penalty units.

The Committee is of the view that the current penalty for failing to report a notifiable death to the coroner is inadequate, as it is inconsistent with the penalty imposed under the *Cemeteries and Crematoria Act 2003* for doctors making false statements on the certificate authorising cremation.

Recommendation 3. That s 13(3)(d) of the *Coroners Act 1985* be amended so that the maximum penalty for doctors who fail to report a notifiable death to the coroner be increased to five years imprisonment and a fine of 600 penalty units.

# Problems with the current system of death certification

The Committee has identified a number of problems with the current death certification system which may limit its effectiveness. As previously noted, one of the purposes of the death certification system is to act as a safeguard against the disposal of bodies without professional scrutiny. Professional scrutiny of deaths is required so that an accurate cause of death can be established and that deaths requiring further investigation can be referred to the coroner. The Committee will now discuss the problems associated with professional scrutiny in the current system.

<sup>&</sup>lt;sup>129</sup> Cemeteries and Crematoria Regulations 2005, Schedule 4.

<sup>&</sup>lt;sup>130</sup> Cemeteries and Crematoria Act 2003 s 140.

<sup>&</sup>lt;sup>131</sup> Births, Deaths and Marriages Registration Act 1996 s 37(4).

<sup>&</sup>lt;sup>132</sup> Coroners Act 1985 s 13(3).

<sup>&</sup>lt;sup>133</sup> The Committee notes that there are wider implications of the failure to accurately record the cause of death on the MCCD. The Registrar of Births, Deaths and Marriages gives the information recorded on the death certificates to the ABS. The ABS then codes this information according to WHO ICD-10 classifications, and this information is used by researchers and governments to guide future funding in relation to health issues. This issue is, of course, beyond the scope of this inquiry.

## Lack of statistics and medical audit

There are a number of difficulties in assessing the effectiveness of the death certification system because there are no statistics available to establish whether all reportable deaths are reported to the coroner. This is due in large part to the absence in the current system of the practice of undertaking, or the requirement to undertake, a comprehensive medical audit or indeed any audit.

Under the *Births, Deaths and Marriages Registration Act 1996,* the Registrar is not required to inform the State Coroner of deaths which should have been referred to the coroner as reportable deaths. However, the Registrar, Ms Helen Trihas, advised the Committee that the Registry has a practice of carrying out clerical checks of medical certificates of the cause of death to establish if there are any deaths which doctors should have referred to the coroner. In 2003, the Coroner's Office and the Registrar adopted a more rigorous approach to this informal referral arrangement. Neither the Coroner's Office nor the Registrar gave reasons for the change in approach. However, Professor Stephen Cordner, Director of VIFM, told an international seminar for the Shipman Inquiry that the change in practice was 'not unrelated' to Dr Aneez Esmail's visit to Melbourne in that year. Dr Esmail was the medical advisor to the Shipman Inquiry.

In response to questions from the Committee, Ms Trihas informed the Committee that in 2003:

Mechanisms for referrals and practical assistance were put in place between the Registry, the Coroners Office and the Victorian Institute of Forensic Medicine (VIFM).

Example of the work that has taken place:

- A form was developed.
- Protocols and definitions of cause of death were agreed.
- Regular reviews to update the definitions of reportable causes of death, e.g. April 2006 wound infections was added to the list. 136

The Committee however understands that there has been a longstanding informal arrangement in which the government statistician has reported those deaths to the coroner which appear to call for coronial attention and which have not otherwise been reported. This practice was noted in the 1981 review of the coronial system in Victoria. <sup>137</sup> In that review, the inquiry recommended that the Government Statist be

<sup>&</sup>lt;sup>134</sup> Registry of Births, Deaths and Marriages, Submission no. S 77-1, 5.

<sup>&</sup>lt;sup>135</sup> Transcript of Proceedings, *The Shipman Inquiry Third Report — Death and Cremation Certification*, Professor Stephen Cordner, 16 January 2003, 63. Available at <a href="https://www.the-shipman-inquiry.org.uk">www.the-shipman-inquiry.org.uk</a>.

<sup>&</sup>lt;sup>136</sup> Registry of Births, Deaths and Marriages, Submission no. S 77-1, 6.

<sup>&</sup>lt;sup>137</sup> JG Norris, *The Coroners Act 1958 — A General Review* (1981).

placed under a duty to report deaths to the coroner.<sup>138</sup> This recommendation was however never enacted in the legislation.

Ms Trihas advised that there is at present no system for doctors to register deaths online. <sup>139</sup> Instead, clerks manually check doctors' handwritten paper certificates to make sure that the handwriting is legible and that doctors have completed a response to all questions on the form. <sup>140</sup> Four clerks, supervised by a Victorian Public Service level 4 manager, are employed to manually check the forms.

The clerks also check to ensure that the doctor whose name appears on the form is currently registered by manually cross-checking the details with registration data details held by the Medical Practitioners Board. The current clerical check does not include a verification of doctors' signatures. Ms Trihas advised the Committee that the certificates are not assessed for potential forgery, because the Registry did not hold a central repository of specimen signatures.<sup>141</sup> She indicated that the Registry would however like to develop an online system which incorporated digital signatures.

Following this, the clerks consider what the doctor has listed as the cause of death to see if it appears to be a death which should have been reported to the coroner. To establish this, a clerk will check this section of the form to see if a doctor has used medical terms which may indicate that the death should have been reported to the coroner. For example, if the medical term 'mesothelioma' is listed on the form it may indicate to the clerk that this is an asbestos-related disease and that therefore it should be reported to the coroner because since 2003 the Coroner's Office has considered that such deaths should be reported. The clerk will then immediately send the certificate to the Coroner's Office or phone the doctor to elicit further information about the death if requested to do this by a coroner.

While the clerks have no medical training, the Registrar advised the Committee that the clerks attended a training course in medical terminology in 2004. Ms Trihas also advised the Committee that, while the clerks are not required to have any formal qualifications to undertake the role, each clerk had over 15 years' clerical experience at the Registry. The clerks do not interpret and review medical files, as they do not have access to the medical records of the person who has died — their task is limited to reviewing the medical terminology which doctors have used to describe the cause of death. For example, clerks check the stated direct and antecedent causes of death to ensure that they are consistent.

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<sup>&</sup>lt;sup>138</sup> Ibid 26.

<sup>&</sup>lt;sup>139</sup> John Thwaites, Minister for Victorian Communities, *Submission no. 77S*, answer to question 10. In this submission the Registrar advises that online registration 'is on the 2006 work plan'.

<sup>&</sup>lt;sup>140</sup> Ibid answer to question 1.

<sup>&</sup>lt;sup>141</sup> Registry of Births, Deaths and Marriages, Submission no. S 77-1, 6.

<sup>142</sup> Ibid.

# Measures proposed by the Registrar of Births, Deaths and Marriages

There is some indication that the Registry considers that there is a need to increase the skills of the staff who check the certificates. Ms Trihas provided the Committee with a list of estimated resource requirements for the Registry. One such requirement is to increase the skill level of staff involved in assessing the certificates. In addition to ongoing training of existing staff, the Registrar submitted that the Registry would require one or two medically trained staff along with a doctor to assess the 'causes of death' and to contact the certifying doctor where necessary. Other measures which Ms Trihas advised the Committee that the Registry was considering included the development of a national online death registration system. Have the view that the development and implementation of an online system should be completed by the end of 2007. The Registry has plans to educate doctors about how to use the online system and their reporting obligations.

### Problems with clerical review of death certificates

There are a number of problems with the current practice of only carrying out a clerical review of death certificates. Associate Professor David Ranson, Deputy Director at VIFM, considered that clerical staff do not have the necessary skills to scrutinise a medical opinion as to the cause of death provided by a treating medical practitioner. He told the Committee that there have been a number of cases in which the clerical staff at the Registry have incorrectly concluded that the MCCD indicated that the death was reportable and then referred the case to the Coroner's Office. While he was unable to provide statistics to establish the exact number of misreferrals, he supplied the Committee with examples to illustrate the nature of the problem. The Committee considers that the issue of misreferrals needs to be taken into consideration when determining the extent of the under-reporting problem. This is discussed later in the chapter.

# Under-reporting of deaths to the coroner

While there is an absence of statistics which could establish the extent of underreporting, small-scale studies undertaken before 2002 suggest that there is some cause for concern.<sup>147</sup> A 1995 Victorian study examined the death certification

<sup>&</sup>lt;sup>143</sup> Registry of Births, Deaths and Marriages, *Submission no. S 77-2*, table headed 'Resourcing needs'; letter, Helen Trihas, Registrar of Births Deaths and Marriages, to Committee Executive Officer, 3 May 2006,1.

<sup>&</sup>lt;sup>144</sup> Registry of Births, Deaths and Marriages, Submission no. S 77-2, 4.

<sup>&</sup>lt;sup>145</sup> Conversation, David Ranson and Committee Legal Research Officer, 21 March 2006; letter, David Ranson to Committee Legal Research Officer, 10 May 2006.

<sup>&</sup>lt;sup>146</sup> Personal communication, David Ranson to Committee Legal Research Officer, 10 May 2006.

<sup>&</sup>lt;sup>147</sup> D Brumley, *Death Certification by Doctors in Non-Metropolitan Victoria*, (M.Sc (Primary Health Care) Thesis, Flinders University of South Australia, 1995); T Weeramanthri and B Beresford, 'Death Certification in Western Australia — Classification of Major Errors in Certificate Completion', *Australian Journal of Public Health*, vol 16, no.

process.<sup>148</sup> The study involved doctors practising in non-metropolitan Victoria, including resident medical officers (RMOs)<sup>149</sup>, hospital doctors, specialist physicians, surgeons and GPs. It found that, overall, 27 percent of certificates inaccurately represented the cause of death, with a higher inaccuracy rate (51 percent) for RMOs.<sup>150</sup> It also found that 20 percent of the doctors involved in the survey would be prepared to alter certificates to avoid the involvement of the coroner.<sup>151</sup> This figure is consistent with a UK study which found that 17.2 percent of GPs surveyed would alter certificates to avoid referrals to the coroner.<sup>152</sup>

In 1998 Associate Professor Ranson considered the issue of under-reporting in hospitals.<sup>153</sup> He referred to a Quality in Australian Health Care Study commissioned by the Commonwealth in 1994. While acknowledging that extrapolating from the study was extremely difficult, he used estimates based on the study to conclude that up to 3000 deaths per year in Victoria may result from medical treatment errors in hospitals. However, he noted that only about 300 hospital deaths a year were investigated by the coroner. This would indicate that up to 2700 hospital deaths in a given year may, incorrectly, not be referred to the coroner.

There is some evidence which suggests that the under-reporting rate may have increased since 2002. It is however important to note that this increase may not be necessarily attributable to an increased rate of doctors intentionally failing to report notifiable deaths to the coroner. The following factors should also be taken into account:

• the Registry of Births, Deaths and Marriages increased its level of clerical checking and scrutiny in 2003, which may indicate that there has only been an increase in the detection of incidences of under-reporting;

<sup>4, 431–434.</sup> B Swift and K West, 'Death Certification: An Audit of Practice Entering the 21<sup>st</sup> Century' *Journal of Clinical Pathology*, vol 55, 2002, 275–279.

<sup>&</sup>lt;sup>148</sup> D Brumley, *Death Certification by Doctors in Non-Metropolitan Victoria*, (M.Sc (Primary Health Care) Thesis, Flinders University of South Australia, 1995).

<sup>&</sup>lt;sup>149</sup> RMOs are junior doctors at a hospital.

<sup>&</sup>lt;sup>150</sup> D Brumley, *Death Certification by Doctors in Non-Metropolitan Victoria*, (M.Sc (Primary Health Care) Thesis, Flinders University of South Australia, 1995) 10.

<sup>&</sup>lt;sup>151</sup> Ibid 126.

<sup>&</sup>lt;sup>152</sup> G Maudsley and EM Williams, 'Death Certification by House Officers and General Practitioners — Practice and Performance, *Journal of Public Health Medicine*, vol 15(2), 1993, 192–201. Cited in D Brumley, *Death Certification by Doctors in Non-Metropolitan Victoria*, (M.Sc (Primary Health Care) Thesis, Flinders University of South Australia, 1995) 126.

<sup>&</sup>lt;sup>153</sup> David Ranson, 'How Effective? How Efficient? — The Coroner's Role in Medical Treatment Related Deaths' (1998) 23 (6) *Alternative Law Journal* 285.

- there have also been a number of incidences of misreferrals in which clerks have incorrectly referred unreportable deaths to the coroner. As discussed above, the precise number of such cases is unknown; and
- between 2003 and 2006, the State Coroner required doctors to also report asbestos-related deaths and those associated with falls and wound infections. It is not known whether all doctors are aware of these new requirements. If doctors are failing to report these kinds of deaths, it may be that they are simply unaware of the new requirements.

The Committee considers this issue in the next section of the chapter.

Jurisdictions such as England and Wales have had major problems with their death certification system and are involved in a detailed process of reviewing the system.<sup>154</sup> Also, since the Committee published its discussion paper in March 2005, Queensland has encountered problems with its reporting system. The Queensland Public Hospitals Commission of Inquiry recently found that Dr Patel, former Director of Surgery at Bundaberg Base Hospital, had failed to refer 13 reportable deaths to the Queensland State Coroner.<sup>155</sup>

# **Evidence of under-reporting received by the Committee**

In its discussion paper, the Committee asked stakeholders if they had further evidence to establish whether there was under-reporting of deaths to the coroner. Both the State Coroner's Office and VIFM accepted that there were issues associated with the current system and that there was evidence of under-reporting. While the issue of quantifying the full extent of the problem remains, both VIFM and the State Coroner were able to provide some further evidence to the Committee on this issue.

The State Coroner's Office assisted the inquiry by providing the Committee with recent data compiled from the results of clerical checks carried out at the Registry of Births, Deaths and Marriages. According to these statistics, doctors' failure to report reportable deaths had increased from 50 per 1000 reportable deaths in 2002 to 99 per 1000 reportable deaths in 2004. The Committee notes that these statistics are based on the results of clerical checking and are not the result of a medical audit. As discussed earlier in the chapter, there is some evidence to show that there are also a number of cases where clerks have incorrectly identified an unreportable death as a reportable one and then referred the MCCD to the Coroner's Office. Also, the Committee notes that, apart from increasing the overall level of scrutiny of death certificates, from 2003 onwards the State Coroner also required doctors to report additional kinds of deaths, such as those caused by asbestos-related diseases.

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<sup>&</sup>lt;sup>154</sup> This is described in further detail in a later section of this chapter.

<sup>&</sup>lt;sup>155</sup> Queensland, *Public Hospitals Commission of Inquiry Report* (2005) 190. Available at www.qphci.qld.gov.au.

<sup>&</sup>lt;sup>156</sup> Graeme Johnstone, State Coroner's Office, Submission no. 70, 122-123.

According to the State Coroner, the explanation for the increase in the failure to report has not been determined. The State Coroner's submission however suggests that the increase may be partly explained by a number of determinations made by the State Coroner in 2003–04. In 2003 the State Coroner wrote to medical colleges and hospitals requesting that doctors report to his Office deaths associated with falling, even where the medical cause of the death was from a natural cause and not from falling over. Similarly, in 2004 the State Coroner requested that doctors report deaths associated with asbestos. According to the Registrar of Births, Deaths and Marriages, a new category — deaths associated with wound infections — was added to the list in 2006.

While the full extent of the under-reporting issue cannot be understood and analysed without a medical audit of the cases, the State Coroner was able to provide the Committee with indicative snapshot information. The information provided in the State Coroner's submission to the Committee was based on a detailed analysis of cases which were identified by the clerks at the Registry during a three-month period from April to June 2005. During this period, the clerks identified 69 cases which, based on a clerical review of the medical certificates, should have been reported to the coroner. According to the State Coroner's analysis, hospitals and nursing homes were the most usual group which did not report reportable deaths, and these groups were evenly distributed between Melbourne and regional Victoria. Deaths associated with falls' were most frequently unreported during this period. This category includes deaths occurring directly or indirectly from injuries sustained as a result of physically falling.

Professor Stephen Cordner, Director of VIFM was able to provide further evidence of incidences of under-reporting. He advised the Committee that further evidence of the under-reporting of deaths to the coroner has been found in recent research by the Clinical Liaison Service (CLS)<sup>166</sup> into the reporting of hospital deaths.<sup>167</sup> The CLS survey of two hospitals revealed an unreported reportable death rate of between 10

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<sup>&</sup>lt;sup>157</sup> Ibid 124.

<sup>&</sup>lt;sup>158</sup> Ibid 122-124.

<sup>&</sup>lt;sup>159</sup> Ibid 123.

<sup>&</sup>lt;sup>160</sup> Ibid. The Protocol is attached to the State Coroner's submission at Appendix C.

<sup>&</sup>lt;sup>161</sup> Registry of Births, Deaths and Marriages, *Submission no. S* 77-2.

<sup>&</sup>lt;sup>162</sup> Graeme Johnstone, State Coroner's Office, Submission no. 70, 124.

<sup>163</sup> Ibid.

<sup>164</sup> Ibid.

<sup>&</sup>lt;sup>165</sup> Ibid. The submission does not provide the actual number of deaths associated with falls which were not reported. nor does it provide information as to the other kinds of deaths which were not reported to the Coroner.

<sup>&</sup>lt;sup>166</sup> A joint service of VIFM and the State Coroner's Office.

<sup>&</sup>lt;sup>167</sup> Professor Stephen Cordner, Victorian Institute of Forensic Medicine, Submission no. 40, 14.

percent and 40 percent.<sup>168</sup> VIFM advised the Committee that extrapolation from these survey results gives a conservative estimate of under-reporting of approximately 1500 hospital deaths each year.<sup>169</sup>

The study, undertaken by an experienced researcher, reviewed 230 deaths that had occurred at two public hospitals in Victoria.<sup>170</sup> The researcher reviewed all the hospital medical files and consulted with coroners, clinicians and a forensic pathologist to determine which of these deaths had been reported to the coroner. The conclusion was that, out of the 230 deaths, 54 were classified as reportable deaths but that only 22 had been reported to the coroner. The first public hospital reported nine out of 35 reportable deaths, while the second hospital had a higher reporting rate, with 13 out of 19 reportable deaths reported.

Associate Professor David Ranson, Deputy Director at VIFM in his personal submission also considered the issue of whether GPs or hospital doctors were not reporting medical treatment deaths to the coroner. He submitted:

There is clearly a very significant "under-reporting" of deaths associated with recent medical treatment. [...] [I]t would appear from recent studies undertaken by the Clinical Liaison Service of the Victorian Institute of Forensic Medicine that a crude estimate of underreporting would be of the order of 1500 hospital treatment related deaths a year.<sup>171</sup>

While he referred to the issue of under-reporting of hospital deaths in an article he wrote in 1998, 172 Associate Professor Ranson based this conclusion on a Quality in Australian Health Care Study commissioned by the Commonwealth Government in 1994. As discussed earlier in the chapter, he concluded that up to 3000 deaths per year in Victoria may result from medical treatment errors in hospitals. However, in the article he noted that only approximately 300 hospital deaths a year were investigated by the coroner.

He advised the Committee that there was no clear estimate of the number of deaths involving medical treatment by GPs as research in this area has not been conducted.<sup>173</sup> However he submitted that GPs were probably the most common death certificators because they were responsible for writing the death certificates in respect

<sup>169</sup> Ibid.

<sup>&</sup>lt;sup>168</sup> Ibid.

<sup>&</sup>lt;sup>170</sup> Ian Freckelton and David Ranson, *Death Investigation and the Coroner's Inquest* (2006) 161.

<sup>&</sup>lt;sup>171</sup> David Ranson, Submission no. 19, 14.

<sup>&</sup>lt;sup>172</sup> David Ranson, 'How Effective? How Efficient? — The Coroner's Role in Medical Treatment Related Deaths' (1998) 23 (6) *Alternative Law Journal* 285.

<sup>&</sup>lt;sup>173</sup> David Ranson, Submission no. 19, 14.

of their former patients who did not die in hospital and are not reported to the coroner.<sup>174</sup>

A number of witnesses with experience in both the health and coronial systems were also in agreement that not all reportable deaths were being reported to the coroner. In her submission, Health Services Commissioner Beth Wilson acknowledged that deaths in hospitals were under-reported<sup>175</sup> while barrister Dr Ian Freckelton concurred, commenting that:

It seems clear that the under reporting of deaths is a major phenomenon that spans from the inadequate completion of death certificates right through to whether deaths are reported under the categories to the coroner.<sup>176</sup>

Representatives from two medical error lobby groups also addressed the issue of the under-reporting of medical treatment deaths. Mr Jason Rosen, President of the Association for the Prevention of Medical Errors (APME), contended that:

it is worth noting that the average road toll in Victoria over the past five years has been 307 deaths annually.[...]. The discrepancy between the number of medical error deaths occurring and the number of deaths being reported can be explained by the following statistics. Studies have estimated that under-reporting of adverse events in hospitals ranges from 50%-96%, that 27% of death certificates in a Victorian survey misrepresented the cause of death, and that 20% of Victorian doctors surveyed would alter death certificates to avoid coronial review. It is evident that the system for reporting medical treatment deaths is in crisis and only a fraction of unexpected deaths resulting from medical treatment is being reported to the coroner.<sup>177</sup>

Ms Lorraine Long, founder of the Medical Error Action Group, also made a submission and described the problem of under-reporting of medical adverse events to coroners as serious.<sup>178</sup>

Two medical stakeholders also acknowledged that under-reporting was an issue of concern. General Practice Division Victoria (GPDV), a peak body representing over 80 percent of GPs in Victoria, described the problem as significant, which was borne out by anecdotal evidence among GPs.<sup>179</sup> Austin Health conceded that under-

<sup>&</sup>lt;sup>174</sup> Ibid. This is consistent with the Committee's research, which indicated that the ABS does not collect this kind of information in its mortality data.

<sup>&</sup>lt;sup>175</sup> Beth Wilson, Health Services Commissioner, Victoria, *Minutes of Evidence*, 20 September 2005, 176.

<sup>&</sup>lt;sup>176</sup> Ian Freckelton, *Minutes of Evidence*, 20 September 2005, 202.

<sup>&</sup>lt;sup>177</sup> Association for the Prevention of Medical Errors, *Submission no. 78*, 6. Footnotes omitted. A number of family members also believed that there were incidences of under-reporting. See for example Caroline Storm, *Submission no. 28*, 1; Graeme Bond, *Submission no. 48*.

<sup>&</sup>lt;sup>178</sup> Medical Error Action Group, Submission no. 7, 26.

<sup>&</sup>lt;sup>179</sup> General Practice Division Victoria, *Submission no. 40*, 2.

reporting remained a legitimate concern but also submitted that amongst many groups there was a high level of vigilance in relation to reporting.<sup>180</sup>

While the Medical Practitioners Board of Victoria (MPBV) in its submission advised the Committee that it had not assessed whether there was an under-reporting problem, the Board later confirmed that, to its knowledge, it had never received a complaint about a doctor failing to refer a reportable death to the coroner. The Board advised that, if it were to receive a complaint, it would conduct a preliminary investigation into the matter and that, depending on the outcome of that investigation, it might choose to conduct an informal or formal hearing into the practitioner's professional conduct. 182

Two stakeholders however did not accept that there was a problem in relation to under-reporting of deaths. The Royal Women's Hospital did not believe that there was under-reporting of deaths involving medical treatment but did not elaborate on the issue.<sup>183</sup> Similarly, Mr Jack Forrest QC for the Victorian Bar told the Committee that the Bar did not see any real indication of under-reporting but advised the Committee that the Bar was not in the best position to comment because its members were only involved in the later stages of the coronial process.<sup>184</sup>

Although the Committee invited all private and public hospitals in Victoria to comment, the Committee did not receive any further evidence on this issue. Also, the Committee notes that a number of medical stakeholders such as the Australian Medical Association (AMA) did not address the issue of under-reporting in their submissions.

## Discussion and conclusion

Following the discussion paper in April 2005, the Committee conducted further research on the issue of under-reporting. A further search of the medical literature did not reveal any recently published qualitative studies on the under-reporting of deaths to the coroner apart from the study undertaken by VIFM which the Committee referred to earlier in the chapter.<sup>185</sup> The lack of research in this area has also been confirmed by Dr Freckelton and Associate Professor Ranson in their recently published book on

Austin Health, Submission no. 45, 2

<sup>&</sup>lt;sup>180</sup> Austin Health, Submission no. 45, 2.

<sup>&</sup>lt;sup>181</sup> Medical Practitioners Board of Victoria, *Submission no. 56*, 1; email, Gabrielle Wolf, Solicitor, Medical Practitioners Board of Victoria, to Committee Legal Research Officer, 10 April 2006.

<sup>&</sup>lt;sup>182</sup> Email, Gabrielle Wolf, Solicitor, Medical Practitioners Board of Victoria, to Committee Legal Research Officer, 10 April 2006.

<sup>&</sup>lt;sup>183</sup> The Royal Women's Hospital, Melbourne, Submission no. 18, 1.

<sup>&</sup>lt;sup>184</sup> Jack Forrest QC, Victorian Bar, Minutes of Evidence, 5 December 2005, 282.

<sup>&</sup>lt;sup>185</sup> There has also been very limited research conducted in Australia on the issue of in-house 'incident reporting' by doctors and nurses in hospitals: Marilyn Kingston, Sue M Evans, Brian J Smith and Jesia G Bery, 'Attitudes of Doctors and Nurses Towards Incident Reporting: A Qualitative Analysis', *Medical Journal of Australia*, vol 181, No. 1, 5 July 2004, 39.

death investigation and coronial law.<sup>186</sup> The authors suggested that sophisticated statistical analysis of death registration records may be able to detect patterns of clinical behaviour and death certification practice among doctors that could indicate questionable medical practice.<sup>187</sup> According to the authors this would however require a considerable research effort involving pattern evaluation and analysis of death data across large population groups.<sup>188</sup>

The Committee considers that, while there is considerable evidence which establishes that there are incidents of under-reporting, the full extent of the problem cannot be understood without further research which could quantify the issues. Associate Professor Ranson's estimated calculation that up to 2700 medical error deaths may occur in hospitals per year which are not reported to the coroner, clearly demonstrates the need for further research which will indicate the source of the under-reporting problem. The issue of under-reporting is of considerable concern to the Committee because evidence of under-reporting indicates that the reporting system clearly is not working and therefore needs to be strengthened. In this regard the Committee makes a number of recommendations to reform the system later in this chapter as well as in chapter four.

The Committee considers that it is important that further research be conducted to conclusively determine the reasons why some doctors fail to report deaths to the coroner. For instance, part of the problem may result from doctors failing to understand which deaths should be reported because there is a lack of clarity in the definitions of reportable deaths. This issue is examined in more detail in chapter four. The research would also need to establish the types of deaths which doctors are not reporting and the source of the problem — whether under-reporting predominately occurs in relation to hospital deaths or whether the problem also extends to deaths certified by GPs.

Recommendation 4. That the State Government resource a research project to further investigate incidences of under-reporting of deaths to the coroner and that an analytical report on the data be prepared and published.

# Risks with the current system

The present system is largely dependant on a doctor's integrity and understanding of the reporting requirements to ensure that reportable deaths come to the attention of the coroner. The reliance on a single doctor to certify the cause of death exposes the death certification system to a number of risks which may have an impact on its effectiveness.

<sup>&</sup>lt;sup>186</sup> Ian Freckelton and David Ranson, *Death Investigation and the Coroner's Inquest* (2006).

<sup>&</sup>lt;sup>187</sup> Ibid 762.

<sup>188</sup> Ibid.

The Committee wishes to emphasise that by examining this issue it is not questioning the integrity of the general medical profession in Victoria. While the Committee has heard evidence during the course of its inquiry that not all reportable deaths are reported to the coroner, the Committee is not aware of any incidences of deaths which may have been intentionally concealed from the coroner. Experiences in other jurisdictions such as England and Queensland however suggest that it is indeed possible for an unscrupulous doctor to conceal a reportable death from investigation by the coroner. This clearly has the potential to undermine the effectiveness of the certification system, which is designed to provide a safeguard against the disposal of bodies without medical scrutiny to establish the true cause of death. The Committee now reviews the evidence from other jurisdictions on this issue.

### Deaths concealed from the coroner

The experience in other jurisdictions indicates that the concealment of the true cause of death may occur in the following ways:

- secret homicide deaths where a doctor intentionally harms or kills a patient and, after the patient dies, certifies that the death was due to natural causes so that it does not have to be reported and examined by the coroner (this was the case with Dr Shipman in England).
- medical error deaths in which a doctor may not necessarily have intended to harm or kill the patient, but professional incompetence or error may have caused the patient's death, and the doctor does not report the death to the coroner (this was possibly the case with Dr Patel in Queensland).
- medical error deaths in which a doctor, nurse or hospital administrator fails to report to the coroner instances where a doctor has intentionally or unintentionally harmed patients (this was possibly the case with some doctors, nurses and hospital administrators who may have been aware of Dr Patel's alleged medical errors but did not report them to the coroner).

## Secret homicide deaths

In the report of the committee responsible for the 1971 review of the UK death certification system (known as the Brodrick Report), 189 that committee concluded that:

the risk of secret homicide occurring and remaining undiscovered as a direct consequence of the state of the current law on the certification of death has been much exaggerated, and that it has not been a significant danger at any time in the past 50 years.<sup>190</sup>

In reaching this conclusion, the Brodrick Committee reasoned that the risk of homicide by doctors would not be higher than for any other profession. However, it

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<sup>&</sup>lt;sup>189</sup> United Kingdom, Report of the Committee on Death Certification and Coroners, Cm 4810 (1971) 30.

<sup>&</sup>lt;sup>190</sup> Ibid.

was later pointed out by the Shipman Inquiry that the weakness of this analysis was that it did not consider whether there might be concealed homicides that had never come to the attention of the coroner in the first place.<sup>192</sup>

At the same time that the Brodrick Committee delivered its report in 1971, Dr Shipman was a newly qualified doctor who was just about to commence his career as a GP. During that career he was able to conceal the true cause of death of approximately 250 of his patients, whom he killed by injecting with fatal doses of diamorphine. As part of his sole practice in northern England, he routinely made house calls to some of his older patients. As the treating doctor, Dr Shipman was responsible for completing the medical certificates for the cause of death for those patients. To ensure that the deaths were never reported to the local coroner, he stated on the certificates that the deaths were the result of natural causes such as cancer, heart conditions, pneumonia or even 'old age'. He added fabricated clinical histories to a number of his patients' medical records to corroborate his claim that they had died from natural causes. Also, to alleviate relatives' concerns, Shipman usually told them that an autopsy was not necessary.

Shipman continued to kill a number of his elderly patients in this manner for over 20 years. It was not until 1998 that concerns about the high number of deaths at Shipman's practice were finally reported to the local coroner by a funeral director and a neighbouring medical practice. However, the subsequent police investigation was flawed as it did not consult any of the deceased patients' relatives or check for forged medical records and Shipman was initially cleared. Another three patients died before he was arrested in 1999. In 2000 Shipman was found guilty of murdering 15 of his patients and was sentenced to life imprisonment. A clinical audit later established that during his medical career Shipman issued 521 medical certificates of cause of death, while the Shipman Inquiry recently concluded that he had killed about 250 patients, making him Britain's worst known serial killer.

While some commentators described Dr Shipman's criminal activities as 'unique', the Committee notes that there are other reported cases of doctors who have murdered their patients and gone undetected for long periods of time. For example, in 2000 Dr Michael Swango was convicted of murdering three patients in a US hospital. <sup>195</sup> According to one report, Swango may have committed similar crimes over a 20-year period in the US, Zimbabwe and Zambia without being detected. <sup>196</sup> Another case

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<sup>&</sup>lt;sup>191</sup> Cited in: United Kingdom, *Death Certification and the Investigation of Death by Coroners* (The third report), Cm 5854 (2003) 77.

<sup>&</sup>lt;sup>192</sup> United Kingdom, *Death Certification and the Investigation of Death by Coroners* (The third report) 77.

<sup>&</sup>lt;sup>193</sup> 'Audit Further Exposes UK's Worst Serial Killer', *The Lancet*, vol 327, 31 January 2001.

<sup>&</sup>lt;sup>194</sup> United Kingdom, Shipman: The Final Report, 2005, para 28.

<sup>&</sup>lt;sup>195</sup> D Woods, 'US Doctor May Have Killed 60', *British Medical Journal*, vol 321, 16 September 200, 657.

<sup>&</sup>lt;sup>196</sup> Ibid.

involved Norwegian doctor Arnfinn Nesset, who may have killed as many as 138 of his patients by injecting them with curare, a muscle relaxant.<sup>197</sup>

## Concealed medical error deaths

The recent Commission of Inquiry into Queensland Public Hospitals which examined the medical competence of Dr Jayant Patel clearly demonstrates how the current reporting system depends on the integrity of doctors to report deaths occurring from medical error. The case shows that it is possible for a doctor to conceal medical errors and to evade the scrutiny of the coroner when a patient dies from medical error.

The Commission made a finding that Dr Patel performed unnecessary surgery as well as surgical procedures that were beyond his skill, competence and expertise, and that he was able to avoid reporting these deaths to the Queensland State Coroner. <sup>198</sup> In the Commission's report published in November 2005, Commissioner Davies stated that:

Dr Patel has shown that it is easy for a doctor to avoid reporting a death to the coroner and thus also to avoid any official inquiry into the death of a patient. There was evidence before the Commission of Dr Patel asking junior doctors to certify deaths. (...) It would take little for a dishonest doctor to try and persuade a junior doctor to certify a false cause of death so as to avoid it being reported to a coroner. It would be very hard for a junior doctor to withstand that sort of pressure. <sup>199</sup>

The Commission found that Dr Patel had failed to refer 13 reportable deaths to the Queensland State Coroner and it also recommended that his conduct be referred for criminal investigation on charges which included manslaughter.<sup>200</sup> In February 2006, the Queensland Police Commissioner announced that a brief of evidence had been forwarded to the Director of Public Prosecutions (DPP) recommending that Dr Patel be indicted on four charges of manslaughter, eight charges of grievous bodily harm and 16 charges of fraud.<sup>201</sup> At the time of writing, a decision by the DPP on whether to proceed with charges had yet to be made.<sup>202</sup>

<sup>&</sup>lt;sup>197</sup> H Kinnell, 'Serial Homicide by Doctors: Shipman in Perspective', *British Medical Journal*, vol 321, December 2000, 1596; further cases are cited in Ian Freckelton and David Ranson, *Death Investigation and the Coroner's Inquest* (2006) 203.

<sup>&</sup>lt;sup>198</sup> Queensland, *Public Hospitals Commission of Inquiry Report* (2005) 190. Available at www.qphci.qld.gov.au.

<sup>&</sup>lt;sup>199</sup> <u>Ibid</u>, 524.

<sup>&</sup>lt;sup>200</sup> Ibid 190.

<sup>&</sup>lt;sup>201</sup> Queensland Police Service, *Bundaberg Hospital Investigation: Media Advisory*, 6 February 2006. Available at www.police.qld.au.

<sup>&</sup>lt;sup>202</sup> Hon Linda Lavarch Attorney-General (QLD), Media Statement, 24 August 2006.

The circumstances of these deaths offers some insight into the weaknesses of the system of reporting which Dr Patel was able to exploit to avoid scrutiny by the coroner. One case involved an elderly man with cancer of the oesophagus who was a patient at the regional hospital in Bundaberg where Dr Patel had been appointed as Director of Surgery.<sup>203</sup> An initial medical assessment indicated that this patient's life expectancy was somewhere between six and 12 months. The treating doctor considered that the patient needed to be transferred from the regional hospital to a larger hospital in Brisbane. However, before this took place Dr Patel decided to perform an oesophagectomy<sup>204</sup> on the patient at the regional hospital. Unfortunately, the patient died within 20 hours of the surgery following unexpected complications. Clearly, the case was a death which the responsible doctor should have reported to the coroner as the death was an 'unexpected outcome of the surgery', which under the Queensland Act is a reportable death.<sup>205</sup>

However, one of the junior house doctors, who was assisting in his first operation of this kind and whose role was limited to holding the retractors during the surgery, was asked to complete the cause of death certificate. According to this junior doctor, he made the decision as to what he should write as the cause of death after a discussion with Dr Patel.<sup>206</sup> He said that Dr Patel told him that:

we knew what the cause of death was, so therefore we didn't need a coroner's inquest'. [...] He told me what the cause of death was, then I filled in the gaps.<sup>207</sup>

On Dr Patel's instructions, the junior doctor then listed the cause of death as refractory shock as a result of post operative aortic bleeding.<sup>208</sup>

One of the questions on the Queensland certificate requires doctors to consider whether the death was reportable under the *Coroners Act 2003*. In this instance, the junior doctor indicated on the form that this death was not a reportable death. However, in his evidence before the Commission he agreed in an answer to a question from counsel assisting the Commission that the listed cause of death was mere speculation and that the patient was not expected to die as a result of this surgery.<sup>209</sup>

<sup>&</sup>lt;sup>203</sup> Queensland, *Public Hospitals Commission of Inquiry Report* (2005) 193.

<sup>&</sup>lt;sup>204</sup> Removal of all or part of the oesophagus (food pipe).

<sup>&</sup>lt;sup>205</sup> Coroners Act 2003 (QLD) s 8 (3)(d).

<sup>&</sup>lt;sup>206</sup> *Transcript of Proceedings*, Queensland, Public Hospitals Commission of Inquiry (2005) 2066. Available at www.qphci.qld.gov.au.

<sup>&</sup>lt;sup>207</sup> Ibid.

<sup>&</sup>lt;sup>208</sup> Exhibit 126, Queensland, Public Hospitals Commission of Inquiry (2005) Attachment AJK2 in Statement of Aleida Judith Kemps, 6 May 2005.

<sup>&</sup>lt;sup>209</sup> *Transcript of Proceedings*, Queensland, Public Hospitals Commission of Inquiry, 2005–06. Available at www.qphci.qld.gov.au

In the aftermath of the medical scandal, social commentators have also offered possible explanations as to why some of Dr Patel's alleged medical errors were never initially reported. For instance, Roger Sandall suggests that one reason was the pressures felt by junior doctors, fearful of creating difficulties for themselves by trying to oust a superior in the medical system:<sup>210</sup>

At Bundaberg Hospital, over a period of two years, there must have been at least a dozen doctors aware of what was taking place. But some were only visitors, some were immigrant doctors who did not want to jeopardise their status, and some were young men with families, fearful of the economic consequences of trying to get rid of a powerful and aggressive superior. All of them hoped to solve a problem they mainly saw as endangering their personal careers by moving on.<sup>211</sup>

Mr Sandall also cited misguided professional loyalty as a possible factor. The pressures faced by junior doctors were also referred to by Dame Janet Smith in the Shipman Inquiry. She noted that the UK system:

depends on the courage and independence of doctors, for the system to certify a death which may have been contributed to by some misconduct, lack of care or medical error on the part of a professional colleague. It may not be easy for a junior member of the clinical team responsible for the care of the deceased to withstand the expectation that s/he will certify the cause of death, rather than report the cases to the coroner for investigation.<sup>212</sup>

# Doctors' understanding of what is a reportable death

Another risk associated with the current death certification system is that it is dependant on doctors having a good understanding of the kinds of deaths which should be referred to the coroner. On this issue the Committee received a considerable amount of evidence which suggests that doctors in Victoria may not have a good level of understanding of the legal categories of reportable deaths in the Act.

The Committee reviews the categories of deaths which should be reported and investigated under the Act in further detail in chapter four.

# Clarity in legal definition of 'reportable death'

In the last review in Victoria in 1981, the Hon Sir John Norris considered that the longstanding terms, such as 'violent and unnatural deaths', used in coronial law to categorise the kinds of deaths which should be reported to the coroner should be

<sup>&</sup>lt;sup>210</sup> Roger Sandall, 'Doctor Death in Bundaberg', *Quadrant Magazine*, vol XLIX, No. 12, December 2005. Available at http://www.quadrant.org.au.

<sup>&</sup>lt;sup>211</sup> Ibid.

<sup>&</sup>lt;sup>212</sup> United Kingdom, *Death Certification and the Investigation of Death by Coroners* (The third report), Cm 5854 (2003) 118.

retained.<sup>213</sup> He reasoned that general terms such as 'violent' and 'unnatural' did not need to be stated in any greater detail in the legislation because he had also recommended that there should be a power to prescribe by regulations certain categories of deaths as reportable deaths.<sup>214</sup> This recommendation was later incorporated into the present Act's definition, which includes as a category of reportable deaths those which occur in 'prescribed circumstances'.<sup>215</sup>

In the Bill's second reading speech, the Minister for the Arts recognised the need for the legislation to clearly state the circumstances in which a death should be reported, acknowledging that 'uncertainty clearly provided scope for homicide and medical malpractice to remain undetected'.<sup>216</sup> In 1986 the Coroners Regulations included prescribed circumstances, so that a death should also be reported if the circumstances of the death met these criteria. The criteria included deaths which occurred as the result of a 'negligent act or omission of any person'.<sup>217</sup> These regulations expired in 1996 and the current regulations do not prescribe any categories of deaths which should be reported to the coroner.<sup>218</sup>

A number of witnesses told the Committee of their concerns that the present categories of reportable deaths are not stated with sufficient clarity. Dr Freckelton told the Committee that:

General experience suggests that [doctors] do not—because the concept of a reportable death, while reasonably clearly articulated within the legislation, uses terminology which is not easy for persons who are not versed in the interpretation of legislation and most particularly who are not familiar with the case law, which is of some considerable substance, that has interpreted what constitutes an unexpected death and especially an unnatural death.<sup>219</sup>

Health Services Commissioner Wilson agreed that it was sometimes unclear to doctors which deaths should be reported to the coroner.<sup>220</sup> This view was also shared by Magistrate and former coroner Ms Jacinta Heffey, who advised the Committee that she believed that there was a lack of clarity in the current categories of reportable deaths.<sup>221</sup>

<sup>&</sup>lt;sup>213</sup> JG Norris. *The Coroners Act 1958 — A General Review* (1981) 42.

<sup>&</sup>lt;sup>214</sup> Ibid Recommendation 59(e), 40.

<sup>&</sup>lt;sup>215</sup> Coroners Act 1985, s3(1); definition of 'reportable death', paragraph (h).

<sup>&</sup>lt;sup>216</sup> Mr Matthews, Minister for the Arts, Coroners Bill, Second Reading Speech, 21 November 1985, 2305.

<sup>&</sup>lt;sup>217</sup> Coroners Regulations 1986 r 5.

<sup>&</sup>lt;sup>218</sup> Coroners Regulations 1996. Note that the 1996 regulations, which were due to expire in May 2006, have been extended to May 2007.

<sup>&</sup>lt;sup>219</sup> Ian Freckelton, *Minutes of Evidence*, 20 September 2005, 202.

<sup>&</sup>lt;sup>220</sup> Beth Wilson, Health Services Commissioner, Victoria, *Minutes of Evidence*, 20 September 2005, 177.

<sup>&</sup>lt;sup>221</sup> Jacinta Heffey, Submission no. 33, 2–4.

The difficulties sometimes experienced by doctors in determining what constitutes a reportable death were also addressed by Associate Professor Ranson in his personal submission. He outlined the problem in the following terms:

I have been involved in teaching doctors and medical students the legislation regarding the coroner's jurisdiction for some 25 years, the last 17 years in Victoria. I have always found it difficult to provide clear guidance as to what the terms in this guestion might mean when considering whether a death should be reported to the coroner. If a person with my background and experience sometimes finds this difficult how much more difficult might this problem be for a newly qualified medical practitioner without any legal experience. 222

This view was shared by GPDV, which reported that GP members it had surveyed had experienced difficulty in correctly completing death certificates, especially because of uncertainty about cause of death and lack of confidence that they had upto-date information about the law.<sup>223</sup>

While the AMA did not address the issue of whether it believed its members had a good understanding of the various categories of reportable deaths, the Association did comment that it would be beneficial for the Act to state the categories with more clarity.224

## Death certification training

The view that medical students and interns also do not have a good understanding of the categories of reportable deaths was expressed by Dr Eleanor Flynn, who teaches final year medical students at the University of Melbourne. In a personal submission, she advised the Committee that:

Almost universally, when questioned, interns (recently qualified doctors in their first year of hospital work) will suggest that "suspicious" deaths must be reported, but are not able to define suspicious deaths.<sup>225</sup>

Dr Flynn advised the Committee that sixth year medical students at the University of Melbourne received a formal training session on reportable deaths and how to complete death certificates.<sup>226</sup> There is also the possibility that students will be assessed in a practical exam. For instance, in 2005 students had to confirm death on

<sup>&</sup>lt;sup>222</sup> David Ranson, Submission no. 19, 9.

<sup>&</sup>lt;sup>223</sup> General Practice Divisions Victoria, *Submission no. 40*, 4.

<sup>&</sup>lt;sup>224</sup> Australian Medical Association, Submission no. 38, 1.

<sup>&</sup>lt;sup>225</sup> Eleanor Flynn, Submission no. 37, 1.

<sup>&</sup>lt;sup>226</sup> Email, Eleanor Flynn, Senior Lecturer in Medical Education, University of Melbourne, to Committee Research Officer, 13 March 2006.

a breathing but 'playing dead' simulated patient and then complete the death certificate using the clinical notes provided.<sup>227</sup>

The training of medical students differs at Monash University. At Monash, fifth year medical students this year will attend a lecture by Associate Professor Ranson on doctors' reporting requirements.<sup>228</sup> Currently, death certification is not an examinable topic at Monash.<sup>229</sup>

The Health Commissioner told the Committee of two separate training issues — for junior doctors and overseas trained doctors:

too often the certification of deaths, particularly in hospitals, is left to junior doctors who have insufficient training. Death certificates are very important and senior assistance and involvement should be available to junior doctors if they are being asked to do this.

I am also interested in the situation in which our international medical graduates find themselves. We currently give them far too little support and training on their requirements under the law here in Australia. I was talking to about 12 international medical graduates working in the psychiatric area. One of them said, 'I have to write a report for the coroner. Can you please tell me what a coroner is because we do not have one in our country'. If we are going to use people like that in very difficult areas such as psychiatric services, we have to give them much more training about their responsibilities.<sup>230</sup>

The Medical Practitioners Board of Victoria (MPBV) advised that there are currently 7046 non-Victorian-trained medical practitioners registered in Victoria. In 2005 there were 81 overseas trained medical practitioners who were granted general registration following completion of exams conducted by the Australian Medical Council (AMC) and completion of one year of supervised training at an approved Australian institution. A further 24 medical practitioners who were graduates of international medical schools were granted provisional registration, with general registration dependant on successfully completing AMC exams. There were also 2743 undergraduate medical students studying in Victoria who were registered with MPBV.

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<sup>227</sup> Ibid.

<sup>&</sup>lt;sup>228</sup> Conversation, Dr Leanna Darvall, Convenor of Medical Law Curriculum, Monash University, and Committee Legal Research Officer, 16 March 2006.

<sup>&</sup>lt;sup>229</sup> Ibid.

<sup>&</sup>lt;sup>230</sup> Beth Wilson, Health Services Commissioner, Victoria, *Minutes of Evidence*, 20 September 2005, 178.

<sup>&</sup>lt;sup>231</sup> Table 3 'Medical practitioners granted general registration', in *Medical Practitioners Annual Report 2005*, 9.

<sup>&</sup>lt;sup>232</sup> Ibid.

<sup>&</sup>lt;sup>232</sup> Table 2 'Medical practitioners granted provisional registration', in *Medical Practitioners Annual Report 2005*, 9.

<sup>&</sup>lt;sup>233</sup> Table 1B 'Medical student database', in *Medical Practitioners Annual Report 2005*, 9.

MPBV also advised the Committee that these practitioners do not have to demonstrate an understanding of the professional requirements needed to complete a medical cause of death certificate before being registered to practice in Victoria but that they would receive on the job training and advice from others.<sup>234</sup>

As part of the inquiry the Committee undertook research in other jurisdictions to consider the level of instruction and training medical students received in death certification. The Committee was particularly impressed with the intensity of the training which is undertaken at the undergraduate level in Finland. Finland. Finnish medical students undergo an extensive formal training process in death certification before they complete their medical studies. All medical students are required to complete 22 hours of small-group teaching on the completion of death certificates and external examination of the body. Later, students' knowledge on these subjects is tested in the final examinations, where they must complete five death certificates based on hypothetical examinations. All students also must attend five autopsies and specialist seminars on forensic pathology.

The Committee considers that greater emphasis should be placed on the need for medical students, interns and overseas trained doctors to have a good understanding of their responsibilities in relation to death certification. As such, the Committee recommends that VIFM consider providing further advice and assistance to medical schools and MPBV as to the training requirements needed to ensure that medical students, interns and overseas trained doctors have an adequate understanding of their responsibilities.

Recommendation 5. That the Victorian Institute of Forensic Medicine in consultation with the State Coroner's Office review the level of training currently provided to students, interns and overseas trained doctors with a view to developing a consistent training programme that could be used by the Medical Practitioners Board of Victoria and all medical schools in Victoria.

#### Other issues affecting whether deaths are reported to the coroner

Social factors such as his or her attitudes, values and norms may affect whether a doctor decides to report a death to the coroner. There is some evidence to suggest that doctors may be motivated by what they perceive as altruistic reasons for not reporting deaths to the coroner. For example, some doctors may justify not reporting a death on the ground of shielding the family of the person who has died from the further grief that s/he anticipates a coronial investigation may cause.

<sup>235</sup> Committee Meeting, Helsinki, Finland, 4 July 2005, University of Helsinki, Department of Forensic Medicine, Professor Erkki Vuori, Head of Department; Dr Phillipe Lunetta, Forensic Pathologist; Provincial State Office of Southern Finland; Dr Erkki Tiainen, Senior Medical Examiner; Helsinki Police Department; Mr Mika Taura.

<sup>&</sup>lt;sup>234</sup> Email, Gabrielle Wolf, Solicitor, Medical Practitioners Board of Victoria, to Committee Legal Research Officer, 10 April 2006.

One of the cases from the Queensland Public Hospitals Commission of Inquiry offers some insight into factors which may influence whether a doctor reports a death. In one particular case, an anaesthetist attended an operation which was carried out by Dr Patel. The patient later died and there were issues as to whether Dr Patel should have performed complicated surgery of this kind on this patient at a regional hospital. Approximately two days after the operation, the theatre staff who had attended the operation had a discussion about what had happened during the surgery and there was general agreement that the death should be reported to the coroner.<sup>236</sup> When asked about why the theatre staff did not inform the coroner, the anaesthetist replied:

Because we thought that under those circumstances the family went through the grievance already, the patient has been buried and that would be too much of a trauma, basically, to them, to suddenly realise there is - this patient should have been (sic) actually gone to the coroner and has to be exhuminated (sic) now.<sup>237</sup>

In a case from South Australia, a doctor did not report the death of a newborn baby to the coroner for similar reasons.<sup>238</sup> According to the specialist neonatologist who treated the baby, he decided not to report the death because he thought it was the humane thing to do. He believed that an autopsy was a "particular academic exercise" and he 'did not want to put the family through any more because they had been through enough'.<sup>239</sup>

Altruistic motivation as a reason for not reporting a death was also borne out by anecdotal evidence which the Committee received in this inquiry. For example, in the GPDV submission, Mr Bill Newton, CEO, referred the Committee to the comments of one GP on this issue:

Many colleagues have come to me and said, "What do I do? I have an 80-year-old patient who's had one minor stroke in the past and one minor heart attack and has high blood pressure. She dies in the middle of the night. What am I going to put down on the death certificate?"

They toss a coin and put down heart attack or stroke. You've got a family who require a Death Certificate for the patient to be buried. They don't want it to be made into a coroner's case.<sup>240</sup>

A GP also advised the Committee of the pressure from a funeral director not to refer a death to the coroner when the doctor felt that the cause of death was not known:

<sup>&</sup>lt;sup>236</sup> *Transcript of Proceedings*, Queensland, Public Hospitals Commission of Inquiry (2005) 1942: evidence of Dr Berens.

<sup>&</sup>lt;sup>237</sup> Ibid 1943.

<sup>&</sup>lt;sup>238</sup> David Ranson, 'The Value of an Autopsy' (2005) 13 *Journal of Law and Medicine* 19.

<sup>&</sup>lt;sup>239</sup> Transcript of Proceedings, South Australian Coroner's Inquest No. 8/2005, 44, cited in David Ranson, 'The Value of an Autopsy' (2005) 13 *Journal of Law and Medicine* 21.

<sup>&</sup>lt;sup>240</sup> General Practice Division Victoria, Submission no. 40, 4.

The funeral directors told the family that I was deliberately holding up the funeral, that I was being a pedantic little pain. I had them on the phone 5 times in 48 hours harassing me, saying 'What difference does it make? She was 75 - just put anything'.<sup>241</sup>

Associate Professor Ranson also advised the Committee that, in his experience, one of the most common reasons doctors do not report deaths to the coroner was that the family of the person who died did not want an autopsy.<sup>242</sup>

# Alternative systems for reporting deaths

## The United Kingdom

Problems with the death certification process and under-reporting have been extensively documented in the United Kingdom, both in the medical literature and in official reports.<sup>243</sup> Despite this, the death certification process has remained largely the same since the 1920s. A comprehensive overhaul of the coronial system is however now underway in England and Wales. It is a result of multiple inquiries into the adequacy of the system following the murder conviction of Dr Shipman in 2000.<sup>244</sup>

### The Luce Report

In 2001 the British Home Office set up the first of many inquiries into the coronial and death certification process. The first inquiry, chaired by Mr Tom Luce, published its recommendations in 2003.<sup>245</sup> The terms of reference included a consideration of the most effective arrangements for ascertaining the medical cause of death, including the necessary structural arrangements required, and the qualifications and experience of persons who would certify deaths.<sup>246</sup>

It found that a critical weakness of the death certification and coronial processes was that the two processes were separate from each other:

<sup>&</sup>lt;sup>241</sup> Ibid.

<sup>&</sup>lt;sup>242</sup> David Ranson, Submission no. 19, 10.

<sup>&</sup>lt;sup>243</sup> See for example Aileen Clarke and Jean Gladwin, *Improving the Health of the Living? An Investigation Into Death Certification and Coronial Services and Some Suggestions for Change*, Report to the Fundamental review of Death Certification and the Coroner Services in England, Wales and Northern Ireland, 2003, which cited the following reports and journal articles: United Kingdom, *Report of the Committee on Death Certification and Coroners*, Cmnd 4810 (1971); S Leadbetter and B Knight, 'Reporting Deaths to Coroners — All the Legal Aspects of Dying Need Re-examining', *British Medical Journal*, 1993, 1018; T Hennell, *Civil Registration and Cremation Certification of Dr Shipman's Patients*, Report prepared for the Home Office Review of Death Certification, 2000.

<sup>&</sup>lt;sup>244</sup> The trial was held at Preston Crown Court before Mr Justice Forbes in 1999–2000. A transcript of the trial is available at www.the-shipman-inquiry.org.uk/trialtrans.asp.

<sup>&</sup>lt;sup>245</sup> United Kingdom, *Death Certification and Investigation in England, Wales and Northern Ireland: The Report of a Fundamental Review*, Cm 5831 (2003). Available at http://www.archive2.official-documents.co.uk/document/cm58/5831/5831.pdf.

<sup>&</sup>lt;sup>246</sup> Ibid vii.

The coroner has no information on or responsibility for deaths not reported to him. No public authority is tasked or resourced to see that the certification process is being properly carried out and that deaths which ought to be investigated by the coroner are reported for investigation. There is thus little to stop an unscrupulous doctor from "certifying his way out of trouble".<sup>247</sup>

In relation to death certification, the inquiry recommended that deaths should be audited by a Statutory Medical Assessor within the office of the coroner.<sup>248</sup> It concluded that this would improve the quality of certification and encourage more attention and wariness to be brought to the certification process.<sup>249</sup>

For those deaths which were not reportable to the coroner, the inquiry recommended that two professional medical opinions should be required to certify the cause of death.<sup>250</sup> The Statutory Medical Assessor should be responsible for the appointment of a panel of doctors who would act as the second certifier.<sup>251</sup> The second certifier should be an experienced clinical doctor chosen for his or her skill and professional independence. Second certifiers would not be able to act in this role for his or her own former patients or former patients from a general practice at which the second certifier worked.<sup>252</sup> The first certifier would choose a second certifier from an approved rostered panel so as to prevent the first certifier continually choosing the same second certifier.<sup>253</sup>

In relation to hospital deaths, the inquiry recommended that the second certifier should be 'the considered judgement of a mature and fully qualified hospital specialist' of consultant status.<sup>254</sup> The inquiry recommended also that no hospital death should be second-certified by any doctor from the same department or 'firm'.<sup>255</sup>

The inquiry further proposed that the families of the person who died should have a defined right to pursue any anxieties about the death with the second certifier or the Coroner's Office.<sup>256</sup> The family representative should also be given the right to be informed of the cause of death given by the first certifier and the right to talk to the second certifier.<sup>257</sup> The inquiry also noted the need to make the reporting system more accessible to families, friends and whistleblowers, who should be able to approach

<sup>248</sup> Ibid 220.

<sup>&</sup>lt;sup>247</sup> Ibid 16.

<sup>&</sup>lt;sup>249</sup> Ibid 50.

<sup>&</sup>lt;sup>250</sup> Ibid 221.

<sup>&</sup>lt;sup>251</sup> Ibid 51.

<sup>&</sup>lt;sup>252</sup> Ibid 52.

<sup>&</sup>lt;sup>253</sup> Ibid.

<sup>&</sup>lt;sup>254</sup> Ibid 56.

<sup>&</sup>lt;sup>255</sup> Ibid 55.

<sup>&</sup>lt;sup>256</sup> Ibid 23.

<sup>&</sup>lt;sup>257</sup> Ibid 59.

the Coroner's Office with any unresolved concerns about both reported and unreported deaths.<sup>258</sup>

A general requirement that the certifiers should examine all bodies as part of the certification process was rejected by the inquiry, largely due to the cost involved and a shortage of forensic pathologists, who would be required to undertake this work.<sup>259</sup> Instead, the inquiry recommended that bodies should be inspected by a trained health care professional at the scene of the death.

The Luce Report also recommended the establishment of an independent statutory Coronial Council which would have powers to monitor the death certification process.<sup>260</sup> Proposed statutory functions would include reviewing the performance and objectives of the death certification process from a public health and safety aspect. It was envisaged that the Council would have a strategic reporting and guidance role but not have influence over individual cases.

It was also proposed that the Coronial Council should have a research role, including responsibility for deciding what statistics were needed to effectively monitor the coronial system.<sup>261</sup>

In relation to the training of medical students and doctors in death certification, the inquiry recommended that the British Medical Colleges should acknowledge the importance of this training both at the undergraduate and continuing professional education level.<sup>262</sup>

The Inquiry provided a detailed costing analysis, which included £6.7m for the cost of creating the new Statutory Medical Assessor posts and £3.6m for the cost of training second certifiers and monitoring the quality of certification.<sup>263</sup>

# The Shipman Inquiry by Dame Janet Smith DBE

In 2001, following a High Court decision recommending a public inquiry, Dame Janet Smith DBE, a High Court judge, was appointed Chairman of the Shipman Inquiry.

By 2005 the inquiry had published six reports<sup>264</sup> and had concluded that:

<sup>259</sup> Ibid 54.

<sup>&</sup>lt;sup>258</sup> Ibid 34.

<sup>&</sup>lt;sup>260</sup> Ibid 173.

<sup>&</sup>lt;sup>261</sup> Ibid 174.

<sup>&</sup>lt;sup>262</sup> Ibid 44.

<sup>&</sup>lt;sup>263</sup> Ibid 216. Costings were provided by Peter Jordan in an unpublished background paper 'Indicative Cost Estimates of Processes in the Proposed Coroner System for England and Wales'. A copy of the paper was provided to the Committee by the Department of Constitutional Affairs, United Kingdom.

The Shipman case has shown that the present procedures fail to protect the public from the risk that in certifying a death without reporting it to the coroner, a doctor might successfully conceal homicide, medical error or neglect leading to death.<sup>265</sup>

The Shipman Inquiry recommended that the coronial system should be retained but that it should be radically reformed. Unlike the Luce model, the Shipman Inquiry recommended a system in which all deaths should be reported to the coroner, removing from doctors the requirement to certify deaths. Under this system, doctors who treated the patient during his or her last illness would only be able to express an opinion as to the cause of death rather than certifying the cause of death. Expressing the opinion would also be restricted to senior and experienced doctors — hospital doctors requiring four years' post-admission experience, and overseas-trained doctors requiring additional training. The opinion would then be considered by the coroner's investigator after consultations with the deceased's family (in order to check for any inconsistencies between the family's version of the circumstances leading up to the death and the version in the medical records). If the investigator has any concerns the death would be referred to the coroner for further investigation; otherwise, the investigator would certify the cause of death based on the medical opinion of the treating doctor.

The Shipman Inquiry preferred this option to the one proposed in the Luce Report on a number of grounds. First, the coroner's investigator would have a more independent role than that of a second doctor overseeing another doctor's certification. Second, the inquiry considered that it was more appropriate for an investigator to confer with the family rather than a second doctor as this task did not require medical qualifications. (This system would have the added benefit of relieving busy doctors from the time-consuming tasks of consulting the deceased's family and the actual certification of the death.) Third, there would be a centralised coronial system in which all deaths, not just reported deaths, would be examined by the coroner. The support of the deaths are coroner.

United Kingdom, *Death Disguised*, (The first report); United Kingdom, *The Police Investigation of March 1998*, (Cm 5853, 2003). (The second report); United Kingdom, *Death Certification and the Investigation of Death by Coroners*, (Cm 5854, 2003). (The third report); United Kingdom, *The Regulation of Controlled Drugs in the Community*, (Cm 6249, 2004). (The fourth report); United Kingdom, *Safeguarding Patients: Lessons from the Past — Proposals for the Future*, (Cm 6394, 2004). (The fifth report); *Shipman: The Final Report*, (The sixth report). All reports available at http://www.the-shipman-inquiry.org.uk/reports.asp.

<sup>&</sup>lt;sup>265</sup> United Kingdom, *Death Certification and the Investigation of Death by Coroners*, (The third report), Cm 5854 (2003) 487.

<sup>&</sup>lt;sup>266</sup> Ibid 25.

<sup>&</sup>lt;sup>267</sup> Ibid 502.

<sup>&</sup>lt;sup>268</sup> Ibid 499.

<sup>&</sup>lt;sup>269</sup> Ibid 502.

<sup>&</sup>lt;sup>270</sup> Ibid 504.

Auditing and random investigation of deaths which had been certified by coronial investigators were also a recommendation of the Inquiry,<sup>271</sup> for three reasons. First, an audit would provide evidence to ensure that the system was operating as it should. Second, the Inquiry acknowledged that even the new system would be unable to provide a full investigation of every death and that it was potentially open to abuse by two or more people acting in collusion, such as a doctor, nurse and family member concealing the hastened death of a elderly patient. Third, a general awareness that a certain number of deaths would be randomly audited would act as a deterrent to misconduct and would also promote good certification practice.

Although the Inquiry did not provide a costing analysis for its proposed system, it did acknowledge that the resource implications would be quite considerable.<sup>272</sup> There were also concerns expressed in relation to the practicality of some of the recommendations. Following its third report on death certification in 2003, the Shipman Inquiry did however commission a study to assess the feasibility of using the new death certification forms it had proposed in that report.<sup>273</sup> Key findings from the study were that, while doctors and family members both accepted the need for a new system to give a greater degree of protection, doctors had difficulties in supplying the amount of contextual detail required and were concerned by the extra time needed to complete the form.<sup>274</sup>

## The UK Government response

In March 2004 the Home Office<sup>275</sup> released its position paper Reforming the Coroner and Death Certification Service.<sup>276</sup> It acknowledged the need to build a better system of death certification and investigation so that tragedies like the Shipman killings could never happen again.<sup>277</sup> In what was described as the biggest overhaul of the coronial system in 200 years,<sup>278</sup> the Home Office proposed the implementation of a system similar to the one recommended in the Luce Report, although it proposed that the second certifier be attached to the coronial service so that the service could potentially examine every death, as opposed to only reported deaths, as at present.

<sup>&</sup>lt;sup>271</sup> Ibid 504–505.

<sup>&</sup>lt;sup>272</sup> Ibid 515.

<sup>&</sup>lt;sup>273</sup> Paul Sinfield and Andrew Wilson, *Death Certification: Issues from a Pilot of the Shipman Inquiry's Interim Proposals*, National Statistics, 23–32. Available at www.nationalstatistics.gov.uk.

<sup>&</sup>lt;sup>274</sup> Paul Sinfield and Andrew Wilson, *Death Certification: Issues from a Pilot of the Shipman Inquiry's Interim Proposals*, National Statistics, 26.

<sup>&</sup>lt;sup>275</sup> In June 2005, the Coroners Unit was transferred to the Department for Constitutional Affairs.

<sup>&</sup>lt;sup>276</sup> United Kingdom, *Reforming the Coroner and Death Certification Service: A Position Paper*, Cm 6159 (2004). Available at <a href="https://www.official-documents.co.uk">www.official-documents.co.uk</a>.

<sup>&</sup>lt;sup>277</sup> Ibid 2.

<sup>&</sup>lt;sup>278</sup> C Dyer, 'New Coroner's System Will Require Two People to Verify Cause of Death' (2004) 328 *British Medical Journal* 727.

The new system will require that two doctors certify the cause of death.<sup>279</sup> A 'first certifier' (a doctor who treated the deceased before his or her death) will complete a certificate of the medical cause of death and will be required to justify why s/he is satisfied that s/he can accurately certify the cause of death. S/he may also be required to produce evidence such as medical records or x-rays to support the claim.

Under the new system, the second certifier will be the medical examiner who will be a qualified doctor employed by the coroner service. A clinical team supervised by the medical examiner will screen cases and will be able to request further information from the deceased person's family about the circumstances of the death. The UK Home Office position paper also recommended that an advisory Coronial Council be established to provide advice to the coronial service.

While not in a position to provide final costings for its proposed reforms, the Home Office did indicate that its final decision would have regard to both affordability and value for money and that the reformed system would be funded from the existing resources in the coronial and death certification services.<sup>280</sup>

The position paper indicated that a draft bill on the changes would be introduced by March 2005. Constitutional Affairs Minister Rt Hon Harriet Harman QC MP has now advised the UK Parliament that a draft Coroner Reform Bill will be published in April 2006, with a white paper to follow later in the year.<sup>281</sup> A recently published briefing note advised that the UK Government is still considering reforms but that the Government will not be introducing a requirement to report every death to a coroner for second scrutiny.<sup>282</sup> Instead, the Government will adopt a whole of government approach and consider 'affordable and proportionate reforms'.<sup>283</sup>

In January 2006 the Constitutional Affairs Committee of the UK Parliament also commenced the 'Reform of the Coroners System and Death Certification Inquiry'.<sup>284</sup> The Committee considered problems with the existing system, existing proposals for reform and alternatives to the current system as practised in other jurisdictions. The Inquiry took oral evidence from Dame Janet Smith and Mr Tom Luce and tabled its

<sup>281</sup> Harriet Harman, Minister of State for Constitutional Affairs, *Reform of the coroners' system* – Oral ministerial statement, 6 February 2006. Available at www.dca.gov.uk/pubs/statements/2006/st060206.htm.

<sup>&</sup>lt;sup>279</sup> United Kingdom, *Reforming the Coroner and Death Certification Service: A Position Paper*, Cm 6159 (2004) 13.

<sup>&</sup>lt;sup>280</sup> Ibid 25.

<sup>&</sup>lt;sup>282</sup> United Kingdom, *Coroners Service Reform: Briefing Note*, Department for Constitutional Affairs, February 2006, 6. Available at www.dca.gov.uk.

<sup>&</sup>lt;sup>283</sup> Ibid 6.

<sup>&</sup>lt;sup>284</sup> United Kingdom, *Announcement of Inquiry*, Press notice 12 of Session 2005–06, 20 January 2006. Available at www.parliament.uk.

report in July 2006.<sup>285</sup> While acknowledging that the Government's draft bill would do much to improve the coronial system, the Report found that the Bill would not remedy the critical defects in the death investigation system.<sup>286</sup> In particular the report noted that there was no effective supervision of, or support for, certifying doctors, or any mechanism for ensuring that deaths which should be investigated are reported to the coroner.<sup>287</sup>

#### Queensland

The Queensland Public Hospitals Commission of Inquiry was appointed in September 2005 following the termination of an earlier inquiry on the grounds of apprehended bias. That inquiry was referred to as the Bundaberg Hospital Commission of Inquiry. The new inquiry, chaired by retired Court of Appeal Justice, Hon Geoffrey Davies AO, was then required to report by 30 November 2005.

Under the original terms of reference, the Commission was required to report on a range of medicolegal issues which arose following the employment of Dr Jayant Patel at the Bundaberg Base Hospital and the concerns arising from clinical practice and procedures by him and others at the hospital. The terms of reference were amended to allow the Commission to include an inquiry into whether there was sufficient evidence to justify amendments to the *Coroners Act* 2003 (Queensland).

Under the Queensland Act, a doctor should report a death to the Queensland Coroner if the death 'was not reasonably expected to be the outcome of a health procedure'.<sup>288</sup> 'Health procedure' is defined as 'a dental, medical, surgical or other health related procedure' and includes the administration of an anaesthetic, analgesic, sedative or other drug.<sup>289</sup>

The Queensland guidelines offer direction on the types of deaths which should be reported under this category.<sup>290</sup> The guidelines direct that the first issue to consider is the question of causation — did the health procedure cause the death? According to the guidelines, the procedure caused the death if the death did not directly result from the ailment, disease or injury, if the procedure was not carried out with all reasonable skill and care and if the patient would not have died at about the same time if the procedure was not undertaken.

<sup>&</sup>lt;sup>285</sup> House of Commons Constitutional Affairs Committee, *Reform of the coroners' system and death certification*, 2006, 3.

<sup>&</sup>lt;sup>286</sup> Ibid.

<sup>&</sup>lt;sup>287</sup> ibid.

<sup>&</sup>lt;sup>288</sup> Coroners Act 2003 (QLD) s 8(3)(d).

<sup>&</sup>lt;sup>289</sup> Coroners Act 2003 (QLD), Schedule 2, definition of 'health procedure'.

<sup>&</sup>lt;sup>290</sup> State Coroner's Guidelines — Version 0 December 2003. Paragraph 6.1.4. Available at http://www.justice.qld.gov.au/courts/coroner/pdfs/guidelines.pdf.

The second question the guidelines consider is the issue of foreseeability — could the death have been foreseen by an independent doctor to be a reasonably expected outcome of the procedure? In order to determine this, the doctor should consider whether the decision to undertake the procedure was, in the circumstances, a reasonable one, given the patient's condition.

The Inquiry delivered a report centred on an investigation into the alleged activities of Dr Patel, as well as those of other doctors in Queensland public hospitals, and an investigation into the system of registration of overseas trained doctors. While this was not a focus of the inquiry, the Commission briefly examined the provisions of the Queensland Act, concluding that the Act was unsatisfactory because it permitted a single doctor to decide whether a death, particularly a death from elective surgery in a public hospital, should be reported to the coroner.<sup>291</sup> The 12 cases not reported to the coroner which the inquiry examined had demonstrated to the Commission that there was a need for the provision to be amended.

When considering options for reform, the Commission concluded that any changes to the current system would need to deal not only with deaths in hospitals; the reforms would need to be broad and robust enough to capture all cases of medical error, neglect and misconduct by health service practitioners leading to death.<sup>292</sup>

Options for reform which were considered by the Commission included the three options proposed in the UK which followed on from the Shipman case. While acknowledging that time constraints for the inquiry did not allow for the Commission to examine closely the ramifications of any changes to the system, the Commission concluded that it was not convinced that dramatic changes such as those proposed in the Shipman Inquiry and the Luce Report were necessary.<sup>293</sup> The concern with the Shipman proposal was based on financial considerations. The Commission considered that this system would require substantial support and resources to enable such an extensive level of certification, given that the Queensland system did not currently have a full time medical officer assisting the State Coroner.<sup>294</sup>

In relation to the Luce system, the Commission considered that it also presented difficulties. While that system did remove the risks associated with a single doctor assuming responsibility for certifying deaths, the Commission thought that the system would still be exposed to the risk of a dishonest doctor seeking out a careless or dishonest doctor to act as the second certifier.<sup>295</sup> A particular difficulty of the Luce system for Queensland would be the problems it would create in remote rural

<sup>293</sup> Ibid 532.

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<sup>&</sup>lt;sup>291</sup> Queensland, *Public Hospitals Commission of Inquiry Report* (2005) 530.

<sup>&</sup>lt;sup>292</sup> Ibid.

<sup>&</sup>lt;sup>294</sup> Ibid 531.

<sup>&</sup>lt;sup>295</sup> Ibid 532.

locations where it would be extremely difficult for some doctors to locate a doctor deemed appropriate to act as the second certifier.<sup>296</sup>

Ultimately the Commission recommended a number of changes to the Queensland Act, making it a requirement in the Act that all deaths within a prescribed period following elective surgery should be reported to the coroner.<sup>297</sup> According to the Commission, the merit of such a provision would be that it would remove the reliance placed on a single doctor to notify the coroner of reportable deaths and it should not overburden the coronial system with investigating all medical procedure related deaths. The suggested provision to be inserted into the Act was set out in the following terms:

- (a) The Coroners Act 2003 be amended by:
- (ii) adding a new subparagraph to s 8(3) after subparagraph (d) to read:

The death happened within 30 days of an elective health procedure.

(ii) adding a new definition in schedule 2 to read:

"Elective Health procedure" means a health procedure that can be delayed for a period of 24 hours without death being a likely outcome. <sup>298</sup>

The Commission considered that further medical input may be required to determine the appropriate period of time following an elective procedure which should be specified in the Act, as a period shorter than 30 days may be appropriate.

A further recommendation of the Commission was for the appointment of a dedicated medical officer to assist the entire coronial system in reviewing medical charts and providing medical advice on whether a cause of death certificate should be issued without the need for further investigation.<sup>299</sup> The Commission also identified the need for coroners to have specialist medical advisors, given the difficulties faced by non-medically qualified coroners and police officers investigating deaths involving medical treatment. It recommended that a panel of specialists trained in various health disciplines be appointed to assist coroners with medical investigations.<sup>300</sup> These difficulties included the reported frequent failure by Queensland hospitals to cooperate with police investigators and the fact that there is no system in place for an investigator with medical expertise to interview doctors and thus challenge medical reports and self-serving statements which doctors may provide.

<sup>297</sup> Ibid.

<sup>&</sup>lt;sup>296</sup> Ibid.

<sup>&</sup>lt;sup>298</sup> Ibid 536.

<sup>&</sup>lt;sup>299</sup> Ibid 533.

<sup>&</sup>lt;sup>300</sup> Ibid 534.

In regard to what it described as the 'anomalous practice of Dr Patel' in getting the most junior doctor to certify the cause of death, the Commission recommended that the Act should require that the person responsible for the care of the patient or in charge of the relevant health procedure should sign the death certificate.<sup>301</sup> In the case of deaths occurring within 30 days of elective health procedures, the Commission recommended that the *Births, Deaths and Marriages Registration Act 2003* (Qld) be amended so that the health practitioner in charge of the procedure is required to provide an opinion as to the cause of death to the coroner.<sup>302</sup>

Additional recommendations included that all public hospitals be required to comply with audits to ensure that the reporting obligation was satisfied and that the Queensland Department of Health ensure that an internal investigation is undertaken in relation to every death which occurs in its facilities. The Commission also recommended that the report be provided to the coroner as well as to the family of the person who died.

While not examining the level of training currently provided to medical students and doctors, the Commission recommended that continuing training be provided to all doctors to ensure that they remain aware of their obligations to report.<sup>303</sup>

Following on from the Commission's recommendations, the Queensland Department of Justice and Attorney-General is undertaking a consultation process in relation to changes to the *Coroners Act 2003*.

# Need for reform of system for reporting deaths

These recent inquiries both interstate and overseas have clearly stated the case for the need for a death certification system which is not dependent on one doctor who is responsible, without any supervision or medical audit, for certifying deaths and ensuring that reportable deaths are referred to the coroner.

In the discussion paper, the Committee identified three possible options for consideration:

The system recommended by the Shipman Inquiry in its third report in 2003:

All deaths should be reported to a coroner so that the coroner makes the decision about which deaths require further investigation. The coroner should be responsible for certifying all deaths, whereas doctors should only provide a medical opinion on the cause of death. The coroner should also consult with the family of the person who has died on the cause of death.

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<sup>&</sup>lt;sup>301</sup> Ibid 535–6.

<sup>&</sup>lt;sup>302</sup> Ibid 536.

<sup>303</sup> Ibid.

The system recommended in the Luce Report in 2003:

The coroner should continue to be informed of notifiable deaths only but all death certificates would be scrutinised by a medical assessor at the Coroner's Office. For deaths not reportable to the coroner, two professional medical opinions should be required to certify the cause of death.

The system proposed by the UK government in 2004:

Doctors should continue to certify the cause of death, but two doctors should be required to certify a death. The second doctor should be attached to the Coroner's Office so that the office would have the opportunity to scrutinise all deaths. A clinical team supervised by the medical examiner should screen cases and will be able to request further information from the deceased person's family about the circumstances of the death.

The Committee also invited stakeholders to consider other options for reform relevant to Victoria.

### Evidence received by the Committee

Most stakeholders were in agreement that the present system of death certification in Victoria is in need of reform. While acknowledging that there are many similarities and some important differences in the Victorian system compared with the systems in place in Queensland, England and Wales, most stakeholders considered that the system needed to be strengthened in order to reduce the risks which had been exposed in the other jurisdictions.

The State Coroner commented on the three proposals but ultimately rejected these proposals in favour of his own proposal for Victoria. First, he considered that the Shipman Inquiry proposal was:

impracticable, resource intensive and, in the context of regional Victoria, disrespectful of the needs of families who prefer quick turnaround of a body and it to stay as near as possible to home.<sup>304</sup>

Second, he rejected the UK government approach which favoured a two-tier certification process, on the following grounds:

the information on which the two doctors determine cause of death prior to autopsy will not usually change from the information currently interpreted by one doctor. Further, it will be resource intensive, there is a dearth of forensic pathologists already, particularly in regional areas [...], it may not sufficiently protect victims from undetected unnatural death and, in many

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<sup>&</sup>lt;sup>304</sup> State Coroner's Office, Submission no. 70, 125.

cases, it will require transfer of bodies to Melbourne and back to regional areas for funerals with associated delays in their release to families and resource implications.<sup>305</sup>

He did however accept that such a system would provide immediate accountability for doctors who were deliberately falsifying cause of death in order to evade reporting the death to the coroner and that it would also ensure that autopsies were available in these cases.

The State Coroner submitted that the present system should be retained but that it should be strengthened to provide an added degree of protection and confidence for the public by implementing the following measures:

- a computer surveillance system and a specialist medical assessment team should be established at the Registry of Births, Deaths and Marriages to identify trends in deaths that may require investigation and to monitor death certificates for deaths that should have been reported to the coroner;<sup>306</sup>
- the Act be amended so that the State Coroner has jurisdiction to conduct 'own initiative and limited purpose investigation' on any death at the direction of the State Coroner;<sup>307</sup>
- regular education campaigns aimed at educating doctors as to their reporting obligations through the medical colleges, medical schools, hospitals and nursing homes (the campaign would not need to be directed to the general community because if a person has a concern about the accuracy of the death certificate, s/he can contact the State Coroner or the Health Commissioner);<sup>308</sup> and
- establishing an independent audit process to monitor reporting in key institutions such as nursing homes.<sup>309</sup>

Professor Stephen Cordner, Director of VIFM also had concerns with a system of death certification based on every death being referred to the coroner.<sup>310</sup> While he conceded that Victoria arguably has an appropriate structure to establish a system to oversee all death certificates, he advised the Committee that there would be substantial establishment costs as well as annual costs of approximately \$8 to \$10 million in order to investigate approximately 35,000 deaths per year.<sup>311</sup> VIFM submitted that such a system was not justified without there being further research in

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<sup>305</sup> Ibid.

<sup>&</sup>lt;sup>306</sup> Ibid 126–127.

<sup>&</sup>lt;sup>307</sup> Ibid 127.

<sup>&</sup>lt;sup>308</sup> Ibid 126.

<sup>&</sup>lt;sup>309</sup> Ibid 127.

<sup>&</sup>lt;sup>310</sup> Victorian Institute of Forensic Medicine, *Submission no. 40*, 14.

<sup>&</sup>lt;sup>311</sup> Ibid.

the Victorian context which would provide evidence to support the need for this model, given the significant cost.

Instead, VIFM considered that a targeted approach may prove to be equally effective and that reform options to consider include better training and guidance for medical practitioners responsible for certifying deaths, along with a greater level of medical scrutiny of death certification through an auditing process. Other measures VIFM put forward for consideration include the rationalisation of the responsibilities and arrangements for death and cremation certification.<sup>312</sup>

VIFM submitted that it should be responsible for drafting guidelines and training the medical profession and that medically qualified practitioners employed by VIFM should have the responsibility of auditing death certificates to identify cases which should be reported to the coroner for further investigation. This auditing process would identify where there are misunderstandings or lack of knowledge amongst medical practitioners and should inform the training program.<sup>313</sup> According to VIFM, it should be charged with this responsibility because it represents the best use of the medical expertise which is already located at VIFM.

VIFM proposed that a new model of death investigation should be established and that it should be based on a triage model.<sup>314</sup> In this triage system, VIFM proposed that an appropriate level of death investigation for each type of case should depend on the type of case, with deaths involving questions of accountability, prevention and public policy being subject to full medical and legal investigation.<sup>315</sup>

If VIFM were to be charged with responsibility for the role of medical death investigation, VIFM proposed that it would review all reported cases and decide, in consultation with family members, when an autopsy is required. As part of this role, VIFM proposed that it would be responsible for recommending which cases require further death investigation and which can be completed by a medical death investigation report. VIFM also proposed that the cases which require further investigation should be allocated to a death investigation team. VIFM suggested that this team should be supported by a research unit with data analysis and epidemiology expertise to operate independently of the coroner. Finally, VIFM proposed that a Coronial Council be established to take on the role of reviewing research and providing the policy direction for death investigation.

<sup>&</sup>lt;sup>312</sup> Ibid 15.

<sup>&</sup>lt;sup>313</sup> Ibid 35.

<sup>314</sup> Ibid.

<sup>315</sup> Ibid.

<sup>&</sup>lt;sup>316</sup> Ibid 36.

<sup>&</sup>lt;sup>317</sup> Ibid.

<sup>318</sup> Ibid.

The Royal College of Pathologists of Australia (RCPA) also supported measures aimed at strengthening the death certification system and agreed with VIFM that further research was required.<sup>319</sup> Dr Debra Graves, Chief Executive Officer of the RCPA, advised the Committee that the College endorsed an approach requiring a higher level of auditing and more involvement of relevant medical expertise, including forensic pathology and public health and epidemiology.<sup>320</sup> The College, like VIFM, also believed that there was a need for further evaluation of the risk that a Dr Shipman, if at work in Australia, would escape detection, before investing in a multimillion-dollar system. According to the College, further evaluation may or may not prove whether such an investment was justified or whether expenditure would be more profitably channelled into other areas of death and injury prevention.<sup>321</sup>

Associate Professor Ranson in his personal submission identified a crucial difference between the English/Welsh system and the system in Victoria which he argued, should be taken into consideration when assessing the type of system change appropriate for Victoria. He noted that, with the exception of the city of Sheffield, England and Wales do not have institutes of forensic pathology or forensic medicine which could be used to establish a medical system to scrutinise medical certificates of death. This is in contrast to the system in Victoria, which since 1985 has established an integrated coronial system incorporating both the State Coroner's Office and VIFM.

Associate Professor Ranson also provided a detailed analysis of the strengths and weaknesses of the three proposals outlined in the discussion paper. He considered that there were considerable advantages associated with the Shipman Inquiry recommendation that all deaths be reported to a coroner or an equivalent agency capable of carrying out a medical investigation into a death. However, he noted that the Coroner's Office would not have the necessary medical skills and would therefore be manifestly unable to review all deaths in Victoria. He expressed the opinion that the staff would also not have the necessary skills to scrutinise the medical opinion as to the cause of death provided by a treating medical practitioner. He provided four examples of representative cases where clerical staff at the Registry of Births, Deaths and Marriages had incorrectly referred cases to the Coroner's Office. For instance, in one case a clerk inappropriately referred the following MCCD to the coroner.

<sup>&</sup>lt;sup>319</sup> The Royal College of Pathologists of Australia, *Submission no. 65*, 2.

<sup>320</sup> Ibid.

<sup>321</sup> Ibid.

<sup>322</sup> David Ranson, Submission no. 19, 31.

<sup>&</sup>lt;sup>323</sup> Ibid 31-32.

<sup>&</sup>lt;sup>324</sup> Ibid 31.

<sup>&</sup>lt;sup>325</sup> Personal communication, David Ranson to Committee Legal Research Officer, 10 May 2006.

Table 1 - Extract from Medical Certificate of Cause of Death (MCCD)

9. Cause of Death (use	₽Β	OCK letters)	Jan 4 (A)	
Part 1		Description of causes	·- : ·-, ·	Duration between onset & death
Disease or condition directly leading to death This means the disease, injury or complication that caused death, not only the mode of dying, such as heart failure, respiratory failure etc.	(a)	Subdual harmating		weeks
		(multiple	Due to	
Antecedent causes (b) - (d) Morbid condition, if any, giving rise to the above cause, stating the underlying condition last	(b)	sovere Thromboay per	uci	
		Chohotoly of fall	Due to	
	(c)	rujetodipplastic synd	ime	- 10 years
		= C MML	Que to	J
	-		٠.	
	(d)	•	Due to	
10-10	,	Description of causes	T	Duration between onset & death
Part 2 Other significant conditions	1	classic renal facture	e 5	a f
contributing to death but not related to the disease or condition causing it				
·				

Source: Victorian Institute of Forensic Medicine

The listed 1(a) cause of death indicates that a subdural haematoma was the condition which directly led to the death. An acute subdural haematoma is most likely to occur after a head injury from a fall; however, chronic subdural hematoma may result from thrombocytopenia. The certifying doctor clearly indicated this at antecedent cause (b) on the cause of death section of the MCCD and also made a note that there was no history of falls for this patient. Thrombocytopenia is a disorder in which there are not enough platelets in the blood. This may lead to abnormal bleeding and result in subdural haematoma. A death of this nature is therefore not a reportable death because the death did not result either directly or indirectly from an accident or injury.

Associate Professor Ranson also commented on the system proposed by the Luce report. He considered that this system would permit a system of audit and quality assurance to be developed but that there would be questions as to the qualifications and skills required for those acting in the position of medical assessor.<sup>326</sup> He pointed out that, while forensic pathologists and forensic physicians have the necessary medicolegal skills to carry out such assessments and audits, there is an inadequate number of people with these skills in Victoria.<sup>327</sup>

<sup>327</sup> Ian Freckelton and David Ranson, *Death Investigation and the Coroner's Inquest* (2006) 292: the authors refer to these skills as including the completion of a medical course, including a clinical internship and other clinical

<sup>&</sup>lt;sup>326</sup> David Ranson, Submission no. 19, 32.

Associate Professor Ranson accepted that there were many general clinicians available to perform this work; however, he submitted that the majority would lack the necessary medicolegal skills.<sup>328</sup> He suggested that a suitable method for implementing this model would be for VIFM to recruit and manage a range of general and specialist medical practitioners and train them in medicolegal work.

Associate Professor Ranson offered the opinion that the model proposed by the UK Government was, in some regards, similar to the situation in Victoria. He noted however that in Victoria the medical team of forensic pathologists and clinicians only reviewed deaths reported to the coroner rather than all deaths. He also referred to the CLS at VIFM and advised that the CLS currently carries out a medical review of the majority of hospital deaths reported to the coroner. In Associate Professor Ranson's opinion, the CLS has developed systems of inquiry and case management and audit review filters which could form the basis of a new death investigation process similar to the system proposed in the Luce Report and by the UK Government.

However, Associate Professor Ranson expressed a number of concerns with adopting any of the proposed UK models in Victoria, advising that there were a number of reasons that the three proposed UK systems were inappropriate for Victoria:

the capacity to develop a higher-level system for death investigation is greater in Victoria than in the United Kingdom given the well recognised highly developed coroner's system and forensic medical system. However, numbers of forensic pathologists and clinical forensic physicians in Victoria, Australia and overseas are limited. In addition the current coroners system does not have the organisational systems or personnel necessary to carry out the detailed medical investigation necessary to audit all deaths and validate all death certificates issued in Victoria. Indeed it is debatable whether a formal judicial process linked to a court represents the ideal model to do this.<sup>329</sup>

The system proposed by Associate Professor Ranson for Victoria instead involved what he referred to as the 'medicalisation' of the front end of the coronial system.<sup>330</sup> According to Associate Professor Ranson, in the present system the coroner's involvement in the front-end process is limited. He identified the following front end procedures, currently the responsibility of coronial clerical staff, as procedures which could become the responsibility of a medical team:

receiving the report of death and determining whether the death is reportable;

appointments. They describe the skills as covering a wide variety of subdisciplines in medicine, particularly in subspecialities within pathology. The skills can be divided into clinical, pathological and legal areas together with general skills in science and communication.

<sup>&</sup>lt;sup>328</sup> David Ranson, Submission no. 19, 32.

<sup>&</sup>lt;sup>329</sup> Ibid.

<sup>330</sup> Ibid 33.

- liaising with the family;
- organising visual identification of the body; and
- arranging the initial medical investigation by ordering a medical examination which may include an autopsy.<sup>331</sup>

In the system proposed by Associate Professor Ranson, these processes would be best managed by a broad medical team whose individual skills were ideally suited to various aspects of this work:

Experienced nurses, social support and medical administrative staff as well as forensic pathologists, clinicians and medical technical or scientific staff clearly have many of the necessary skills in this area. Given that many of our forensic pathologists and clinicians have high-level legal skills (including formal legal qualifications) and have direct access to the coroners who work in the same building, many of the legal issues that might arise in the early stages of an investigation could be easily addressed.<sup>332</sup>

An advantage of 'medicalising' the front end of the death investigation system, according to Associate Professor Ranson, is that it would provide a more 'therapeutic' environment for grieving families.<sup>333</sup> Other identified benefits include enhancing the speed of medical assessments because there would no longer be a duplication of effort by coroners, clerks and medical staff. Also, Associate Professor Ranson submitted that increased capacity would be generated to review a far wider range and number of deaths than those currently reported to the coroner.

Overall, Associate Professor Ranson contended that this would enhance the coroner's effectiveness and efficiency with respect to preventing avoidable deaths. He submitted that forensic pathologists and forensic physicians are formally trained in public health and are well aware of the coroner's needs in respect of the identification of preventable factors in a death — arguably more so than many of the coroner's own administrative staff.<sup>334</sup>

Other medical stakeholders also questioned the appropriateness of some of the UK recommendations for Victoria. While Health Service Commissioner Beth Wilson favoured the system recommended by the Luce Inquiry, she later questioned whether scrutiny of every death certificate was necessary.<sup>335</sup> At the public hearings, she told the Committee that she believed the most appropriate system would be one involving a statutory medical assessor in the Coroner's Office who would undertake selective

332 Ibid.

<sup>331</sup> Ibid.

<sup>333</sup> Ibid.

<sup>&</sup>lt;sup>334</sup> Ibid 34.

<sup>&</sup>lt;sup>335</sup> Health Services Commissioner, Victoria, Submission no. 62, 4.

audits of death certificates. She rejected the need for a process involving a review of every death certificate, arguing that:

All of the recommendations in the report are resource intensive. It would be fantastic if we could review every single death that was in any way a little bit suspicious, but we have to be realistic about how much work the coroner can take on.<sup>336</sup>

Mr Ian Stoney, Chief Executive Officer MPBV, also accepted the need for reform and favoured the model proposed by the UK Government, but he warned that significant additional expenses would be required to implement this proposal, including a substantial number of medical practitioners acting as second certifiers who would be required to become familiar with the deceased's clinical background. In its submission the Board emphasised that a successful system requires a second medical practitioner who has real involvement in the certification process and a mechanism which enables patterns of unusual death rates to be identified and investigated. In the certification process and a mechanism which enables patterns of unusual death rates to be identified and investigated.

Other medical stakeholders also had doubts as to whether the three death certification reform options suggested in the discussion paper were appropriate in the Australian context. For instance, the AMA suggested that the proposals would be impractical, expensive and, in all likelihood, unnecessary and unlikely to achieve the objectives which presumably underpin the proposal. The AMA however did not suggest an alternative model. Similarly, GPDV CEO Mr Newton suggested that the options suggested in the discussion paper would be unlikely to substantially improve the system, commenting that its doctors believed that a requirement for a second signatory would make the death certification process more lengthy and bureaucratic, and that it would not really function as an effective check but rather as a rubber stamp. GPDV believed that rural doctors in many areas would have practical difficulties in finding a second doctor to sign the certificate, which in turn would make that signature likely to be little more than a rubber stamp.

GPDV also expressed reservations about how resource-intensive a system such as that recommended by the Shipman Inquiry would be.<sup>341</sup> Its members expressed concern with the level of detail time-poor doctors would need to supply in order to enable the coroner to certify the death. The submission noted that GPs were particularly concerned that all the options outlined in the discussion paper appear likely to increase the burden of reporting and it referred to the Red Tape Taskforce Review in 2003–04, which made a number of recommendations to reduce red tape in

 $^{\rm 339}$  Australian Medical Association, Submission no. 38, 3.

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<sup>&</sup>lt;sup>336</sup> Beth Wilson, Health Services Commissioner, Victoria, *Minutes of Evidence*, 20 September 2005, 178.

<sup>&</sup>lt;sup>337</sup> Medical Practitioners Board of Victoria, Submission no. 56, 4.

<sup>338</sup> Ihid

<sup>&</sup>lt;sup>340</sup> General Practice Division Victoria, Submission no. 40, 4.

<sup>&</sup>lt;sup>341</sup> Ibid 5.

general practice in order to free up more time for health care delivery.<sup>342</sup> The solution proposed by GPDV is that data from the Registry of Births, Deaths and Marriages be reviewed for unusual patterns which may require further investigation and possible referral to the coroner.

Representatives from the Austin Hospital also outlined a number of concerns with the three systems outlined in the discussion paper. Mr Simon Rosalie, a mortuary scientist at Austin Health, told the Committee that:

All of [the options] were physically removed from the institution in which the death occurred, and that makes accessing medical records either difficult or time consuming. Instigation of any audit processes around death certificates in a major teaching hospital would be likely to result in delay in funerals or non coronial autopsies, and therefore we believe they would be unlikely to get widespread community support on those grounds.<sup>343</sup>

Other hospitals which provided submissions did not raise any major concerns with any of the proposals outlined in the discussion paper. Austin Health was of the view that any audit should ideally occur before the lodgement of the death certificate. While admitting that this would be difficult to achieve centrally, Austin Health proposed that a local audit could be conducted by an independent medical auditor. Mr Rosalie outlined the benefits of such a process to the Committee and told the Committee that the:

audit process should allow easy communication with the signing medical officer in a timely manner so that any identified issues can be dealt with quickly and that any audit system should incorporate a defined process for escalation, so whether the auditor reports directly to the coroner or whether they talk to the medical unit, it needs to have some defined process surrounding it.<sup>344</sup>

Ms Jennifer Williams, Chief Executive at Bayside Health, did not express any particular concerns with the three death certification options apart from expressing the opinion that the Luce model would retain the risk of subjectivity of assessment. Mr Bill O'Shea, corporate counsel at Bayside Health, told the Committee that, out of the three options, the Hospital supported the model proposed by the UK Government. Similarly, the Royal Women's Hospital did not express any concerns with the suggested options. Ms Elizabeth Kennedy, corporate counsel at the Hospital, suggested that the Committee give serious consideration to the recommendations of

<sup>342</sup> Ibid

<sup>&</sup>lt;sup>343</sup> Simon Rosalie, Austin Health, *Minutes of Evidence*, 28 November 2005, 230.

<sup>&</sup>lt;sup>344</sup> Ihid

<sup>&</sup>lt;sup>345</sup> Austin Health, Submission no. 45, 4.

<sup>&</sup>lt;sup>346</sup> Bill O'Shea, *Minutes of Evidence*, 28 November 2005, 214.

the Shipman Inquiry as well as to those arising from the Queensland inquiry into public hospitals.<sup>347</sup>

Mr Jason Rosen, President of the Association for the Prevention of Medical Errors (APME) acknowledged that there was no easy solution for the under-reporting of medical error deaths to the coroner.<sup>348</sup> APME considered that it was improper for treating doctors in hospitals to have the responsibility for reporting unnatural deaths when they were the individuals most subject to coronial scrutiny over such deaths. To overcome this problem, APME suggested that an element of independence should be introduced into the reporting scheme to ensure that there is external oversight of the process, which the Association felt was necessary, given what it referred to as a professional culture of silence which obstructs open disclosure.<sup>349</sup>

APME considered that the system outlined by the UK Government would provide an eminently workable model. APME also argued that the need to allocate additional resources to the State Coroner's Office should not impede the creation of a medical examination unit, given that medical errors were a leading cause of death and that there was substantial public interest in reducing preventable medical deaths.<sup>350</sup>

In relation to a proposed system for Victoria, APME submitted that a medical examination unit should be established and that medical practitioners within the unit should be responsible for notifying the coroner of reportable deaths.<sup>351</sup> While the unit should be subject to the directions of the State Coroner, APME suggested that the functions of the unit should be to:

- provide facilities and staff to oversee the certification of deaths. (Medical examiners may consult the treating doctor who provided the first opinion on the cause of death, the deceased's family, and any documentary evidence before providing a second and final medical determination of the cause of death); and
- conduct other appropriate investigations in relation to the cause of death of any person when the death appears to have been unexpected, unnatural or violent or to have resulted, directly or indirectly, from accident or injury. (Medical examiners must then report to the coroner any deaths that fall within the definitions of a reportable death or reviewable death).<sup>352</sup>

Ms Lorraine Long, founder of Medical Error Action Group (MEAG) also expressed concerns with the way the current reporting system relies on a single certifier. MEAG

<sup>350</sup> Ibid 7.

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<sup>&</sup>lt;sup>347</sup> The Royal Women's Hospital, Melbourne, *Submission no. 18*, 4.

<sup>&</sup>lt;sup>348</sup> Association for the Prevention of Medical Errors, Submission no. 79, 6.

<sup>&</sup>lt;sup>349</sup> Ibid.

<sup>&</sup>lt;sup>351</sup> Ibid.

<sup>352</sup> Ibid.

submitted that every hospital death should be reported to the relevant hospital's CEO to establish if the death is reportable to the coroner, as opposed to relying on the decision of the individual treating doctor. Another measure to strengthen the death certification process, according to MEAG, is to require two doctors to sign the medical cause of death certificate. MEAG also identified the need for the Coroner's Office to have an internal medical team with the ability to interpret medical records and an understanding of the internal workings of the hospital system.

Apart from those of medical stakeholders, several other submissions also addressed the issue of reforms to the death certification system. Ms Jacinta Heffey, a former coroner in Victoria informed the Committee that she believed that the Shipman case had led to an overreaction.<sup>355</sup> While conceding that a Shipman-type situation could arise in Victoria, she did not think that the solutions proposed by the Luce Report or the Shipman Inquiry were practical or warranted.<sup>356</sup> She had concerns with the Luce recommendation requiring that two doctors certify a death because she believed that this process could become a countersigning formality. Her other concerns with the proposals were that the infrastructural and resource requirements would be huge and that overall the practical implementation and monitoring of the proposals raised many doubts in her mind as to the ultimate effectiveness of the proposals.<sup>357</sup>

Ms Heffey advised the Committee that there were a number of ways in which the present system could be strengthened. She proposed that a coroner should have the power to investigate any death and should be able to investigate any concern of a general nature, as opposed to the current system, in which a coroner only has the power to investigate deaths which have been reported to the coroner.<sup>358</sup>

A second measure suggested by Ms Heffey was that there should be audits of the data held at the Registry of Births, Deaths and Marriages.<sup>359</sup> She suggested that a database queries facility should be established which could audit individual certifying doctors or different death types or that some sort of 'flagging' system be introduced.

The Traffic Accident Commission (TAC) also responded to the issue of death certification reform. While not endorsing any of the proposed systems in their entirety, the TAC supported a number of the measures which were proposed by the UK Government.<sup>360</sup> According to the TAC, an audit process is critical to ensure that the system operates effectively and would also lead to a higher likelihood that deaths

<sup>&</sup>lt;sup>353</sup> Medical Error Action Group, Submission no. 7, 7.

<sup>354</sup> Ibid.

<sup>&</sup>lt;sup>355</sup> Jacinta Heffey, Submission no. 33, 11.

<sup>356</sup> Ibid.

<sup>&</sup>lt;sup>357</sup> Ibid.

<sup>358</sup> Ibid.

<sup>&</sup>lt;sup>359</sup> Ibid.

<sup>&</sup>lt;sup>360</sup> Transport Accident Commission, Submission no. 50, 6.

which are ultimately the result of transport accident injuries are reported to the coroner.<sup>361</sup>

The TAC also supported the proposal that family members of the person who has died should be consulted and actively involved in the information gathering stage of the death investigation process. The TAC considered that this was important, given that many family members are intimately involved in issues such as health care, medical treatment and day-to-day living arrangements.<sup>362</sup>

A number of family members who have been involved in the coronial process also supported the measure that families should be consulted during the investigation process. Mr Graeme Bond supported the proposal put forward by the Shipman Inquiry, describing it as the strongest of the three proposals. He stressed that consultation with family members should be regarded as an essential part of the death certification process. Mr Bond also suggested that the registration of deaths function could be brought under the oversight of the State Coroner and that all deaths could be subject to basic screening which could lead to a closer analysis of particular doctors or hospital departments. He are the coronic process also supported the investigation process.

#### Discussion and conclusion

The Committee strongly agrees that there are a number of problems with the death certification system as it stands and that reform is indeed warranted. The Committee considers that the fundamental flaw of the current system is that the certification process does not occur in a team setting and the whole process is not subject to any kind of effective professional oversight. The practice of employing clerks at the Registry of Births, Deaths and Marriages to scrutinise death certificates is inadequate because the clerks have no medical qualifications and are therefore unable to effectively monitor the integrity of the information which is stated on the medical certificate of the cause of death.

The present system is unsatisfactory because it places reliance on a single doctor to certify the cause of death. This exposes the system to the risk that not all deaths requiring further investigation will be reported to the coroner. The Committee is concerned by the evidence it received which suggests that some doctors are not fulfilling their reporting obligations. The failure to notify the coroner has an obvious impact on the effectiveness of the Act because the coroner is unable to examine all deaths which may require further investigation. Accordingly, the Committee considers

<sup>362</sup> Ibid 6.

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<sup>&</sup>lt;sup>361</sup> Ibid 7.

<sup>&</sup>lt;sup>363</sup> See for example the submissions of Anne Anderson, Submission no. 43; Graeme Bond, Submission no. 48.

<sup>&</sup>lt;sup>364</sup> Graeme Bond, Submission no. 48, 6.

<sup>&</sup>lt;sup>365</sup> Ibid.

<sup>&</sup>lt;sup>366</sup> Ibid 7.

that greater emphasis needs to be placed on a team approach to the death certification process so that responsibility for certification of a death is not left to only one individual.

A measure designed to ensure that this occurs requires junior doctors (interns and doctors with less than five years' post-internship experience in Victoria) who certify the cause of a death to have the certification reviewed and endorsed by a more senior doctor. The Committee agrees with the conclusion of both the Shipman Inquiry and the Davies Commission in Queensland that a junior member of the clinical team may find it difficult to withstand the expectation of some treating doctors that s/he will inaccurately certify the cause of death rather than report a medical error related death to the coroner for investigation. Unlike the Davies Commission, which recommended that the doctor responsible for the care of the patients be responsible for certifying a death, the Committee considers that junior doctors should still be permitted to certify deaths but that they should be subject to the oversight of a more senior independent doctor who was not responsible for treating the patient before his or her death.

The Committee considers that this measure would introduce a level of objectivity and peer review to the death certification process because a junior doctor would be required to justify the diagnosis of the cause of death to another more experienced doctor who was not involved in the medical treatment which may or may not have caused the death of the patient.

Recommendation 6. That the *Births, Deaths and Marriages Registration Act* 1996 be amended to include a requirement that junior doctors who certify hospital deaths be required, wherever practicable, to have the certification reviewed and endorsed by a more senior doctor who was not responsible for treating the patient before his or her death. If the reviewer does not endorse the certificate, the reviewer must report the death to the coroner.

The Committee has also considered other measures including the reform proposals put forward in the Shipman Inquiry. The recommendation that the family of the person who died is consulted and has involvement in the death certification process is a sound proposal which the Committee also proposes to recommend. However, the Committee has a number of concerns regarding the viability of some of the measures proposed in the Shipman Inquiry. The Committee considers that the majority of deaths, which are unreportable deaths, do not require detailed oversight by a legally trained coroner and that in these cases families should be in a position to proceed with the funeral as soon as possible. In this regard, the Committee accepts the evidence of the Coroner's Office that over 86 percent of deaths are natural, uncontroversial, unpreventable and unreportable.<sup>367</sup>

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<sup>&</sup>lt;sup>367</sup> State Coroner's Office, Submission no. 70, 117.

Also, the Committee notes that a system such as the one proposed by the Shipman Inquiry requiring that every death be subject to coronial oversight would require ongoing annual funding in the vicinity of \$10 million. This would require more than double the annual budget, which is currently \$4.3 million. The Committee is therefore mindful of the need to consider measures which are effective, targeted and affordable.

The Committee is also mindful of the fact that any reform proposals need to be relevant to the system in place in Victoria and should utilise existing professional services and infrastructure. Unlike any other jurisdiction both in Australia and overseas, Victoria has established a coordinated coronial service essentially partnering the State Coroner's Office with VIFM, and this is recognised in the Act. The Committee believes that building on this successful partnership is the key to developing a more sophisticated death investigation system in which VIFM would have the responsibility for providing expert medical scrutiny, advice, training and leadership. As noted earlier, the Committee does not consider that every death should be referred to a legally trained coroner to consider whether it requires further scrutiny. Further, the Committee believes that there should be medical scrutiny and oversight of the death certification process and that VIFM, with its medical expertise, is best placed to undertake this role.

The Committee therefore proposes to recommend a new death certification system for Victoria in which all notifiable deaths will continue to be reported to the coroner but that all deaths will be subject to medical scrutiny by VIFM. The Conclusion to this report includes a flowchart representation of this system. Unlike the recommendation in the Luce Report that a doctor at the Coroner's Office should be responsible for undertaking this check, the Committee considers that VIFM should undertake this role as it has the appropriate medical expertise necessary to recruit, train, mentor and supervise medical specialists who would scrutinise the certificates. The Committee considers that it would be inappropriate for the Registrar of Births, Deaths and Marriages to carry out this function, as the Registrar's primary function is to administer the Births, Deaths and Marriages Registration Act 1996. While the Committee is of the view that the coronial system should be retained, the Committee considers that there should be an increased role for medically qualified investigators in the new system. The Committee therefore considers that the triage model proposed by VIFM in which VIFM is responsible for the front end functions of the coronial process, subject to oversight by the State Coroner, is the most appropriate model for the reform of the system.

Recommendation 7. That a medical review process for death certification be introduced so that all medical certificates of cause of death are reviewed by medical specialists at the Victorian Institute of Forensic Medicine, following the release of the body to the family, to establish whether further review of the death is required.

Recommendation 8. That where further review is necessary, this is to include the review of the medical case file, discussions with the doctor who certified the death and other medical personnel who were involved in treating the person before s/he died, along with consultation with family members and carers.

Recommendation 9. That the medical review process incorporate a triage approach to the review in which medical specialists at the Victorian Institute of Forensic Medicine would recommend which reported cases require further death investigation and which can be completed by a medical death investigation report

Recommendation 10. That legislation be enacted which requires the Registrar of Births, Deaths and Marriages to transmit a copy of the medical cause of death certificate to the Victorian Institute of Forensic Medicine within 24 hours of lodgement of the certificate at the Registry.

Recommendation 11. That, in the event that a system is developed which allows doctors to submit certificates online, legislation be enacted which permits the Victorian Institute of Forensic Medicine to access the live data in that system.

Recommendation 12. That the Victorian Institute of Forensic Medicine establish a computerised auditing system which enables patterns of unusual death rates to be identified and then further investigated, and that the Victorian Institute of Forensic Medicine provide regular reports on auditing outcomes to the State Coroner.

Recommendation 13. That the medical specialists at the Victorian Institute of Forensic Medicine be required to promptly report to the State Coroner all incidences in which doctors have failed to notify the coroner of a reportable death.

Recommendation 14. That the State Government resource the proposed medical review process and auditing system so that the Victorian Institute of Forensic Medicine is able to recruit, fund and manage a range of general and specialist medical practitioners and to train them in medicolegal work.

The Committee considers that in order to make the death certification system more effective there also needs to be an increased level of coronial oversight. While the Committee does not believe that there is a need for every death to be subject to the scrutiny of a coroner, the Committee considers that the system would be more effective if the State Coroner had the power to inquire into deaths which may not have been reported but which nevertheless may require further investigation.

An example of a situation where this power may prove effective is in relation to deaths identified through an auditing process as requiring further investigation. In the proposed system, concerns about patterns of unusual death rates in a particular institution or practice may be picked up by VIFM following a computer audit. In the current system, the State Coroner would only have jurisdiction to investigate these kinds of deaths if they had been reported. Giving the State Coroner a general power to undertake a preliminary investigation into unreported deaths to establish if further

investigation is warranted, will therefore make the system more effective. This matter is discussed in more detail in chapter five and a recommendation made to this effect.

Another measure to address the weakness of the current death certification system is to ensure that the new system is subject to supervisory oversight and that there is also accountability for that oversight. While the Committee is concerned by evidence suggesting that some doctors may be willing to alter certificates to avoid a death being reported to the coroner, the Committee is equally concerned that it appears that no such incidences have been reported to the MPBV for possible professional disciplinary action or to the DPP for criminal investigation. The Committee therefore considers that it is appropriate that the State Coroner be required to monitor the incidence of reportable deaths which are not reported and, where necessary, to refer specific incidents for further investigation. Furthermore, the Committee considers that the State Coroner should be required to provide this information to Parliament in an annual report.

Recommendation 15. That the *Coroners Act 1985* be amended to require the State Coroner to submit to Parliament an annual report which includes information on the number of reportable deaths which were not reported to the coroner during that year. The report must also include a summary of the action the State Coroner took in relation to each incident, including whether the State Coroner referred the matter to the Medical Practitioners Board of Victoria for possible investigation into a medical practitioner's professional conduct.

Other measures to strengthen the existing death certification system which the Committee recommends in other parts of this report include:

- reviewing the definitions of what constitutes a reportable death to ensure that the definitions are stated with a greater degree of clarity (see chapter four);
- reviewing the reporting requirements for particular kinds of deaths, such as nursing home deaths (see chapter four);
- an ongoing education campaign aimed at lifting the profile of the Coroner's Office so that the community and health professionals are more aware of the role of the coroner and are therefore more likely to raise general concerns about a death to the coroner (see chapters four and nine);
- a review of training programmes in death certification responsibilities (recommendation 5 above);
- a provision for the verification of the fact of death (recommendation 1 above); and
- increasing the maximum penalty for doctors who deliberately fail to notify the coroner of a reportable death to five years' imprisonment so that the penalty is consistent with the penalty imposed under the Cemeteries and Crematoria Act

2003 for doctors making false statements on the certificate authorising cremation (recommendation 3 above).

# CHAPTER FOUR — REPORTABLE DEATHS

When a doctor certifies a death, s/he must apply his or her medical knowledge to categorise the death according to legal terms in the Act. So that the coroner is informed of all reportable deaths, a doctor needs to be able to clearly understand and apply these definitions to every death which s/he certifies.

In this chapter the Committee considers the kinds of deaths which should be reported to the coroner under the Act. As part of this analysis, the Committee examines what a 'reportable' and 'reviewable' death is, as under the Act there is a general obligation to notify the coroner of these deaths. The Committee considers whether these categories of notifiable deaths are stated with sufficient clarity. This is an important issue for the inquiry because it is one of the reasons cited for under-reporting of deaths to the coroner. In the previous chapter the Committee discussed evidence received which suggested that doctors sometimes experience difficulty in determining whether a death falls into one of the legal categories of 'reportable death'.

Also in this chapter, the Committee considers whether there are any kinds of deaths which ought to be included as reportable deaths which are not currently within this category. In the discussion paper, the Committee questioned whether the current categories should be extended so that the deaths of additional vulnerable persons are also subject to coronial scrutiny. In the final part of this chapter the Committee considers an associated issue—whether there is an awareness in the community and in the medical profession of the general obligation to report notifiable deaths to the coroner.

# Categories of reportable deaths

'Reportable death' is defined in the Act<sup>368</sup>. There are two requirements. First, the Act requires that the death must be in some way 'connected' with Victoria.<sup>369</sup> Second, the death must meet one of the criteria set out in the Act, which in general terms include:

- unexpected, unnatural, violent and accidental deaths;
- deaths involving anaesthetics;
- deaths of persons in care or custody; and

<sup>&</sup>lt;sup>368</sup> Coroners Act 1985 s 3(1): definition of 'reportable death'.

<sup>&</sup>lt;sup>369</sup> For example, the person's body is in Victoria; or the death occurred in Victoria, or the cause of death occurred in Victoria or the person ordinarily resided in Victoria at the time of death: s 3(1): definition of 'reportable death'.

 deaths where the identity of the person or the cause of his or her death has not been established.<sup>370</sup>

The full definition of 'reportable deaths' from the Act is set out below:

S 3(1)

a death-

- (e) that appears to have been unexpected, unnatural or violent or to have resulted, directly or indirectly, from accident or injury; or
- (f) that occurs during an anaesthetic; or
- (g) that occurs as a result of an anaesthetic and is not due to natural causes; or
- (h) that occurs in prescribed circumstances; or
- (i) of a person who immediately before death was a person held in care; or
  - (iaa) of a person who immediately before death was a patient within the meaning of the *Mental Health Act 1986* but was not a person held in care; or
  - (ia) of a person under the control or care of the Secretary to the Department of Justice or a member of the police force; or
- (ib) of a person in respect of whom a court has made a non-custodial supervision order under section 26 of the *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997*; or
- (j) of a person whose identity is unknown; or
- (k) that occurs in Victoria where a notice under section 37(1) of the *Births, Deaths and Marriages Registration Act 1996* has not been signed; or
- (I) that occurs at a place outside Victoria where the cause of death is not certified by a person who, under the law in force in that place, is authorised to certify that death;

When the Act commenced in 1985, the Attorney-General indicated in the Bill's second reading speech that the drafters had adopted a plain English style in the Act:

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<sup>&</sup>lt;sup>370</sup> In this report the Committee does not include an analysis of the fourth category, i.e. 'deaths where the identity of the person or the cause of his or her death has not been established'. The question of the level of certainty required in establishing the cause of death is discussed later in this chapter.

(I)engthy sentences and complex words have been avoided where possible. Legal language need not be obscure and complex. While the ideas expressed in legislation may be complicated, they can be written in very simple terms.<sup>371</sup>

However the section 3(1) definition of reportable death followed a drafting style that is inconsistent with a plain English drafting style, which recommends the use of the active voice rather than the passive voice.<sup>372</sup> The use of the passive voice creates a degree of confusion. For example, the use of the words 'which appears to be unexpected/unnatural etc...' does not inform a person reading the legislation whether it is a coroner, a doctor or some other person to whom the death was unexpected etc.

Further, the terms used to describe the categories of reportable deaths retained similar language to that used in the UK *Coroners Act 1887*, which referred to general terms such as 'violent or an unnatural death' or 'sudden death the cause of which is unknown'.<sup>373</sup> This style of drafting, which states the law in general terms and leaves the details to be filled in by the courts or delegated legislation, has a major disadvantage.<sup>374</sup> While the descriptions of what constitutes a reportable death are stated in simple terms such as 'unexpected', 'unnatural', 'violent' and 'accidental', the precise meaning of these terms is often uncertain to the person with a duty to report these kinds to deaths to the coroner.

While the State Coroner does not issue formal legal guidelines to medical practitioners as to how these terms in the legislation should be interpreted, he has, in the last few years issued information sheets to medical practitioners in which he has indicated that specific kinds of deaths, such as asbestos-related deaths, should be classified as reportable deaths.<sup>375</sup>

The Victorian Institute of Forensic Medicine (VIFM) also does not issue medicolegal guidelines. The Institute has however published information on reportable deaths — Statement on Death Certificates and Reportable Deaths — which doctors can refer to. That information, while not amounting to formal legal guidelines, does offer some explanation of what kinds of deaths the legislation requires doctors to report to the coroner. It explains the legal categories of reportable deaths in a manner appropriate for a medical audience and refers doctors to the relevant State Coroner opinions on

<sup>&</sup>lt;sup>371</sup> The Hon JH Kennan, Attorney-General, Coroners Bill, Second Reading Speech, 16 October 1985, 372.

<sup>&</sup>lt;sup>372</sup> See for example the *Plain English Manual* published by the Commonwealth Office of Parliamentary Counsel,

<sup>12.</sup> Available at www.opc.gov.au.

<sup>&</sup>lt;sup>373</sup> Coroners Act 1887 (UK) s 3.

<sup>&</sup>lt;sup>374</sup> Office of Parliamentary Counsel, *Plain English Manual*, 6. Available at www.opc.gov.au.

<sup>&</sup>lt;sup>375</sup> See for example 'An Information Sheet for Reporting Medical Practitioners, Palliative Care Practitioners and Asbestos Support Groups', in which he advised that 'all deaths caused by asbestos or where asbestos is a contributory factor will now be managed by The State Coroner's Office'. The information sheet is not available on the State Coroner's Office web site but is reproduced in the State Coroner's Office, *Submission no. 70*, Appendix C.

what kinds of deaths the State Coroner considers to be reportable. The statement was revised in April 2006 and is available on the Medical Practitioners Board of Victoria (MPBV) website.<sup>376</sup> As an aid to readers, the statement is also reproduced in appendix 5.

### Categories of reportable deaths in other Australian jurisdictions

Laws determining which deaths are reportable to a coroner vary from jurisdiction to jurisdiction. Differences between jurisdictions mean that a death which may be reportable in one jurisdiction may not be reportable in another jurisdiction.

In relation to the category 'unexpected, unnatural, violent and accidental deaths', the laws in the Northern Territory, Tasmania, South Australia and Western Australia are similar to that in Victoria. In both New South Wales and the ACT the laws are also similar but use 'sudden death, the cause of which is unknown', not 'unexpected death'. New South Wales excludes the term 'unexpected' from its definition, while the ACT does not include 'unnatural'. Also, in New South Wales, accidental deaths are not reportable unless the person dies within a year and a day of the accident to which the cause of death is or may be attributable. In the ACT an accidental death is only reportable if it appears to be *directly* attributable to the accident. Other types of deaths which are reportable in the ACT include the deaths of persons who are killed or found drowned.

In Queensland, a reportable death includes a death which was 'violent or otherwise unnatural' or where the 'death happened in suspicious circumstances', 382 while in South Australia, the definition of reportable death also includes 'unusual deaths'. 383

<sup>&</sup>lt;sup>376</sup> 'Doctors and Death: Certificates and Coroners', Stephen Cordner, Professor, Forensic Medicine, Monash University, Director of the Victorian Institute of Forensic Medicine, and Helen McKelvie, Manager, Medico-legal Policy and Projects, Victorian Institute of Forensic Medicine. Available at <a href="http://medicalboardvic.org.au">http://medicalboardvic.org.au</a>. As an aid to readers, the article is reproduced at appendix 5.

<sup>&</sup>lt;sup>377</sup> Coroners Act 2003 (SA) s 3 (definition of reportable death: also includes 'unusual deaths' in this definition); Coroners Act 1995 (TAS) s 3 (definition of reportable death); Coroners Act 1996 (WA) s 3 (definition of reportable death). As to deaths from asbestos related diseases, it is understood that in the early 1990s, the Western Australian State Coroner investigated about 150 cases in an 18-month period but, by 2000, deaths of this kind were no longer investigated due to difficulties in obtaining evidence and resource issues: Comments of State Coroner in Case no.1598/03. Available at <a href="https://www.coronerscourt.vic.gov.au">www.coronerscourt.vic.gov.au</a>.

<sup>&</sup>lt;sup>378</sup> Coroners Act 1980 (NSW) s 12B(1)(b).

<sup>&</sup>lt;sup>379</sup> Coroners Act 1980 (NSW) s 12B(1)(f).

<sup>&</sup>lt;sup>380</sup> Coroners Act 1997 (ACT) s 13(1)(h), 13(1)(c).

<sup>&</sup>lt;sup>381</sup> Coroners Act 1997 (ACT) s 13(1)(a)-(b).

<sup>382</sup> Coroners Act 2003 (QLD) s 8(3)(b)-(c).

<sup>383</sup> Coroners Act 2003 (SA) s 3.

# Unexpected, unnatural, violent, accidental and anaestheticrelated deaths

A number of stakeholders expressed a degree of difficulty in understanding what is meant by these categories. This was discussed in chapter three. Each category is discussed below in further detail.

### Unexpected death

## Other Australian jurisdictions

'Unexpected' deaths, reportable in Victoria, are also reportable deaths in the Northern Territory, Tasmania, South Australia and Western Australia.<sup>384</sup> The remaining jurisdictions do not refer to this term in their legislation. In New South Wales the law is modelled on its UK counterpart and refers to 'sudden death, the cause of which is unknown'.<sup>385</sup> The Queensland legislation also makes no reference to unexpected deaths as a separate category of reportable deaths. It instead refers to deaths occurring in 'suspicious circumstances'.<sup>386</sup>

### **Evidence received by the Committee**

A number of stakeholders commented on the ambiguity associated with the term 'unexpected'. Associate Professor David Ranson pointed out that the Act refers to an unexpected death but does not state whether it is the treating doctor or some other person who determines whether the death is unexpected.<sup>387</sup> Furthermore, the concept of what is an unexpected death is at times subjective when it is dependent on the amount of information a person has about the medical history of the person who has died. In his personal submission, Associate Professor Ranson gave an example which illustrates the confusion that this phrase may occasionally cause:

If a patient attends a hospital for a routine hernia repair they and their family probably do not believe they will die in association with the procedure and neither would the nursing or medical staff involved in their care. However, if they develop a postoperative complication such as a deep vein thrombosis their risk of dying may have increased slightly from a medical perspective although the patient and their family might not appreciate this. If a pulmonary embolus develops from the deep vein thrombosis the medical staff may well believe they are [at] a very significantly increased risk of dying and indeed if death were to occur at this time the medical staff would not consider the death unexpected. From the perspective of the family however the patient's death

<sup>&</sup>lt;sup>384</sup> Coroners Act 2003 (SA) s 3 (definition of reportable death: also includes 'unusual deaths' in this definition); Coroners Act 1995 (TAS) s 3 (definition of reportable death); Coroners Act 1996 (WA) s 3 (definition of reportable death).

<sup>&</sup>lt;sup>385</sup> Coroners Act 1980 (NSW) s 12B(1)(b).

<sup>386</sup> Coroners Act 2003 (QLD) s 8(3)(b), (c).

<sup>&</sup>lt;sup>387</sup> D Ranson, 'How Effective? How Efficient? — The Coroner's Role In Medical Treatment Related Deaths' (1998) 57 *Health Issues* 287.

might still be completely unexpected as they only went into hospital to have their hernia repaired.<sup>388</sup>

Another problem which contributes to the confusion surrounding the interpretation of what is meant by the term 'unexpected death' is that the Act does not provide any guidance on the time in the course of a patient's illness that the unexpectedness needs to take place. This was also raised by Associate Professor Ranson in his submission.<sup>389</sup> He referred to another scenario to illustrate this point. He considered that, at the moment before that person dies, it is not unreasonable for the treating doctor to conclude that the person is about to die and therefore, on some level, it could be argued that the death at that moment in time is expected. He observed that the more fundamental question to consider is how the patient came to be in the terminal state.<sup>390</sup>

Former coroner Jacinta Heffey agreed that the term was ambiguous. She provided the Committee with an example of a case she dealt with when she was a coroner to illustrate her point. She referred to a case in which a terminally ill patient died not from the terminal illness but from medical error:

I recall one case of an elderly lady with oesophageal cancer who was dying from the disease but whose death was actually as a result of complications arising from the perforation of the oesophagus during an exploratory procedure. Her death was imminent in any event, but not from that cause. From recollection, this case was not reported as an "unexpected or accidental death" but came to the attention of the Coroners Office due to the fact that the deceased was a "person in care". <sup>391</sup>

VIFM also agreed that the term was too subjective and was therefore unhelpful.<sup>392</sup> VIFM submitted that unexpected deaths usually involve situations where the death was reportable as an unnatural, violent or accidental death and that the Committee should therefore consider excluding this term from the definition of reportable death.

A number of medical stakeholders also commented on the problems faced by medical staff in interpreting the legal meaning of the term 'unexpected death'. For instance, Dr Andrea Kattula, Medical Leader in Clinical Governance at the Austin Hospital, told the Committee that:

Doctors tend to approach that from a clinical perspective so they think of the term 'unnatural or unexpected' in the sense of the natural progression of that disease or that clinical problem. They find it quite difficult to view it from a legal perspective in terms of whether it was unnatural or unexpected in terms of the patient's background.

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<sup>&</sup>lt;sup>388</sup> David Ranson, *Submission no. 19*, 9–10.

<sup>389</sup> Ibid.

<sup>&</sup>lt;sup>390</sup> Ibid.

<sup>&</sup>lt;sup>391</sup> Jacinta Heffey, Submission no. 33, 2.

<sup>&</sup>lt;sup>392</sup> Victorian Institute of Forensic Medicine, Submission no. 40, 10.

Determining when that reasonable therapy becomes an unexpected or unnatural complication can be very difficult, particularly if the patient has a lot of complex medical problems. In the current environment we are treating a lot more complex patients, and there is a reasonable expectation that some of those patients will have complications even if their treatment is optimal. It is trying to define when does a complication become unnatural or unexpected.<sup>393</sup>

Mr Bill O'Shea, corporate counsel at Bayside Health, told the Committee that the term 'unexpected' by itself was 'not always enough', while Dr Eleanor Flynn submitted that a more detailed provision would be preferable. She considered that:

The fact that the death was expected by the medical staff should not relieve doctors of the need to report a death that was related to medical treatment, it may help the coroner to decide on the part played by the specific medical treatment in the death. <sup>396</sup>

#### Discussion and conclusion

The Committee received a considerable amount of evidence which indicates that 'unexpected death' is a subjective and ambiguous term. The Committee considers that the term is unnecessary in the legislation because 'unexpected deaths' would in any event be reported as unnatural, violent or accidental deaths. Also, the Committee notes that the term 'unexpected' is not used in a number of jurisdictions in Australia nor in the UK. The Committee therefore considers that, because the term causes a degree of confusion, it should be repealed from the definition of reportable death in the Act.

In a later section of this chapter the Committee considers whether there is a need for a specific provision which sets out the types of deaths occurring in a medical setting which should be reported to the coroner. In that section the Committee again examines the issue of 'unexpectedness' in the context of whether a death was an unexpected consequence of a health procedure.

Recommendation 16. That the *Coroners Act 1985* be amended to remove the word 'unexpected' from the definition of the term 'reportable death'.

### Unnatural death

Commentators have for some time questioned what the Act means when it uses this term, as there is no clear legal definition of 'unnatural death'.<sup>397</sup> A question that has

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<sup>&</sup>lt;sup>393</sup> Andrea Kattula, *Minutes of Evidence*, 28 November 2005, 227–8.

<sup>&</sup>lt;sup>394</sup> Bill O'Shea, *Minutes of Evidence*, 28 November 2005, 211.

<sup>&</sup>lt;sup>395</sup> Eleanor Flynn, Submission no. 37, 2.

<sup>&</sup>lt;sup>396</sup> Ibid.

been open to debate for some time is whether a death from mesothelioma<sup>398</sup>, caused by industrial exposure to asbestos 40 years before, is a natural or unnatural death.<sup>399</sup> The Act itself does not offer guidance to doctors faced with this question.<sup>400</sup> However, the VIFM statement on reportable deaths, which was updated in April 2006, refers to the fact that the State Coroner considers that deaths from diseases caused by asbestos are reportable.<sup>401</sup>

In November 2004 State Coroner Graeme Johnstone stated in a coronial finding that since January 2004 asbestos exposure deaths 'have been required to be reported'. 402 In the findings he explained that these kinds of deaths occur from accident or injury or are from an 'unnatural' cause. He reasoned that the 'accident or injury' which occurs in these cases is the initial exposure to the asbestos fibres, which eventually leads to the fatal disease. According to the State Coroner, the 'unnatural' element relates to the product creating the hazard (e.g. manufactured asbestos sheeting).403

# Other Australian jurisdictions

The ACT is the only Australian jurisdiction which does not refer to the term 'unnatural' in its coronial legislation. 404 All other jurisdictions refer to 'unnatural deaths', while the wording in the Queensland Act is slightly different. In that jurisdiction, a reportable death includes a death which was 'violent or otherwise unnatural'. 405 The Queensland

<sup>&</sup>lt;sup>397</sup> M Lynch, 'Natural Disease and the Coroner', *Journal of Law and Medicine*, Vol. 7 May 2000, 345–50; D Ranson, 'How Effective? How Efficient? — The Coroner's Role in Medical Treatment Related Deaths' (1998) 57 *Health Issues* 287.

<sup>&</sup>lt;sup>398</sup> Mesothelioma is a cancer which usually affects the outer membrane of the lungs (pleura). It is linked to exposure to asbestos: www.cancervic.org.au.

<sup>&</sup>lt;sup>399</sup> D Ranson, 'How Effective? How Efficient? — The Coroner's Role in Medical Treatment Related Deaths' (1998) 57 *Health Issues* 287.

The statement does however acknowledge that 'doctors should feel that they have a right to speak to a coroner or a pathologist if they think it is appropriate': Victorian Institute of Forensic Medicine, 400 'Doctors and Death: Certificates and Coroners', Stephen Cordner, Professor, Forensic Medicine, Monash University, Director of the Victorian Institute of Forensic Medicine, and Helen McKelvie, Manager, Medico-legal Policy and Projects, Victorian Institute of Forensic Medicine. Available at <a href="http://medicalboardvic.org.au">http://medicalboardvic.org.au</a>. As an aid to readers, the article is reproduced at appendix 5.

<sup>&</sup>lt;sup>401</sup> Ibid

<sup>&</sup>lt;sup>402</sup> Record of Investigation into a Death, Case No: 2286/04, State Coroner's Office, Victoria, 19 November 2004. Available at www.coronerscourt.vic.gov.au.

<sup>&</sup>lt;sup>403</sup> Ibid 1.

<sup>&</sup>lt;sup>404</sup> Coroners Act 1997 (ACT) s 13(1)(c).

<sup>&</sup>lt;sup>405</sup> Coroners Act 2003 (QLD) s 8(3)(b), (c).

State Coroner's guidelines<sup>406</sup> elaborate on the kinds of deaths which are reportable under this category:

By convention, diseases due to the longstanding effects of repeated relatively low-level exposure to chemicals are generally not regarded as unnatural. One reason for this is that the diseases that ultimately develop often involve the complex interplay between multiple environmental and genetic factors. Diseases arising in this way include cirrhosis in chronic alcoholics, lung cancer in smokers, mesothelioma in asbestos workers and dust-induced lung diseases in certain occupations. (...) See Matthews P, Foreman J, *Jervis on the Office and Duties of Coroners*, Sweet & Maxwell, London, 11<sup>th</sup> edition, 1983 at p 136. 407

The guidelines further explain that the conventional distinction between natural and unnatural deaths reflects the distinction adopted by the World Health Organisation (WHO) between natural and 'external' causes. The Australian Bureau of Statistics (ABS) also uses this distinction.

In the guidelines, specific causes of unnatural deaths are divided into three broad categories:

- Acute effects from or intoxication with chemicals (e.g. alcohol, drugs, poisons)
- Deprivation of air, food or water (e.g. asphyxia, drowning, dehydration, starvation)
- Physical factors (e.g. trauma, fire, cold, electricity, radiation).

According to the guidelines, deaths should still be regarded as unnatural even where the causative event occurred a long time before death:

In those cases there is frequently some complication that actually causes the death but if it is attributable to the initial injury the death can be said to be unnatural and therefore reportable.<sup>409</sup>

The Queensland State Coroner, Mr Michael Barnes, however considers that, under the current Queensland legislation, deaths from mesothelioma would not ordinarily be reportable in Queensland where the disease had been diagnosed and treated before the death occurred. 410

<sup>409</sup> Ibid.

<sup>&</sup>lt;sup>406</sup> The guidelines are issued under s. 14(1)(b) of the *Coroners Act 2003* (QLD) which requires the State Coroner of Queensland to issue guidelines to all coroners.

<sup>&</sup>lt;sup>407</sup> State Coroner's Guidelines — Version 0 December 2003; para 3.1.4. Available at http://www.justice.qld.gov.au/courts/coroner/pdfs/guidelines.pdf.

<sup>408</sup> Ibid.

<sup>&</sup>lt;sup>410</sup> Email, Nev Bawden, Acting Registrar, Office of the State Coroner, Queensland, to Legal Research Officer, 18 April 2006.

### International jurisdictions

There have been a number of decisions in which UK judges have considered the meaning of 'unnatural death'.<sup>411</sup> Recent case law suggests that in the UK, where a death is by natural causes but there is reasonable cause to suspect that medical neglect, lack of care or other culpable human failure could have contributed to the death, the death may be treated as an unnatural one.<sup>412</sup>

In *R v Poplar Coroner; Ex parte Thomas*<sup>413</sup> the UK Court of Appeal considered that the word unnatural should be given its ordinary meaning.<sup>414</sup> Whether a death is natural or unnatural depends on the cause of death, which is a question of fact. Simon Brown LJ however qualified this statement, adding:

That, however, is not to say that whether or not a particular death is properly to be regarded as unnatural is a pure question of fact. On the contrary it seems to me that some guidance at least can and should be given as a matter of law by the Courts to Coroners so that they may focus their attention upon the real considerations material to the decision and, one hopes, thereby achieve an essential measure of consideration in their approach to the section.<sup>415</sup>

In that case, the Court considered whether a death from asthma which occurred following a significant delay in obtaining medical treatment due to the late arrival of an ambulance was an unnatural death. All three Court of Appeal judges concluded that the death was natural as the asthma attack was the natural cause of the death. However Simon Brown LJ was prepared to recognise that 'cases may well arise in which human fault can and properly should be found to turn what would otherwise be a natural death into an unnatural one'.<sup>416</sup>

In *R v Inner London North Coroner; Ex parte Touche*<sup>417</sup> before the Court of Appeal, Simon Brown LJ again considered the meaning of 'unnatural'. In this case, Mrs Touche had given birth to twins by caesarean section but had later died from cerebral haemorrhage due to severe hypertension. The medical evidence indicated that had her post-operative blood pressure been monitored, her death probably would have been avoided. The coroner had considered that the death was from natural causes.

<sup>&</sup>lt;sup>411</sup> Under s 8(1)(a) of the *Coroners Act 1988* (UK) a coroner is required to hold an inquest where there is reasonable cause to suspect that a person died an unnatural death. There are a number of cases in which families have appealed a coroner's decision not to hold an inquest where the Coroner has concluded that the death was from natural causes. As such there are a number of judicial decisions examining the meaning of the expression 'unnatural death'.

<sup>&</sup>lt;sup>412</sup> Canning v Coroner for Northampton [2005] EWHC 3125, para 12.

<sup>&</sup>lt;sup>413</sup> R v Poplar Coroner; Ex parte Thomas [1993] 2 All ER.

<sup>&</sup>lt;sup>414</sup> Ibid 388.

<sup>&</sup>lt;sup>415</sup> Ibid.

<sup>&</sup>lt;sup>416</sup> Ibid 389.

<sup>&</sup>lt;sup>417</sup> R v Inner London North Coroner; Ex parte Touche [2001] 2 All ER 752.

The Court of Appeal however held that the death was unnatural. Simon Brown LJ referred to his own comments in *R v Poplar Coroner; Ex parte Thomas* to reconcile the different conclusions reached regarding the cause of death in these two cases. He held that a death was unnatural where it was both unexpected and the result of culpable human failing which had allowed the death to happen.<sup>418</sup> He observed that while such deaths may have undoubtedly been the result of natural causes, they should never have happened and that they were in that sense unnatural.<sup>419</sup>

The critical questions to be determined in this case were therefore whether there was a gross failure by the Hospital to provide Mrs Touche with basic medical attention, and, whether her need for medical attention was obvious at the time.<sup>420</sup>

However, where the need for medical attention is not obvious, a death may be interpreted by the UK courts as a natural one. An example is the recent case of *Canning v Coroner for the County of Northampton*.<sup>421</sup> In that case, a 14-year-old boy in respite care who had severe cerebral palsy and was blind and unable to speak died from an infarction<sup>422</sup> of the small bowel. There was medical evidence suggesting that peritonitis<sup>423</sup> was also present and that a delay of one and a half hours in seeking medical attention would not have altered the outcome.

# **Evidence received by the Committee**

A number of stakeholders agreed that the meaning of the term 'unnatural death' in the Act was indeed unclear and concern was expressed that the term did not include omissions or deaths where there had been a failure to treat or diagnose a medical condition.

According to the State Coroner, the problem with the interpretation of 'unnatural death' is that it:

can be difficult for doctors, police and the public to decide whether or not a death is reportable to the coroner. Further, unless the definition of reportable death is read widely, ambulance or medical responses to, say, an asthma attack may be excluded from coronial investigation despite their possible contribution to the cause of death and/or their potential to provide information to the coroner that will improve the safety of Victorians. In deciding whether a death is a 'reportable death' in these cases, a doctor may also have to make a preliminary

<sup>&</sup>lt;sup>418</sup> Ibid 765.

<sup>&</sup>lt;sup>419</sup> Ibid.

<sup>&</sup>lt;sup>420</sup> Ibid 760.

<sup>&</sup>lt;sup>421</sup> Canning v Coroner for Northampton [2005] EWHC 3125.

<sup>&</sup>lt;sup>422</sup> An area of necrosis in a tissue or organ resulting from obstruction of the local circulation by a thrombus or embolus, www.nlm.nih.gov/medlineplus.

<sup>&</sup>lt;sup>423</sup> Inflammation of the smooth transparent serous membrane that lines the cavity of the abdomen, www.nlm.nih.gov/medlineplus

determination about whether or not the patient provided him or her with informed consent for the actions which caused the death. 424

In order to clarify the circumstances in which a death should be reported, the Coroner's Office submitted that the Act should be amended to include a definition of 'natural causes death' in combination with an amended definition of 'reportable death' so that all deaths should be reportable unless they fit into the criteria set out by this new definition of 'natural causes death'.<sup>425</sup> The State Coroner's suggested wording for the definition of a natural causes death was as follows:

"natural causes death" occurs as the result of organ failure which is not caused or exacerbated by any outside influence such as violence, accident or injury (whether it appears to have resulted directly or indirectly), dental or medical intervention, medication, other drugs, poisons or toxins.<sup>426</sup>

However, a medical witness expressed concerns with this proposed definition. Professor Stephen Cordner, Director of VIFM, told the Committee that:

with the greatest of respect to the Coroner's submission, I do not think it fits the bill either, because its use of trying to turn it around, if you like, to define what is or is not a natural death just does the same thing. For example, it makes reference to a natural death being organ failure and then not due to a lot of things. It basically means that every cigarette related death and every alcohol related death is not a natural death and therefore has to be reported, which means we will have 20 000 deaths reported every year in Victoria. That is open to happen now, because with the way the definition is now you could construe tobacco related deaths or alcohol related deaths as unnatural deaths or deaths due directly or indirectly to accident or injury. So tobacco deaths are indirectly due to injury. Technically they are all reportable but there is quite a decent understanding that if we reported every carcinoma of the lung or heart disease due to smoking, we would be submerged. I do not think it will be got around with the definition that is in the Coroner's submission. 427

The second thing about the definition in the Coroner's submission, and I might be doing it a slight disservice, is a reference in it to a death not being expected following a health procedure being a death that is reportable. I just get the feeling that the person who wrote that might be thinking that that captures adverse events, but it does not capture adverse events because adverse events include failure to diagnose — which is not after a health procedure; it includes drug treatment — and it is probably stretching a point to say that drug treatment is a medical procedure — and failure to treat. So the late arrival of an ambulance is not captured by that. I have no difficulty with that specific thing about reporting deaths that are not expected following a health procedure, but if that is intended to capture adverse events, then it does not do that.

<sup>424</sup> State Coroner's Office, Submission no. 70, 71–2.

<sup>&</sup>lt;sup>425</sup> Ibid 72.

<sup>&</sup>lt;sup>426</sup> Ibid.

<sup>427</sup> Stephen Cordner, Victorian Institute of Forensic Medicine, *Minutes of Evidence*, 19 September 2005, 124.

People have been thinking for decades how to put firm walls around what deaths will be reported, and nobody has succeeded. So it will be very interesting to see whether you are able to do that.<sup>428</sup>

In its submission, VIFM acknowledged that there is no definitional basis for excluding tobacco- and alcohol-related deaths, as they can be seen to be 'unnatural' or resulting from 'injury'.<sup>429</sup> However, VIFM submitted that the decision to exclude these deaths from the category of reportable deaths was a practical and sensible one that is maintained around the world.

Ms Heffey advised the Committee of the difficulties the expression 'unnatural death' had presented to her when she was a coroner:

It has never been clear to me what sorts of deaths are intended by this expression. Further, it has, in my view, a regressive consequence. It entrenches the historical notion that the coroner is interested only in deaths that are not from natural causes. This can be a very misleading. A natural cause death may well require investigation if that death could have been avoided with different medical management or if it had been correctly diagnosed.<sup>430</sup>

Apart from VIFM, a number of other witnesses also expressed concern that the category did not make reference to deaths resulting from a failure to treat or diagnose or to deaths resulting from an inappropriate discharge from hospital. The Association for the Prevention of Medical Errors (APME) submitted that the definition posed a particular difficulty in relation to medical errors which occurred through an omission rather than through a positive act and argued that it was unlikely that a death would be reportable under the current definition if:

- a critically ill patient presents at an emergency ward but is incorrectly categorised as a semi-urgent patient and dies without being consulted by a doctor; or
- a critically ill patient is wrongly discharged from hospital without being examined by a doctor and subsequently dies; or
- a critically ill patient is not properly monitored after a drug is administered and dies as a result. 431

Mr Graeme Bond and Mrs Caroline Storm also agreed that the definition did not specifically refer to medical treatment cases which involved a failure to act. They told the Committee about their separate personal experiences which had involved the death of a family member.<sup>432</sup> Mr Bond made the comment that premature or

<sup>428</sup> Ihid

<sup>&</sup>lt;sup>429</sup> Victorian Institute of Forensic Medicine, Submission no. 40, 10–11.

<sup>&</sup>lt;sup>430</sup> Jacinta Heffey, Submission no. 33, 3.

<sup>&</sup>lt;sup>431</sup> Association for the Prevention of Medical Errors, *Submission no.* 78, 9.

<sup>&</sup>lt;sup>432</sup> Graeme Bond, *Minutes of Evidence*, 22 August 2005, 2; Caroline Storm, Submission no. 28, 1.

inappropriate discharge or failure to admit or re-admit were all commonly associated with deaths of the mentally ill.<sup>433</sup> He based this statement on his observations while monitoring coronial cases over a 12-year period commencing in 1994 with the inquest into the death of his son. Jason Bond.

Representatives from the medical profession also detailed a number of problems they have experienced when deciding whether a death is reportable under this category. For example, Dr Mark Garwood, Chief Medical Officer of Austin Health, explained to the Committee that the category was the cause of much confusion, particularly where an initial incident was not known of at the time of death or where it was unclear whether the incident had contributed to death.<sup>434</sup>

The Australian Medical Association (AMA) made a general comment that the categories of reportable deaths allow for misunderstanding and misinterpretation due to the intricate circumstances in which many deaths occur in the medical setting.<sup>435</sup> The MPBV agreed, considering that anecdotal evidence suggested that, while there was considerable law on the meaning of expressions such as 'unnatural', doctors did have difficulties in interpreting what was meant by the category.<sup>436</sup>

The Committee discusses its conclusion on this category following its consideration of accidental deaths and deaths involving medical procedures and anaesthetic.

# Deaths from accidents or injuries

The Act requires that deaths which result, directly or indirectly, from accident or injury be reported to the coroner.<sup>437</sup> VIFM offers the following advice to doctors as to what is included in this category:

This category includes all homicides, suicides and accidental deaths. 'Injury' is widely construed to include not only the effects of trauma but also those of drugs, poisons, heat, cold and electricity. It is not so widely construed to include 'natural' deaths following tobacco or alcohol abuse—for instance, carcinoma of the lung or cirrhosis of the liver, which should not be reported. However, in contrast, the State Coroner has indicated that he considers deaths from diseases caused by asbestos to be reportable. 438

<sup>&</sup>lt;sup>433</sup> Graeme Bond, *Submission no. 48*, 15. He also refers to Dr Peter Archer, Director of Emergency Services at Maroondah Hospital, who wrote to the Minister for Health in February 2004 detailing how to his knowledge some 13 people turned away from his hospital after presenting with mental illness had committed suicide and in one case murdered a partner.

<sup>&</sup>lt;sup>434</sup> Austin Health, Submission no. 45, 1.

<sup>&</sup>lt;sup>435</sup> Australian Medical Association (Victoria), *Submission no.* 38, 1.

<sup>&</sup>lt;sup>436</sup> Medical Practitioners Board of Victoria, *Submission no.* 56, 2.

<sup>&</sup>lt;sup>437</sup> Coroners Act 1985 s 3(1): definition of 'reportable death'.

<sup>&</sup>lt;sup>438</sup> 'Doctors and Death: Certificates and Coroners', Stephen Cordner, Professor, Forensic Medicine, Monash University, Director of the Victorian Institute of Forensic Medicine, and Helen McKelvie, Manager, Medico-legal 100

In relation to 'adverse event deaths', the revised VIFM statement advises that:

It is increasingly being understood that many patients in hospital are subject to adverse events and as a consequence, some die. How does the doctor evaluate this in terms of the obligations to complete a death certificate or report the death to the coroner? The following comments can be made:

- A good baseline would be to ask (if the possibility of an adverse event arises) if this death may be 'directly or indirectly due to accident or injury'.
- The doctor should be mindful that in these circumstances later allegations of a 'cover-up' might arise. Understanding the family's preferences may be helpful here. If the family voices concerns about the adequacy of the patient's management while in hospital, a safe course would be to refer the death to the coroner. (Pursuing this course does not necessarily mean that the coroner will accept the report, or if it is accepted, that there will be an autopsy.)<sup>439</sup>

In November 2003 the State Coroner decided that deaths associated with falls were reportable deaths even if the medical cause of death was natural causes. The Coroner's Office told the Committee that the State Coroner had advised medical colleges and hospitals of the change in a letter. It is a letter of the change in a letter.

### Other Australian jurisdictions

The Northern Territory, Western Australian and Tasmanian legislation is identical to the legislation in Victoria with regard to the requirement that deaths resulting directly or indirectly from accident or injury be reported to the coroner.<sup>442</sup> In New South Wales the law is similar, although that jurisdiction uses the term 'sudden death, the cause of which is unknown', not 'unexpected death'.<sup>443</sup> Also, in New South Wales, accidental deaths are not reportable unless the person died within a year and a day of the accident to which the cause of death is or may be attributable.<sup>444</sup>

Policy and Projects, Victorian Institute of Forensic Medicine. Available at http://medicalboardvic.org.au. As an aid to readers, the article is reproduced at appendix 5.

<sup>&</sup>lt;sup>439</sup> Ibid.

<sup>&</sup>lt;sup>440</sup> State Coroner's Office, *Submission no. 70*, 122. The submission states that in many fall-associated deaths, the immediate cause of death is pneumonia. For further information see T Driscoll, G Henley and JE Harrison, *The National Coroners Information System as an information tool for injury surveillance,* Injury research and statistics series no. 21, AlHW, 2003.

<sup>441</sup> State Coroner's Office, Submission no. 70, 122.

<sup>&</sup>lt;sup>442</sup> Coroners Act 1995 (NT) s 12(1); Coroners Act 1996 (WA) s 3, interpretation of 'reportable death'; Coroners Act 1995 (Tas) s 3, definition of 'reportable death'.

<sup>443</sup> Coroners Act 1980 (NSW) s 12B(1)(b).

<sup>444</sup> Coroners Act 1980 (NSW) s 12B(1)(f).

In the ACT however, an accidental death is only reportable if it appears to be *directly* attributable to the accident.<sup>445</sup> Other types of deaths which are reportable in the ACT include the deaths of persons who are killed or found drowned.<sup>446</sup>

There is an inconsistency in approach in the Australian jurisdictions regarding the classification of deaths associated with accidental falls. While not clearly articulated in the legislation, these kinds of deaths, according to the Queensland guidelines, should be reported in Queensland:

An elderly person falls and fractures her femur. While in hospital she develops pneumonia and dies. It is unlikely that she would have contracted pneumonia had she not been immobilised and therefore the death can be attributed to the fall.<sup>447</sup>

This is in contrast to the position in New South Wales. The New South Wales Act does not require a doctor to report a death of a person who was 65 years old or older where the person died as a result of an accidental injury which was attributable to the age of the person. Doctors are however required to report these kinds of deaths where the accident took place in a nursing home or hospital.

### **Evidence received by the Committee**

Two stakeholders addressed the issue of the reporting requirements for deaths associated with accidents, each with different concerns. The Transport Accident Commission (TAC) submitted that, in some instances when a doctor certifies the cause of death, s/he may not have the patient's full medical history and may therefore not be aware of prior accidents or pre-accident conditions. In its submission the TAC gave an example of a case in which an elderly woman was severely injured in a car accident. She was cared for in a nursing home but later died as a result of complications from a condition which pre-dated the accident. There was medical evidence to suggest that her severely compromised health after the accident had contributed to a deterioration of her condition. The TAC however indicated that it was concerned that the GP who certified the death at the nursing home may not have known the full medical history.

The Australian Council for Safety and Quality in Health Care (ACSQHC) had a different concern.<sup>451</sup> ACSQHC took issue with the rationale for the requirement that

<sup>&</sup>lt;sup>445</sup> Coroners Act 1997 (ACT) s 13(1)(h).

<sup>446</sup> Coroners Act 1997 (ACT) s 3(1)(a), (b).

<sup>&</sup>lt;sup>447</sup> State Coroner's Guidelines — Version 0 December 2003, para 3.1.4. Available at http://www.justice.qld.gov.au/courts/coroner/pdfs/guidelines.pdf.

<sup>&</sup>lt;sup>448</sup> Coroners Act 1980 (NSW) s 12B(2). Note that there are also other requirements: see s 12(B)(2)(b), (c).

<sup>449</sup> Coroners Act 1980 (NSW) s 12B(3).

<sup>&</sup>lt;sup>450</sup> Transport Accident Commission, Submission no. 50, 5.

<sup>&</sup>lt;sup>451</sup> Australian Council for Safety and Quality in Health Care, *Submission no. 51*, 2.

the deaths of elderly people who had accidentally fallen some time prior to the death be reported to the coroner:

There are many deaths that occur in hospitals that fall into the current categories of reporting, but clearly are not 'suspicious' or associated with any culpability whatsoever. These include, for example, deaths resulting from accidental falls in elderly people.

It is not clear whether or why such deaths are required to be reported. If the purpose of reporting is to ensure that all potentially suspicious deaths or deaths in which there is some potential culpability are investigated, the ACSQHC would question whether such broad reporting criteria actually facilitate fulfilment of that purpose.

If, however, reporting is required for some other purpose—for example, to facilitate the collection of epidemiological data about the incidence, prevalence, or aetiology of falls so as to provide a basis for improving public health and safety, then such a purpose should be stated in the Act. 452

The Committee discusses its conclusion on this category following its consideration of deaths involving medical procedures and anaesthetic.

# Deaths involving medical treatment

Medical procedure related deaths are not a separate category of reportable deaths in the Act. 453 However, three other Australian jurisdictions have within the last nine years introduced a special category of medical related deaths which sets out the criteria for when these kinds of deaths should be reported to the coroner. While the categories state with some detail the kinds of deaths which should be reported, the categories do not extend to deaths where there has been a failure to treat or diagnose a patient's condition or to deaths following the inappropriate discharge of a patient from a hospital.

### Other Australian jurisdictions

In Queensland a death is reportable to the coroner if the death 'was not reasonably expected to be the outcome of a health procedure'. 454 'Health procedure' is broadly defined as:

<sup>&</sup>lt;sup>452</sup> Ibid.

<sup>&</sup>lt;sup>453</sup> Deaths resulting from medical procedures should be reported if they meet the 'unexpected, unnatural, violent or accidental death' category discussed above. If anaesthesia is involved with the death it may be reportable as a death involving anaesthetics. This is discussed in the next section.

<sup>&</sup>lt;sup>454</sup> Coroners Act 2003 (QLD) s 8(3): definition of 'reportable death'; Schedule 2: definition of 'health procedure'. As noted in chapter three, the royal commission which investigated Dr Patel and other doctors in public hospitals in Queensland recommended that the Queensland Act be amended to include an additional subcategory of medical procedure deaths. The Commission recommended that all deaths occurring within 30 days of elective surgery should be reported to the Coroner: Queensland, *Public Hospitals Commission of Inquiry Report*, 2005, 532. The

A dental, medical, surgical or other health related procedure, including for example the administration of an anaesthetic, analgesic, sedative or other drug.<sup>455</sup>

The Queensland State Coroner's guidelines give further direction for doctors to consider when to report a death:

Did the health procedure cause the death?

Would the person have died at about the same time if the procedure was not undertaken?

Was the procedure necessary for the person's recovery rather than optional or elective?

Did the death result directly from the underlying ailment, disease or injury?

Was the procedure carried out with reasonable care and skill?

If "yes" to all—the procedure didn't cause the death.

Was the death an unexpected outcome?

Was the condition of the patient such that death was foreseen as more likely than not to result from the procedure?

Was the decision to undertake the procedure anyway, a reasonable one in the circumstances having regard to the patient's condition including his/her quality of life if the procedure was not carried out?

Did the decision to undertake the procedure consider the risk of death was outweighed by the potential benefits the procedure could provide?

Was the procedure carried out with all reasonable care and skill?

If "yes" to all—death was not an unexpected outcome. 456

The ACT also has a special category of reportable deaths relating to medical procedures. Deaths are reportable where a person:

- (e) dies during or within 72 hours after, or as a result of—
  - (i) an operation of a medical, surgical, dental or like nature; or
  - (ii) an invasive medical or diagnostic procedure;

Commission indicated that further consultation may be required to establish an appropriate time frame for the reporting period, as a period shorter than 30 days may be appropriate.

<sup>&</sup>lt;sup>455</sup> Coroners Act 2003 (QLD) s 8(3): definition of 'reportable death'; Schedule 2: definition of 'health procedure'.

<sup>&</sup>lt;sup>456</sup> State Coroner's Guidelines — Version 0 December 2003, para 3.1.3. Available at http://www.justice.qld.gov.au/courts/coroner/pdfs/guidelines.pdf.

other than an operation or procedure that is specified in the regulations to be an operation or procedure to which this paragraph does not apply.

### The relevant regulations provide that:

- (1) An operation or procedure specified for this section is not an operation or procedure for the Act, section 13 (1) (e) if the doctor responsible for carrying it out gives a certificate stating that the death has not happened as a result of that operation or procedure.
- (2) The following operations or procedures are specified for this section:
  - (a) the giving of an intravenous injection;
  - (b) the giving of an intramuscular injection;
  - (c) intravenous therapy;
  - (d) the insertion of a line or cannula;
  - (e) artificial ventilation;
  - (f) cardiac resuscitation;
  - (g) urethral catheterisation. 457

The South Australian Act also has a separate category of reportable deaths for medical related deaths. This provision is similar to the ACT provision but specifies a shorter 24-hour time frame so that deaths which occur within 24 hours of procedures must be reported. The South Australian provision is however drafted in wider terms as doctors are also required to report deaths where a person has sought emergency treatment at a hospital in the 24-hour period before his or her death. The relevant section provides that deaths are reportable in the following circumstances:

- (d) that occurs during or as a result, or within 24 hours, of-
  - (i) the carrying out of a surgical procedure or an invasive medical or diagnostic procedure; or
  - (ii) the administration of an anaesthetic for the purposes of carrying out such a procedure, not being a procedure specified by the regulations to be a procedure to which this paragraph does not apply;
- (e) that occurs at a place other than a hospital but within 24 hours of—
  - (i) the person having been discharged from a hospital after being an inpatient of the hospital; or

<sup>&</sup>lt;sup>457</sup> Coroners Regulations 1994 (ACT) s 5.

<sup>&</sup>lt;sup>458</sup> Coroners Act 2003 (SA) s 3, definition of reportable death.

(ii) the person having sought emergency treatment at a hospital;

The regulations currently specify a number of procedures to which the section does not apply.<sup>459</sup>

### **Evidence received by the Committee**

A number of stakeholders commented favourably on the approach taken in the other Australian jurisdictions which have created a separate category of reportable deaths for medical procedure deaths. For instance, General Practice Division Victoria (GPDV) made the following observation:

Recent discussions with practising doctors [...] suggest that there is a poor understanding of when deaths involving medical treatment should be reported, partly because they are not a distinct category. This may well contribute to the problem of under-reporting. More detailed provisions could only assist, as long as they are backed up by effective education.<sup>460</sup>

Associate Professor Ranson had doubts about the usefulness of a provision which was based on the requirement to report deaths which occur within a certain period of time following a medical procedure:

The ACT category of reportable deaths relating to medical procedures involves very specific situations including timelines such as: 72 hours after an operation, and refers to: invasive medical diagnostic procedures. Again whilst the period of time is easy to assess it is arguable whether the death of all individuals within 72 hours of surgery is a sufficient discriminator of deaths that need to be reported to a coroner.<sup>461</sup>

Mr Bond however favoured the approach taken in the ACT legislation, which specifies a 72-hour period, as opposed to the shorter 24 hour period specified in South Australia. He was also of the view that deaths where there had been a failure to treat should be specifically included in the legislation because failure to treat a patient may have the same fatal consequences as unsuccessfully treating a patient. He therefore submitted that the category should be extended to include deaths which occur following 'any presentation at a hospital'.

Ms Kathryn Booth, a principal at law firm Maurice Blackburn Cashman (MBC), provided a submission on behalf of its Medical Negligence Practice Group. She advised the Committee that the group had provided legal representation at about 20 inquests over the last five years and has acted for individuals and families who have had concerns about their medical care. Based on that experience, the group submitted that a more detailed provision for death involving medical treatment was

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<sup>&</sup>lt;sup>459</sup> Coroner's Regulations 2005 (SA), r 4.

<sup>&</sup>lt;sup>460</sup> General Practice Division Victoria, *Submission no. 40*, 2.

<sup>&</sup>lt;sup>461</sup> David Ranson, *Submission no. 19*, 11.

<sup>462</sup> Graeme Bond, Submission no. 48, 3.

required.<sup>463</sup> The group considered that the Queensland State Coroner's guidelines provided a good foundation but that any proposed provision should also include deaths caused by the failure or refusal to perform a procedure or to treat, because deaths, particularly in relation to psychiatric patients, had frequently occurred in this manner.

The president of APME, Mr Jason Rosen, identified a number of advantages in drafting a provision based on the Queensland provision. APME preferred the Queensland model over the South Australian and ACT models because the Queensland model did not place arbitrary time constraints on when the death must occur for it to be reportable. APME considered however that the preferred model should be altered to ensure that deaths caused by an omission to act in the medical context were also included in the definition. The provision suggested by APME was that the definition of 'health procedure' should:

(b) include[..] an omission to act in a hospital or other health related institution when such a failure departs from a standard of reasonable care or is in breach of a recognised duty to act.<sup>465</sup>

Ms Heffey considered that hospital related deaths were an area of concern and that the test for whether a hospital death is reportable should be whether the death from the particular cause was potentially avoidable or preventable had the clinical management been different. She considered that this category would cover a number of the scenarios, including deaths:

- occurring consequent on premature discharge from hospital;
- due to misdiagnosis;
- due to failure to administer appropriate therapy; and
- due to failure to respond in a timely fashion.

One stakeholder, the Victorian Bar, did not favour a change to a more detailed provision, reasoning that there will always be an element of judgement involved in whether to report, even with a more detailed provision.<sup>467</sup>

The Committee discusses its conclusion on this category following its consideration of anaesthetic-related deaths.

ibid.

<sup>&</sup>lt;sup>463</sup> Maurice Blackburn Cashman, Submission no. 42, 2.

<sup>&</sup>lt;sup>464</sup> Association for the Prevention of Medical Errors, *Submission no.* 78, 11.

<sup>&</sup>lt;sup>465</sup> Ihid

<sup>466</sup> Jacinta Heffey, Submission no. 33, 5.

<sup>&</sup>lt;sup>467</sup> The Victorian Bar, Submission no. 81, 4.

# Deaths involving anaesthetics

The Act also requires doctors to report to a coroner 'a death that occurs during an anaesthetic; or that occurs as a result of an anaesthetic and is not due to natural causes'. 468

Dr Ian Freckelton and Associate Professor Ranson have identified the following as the most common kinds of deaths involving anaesthetic-related issues:

- deaths caused by burns from inflammable anaesthetic agents catching on fire;
- deaths due to incorrect drugs administered by anaesthetists;
- deaths due to medical complications (such as anaphylactic shock) resulting from anaesthetic agents, usually muscle relaxants;
- deaths where anaesthetists have failed to maintain an airway, to monitor a patient adequately, or to assess a patient properly prior to surgery;
- complications following spinal anaesthesia, such as where a haematoma is created at the site of an epidural, leading to necrosis of the spinal cord, which can be fatal:
- inadequate management of prolonged hypotension during surgery;
- inadequate management of hypothermia;
- unsatisfactory preoperative assessment by anaesthetists; and
- air embolisms.<sup>469</sup>

The Act does not define what is meant by the term 'anaesthetic'. The Victorian Consultative Council on Anaesthetic Mortality and Morbidity (VCCAMM)<sup>470</sup> had previously expressed concern with the lack of legislative definition:

The present Victorian legislation for reporting deaths associated with anaesthesia is confusing and less satisfactory than in all other Australian States. Many doctors are unsure when death associated with anaesthetic-related procedures should be reported. [...]

<sup>&</sup>lt;sup>468</sup> For an account of the historical reasons for the inclusion of anaesthesia-related deaths as a separate category of reportable deaths, see the discussion in Ian Freckelton and David Ranson, *Death Investigation and the Coroner's Inquest* (2006) 170.

<sup>&</sup>lt;sup>469</sup> Ibid 173.

<sup>&</sup>lt;sup>470</sup> VCCAMM is a consultative council comprising 13 specialist anaesthetists, a surgeon, an epidemiologist and representatives from the Australian and New Zealand Intensive Care Society, the Royal Australasian College of Surgeons, VIFM, the Australasian College for Emergency Medicine and the Department of Human Services. Its terms of reference include monitoring, analysing and reporting on key areas of potentially preventable anaesthetic mortality and morbidity within the Victorian hospital system: <a href="https://www.health.vic.gov.au/vccamm/about/index.htm">www.health.vic.gov.au/vccamm/about/index.htm</a>.

In addition the definition of an anaesthetic for the purpose of reporting to the coroner should be expanded to identify the changing role of anaesthetists in providing regional and general anaesthesia, sedation, resuscitation and pain management. Moreover provision of anaesthesia is no longer restricted to operative surgery but is involved in an ever expanding range of complex interventional procedures performed outside the operating theatre. These circumstances must be included in any audit of mortality or morbidity.<sup>471</sup>

The VIFM statement on reportable deaths however does offer advice to doctors on what kinds of deaths should be reported to the coroner:

The death is intra- or post-procedural:

\*any death occurring while the patient is under the effects of anaesthesia (anaesthesia is not defined further and therefore could include a general, regional or local anaesthetic or even simply sedation) must be reported to the coroner.

\*where deaths occur as a result of anaesthesia and are not due to natural causes, they must be reported to the coroner. This is meant to capture those deaths where there is an anaesthetic disaster (eg overdose, wrong gases administered, unrecognised oesophageal intubation etc) but the patient 'survives' the surgery, is sent to ICU with irreversible cerebral anoxia and dies some time later. Arguably, this is a death due 'directly or indirectly to accident or injury' but was regarded by the lawmakers as sufficiently important to specify. If however, a patient has a myocardial infarction during anaesthesia that was a complication of the patient's underlying coronary atherosclerosis, and the patient has cerebral anoxia as a consequence and dies in ICU some time later, then this death should not be reported. It is a natural death that did not occur as a result of the anaesthesia and a death certificate could therefore be completed. If the death had occurred from myocardial infarction as a result of the anaesthetic being administered, this must be reported. (It is acknowledged that this different handling by the law of a death from the same cause in the same setting simply because one was delayed, is inconsistent. It may be something that is remedied by the Parliamentary review of the requirements for reportable deaths.). 472

### Other Australian jurisdictions

The Western Australian and the Northern Territory Acts are identical to the Victorian Act with regard to the requirement that a doctor report a death that occurs during an anaesthetic; or that occurs as a result of an anaesthetic and is not due to natural

<sup>&</sup>lt;sup>471</sup> 'Statement on Uniformity of Coronial Legislation'. Available at www.health.vic.gov.au/vccamm.

<sup>&</sup>lt;sup>472</sup> 'Doctors and Death: Certificates and Coroners', Stephen Cordner, Professor, Forensic Medicine, Monash University, Director of the Victorian Institute of Forensic Medicine, and Helen McKelvie, Manager, Medico-legal Policy and Projects, Victorian Institute of Forensic Medicine. Available at <a href="http://medicalboardvic.org.au">http://medicalboardvic.org.au</a>. As an aid to readers, the article is reproduced at appendix 5.

causes.<sup>473</sup> The requirement in the Tasmanian Act is similar — the only difference is that the Tasmanian Act also refers to sedation.<sup>474</sup>

In the South Australian Act 'anaesthetic' is defined and means 'a local or general anaesthetic, and includes the administration of a sedative or analgesic'. 475 Under this Act, deaths must be reported to a coroner for the death of a person:

- d) that occurs during or as a result, or within 24 hours, of-
- (i) the carrying out of a surgical procedure or an invasive medical or diagnostic procedure; or
- (ii) the administration of an anaesthetic for the purposes of carrying out such a procedure, not being a procedure specified by the regulations to be a procedure to which this paragraph does not apply;<sup>476</sup>

In New South Wales, the criterion is that:

the person died while under, or as a result of, or within 24 hours after the administration of, an anaesthetic administered in the course of a medical, surgical or dental operation or procedure or an operation or procedure of a like nature, other than a local anaesthetic administered solely for the purpose of facilitating a procedure for resuscitation from apparent or impending death.<sup>477</sup>

In the ACT, there is no specific reference in the legislation to deaths involving anaesthetics. This is because anaesthesia related deaths are reportable as medical procedure related deaths. In Queensland the position is the same, as deaths involving anaesthetics are also classed under the broader category of reportable deaths associated with health procedures.

### **Evidence received by the Committee**

Most stakeholders agreed that the definition of deaths involving anaesthetics needed to be revised. However, differing views emerged regarding the form of the revision that was required. A number of stakeholders, including the State Coroner, submitted that a definition of anaesthesia was required, whereas VCCAMM endorsed the approach in the Queensland legislation, which was to include these deaths under the

<sup>&</sup>lt;sup>473</sup> Coroners Act 1996 (WA) s 3, definition of 'reportable death'; Coroners Act 1993 (NT), s 12: definition of 'reportable death'.

<sup>&</sup>lt;sup>474</sup> Coroners Act 1995 (TAS) s 2, definition of 'reportable death'.

<sup>&</sup>lt;sup>475</sup> Coroners Act 2003 (SA) s 3, definition of 'anaesthetic'.

<sup>&</sup>lt;sup>476</sup> Coroners Act 2003 (SA) s 3, definition of 'reportable death'.

<sup>&</sup>lt;sup>477</sup> Coroners Act 1980 (NSW) s 13(1)(f).

<sup>&</sup>lt;sup>478</sup>Coroners Act 1997 (ACT) s 13.

<sup>&</sup>lt;sup>479</sup> Only one stakeholder, the Royal Women's Hospital, did not think that this category of reportable deaths needed to be more clearly defined. The hospital did not give reasons for its view: The Royal Women's Hospital, Melbourne, *Submission no.18*, 3.

broader health procedure heading.<sup>480</sup> VCCAMM's views were endorsed by a number of medical stakeholders, including VIFM.

VCCAMM considered that anaesthetic related deaths should be included in a general medical procedure related death category, as there was increasing recognition of the fact that in modern-day surgery the administration of anaesthesia is considered an integrated component in the overall medical treatment of a patient undergoing an operation and some treatments. VCCAMM advised, that as part of its work in analysing and reporting on anaesthetic mortality, it was establishing that factors apart from the administration of anaesthesia may contribute to a patient's death during or following surgery:

We are increasingly identifying the role of overall perioperative care in outcome. This encompasses surgical and anaesthetic preoperative assessment, as well as postoperative issues including pain management techniques, provision of high dependency or intensive care etc.<sup>481</sup>

The results of VCCAMM's work support this conclusion and are detailed in a report in which it reviewed 59 cases in 2004 in which patients died during or after the administration of a sedative, analgesic, or local or general anaesthetic drug.<sup>482</sup> The report found that in 16 of these deaths (27 percent), anaesthesia did not contribute to the death and that the surgery and other factors were implicated in the deaths. In 15 deaths (25 percent) which it classified as caused by anaesthesia or surgical factors, VCCAMM identified that organisational problems contributed to eight of these deaths. These problems included:

- delay in diagnosis;
- delay in calling for help in an emergency;
- delay in obtaining surgical management;
- delay in transfusing blood during resuscitation;
- inadequate supervision of medical/nursing staff; and
- poor communication between hospitals.

In its submission, VCCAMM acknowledged that its research demonstrated that anaesthesia related deaths needed to be considered as a component in overall perioperative care. It therefore strongly supported the Queensland provision because it incorporated anaesthesia related deaths within its health procedure category of

<sup>&</sup>lt;sup>480</sup> Victorian Consultative Council on Anaesthetic Mortality and Morbidity, Submission no. 22, 1.

<sup>&</sup>lt;sup>481</sup> Ihid

<sup>&</sup>lt;sup>482</sup> VCCAMM Annual Report 2004: Summarised Version. Available atwww.health.vic.gov.au/vccamm/about/index.htm.

reportable deaths. 483 VCCAMM considered that such an approach would also enable reporting of deaths associated with all aspects of anaesthesia, including general and regional, sedation, pain management, drug related, and other procedures in all environments:

[The Queensland provision] is very clear, easy to interpret, and importantly in our view, covers the increasingly broad range of procedures and techniques such as interventional cardiology, endoscopy, radiology etc. Importantly, we also applaud the Queensland State Coroner's Guidelines. [...] In particular, we are impressed with the clarity of these guidelines. 484

VCCAMM also indicated that it approved of the way the Queensland guidelines assessed cases by asking a series of questions to determine the cause of a death, as it was similar to the approach VCCAMM used in classifying deaths.<sup>485</sup>

A number of stakeholders, including VIFM, endorsed the VCCAMM submission. 486 VIFM considered that amending the definition in this way would recognise the changing role of anaesthetists in wider treatment settings. Similarly, Associate Professor Ranson in his personal submission indicated that anaesthesia related deaths should be considered to be simply a particular category of a range of medical processes which if associated with a patient's death needed to be reviewed by the coroner.487

Dr Freckelton agreed that there were anomalies in the categories of reportable deaths and told the Committee that he considered that as part of the review process:

what we perhaps need to do is go back to the drawing board and consider what sorts of hospital deaths these days constitute categories that we are especially worried about and we want the coroner to look at every single time. Whether that remains so in relation to anaesthesia deaths, I am not guite sure. This is part and parcel of the sufficiency of reporting of deaths that occur in the aftermath of hospital and surgical procedures. I suspect that is really what our community would like to look at more fully. If that is so, then we need to specify that rather than leave it up in the air as much as we currently do with terms like anaesthesia deaths. 488

The remaining stakeholders who commented on this issue also accepted that the category needed to be reviewed but considered that the only change required was that the Act should contain a definition of 'anaesthetic'. The Coroner's Office was of the view that a new definition of 'anaesthetic' would improve the understanding of the

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<sup>&</sup>lt;sup>483</sup> Victorian Consultative Council on Anaesthetic Mortality and Morbidity, Submission no. 22, 1.

<sup>&</sup>lt;sup>484</sup> Ibid 2.

<sup>&</sup>lt;sup>485</sup> VCCAMM included its case classification methodology in an attachment to its submission.

<sup>&</sup>lt;sup>486</sup> Victorian Institute of Forensic Medicine, Submission no. 40, 13; Shelley Robertson, Submission no. 35, 2. The Committee notes that Dr Robertson is also the VIFM representative member of VCCAMM.

<sup>&</sup>lt;sup>487</sup> David Ranson, Submission no. 19, 17.

<sup>&</sup>lt;sup>488</sup> Ian Freckelton, *Minutes of Evidence*, 20 September 2005, 202.

need to report these deaths because the current definition was 'too unspecific' and did not provide for developments in anaesthetic techniques. The Coroner's Office suggested that the following definition be included in the Act:

"anaesthetic" includes general anaesthetic, local anaesthetic, spinal or epidural anaesthetic, sedation, regional anaesthetic or any other procedure or administration of an anaesthetic agent which causes partial or complete loss of sensation for the purposes of medical treatment. 490

Austin Health in its submission also considered that definitions of terms such as 'regional anaesthetic' would provide greater clarity. <sup>491</sup> In particular, Austin Health considered that any proposed definition of anaesthesia would need to include or exclude 'post-op epidural analgesia' or the effects of arm blocks and spinal anaesthetics, which it advised may take hours to resolve post-operatively. <sup>492</sup>

# Discussion and conclusion on unnatural, violent, accidental and anaesthetic related deaths

The Committee is of the view that there is a level of confusion surrounding the kinds of deaths which should be reported under these categories, particularly in relation to medical procedure related deaths. The Committee considers that the level of confusion may partly explain why not all reportable deaths are reported to the coroner. The uncertainty surrounding which deaths should be reported may be remedied by creating a separate category of reportable deaths for medical procedure deaths. This would give doctors a detailed, specific provision which would provide a greater level of direction for a doctor faced with the sometimes challenging task of deciding whether a particular death should be reported to the coroner. However, the Committee considers that the Act should retain the reference to the terms 'unnatural', 'violent' and 'accidental' to ensure that reportable deaths which occur in a non-medical setting, such as fatal traffic collisions or suicides, remain reportable deaths.

The Committee has considered a number of models on which a medical procedure related death provision could be based. While the South Australian and ACT provisions have some merit, the Committee considers that a system based on the reporting of all deaths which occur within an arbitrary time frame to be too simplistic. The Committee considers that there are a number of advantages in adopting a medical procedure related death provision based on the Queensland provision. In conjunction with the guidelines, the Queensland provision's focus is on establishing, through a series of questions, whether the health procedure caused the death and whether the death was the unexpected outcome of the procedure. The series of questions in the guidelines turns a doctor's mind to a more detailed and structured

<sup>&</sup>lt;sup>489</sup> State Coroner's Office, Submission no. 70, 59, 63, 80.

<sup>&</sup>lt;sup>490</sup> Ibid 63.

<sup>&</sup>lt;sup>491</sup> Austin Health, Submission no. 45, 3.

<sup>&</sup>lt;sup>492</sup> Ibid.

consideration of these complex issues. This provision has another advantage in that it incorporates anaesthetic related deaths within the same medical death related category. The Committee considers that such an approach reflects the reality that anaesthetic procedures are a component in medical treatment and that the definition should reflect that fact. As such the Committee recommends the repeal of the current anaesthetic related deaths provision, as this category of reportable deaths would be incorporated in the proposed general medical procedure related death provision.

One important issue which the Committee considers needs to be addressed is that of medical omissions — for example, a death which occurs as a result of premature discharge from hospital or a failure to treat. The Committee notes that this is not covered in the Queensland provision. As such, the Committee endorses Ms Heffey's suggestion that the category should also include deaths 'where the death from the particular cause was potentially avoidable or preventable had the clinical management been different.'

Recommendation 17. That the *Coroners Act 1985* be amended to include, within the definition of reportable death, health procedure deaths which doctors should report to the coroner. The provision should:

- a) be modelled on the Queensland provision and guidelines; and
- b) have an additional requirement that the category also include deaths 'where the death from the particular cause was potentially avoidable or preventable had the clinical management been different'.

Recommendation 18. That the *Coroners Act 1985* be amended to remove the words 'that occurs during an anaesthetic' and 'that occurs as a result of an anaesthetic and is not due to natural causes' from the definition of the term 'reportable death'.

# Deaths in custody or care

The Act considers the deaths of all persons 'in care' or 'in custody' to be reportable deaths.<sup>493</sup>

The full definition is set out below:

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s.3 (1) "reportable death" means a death—
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(...)

(i) of a person who immediately before death was a person held in care; or

<sup>&</sup>lt;sup>493</sup> Coroners Act 1985 s 13, s 3(1), definition of 'reportable death' — para (i)-(ib).

- (iaa) of a person who immediately before death was a patient within the meaning of the *Mental Health Act 1986* but was not a person held in care; or
- (ia) of a person under the control or care of the Secretary to the Department of Justice or a member of the police force; or
- (ib) of a person in respect of whom a court has made a non-custodial supervision order under section 26 of the *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997*

s.3(1)

"person held in care" means-

- a) a person under the control, care or custody of the Secretary to the Department of Human Services; or
- (ab) a person—
  - (i) in the legal custody of the Secretary to the Department of Justice or the Chief Commissioner of Police; or
  - (ii) in the custody of a member of the police force; or
  - (iii) in the custody of a protective services officer appointed under the *Police Regulation Act* 1958; or
- (b) a patient in an assessment or treatment centre under the Alcoholics and Drug-dependent Persons Act 1968; or
- (c) a patient in an approved mental health service within the meaning of the *Mental Health Act* 1986

# Deaths in custody

The Act does not provide a definition of what is meant by 'in the custody of', nor does it give any indication as to whether the category would include a death which occurs when a person is evading or escaping from custody or is in detention. However, in its guidelines, VIFM advises doctors to report the death of a person which occurs as a result of police action or while the person is being detained, even if the person had not been arrested at the time of the death.<sup>494</sup>

to readers, the article is reproduced at appendix 5.

<sup>&</sup>lt;sup>494</sup> 'Doctors and Death: Certificates and Coroners', Stephen Cordner, Professor, Forensic Medicine, Monash University, Director of the Victorian Institute of Forensic Medicine, and Helen McKelvie, Manager, Medico-legal Policy and Projects, Victorian Institute of Forensic Medicine. Available at <a href="http://medicalboardvic.org.au">http://medicalboardvic.org.au</a>. As an aid

Besides a sentence of imprisonment in a correctional facility, non-custodial sentencing orders may include:

- combined custody and treatment order (CCTO): the first half of the sentence is served in custody and the remainder in the community, with drug treatment supervised by Community Corrections;
- home detention order:
- drug treatment order: supervision by the Victorian Drug Court following the custodial part of the sentence;
- community custodial orders: examples include intensive correction orders (ICOs), which are non-custodial orders with visits from a corrections officer and supervision, community work, counselling or treatment, Community Custodial Permits which allows prisoners to be temporarily absent from prison for a specified time and purpose;
- suspended sentence: the custodial part of the sentence is wholly or partly suspended;
- community based order (CBO): this involves unpaid community work and supervision, counselling and drug testing if required.<sup>495</sup>

The definition does not specifically refer to deaths occurring in detention such as the death of a person detained as an unlawful non-citizen under the *Migration Act 1958* (Cth). However, it has been the practice of the Coroner's Office to include these deaths as deaths in custody. For example, the death of Mr Villiami Tonginoa in 2000 at the Maribyrnong Detention Centre, which was operated by Australian Correctional Management Pty Ltd, a privately owned detention centre, was investigated as a death in custody.<sup>496</sup>

# Other Australian jurisdictions

In all jurisdictions, deaths 'in custody' are also reportable. The definition of 'custody' is broad and usually extends to a person in the process of being detained or escaping from custody. <sup>497</sup> For example, in the Queensland Act a person's death is a 'death in

<sup>&</sup>lt;sup>495</sup> Fitzroy Legal Service Inc, *The Law Handbook*, 2006, 107–9.

<sup>&</sup>lt;sup>496</sup> Coroner's Case No. 4162/00.

<sup>&</sup>lt;sup>497</sup> Halsbury's Laws of Australia, K Walker, Coroners [115–95] at 16 February 2005; citing the following legislation and annotation: Coroners Act 1997 (ACT) s 13(1)(k) (dies in custody); Coroners Act 1993 (NT) s 12(1) (definition of person held in custody), 15(1)(a), 15(1)(b); Coroners Act 1980 (NSW) s13a, 14b(1)(b); Coroners Act 2003; (QLD) s 10 (definition of death in custody), 27(1)(a)(i); Coroners Act 2003 (SA) s 3 (definition of death in custody), s 21(1)(a); Coroners Act 1995 (TAS) s 3 (definition of person held in custody), s 24(1)(b) (person held in care or custody), s 24(1)(d) (died whilst escaping from prison), s 24(1)(e) (death occurred in process of detaining the person); Coroners Act 1996 (WA) s 3 (definition of person held in care), s 22(1)(c).

custody' if the person died while trying to escape from custody or trying to avoid being put in custody. 498 In the Northern Territory the legislative definition of a death in custody extends to the death of a person detained or escaping from detention in the Northern Territory under Commonwealth law. 499

Unlike Victoria, the ACT and Queensland have made substantive changes to their coronial legislation in response to the recommendations made by the Royal Commission into Aboriginal Deaths in Custody (RCADC).<sup>500</sup>

### **Royal Commission into Aboriginal Deaths in Custody**

The commission was established in October 1987 by the Commonwealth government following the awareness of a rapid increase in Aboriginal deaths in custody in that year.<sup>501</sup> The deaths of 20 Indigenous Australians in custody in that year prompted the commission to consider a broad range of issues associated with the deaths, including the way in which the deaths came to the attention of the coronial system, so that they could then be investigated.<sup>502</sup> In 1991 the commission's national report was presented to the Commonwealth, State and Territory governments.

In relation to the definition of 'death in custody', the commission recommended that the category should be broadly defined. Commissioner Elliot Johnston QC considered that the category should not be confined to situations where a person had actually been taken into physical custody because the use of powers by police and prison officers may result in the death of a person outside custody:

Coronial jurisdiction relating to the category generally referred to as 'deaths in custody' should not depend on the accidental circumstance of where a person eventually dies. Jurisdictional arguments as to whether a person was in, out or in the process of being taken into custody are sterile if they may serve to defeat the public interest in a thorough coronial inquiry. As a matter of elementary principle there is a need to review the use of the exceptional powers conferred on police, prison officers and juvenile custodians for the purpose of performing their public duties. This principle should guide the definition of coronial jurisdiction. <sup>503</sup>

<sup>&</sup>lt;sup>498</sup> Coroners Act 2003 (QLD) s 10.

<sup>&</sup>lt;sup>499</sup> Coroners Act 1995 (NT) s 12(1A) (definition of 'reportable death').

<sup>&</sup>lt;sup>500</sup> Ian Freckelton, 'Glimpses of the Coroner's Future: The Coroners Act 1997 (ACT)' (1998) 6 *Journal of Law and Medicine* 26.

<sup>&</sup>lt;sup>501</sup> John Dawes and Anna Grant, 'Corrections', in Adam Graycar and Peter Grabosky (eds), *The Cambridge Handbook of Australian Criminology*, Cambridge University Press, 2002, 102.

<sup>&</sup>lt;sup>502</sup> Michael Hogan, 'Let Sleeping Watchdogs Lie', in *Death in the Hands of the State*, Michael Hogan et al (eds), Redfern Legal Centre Publishing, Sydney, 1988, 121.

<sup>&</sup>lt;sup>503</sup> Royal Commission into Aboriginal Deaths in Custody, *Royal Commission into Aboriginal Deaths in Custody National Report: Volume 1* (Commissioner Elliott Johnson), Australian Government Publishing Service, Canberra, 1991, 4.5.41 – 4.5.45.

Accordingly, the Commission recommended that the definition of 'deaths in custody' should include at least the following categories:

- The death wherever occurring of a person who is in prison custody or police custody or detention as a juvenile;
- The death wherever occurring of a person whose death is caused or contributed to by traumatic injuries sustained or by lack of proper care whilst in such custody or detention:
- The death wherever occurring of a person who dies or is fatally injured in the process of police or prison officers attempting to detain that person; and
- The death wherever occurring of a person who dies or is fatally injured in the process of that person escaping or attempting to escape from prison custody or police custody or juvenile detention.<sup>504</sup>

In 2005 the Victorian Government undertook a review of the implementation of RCADC recommendations.<sup>505</sup> The State Coroner advised the review that all deaths in custody were reported to the Coroner's Office and that a death in custody was in practice construed broadly by coroners to include a death during arrest, during a police shooting or in a police pursuit.<sup>506</sup> In the final report, the review made a brief reference to the State Coroner's response, stating that the response embraced all deaths in custody and in the circumstances set out in the commission's recommended categories.<sup>507</sup> The review recommended that the Victorian government continue to implement and monitor the commission's recommendation.<sup>508</sup> The current situation appears to be that, while the existing practice of the coroner is compliant with the RCADC recommendation, legislation has not been amended to ensure compliance.

### **Evidence received by the Committee**

The Coroner's Office considered that this category has in practice been construed quite widely by coroners and would include situations such as the deaths of 'offenders involved in police pursuits'. 509 However, other witnesses considered that the current

<sup>&</sup>lt;sup>504</sup>Ibid 4.5.45.

<sup>&</sup>lt;sup>505</sup> Victorian Implementation Review of the Recommendations from the Royal Commission into Aboriginal Deaths in Custody, Review Report, Vol 1, 2005.

<sup>&</sup>lt;sup>506</sup> Ibid 463–4.

<sup>&</sup>lt;sup>507</sup> Ibid 496.

<sup>&</sup>lt;sup>508</sup> Ibid Recommendation 77, 496. The government response to the Review did not specifically refer to this recommendation.

<sup>&</sup>lt;sup>509</sup> State Coroner's Office, Submission no. 70, 74.

legislative definition of 'in custody' was inadequate and needed clarification.<sup>510</sup> For instance, Victoria Legal Aid (VLA) supported the extension of the definition to cover other vulnerable people such as:

- people in the process of being placed in the care, custody or control of the prescribed agencies; and
- persons attempting to escape from the care, custody or control of the prescribed agencies.<sup>511</sup>

VLA considered that the risk of death may be high during the process of detaining a person or recapturing a person who is escaping and that the Act should specifically include these kinds of deaths in the definition:

We note that the VIFM guidelines appear to cover people in the process of being detained. This good practice should be enshrined in legislation. We also note that the definition of 'custody' in other Australian jurisdictions is broad enough to extend to a person escaping from custody. The Victorian legislation should adopt a consistent approach.<sup>512</sup>

The Law Institute of Victoria (LIV) submitted that the definition of 'death in custody' was inadequate and that the Act should clearly state that:

custody extends to all situations where an individual's liberty is actually, or sought to be, affected regardless of the extent to which the individual's liberty is affected and regardless as to whether or not the person or persons affecting the individual's liberty are acting legitimately.<sup>513</sup>

Similarly, the Federation of Community Legal Centres (FCLC) supported a broad definition of 'in custody'. <sup>514</sup> This was to ensure that the deaths of vulnerable persons in a very broad range of circumstances were classified as reportable deaths. The Federation submitted that the category should include all deaths that occur as a result of police action in the process of detaining a person as well as deaths caused or contributed to by a lack of proper care. The Federation considered that it should not be left to the discretion of doctors to determine which deaths should be reported and that therefore a broad definition should be included in the Act.

J. Ibid

<sup>&</sup>lt;sup>510</sup> State Coroner's Office, *Submission no. 70*; Jacinta Heffey, *Submission no. 33*, 8; Royal College of Nursing, Australia, *Submission no. 63*, 4; Victoria Legal Aid, *Submission no. 34*, 3; Victorian Aboriginal Legal Service, *Submission no. 57*; Law Institute of Victoria, *Submission no. 58*, 4; Health Services Commissioner, Victoria, *Submission no. 62*, 3–4.

<sup>&</sup>lt;sup>511</sup> Victoria Legal Aid, Submission no. 34, 3.

<sup>&</sup>lt;sup>512</sup> Ihid

<sup>&</sup>lt;sup>513</sup> Law Institute of Victoria, Submission no. 58, 4.

<sup>&</sup>lt;sup>514</sup> Federation of Community Legal Centres Inc. Submission no. 55, 5.

Ms Heffey also took issue with the current definition, describing it as 'unacceptably vague'. She gave some examples of the kinds of deaths where there was uncertainty as to whether they were included in the definition of 'in custody':

Is the death from natural causes of a person performing unpaid community work pursuant to a community based order for non-payment of a fine a death that should be investigated? A literal interpretation of the current definitions would suggest that this is possibly the case. Another example is the death of a person on parole.<sup>515</sup>

In Ms Heffey's view, the overriding reason for this category of reportable deaths was to enable investigation of deaths which did not fall under other categories of reportable deaths, such as accidental deaths, and applied to situations where an individual's autonomy was restricted.

Beth Wilson, Health Services Commissioner, had a similar view:

the coroner should be able to investigate all deaths relating to persons in custody because these people are not able to make their own choices about medical care. That should be extended to people on parole, or people who have recently been released from prison. At my office it has often been brought to our attention that people who have a life threatening illness may be discharged from prison, but then when they die the coroner may or may not investigate or hold an inquest into that death.

I have also had families come to me whose family member has died because they have not sought health treatment while they were in prison for a life threatening illness. Sometimes they die after release, or sometimes during. The reason they have not had the health service is that they do not like being transported from a low security prison back to Port Phillip Prison for treatment. Prisoners who are in that situation lose all of their privileges. They lose their cell and their job and it can be very distressing. So some people choose not to have treatment, with very unfortunate results. <sup>516</sup>

The Health Services Commission (HSC) indicated that it was also concerned by some cases of prisoners dying from serious illness that had been undiagnosed until just prior to their death:

In these circumstances the prisoner is usually released from custody prior to the death. While the compassionate reasons for this are understandable it results in these deaths not being reported. <sup>517</sup>

In order to ensure that such deaths were reported, the HSC submitted that the categories for deaths in custody could be extended along similar lines to the RCADC

<sup>&</sup>lt;sup>515</sup> Jacinta Heffey, Submission no. 33, 8.

<sup>&</sup>lt;sup>516</sup> Beth Wilson, Health Services Commissioner, Victoria, *Minutes of Evidence*, 20 September 2005, 177–8.

<sup>&</sup>lt;sup>517</sup> Health Services Commissioner, Victoria, Submission no. 62, 3–4.

recommendations to include 'the death wherever occurring of a person whose death is caused or contributed to by....lack of proper care whilst in custody'.

A number of stakeholders also expressed support for incorporating the RCADC recommendations in the Act. For example, the Royal College of Nursing, Australia, considered that the recommendations from RCADC had been poorly implemented and proposed that it was therefore necessary to embrace the recommendations.<sup>518</sup>

Victorian Aboriginal Legal Service (VALS) submitted that the RCADC recommendations had not been adequately implemented in the context of coronial investigations and argued that this needed to be rectified. <sup>519</sup> In particular, VALS supported the RCADC definition of 'in custody'. <sup>520</sup>

The FCLC also supported the view that the Act should include the RCADC definition of 'in custody'. The Federation referred the Committee to section 10 of the Queensland *Coroners Act 2003*, which provided a definition of 'in custody' that was consistent with the RCADC recommendation to include escaping or trying to escape from custody and trying to avoid being put into custody.<sup>521</sup>

While Victoria Police believed that it would be difficult to envisage a death in custody, evading police or escaping police custody which would not be reportable under any other provision under the Act, Victoria Police supported further clarification on what was meant by the definition of 'in custody'.<sup>522</sup>

There was also support for the view that the definition should include the death of a person detained under Commonwealth law. For instance, the federation submitted that the definition should be enlarged to encompass persons held in detention under the *Migration Act 1958* (Cth), the *Fisheries Management Act 1991* (Cth) and any other Commonwealth legislation with the power to detain.<sup>523</sup> The Coroner's Office also supported this view, submitting that people who are held in detention centres under Commonwealth laws should be classified as 'persons held in care'.<sup>524</sup>

The Coroner's Office considered that deaths while serving community custodial orders, such as intensive correction orders should remain reportable to the State Coroner but should not necessarily be included in the definition of 'persons held in care'. 525 While the Coroner's Office considered that the degree of control and care

<sup>521</sup> Federation of Community Legal Centres Inc, *Submission no. 55*, 5.

<sup>&</sup>lt;sup>518</sup> Royal College of Nursing, Australia, *Submission no.* 63, 4.

<sup>&</sup>lt;sup>519</sup> Victorian Aboriginal Legal Service, *Submission no. 57*, 5.

<sup>520</sup> Ibid.

<sup>522</sup> Victoria Police, Submission no. 78, 3.

<sup>&</sup>lt;sup>523</sup> Federation of Community Legal Centres Inc, Submission no. 55, 6.

<sup>524</sup> State Coroner's Office, Submission no. 70, 75.

<sup>&</sup>lt;sup>525</sup> Ibid.

exercised by Community Corrections officers was limited when a prisoner was released, it also considered that the people on these orders were vulnerable. The Coroner's Office further submitted that the Office of Community Corrections acknowledged that it owed a duty of care to these clients.

### Discussion and conclusion

While the Committee accepts that the definition of 'death in custody' has been construed quite widely by coroners in Victoria, the Committee considers that there is still a need to clearly define the term in the Act. As previously discussed in chapter three, the coronial system is dependant on individuals such as doctors, police officers and corrective services officers to report deaths in custody to the coroner. It is therefore vital that such individuals have a clear understanding that the definition not only encompasses deaths which occur within the confines of a prison or police cell but also extends to deaths occurring anywhere in Victoria which are caused by injuries or lack of care in custody. The Committee therefore recommends that, like the ACT and Queensland, Victoria should implement the change to the definition of death in custody recommended by RCADC.

The Committee is of the view that the definition should also specifically state that it includes the death of persons detained under both Commonwealth and State law. This would include the death of a person held in detention by a private company under a government contract — their death would be subject to the same level of scrutiny as the death of a person in a state run facility. Where a contractor has assumed responsibility for the welfare of a person, the contractor owes the same duty of care as the state.

Recommendation 19. That the *Coroners Act 1985* be amended to extend the definition of a death in custody to include the death wherever occurring of a person:

- a) who is in prison custody or police custody or detention as a juvenile or detention under a Commonwealth law;
- b) whose death is caused, or contributed to, by traumatic injuries sustained, or by lack of proper care while in such custody or detention;
- c) who dies or is fatally injured in the process of police or prison officers attempting to detain that person; and
- d) who dies or is fatally injured in the process of that person escaping or attempting to escape from prison custody or police custody or juvenile detention or detention under a Commonwealth law.

### Deaths in care

While the Act has a definition of 'held in care' which includes those in custody, this discussion is limited to those in care who are not in custody. The definition of 'reportable death' in section 3(1) in relation to this category currently includes the death:

(i) of a person who immediately before death was a person held in care; or

(iaa) of a person who immediately before death was a patient within the meaning of the *Mental Health Act 1986* but was not a person held in care; or

...

(ib) of a person in respect of whom a court has made a non-custodial supervision order under section 26 of the *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997* 

s.3(1)

"person held in care" means—

- a) a person under the control, care or custody of the Secretary to the Department of Human Services; or
- (ab) a person—
  - (i) in the legal custody of the Secretary to the Department of Justice or the Chief Commissioner of Police; or

. . .

- (b) a patient in an assessment or treatment centre under the *Alcoholics and Drug-dependent Persons Act 1968*: or
- (c) a patient in an approved mental health service within the meaning of the *Mental Health Act* 1986;

In the discussion paper the Committee questioned whether the Act's current definitions of 'deaths in care' as categories of deaths reportable to the coroner are adequate or should be extended to include deaths of other vulnerable persons.

In Victoria there are a number of services which provide assistance for mentally ill people. There are four kinds of mental health patients:

- informal patients (admitted at their own request);
- patients receiving involuntary treatment on treatment orders;
- security patients (patients who appear to be mentally ill while in custody or on remand); and

• forensic patients (subject to supervision orders which can be custodial or non-custodial)<sup>526</sup>

The Act does not include all of these categories in the definition of 'in care'. For instance, in relation to paragraph (c) of the definition, an 'approved mental health service' only covers services which have been proclaimed or declared to be approved under the *Mental Health Act 1986*.<sup>527</sup> The Act also does not cover informal patients admitted to private hospitals at their own request because such patients are not considered to be *held* in care.

Similarly, the definition of 'in care' does not extend to a person with a disability<sup>528</sup> living in care facilities such as Supported Residential Services (SRS)<sup>529</sup> and residential care services.<sup>530</sup> There are 200 SRS facilities registered in Victoria which provide accommodation and care for people with a disability.<sup>531</sup> These facilities are usually private businesses which do not receive government funding but must be registered with the State Government and are monitored to ensure they provide certain standards of care and accommodation.<sup>532</sup>

# Other Australian jurisdictions

In both Queensland and New South Wales the definition of a 'death in care' extends to specific categories of vulnerable persons such as a person with a disability living in a residential service or hostel. <sup>533</sup> This provides a broader definition of a person held in care than the Victorian definition.

In the discussion paper the Committee questioned whether the category of in care deaths should be extended in any way — for example, to include the deaths of other vulnerable persons. The Committee received submissions that the category should also include:

<sup>&</sup>lt;sup>526</sup> Fitzroy Legal Service Inc, *The Law Handbook*, 2006, 662–6.

<sup>&</sup>lt;sup>527</sup> Mental Health Act 1986 s 3 (definition of 'approved medical health service'), s 94 and 94A.

<sup>&</sup>lt;sup>528</sup> 'Disability' in respect of a person is defined in s 3 of the *Disability Services Act 1991* as meaning a disability which is attributable to an intellectual, psychiatric, sensory or physical impairment or a combination of those impairments; and which is permanent or likely to be permanent; and which results in a substantially reduced capacity of the person for communication, learning or mobility; and the need for continuing support services.

<sup>&</sup>lt;sup>529</sup> This is defined in s 3 of the *Health Services Act 1988* as 'premises where accommodation and special or personal care are provided for fee or reward but does not include a residential care service or a State funded residential care service'.

<sup>&</sup>lt;sup>530</sup> s 3 of the *Health Services Act 1988:* 'residential care service' means premises where accommodation and personal care or nursing care or both personal care and nursing care are provided to a person in respect of whom a residential care subsidy or a flexible care subsidy is payable under an Act of the Commonwealth.

<sup>&</sup>lt;sup>531</sup> Supported Residential Services Program website: www.health.vic.gov.au/srs.

<sup>532</sup> Ibid.

<sup>&</sup>lt;sup>533</sup> Coroners Act 2003 (QLD) s 9 (definition of 'death in care'); Coroners Act 1980 (NSW) s 13AB(1)(e),(f).

- certain child deaths not covered in the 'in care' definition;
- certain mental health patient deaths not covered in the definition;
- the deaths of people with disabilities; and
- the deaths of recently released prisoners.

The Committee also received submissions concerning aged care deaths and work related deaths. These two categories are considered in a later section of this chapter.

### **Evidence received by the Committee**

### Children

Ms Heffey considered that this category should also include certain child deaths where there has been a voluntary delegation of care or custody to another by the parents or guardians and where there has been the assumption by the state of the powers of the parents:

I think it should also extend to circumstances with respect to children where, by operation of the law, the parents of a child have presently forfeited their rights to custody and/or guardianship such as children in foster care, and children otherwise in the custody or guardianship of the state (all under the Children and Young Persons Act). It should include deaths of all children on interim accommodation orders, (including interim accommodation orders to parents or other relatives). It should include the deaths of all persons who are clients of the Office of the Public Advocate; indeed, all persons under the guardianship of another under the Guardianship and Administration Act.<sup>534</sup>

Ms Heffey also suggested that it could be argued that the category should include the deaths of children in circumstances in which the parents have voluntarily delegated the care of the child, even where this did not involve an assumption of those powers by the state. <sup>535</sup> She suggested that this could, for example, include the death of a child in a day care centre, kindergarten or school. This suggestion was supported by Nigel and Martha Baptist, who made a submission to the inquiry in relation to their experience of the coronial process following the death of their four-year-old son Alex. Alex died suddenly and unexpectedly at a kindergarten in Victoria in 2004. <sup>536</sup>

Similarly, the Coroner's Office considered that certain child deaths not already included in the Act should also be defined in the 'in care' category:

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<sup>&</sup>lt;sup>534</sup> Jacinta Heffey, Submission no. 33, 8.

<sup>&</sup>lt;sup>535</sup> Ihid

<sup>&</sup>lt;sup>536</sup> Nigel and Martha Baptist, *Confidential Submission no. 82*. The Baptists are currently waiting for an inquest date in relation to Alex's death.

a 'person held in care' should include a child in the custody or guardianship of or held in detention by the Secretary of the Department of Human Services under the Children and Young Persons Act 1986 or otherwise in care under orders of the Children's Court.<sup>537</sup>

In its submission, the Coroner's Office indicated that, at present, if children are placed in the care of the Secretary of Human Services on guardianship orders, they are not necessarily defined as 'persons in care' for the purposes of the Act because the Secretary does not have the right to have the daily care and control of the child or the right and responsibility to make decisions concerning the daily care and control of the child. Additionally, children who are placed in the care of foster carers by order of the Children's Court are not defined as persons held in care unless the placement is delegated by the Secretary of the Department of Human Services (DHS).

The State Coroner submitted that it was inconsistent that children who die while on guardianship to the Secretary orders and in foster care were not defined as persons held in care and that their deaths, if they are not otherwise reportable to the State Coroner, may be unreportable, whereas children in the custody of the Secretary are defined as persons held in care and their deaths are always reportable and always require an inquest.<sup>539</sup>

LIV also submitted that special provision should be made in the Act to acknowledge the vulnerability of children and young persons.<sup>540</sup> VALS also supported broad definitions of 'death in care'. It noted that Indigenous Australians are arguably overrepresented in the category of being 'in care', as Indigenous Australians were more than 10 times more likely to enter the child protection system than non-Indigenous Australians.<sup>541</sup>

#### Discussion and conclusion on child deaths

The Committee is of the view that the category should be extended to include certain child deaths not already covered in the definition. The Committee agrees that the death of a child who was in the custody and guardianship of the state should be included in the definition regardless of whether the delegation of custody was voluntary, thereby making these deaths subject to coronial scrutiny. Similarly, the Committee considers that the child death category should also include the death of a child where there has been a voluntary but temporary delegation of custody to a child care facility, crèche, kindergarten or school. The Committee is also of the view that the category should extend to the deaths of children who at the time of death were residing at a youth refuge or a women's refuge.

<sup>539</sup> Ibid 73.

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<sup>537</sup> State Coroner's Office, Submission no. 70, 73.

<sup>538</sup> Ibid.

<sup>&</sup>lt;sup>540</sup> Law Institute of Victoria, Submission no.58, 4.

<sup>&</sup>lt;sup>541</sup> Victorian Aboriginal Legal Service, Submission no. 57, 1–2.

Recommendation 20. That the *Coroners Act 1985* be amended to extend the definition of 'in care' to include the following persons:

- a) all children in the custody or guardianship of the state under the Children and Young Persons Act 1989 (or the Children, Youth and Families Act 2005 when this is proclaimed);
- b) children on interim accommodation orders;
- c) children whose care was temporarily delegated to a child care facility or educational institution such as a crèche, kindergarten or school; and
- d) children who at the time of death were residing at a youth refuge or women's refuge which was operated with funding provided by the State or Federal Government for the purposes of providing a refuge.

# Mental health patients recently discharged or under community treatment orders (CTOs)

A number of witnesses told the Committee that the definition of deaths in care should be broadened to include any mental health patient under a CTO or otherwise being 'treated' in the community. Mental Health Legal Centre lawyer Vivienne Topp told the Committee that 'death in care' should include situations where the person is detained in the community because this reflects the reality of modern treatment for mental health following the policy of de-institutionalisation:

in 1986 people were involuntarily detained in hospitals. Now they are involuntarily detained in the community. Hospital stays are short and brief, and people are discharged either voluntarily, having had a hospital admission, or involuntarily on community treatment orders, which are reviewed every 12 months. Sometimes people stay on those orders for up to 10 years with an annual review.<sup>542</sup>

The Royal College of Nursing, Australia, agreed and proposed that:

the categories be extended to reflect changes to the *Mental Health Act*, as we have moved to a community care model, a definition of a 'vulnerable person', whether in care or custody, would be a useful addition in the Act.<sup>543</sup>

Ms Heffey also considered that it was obvious that the definition should apply to involuntary patients, which she considered to include both inpatients and patients in

<sup>&</sup>lt;sup>542</sup> Vivienne Topp, lawyer, Mental Health Legal Centre, *Minutes of Evidence*, *5 December 2005*, 302.

<sup>&</sup>lt;sup>543</sup> Royal College of Nursing, Australia, Submission no. 63, 4.

the community under a CTO because these people have restrictions placed on their freedom.<sup>544</sup>

However, the Coroner's Office disagreed. It acknowledged that a person subject to a CTO is deemed by the case law to be an involuntary patient while the person is subject to the order, but the submission considered that 'voluntary psychiatric outpatients should not be reported as "in care deaths" '.545

A number of witnesses advocated that the definition of deaths in care should be further extended to include people with psychiatric disabilities for a period of eight weeks after their involuntary treatment has ended.<sup>546</sup> Ms Topp told the Committee that:

The other issue with reportable deaths is the flow on effect. Under the *Mental Health Act* eight weeks after detention, if the person is still involuntarily detained, they have to be reviewed under the Act. What happens with short hospital stays is that people might be involuntarily in hospital and then discharged, not on a community treatment order but discharged voluntarily. We know anecdotally from clients of many circumstances where the person really is not well, and if we are going to be examining the deaths of those people, how can we do it? How can we ensure it? If you are involuntarily detained on Thursday and on Friday you are not, and you are dead on Saturday, then in our submission that should be a reportable death too.<sup>547</sup>

The Committee also heard evidence from a number of families who had been involved with the coronial process following the death of a family member who died after being discharged from, seeking re-admission to or leaving a mental health institution. Me Caroline Storm told the Committee about the death of her daughter, Anne Cameron, who killed herself within 30 hours of being discharged from hospital. Me Storm told the Committee that the time following discharge was the most dangerous for mental health patients because there was a high suicide rate at this time. Mr Graeme Bond similarly submitted that the death of any patient who has recently been in such care should also be reportable, as premature discharge or failure to admit or re-admit were all commonly associated with the deaths of the mentally ill. He deaths of the mentally ill.

<sup>&</sup>lt;sup>544</sup> Jacinta Heffey, Submission no. 33, 9.

<sup>&</sup>lt;sup>545</sup> State Coroner's Office, Submission no. 70, 74–5, and n 124 citing *Re XY* 6/3/92 (SCVic AD) 12501/1991 Brooking J at 1 and *Wilson v Mental Health Review Board* [2000] VSC 404.

<sup>&</sup>lt;sup>546</sup> Mental Health Legal Centre, *Submission no. 41*, 3; Federation of Community Legal Centres Inc, *Submission no. 55*, 5–6.

<sup>&</sup>lt;sup>547</sup> Vivienne Topp, lawyer, Mental Health Legal Centre, *Minutes of Evidence*, *5 December 2005*, 302.

<sup>&</sup>lt;sup>548</sup> Caroline Storm, Graeme Bond, Katherine Brand, *Minutes of Evidence*, 22 August 2005.

<sup>&</sup>lt;sup>549</sup> Graeme Bond, Submission no. 48, 4.

#### Discussion and conclusion

The Committee is extremely concerned by the evidence it received regarding incidences in which mental health patients have died shortly after discharge from hospital. The Committee agrees that these deaths require close scrutiny to ensure that they were not the result of an inappropriate or premature discharge from a hospital. The Committee notes however that most of these deaths will already be reportable under the category of unnatural or violent deaths. The Committee examines the deaths of people involved in the mental health system in further detail in chapter seven, particularly the lack of expertise within the Coroner's Office to properly investigate such deaths.

The Committee considers that the death of a person subject to a CTO should continue to be reportable because of the level of vulnerability associated with the person's involuntary status. Accordingly, the Committee considers that the Act should explicitly state that the death of a person subject to a CTO is included in the definition of an 'in care' death.

Recommendation 21. That the *Coroners Act 1985* be amended to extend the definition of 'in care' to include a person subject to a community treatment order.

### Mental health patients in private hospitals

A number of witnesses expressed concern that the definition of 'in care' did not include mental health patients in private psychiatric hospitals and other facilities. These witnesses considered that the deaths of such patients should also be reportable. The Coroner's Office supported the proposal and suggested that the definition should be extended to include:

a person undergoing treatment for a psychiatric disorder as an inpatient in an approved mental health service or a hospital as defined under the registered private hospital [Act]. 550

#### Ms Topp told the Committee that:

it is a real concern for us that people in the private health system who are deemed to have a mental illness do not have the same protections as other people and that they are not going to be reportable deaths. <sup>551</sup>

A number of legal stakeholders, including MBC and the FCLC, supported this view. 552 MBC considered that, as the category appeared to be intended to cover the

<sup>551</sup> Vivienne Topp, Mental Health Legal Centre, *Minutes of Evidence*, 5 December 2005, 302.

<sup>550</sup> State Coroner's Office, Submission no. 70, 77.

<sup>&</sup>lt;sup>552</sup> Federation of Community Legal Centres Inc, *Submission no. 55*, 5–6; Maurice Blackburn Cashman, *Submission no. 42*, 4.

vulnerable, it should be extended to include deaths in the care of mental health services which provide the same services as those approved under the *Mental Health Act 1986.* The firm advised the Committee that:

We have had more of these deaths brought to our attention in recent times. They raise issues of safety, medication, access to medical review, treatment for those with dementia and other mental incapacities.<sup>553</sup>

Mr Bond explained to the Committee that the death of his son, Jason Bond, was not considered an 'in care' reportable death:

In my son's case he had been in a 'pretend' psychiatric inpatient facility which did not, his family later found, come under the *Mental Health Act 1986*. Even had this been stated to us, we would have needed to have the meaning and significance explained.<sup>554</sup>

#### Discussion and conclusion

The Committee agrees with the view that the in care category should also include deaths occurring in private hospitals because any death occurring in a mental health service should be scrutinised regardless of whether the patient was in a private or public facility.

Recommendation 22. That the *Coroners Act 1985* be amended to extend the definition of 'in care' to include a person who at the time of death was undergoing treatment as a mental health patient at a private hospital.

### People with disabilities

There was support among stakeholders for extending the definition of 'in care' to include any person with a disability who was living in residential care. The FCLC considered that, due to the particular vulnerability of people with disabilities, they should be included in the definition, as is the case under section 9 of the *Coroners Act* 2003 in Queensland. 555

VLA also submitted that the definition should be extended on the following grounds:

People with disabilities who reside in institutions live outside the public gaze. They have less control over their lives and their choices are usually limited. Because they must rely on others, they are particularly vulnerable to inadequacies in the standard of care they receive. <sup>556</sup>

<sup>&</sup>lt;sup>553</sup> Maurice Blackburn Cashman, Submission no. 42, 4.

<sup>&</sup>lt;sup>554</sup> Graeme Bond, Submission no. 48, 4.

<sup>&</sup>lt;sup>555</sup> Federation of Community Legal Centres Inc, Submission no. 55, 5–6.

<sup>&</sup>lt;sup>556</sup> Victoria Legal Aid, Submission no. 34, 3.

VLA considered that the definition should cover people with a disability who reside in public or private institutions such as residential care services, Supported Residential Services, hostels or nursing homes within the meaning of the *Health Services Act* 1988. According to VLA, the definition should also include a person with a disability who lives at home but is cared for by a professional service provider.

The Coroner's Office also recognised the particular vulnerability of this group of people. Its submission indicated that it supported the adoption of the Queensland provision which includes in the definition of persons held in care people with a disability living in accredited residential services.<sup>558</sup> According to the submission, the definition should include:

a person with a disability defined under section 3 of the Disability Services Act 1992, who—

- (i) was living in a residential care service or a supported residential service as defined under section 3 of the *Health Services Act 1988*; or
- (ii) was receiving residential services operated, or wholly or partly funded, by the Department of Human Services.<sup>559</sup>

The TAC also supported an extension of the definition of deaths in care to include the deaths of persons with profound or significant disabilities who die in nursing homes, Supported Residential Services or other supported accommodation after being severely injured in transport accidents or other prior traumatic events. The TAC considered that the current definition of deaths in care could be better aligned with the Victoria State Disability Plan 2002-2012.

Dr Flynn also submitted that the definition should include people in Special Residential Service accommodation, hostels and other community accommodation 'who are currently or have recently been patients of a mental health service (possibly with a time limit of 2 years)'. 562 She however did not consider that the deaths of persons in these facilities who did not have a previous mental health service connection should be reported to the coroner as 'in care deaths'.

<sup>558</sup> State Coroner's Office, Submission no. 70, 76.

<sup>&</sup>lt;sup>557</sup> Ibid.

<sup>&</sup>lt;sup>559</sup> Ibid 77.

<sup>&</sup>lt;sup>560</sup> Transport Accident Commission, *Submission no. 50*, 2.

Department of Human Services, *The Victorian State Disability Plan 2002–2012*, 2002. Available at <a href="http://hnp.dhs.vic.gov.au/wps/portal">http://hnp.dhs.vic.gov.au/wps/portal</a>. The plan places emphasis on public housing, private rentals, supported accommodation and support to enable people with a disability to live independently in the community if they choose to do so. According to the plan, the number of people with a disability living in institutional settings (of 30 beds or more) will reduce.

<sup>&</sup>lt;sup>562</sup> Eleanor Flynn, Submission no. 37, 2.

#### Discussion and conclusion

The Committee recognises the particular vulnerability of people with disabilities. In this regard, the Committee agrees with VLA that the deaths of such persons should be subject to a greater degree of scrutiny because this group may be vulnerable to inadequacies in the standard of care they receive. The Committee considers that the provision suggested by the Coroner's Office and modelled on the Queensland provision is an appropriate model but notes that the definitions will need to make reference to the *Disability Act 2006* once it comes into force.<sup>563</sup>

Recommendation 23. That the *Coroners Act 1985* be amended to extend the definition of 'in care' to include a person with a disability as defined under section 3 of the Disability Act 2006, who:

- a) was living in a residential care service or a supported residential service as defined under section 3 of the *Health Services Act 1988*; or
- b) was receiving residential services operated, or wholly or partly funded, by the Department of Human Services.

## Prisoners recently released from prison

The FCLC submitted that the definition of in care deaths should also include the deaths of ex-prisoners occurring within one month of release from custody. The Disability Discrimination Legal Service supported this proposal. Both stakeholders submitted that post-release mortality statistics demonstrated that this group of people was especially vulnerable. In their submissions, both stakeholders referred to a 2003 Department of Justice 'Stats Flash' which indicated that:

Female ex-prisoners were 27 times more likely to die unnatural deaths than were females of the same age within the general Victorian population. Male ex-prisoners were approximately seven times more likely to die than males of the same age in the general Victorian population. Exprisoners were more likely to die as a result of homicide, accident and suicide...In addition, the rate of ex-prisoner unnatural deaths was approximately double the 1996 and 1997 rates of deaths in custody for Victoria. This is in spite of the fact that the deaths in custody figures include natural and unnatural deaths...Risk of unnatural death varied according to release time. The majority of unnatural deaths occurred soon after the deceased left custody. 9.4 % of the 820

<sup>&</sup>lt;sup>563</sup> Disability Act 2006, provisions other than section 1 of this Act come into operation on a day or days to be proclaimed. If a provision referred to in sub-section (2) does not come into operation before 1 July 2007, it comes into operation on that day.

<sup>&</sup>lt;sup>564</sup> Federation of Community Legal Centres Inc, Submission no. 55, 5–6.

<sup>&</sup>lt;sup>565</sup> Disability Discrimination Legal Service, Submission no. 29, 6.

unnatural deaths occurred within the first week of release, and 15.5 % within the first month. Thus, ex-prisoners were at greatest risk immediately following their release from prison. <sup>566</sup>

These statistics were based on the research undertaken by Annette Graham, a suicide research officer at the Coroner's Office. The study found that in 2000 a total of 820 men and women who were released from prison between 1990 and 1999 had died unnatural deaths following their release from prison. Their deaths were a result of suicide, accident or homicide. Ms Graham indicated that further research was required:

The results of this paper alert us to the extent of the problem. However, they do not provide policy makers and those who work to prevent unnatural death with all they need to know to work effectively. [...] Researchers need to determine what it is about Victorian ex-prisoner's lifestyles or the situations in which they are placed that increase their risk of unnatural death. Work needs to be done examining why existing community-based strategies for the prevention of unnatural deaths are having a limited impact on those released from prison.<sup>569</sup>

Further studies have recently indicated that young offenders in Victoria are also over-represented in premature death statistics, with over 25 percent of drug-related deaths in males aged 15 to 19 believed to occur in this group. <sup>570</sup> According to the authors of the study:

Social adversity is common in this group, often accompanied by early offending, psychiatric disorder, substance misuse and self-harming behaviour; these factors predispose to high risk of death. Indigenous young people and those of Asian background are consistently over-

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<sup>&</sup>lt;sup>566</sup> Ibid.

<sup>&</sup>lt;sup>567</sup> Annette Graham, 'Post-Prison Mortality: Unnatural Death Among People Released from Victorian Prisons Between January 1990 and December 1999' (2003) 36 (1) *The Australian and New Zealand Journal of Criminology* 94–108. See also Susanne Davies and Sandy Cook, 'Dying Outside: Women, Imprisonment and Post-Release Mortality' (Paper presented at the Women in Corrections: Staff and Clients Conference convened by the Australian Institute of Criminology, 1 November 2000). Available at www.aic.gov.au/conferences.

<sup>&</sup>lt;sup>568</sup> Annette Graham, 'Post-Prison Mortality: Unnatural Death Among People Released from Victorian Prisons Between January 1990 and December 1999' (2003) 36 (1) *The Australian and New Zealand Journal of Criminology* 94.

<sup>&</sup>lt;sup>569</sup> Annette Graham 'Coronial Research: Post-Prison Fatalities—A Hidden Problem?' (2003) 2 *In Quest: The Journal of the Australasian Coroners Society Inc* 142.

<sup>&</sup>lt;sup>570</sup> C Coffey, F Viet, R Wolfe et al, 'Mortality in Young Offenders: Retrospective Cohort Study' (2003) 336 *British Medical Journal* 1064, 1064–7; C Coffey, R Wolfe, A Lovett et al, 'Predicting Death in Young Offenders: A Retrospective Cohort Study' (2004) 181(9) *Medical Journal of Australia* 473, 473–7; Stuart Ross, 'The Hidden Tragedy of Offender Deaths' (2004) 181 (9) *Medical Journal of Australia* 469, 469–70.

represented in custody and have characteristically high rates of psychiatric disorder and drug offences, respectively; these may be identifiable groups at increased risk of early death. <sup>571</sup>

In 2005 the Victorian Implementation Review examined the issue of post-prison Aboriginal deaths.<sup>572</sup> The review referred to research undertaken by Ms Graham which indicated that the risk of dying an unnatural death following release from prison was not significantly different for Indigenous and non-Indigenous Australians, but that, given their over-representation in prison, Indigenous Australians were at significant risk of dying following release from custody. The review considered that those with mental health and substance abuse problems were a vulnerable group and that, therefore, post-release processes were critical to reduce post-custody deaths. As such, the review recommended that the Department of Justice ensure that adequate and appropriate pre- and post-release procedures and programmes are in place to reduce the risk of post-release death.<sup>573</sup>

By way of comparison, a 2006 UK study investigated suicide rates in recently released prisoners in England and Wales.<sup>574</sup> The study found that 21 percent of suicides occurred within the first 28 days after release from prison and that recently released prisoners were at a much greater risk of suicide than the general population.<sup>575</sup> According to the study, the risk of suicide in recently released prisoners was approaching that seen in discharged psychiatric patients.<sup>576</sup>

#### Discussion and conclusion

These statistics show that recently released prisoners are an at risk group. While many of these deaths will be examined by the Coroner's Office as reportable deaths where the deaths are the result of homicide, suicide or accident, the Committee considers that the statistics indicate that there is a demonstrated need to monitor and investigate these deaths in a systematic way. The Committee understands that the Suicide Research Officer at the Coroner's Office is currently completing a number of projects, including one in relation to overdose deaths, but that further research in relation to post-custody deaths is not on the current work plan.<sup>577</sup>

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<sup>&</sup>lt;sup>571</sup> C Coffey, R Wolfe, A Lovett et al, 'Predicting Death in Young Offenders: A Retrospective Cohort Study' (2004) 181(9) *Medical Journal of Australia* 473, 474.

<sup>&</sup>lt;sup>572</sup> Victorian Implementation Review of the Recommendations from the Royal Commission into Aboriginal Deaths in Custody, Review Report, vol 1, 2005, 128.

<sup>&</sup>lt;sup>573</sup> Ibid Recommendation 2.

<sup>&</sup>lt;sup>574</sup>Daniel Pratt, Mary Piper, Louis Appleby, Roger Webb and Jenny Shaw, 'Suicide in Recently Released Prisoners: A Population-Based Cohort Study' (2006) 368 *The Lancet* 119,119–23.

<sup>&</sup>lt;sup>575</sup> Ibid.

<sup>&</sup>lt;sup>576</sup> Ibid.

<sup>&</sup>lt;sup>577</sup> Email and conversation, Sue Wilson, Manager, Suicide Research, and Committee Legal Research Officer, 30 May 2006.

The Committee believes that it would assist the coronial investigation if the deaths of people recently released from prison were identified as such when they were reported to the coroner. The Committee therefore proposes that a simple check with the Office of the Correctional Services Commissioner be carried out for each death reported to the coroner, to establish whether the person had been released from custody recently. The Committee suggests that a person should be considered recently released for up to 12 months following their release from prison. The Office of the Correctional Services Commissioner check should be carried out within 72 hours of the death being reported to the coroner. It could be done by faxing the person's details to a designated contact person within the Office of the Correctional Services Commissioner for their immediate response. The coroner could then refer his/her findings on deaths in this category to the Office of the Correctional Services Commissioner to inform their development of post-release services.<sup>578</sup>

The practical implementation of the system proposed would need to be developed collaboratively between the Coroner's Office and the Office of the Correctional Services Commissioner.

Recommendation 24. That the Coroner's Office, in conjunction with the Office of the Correctional Services Commissioner, implement and develop guidelines to govern a system whereby, within 72 hours of a death being reported to the coroner, a request is made to the Office of the Correctional Services Commissioner to establish whether that person has been released from custody within the preceding 12 months, and where this is the case, that the coroner provide a copy of the findings in the case to the Office of the Correctional Services Commissioner at the completion of the inquiry or inquest.

# Deaths where a doctor did not view the body

Under s 13(3)(b) of the Act a doctor is required to refer a death to a coroner if s/he did not 'view' the body. Despite this, the *Births, Death and Marriages Registration Act* 1996 allows doctors in certain circumstances to certify deaths under that Act as deaths not reportable to a coroner—without actually 'examining' the body.<sup>579</sup> Under that Act, doctors who are responsible for a person's medical care 'immediately before a person's death' are not required to examine a person's body where the death is not reportable to a coroner. 'Responsible for a person's medical care' has been interpreted to include 'covering doctors', that is 'doctors working in partnerships or in

<sup>&</sup>lt;sup>578</sup> The Committee is aware that measures are being undertaken to develop transitional support services for former prisoners, such as the Lazarus Transition Centre (a pre-release centre that provides for the transitional needs of male prisoners nearing their release date). The Office of the Correctional Services Commissioner has also undertaken a study on transitional support services: Transition from Custody to Community: Transitional Support for People Leaving Prison, June 2001. Prepared by Lisa Ward for the Office of the Correctional Services Commissioner, Victoria. Available at www.justice.vic.gov.au.

<sup>&</sup>lt;sup>579</sup> Births, Death and Marriages Registration Act 1996 s 37(1).

hospitals, who share responsibility for their patients' medical care can complete a death certificate where the 'treating' doctor may be off duty or on holiday when the death occurs'. 580

In the discussion paper, the Committee concluded that these two provisions were contradictory — the *Births, Deaths and Marriages Registration Act 1996* provides that 'treating' and 'covering' doctors can certify a death without examining the body, yet the *Coroners Act 1985* provides under section 13(3)(b) that, if a doctor did not view the body, the death should instead be reported to a coroner. Professor Cordner addressed this inconsistency when he spoke at an international seminar convened for the Shipman Inquiry in the UK. He advised the seminar that the provision:

has never been repealed because we have already said the fact that a doctor does not view the body is not relevant in a doctor's ability to write a certificate; so it does not of itself make the death a reportable death. So nobody quite understands how 13(iii) [sic] came about. It was part of the original Act in 1985 and it has never been repealed, but by common custom everybody disregards it.<sup>581</sup>

The Committee considered the issue of whether it is possible for a doctor to accurately certify a cause of death without examining the body of the person who has died to check for suspicious marks such as intravenous needle or pressure marks or bruising.

In its guidelines, VIFM advises 'covering doctors' that:

Care should be exercised by the covering doctor to ensure that s/he understands the history and the circumstances of the death sufficiently to provide the certificate. A cautious covering doctor may well wish to examine the body of the deceased. 582

The Committee considered that it was relevant for the inquiry to establish the current practice among doctors by determining the percentage of doctors who examined the body as part of the certification process. To this end the Committee sought the assistance of the Registrar of Births, Deaths and Marriages to obtain statistics on the number of doctors who have indicated on the medical certificate of the cause of death

<sup>&</sup>lt;sup>580</sup> 'Doctors and Death: Certificates and Coroners', Stephen Cordner, Professor, Forensic Medicine, Monash University, Director of the Victorian Institute of Forensic Medicine, and Helen McKelvie, Manager, Medico-legal Policy and Projects, Victorian Institute of Forensic Medicine. Available at http://medicalboardvic.org.au. As an aid to readers, the article is reproduced at appendix 5.

<sup>&</sup>lt;sup>581</sup> The Shipman Inquiry, Transcript for Day 122, 16 January 2003, 40.

<sup>&</sup>lt;sup>582</sup> 'Doctors and Death: Certificates and Coroners', Stephen Cordner, Professor, Forensic Medicine, Monash University, Director of the Victorian Institute of Forensic Medicine, and Helen McKelvie, Manager, Medico-legal Policy and Projects, Victorian Institute of Forensic Medicine. Available at <a href="http://medicalboardvic.org.au">http://medicalboardvic.org.au</a>. According to the statement, a 'covering doctor' is a doctor who has acquired responsibility for the patient's care when the 'treating doctor' is off duty or on holiday.

(MCCD) that they examined the body as part of the process of establishing the cause of death. 583

As discussed in chapter three, doctors lodge the MCCD with the Registry of Births, Deaths and Marriages. The MCCD requires the certifying doctor to indicate whether s/he viewed the body after the death. The Committee requested that the Registrar of Births, Deaths and Marriages, Ms Helen Trihas, provide statistics on the number of doctors who had indicated on the form that they had viewed the body. Ms Trihas advised that the Registry was unable to provide these statistics. She however estimated that 60 percent of doctors indicated that they did not view the body. She reasoned that this was possibly because most deaths occur in hospitals and the treating doctor was not necessarily on duty at the time of the person's death.

There is a separate certification requirement for cremations, which requires the examination of a body before a cremation is permitted.<sup>588</sup> Under the *Cemeteries and Crematoria Act 2003*, an independent doctor is required to examine the body of a person who died before the body may be lawfully cremated.<sup>589</sup> Approximately 50 percent of bodies in Victoria are cremated.<sup>590</sup>

There is another provision in the *Coroners Act 1985* which is inconsistent with a provision in the *Births, Deaths and Marriages Registration Act 1996.*<sup>591</sup> Section 13(3)(d) of the Act infers that a doctor must have seen the person who died within 14 days of the death to be able to complete an MCCD.<sup>592</sup> This contradicts section 37(1) of the *Births, Deaths and Marriages Registration Act 1996*, which makes no such

<sup>&</sup>lt;sup>583</sup> The Committee infers that the actual percentage would be over 50 percent, as, under reg 9 of the *Cemeteries* and *Crematoria Regulations 2005*, a second doctor is required to examine the body of the person before the body can be legally cremated.

<sup>&</sup>lt;sup>584</sup> Medical Certificate of Cause of Death, Question 6.

<sup>&</sup>lt;sup>585</sup> The Committee notes that one of the objectives in s 3 of the *Births, Deaths and Marriages Registration Act 1996* is to provide for the collection and dissemination of statistics.

<sup>&</sup>lt;sup>586</sup> Registry of Births, Deaths and Marriages, Submission no. S 77-2, 3.

<sup>&</sup>lt;sup>587</sup> The Committee notes that this conclusion is inconsistent with the evidence it received from the Royal Women's Hospital, Melbourne, to the effect that in relation to all public hospital deaths a medical practitioner views the body before completing part of the death certificate. See the Royal Women's Hospital, Melbourne, *Submission no. 18*, 3.

<sup>&</sup>lt;sup>588</sup> This was discussed in chapter three.

<sup>&</sup>lt;sup>589</sup> Cemeteries and Crematoria Regulations 2005 r 9.

<sup>&</sup>lt;sup>590</sup> Email, Robyn Smith, Chief Executive Officer, Australasian Cemeteries and Crematoria Association, to Committee Legal Research Officer, 10 April 2005.

<sup>&</sup>lt;sup>591</sup> This was referred to by VIFM in its submission at p 12.

<sup>&</sup>lt;sup>592</sup> Section 37(1) provides: 'A doctor who was responsible for a person's medical care immediately before death, or who examines the body of a deceased person after death, must, within 48 hours after the death, notify the Registrar of the death and of the cause of the death in a form and manner approved by the Registrar and specifying any prescribed particulars'.

requirement. Indeed under section 37(1) a 'covering' doctor is able to complete an MCCD without having seen the person before or after the death.

# Other Australian jurisdictions

In all Australian jurisdictions, including Victoria, there is no requirement that a doctor who was responsible for a person's medical care immediately before death view the body before the death is registered under the jurisdiction's *Births, Deaths and Marriages Registration Act.* <sup>593</sup> In Queensland there is however a general requirement that the doctor be able to form an opinion as to the probable cause of death. <sup>594</sup>

## Law reform agencies

The issue of whether a doctor should be required to view a body as part of the death certification process was examined in three UK reviews: the Brodrick review in 1971 and later in the Luce Report and the Shipman Inquiry in 2003. 595

The Brodrick review heard evidence of two cases in which, without seeing a body, a doctor completed the MCCD in the name of someone who was still alive. <sup>596</sup> It also identified one case in which a doctor gave the MCCD in the wrong name. The review considered that there was a sufficiently strong case for introducing a statutory requirement of 'inspection' of the body, as it may lead to the detection of deaths from obvious signs of violence or from a cause such as carbon monoxide poisoning. <sup>597</sup>

In 2003, the Luce Report considered the same issue and concluded that the financial burden on the coronial service would be extreme if doctors in England and Wales were legally required to view the bodies of persons who had died as part of the death certification process.<sup>598</sup> As such, the inquiry recommended that there should be no general requirement that all bodies be viewed by a certifying doctor. Instead, the

<sup>&</sup>lt;sup>593</sup> Births, Deaths and Marriages Registration Act 1997 (ACT) s 35(1); Births, Deaths and Marriages Registration Act 1996 (NT) s 34(1); Births, Deaths and Marriages Registration Act 1995 (NSW) s 39(1); Births, Deaths and Marriages Registration Act 1996 (SA) s 36(4); Births, Deaths and Marriages Registration Act 1999 (TAS) s 35(1).

<sup>&</sup>lt;sup>594</sup> Births, Deaths and Marriages Registration Act 2003 (QLD) s 30(1)(a),(b).

<sup>&</sup>lt;sup>595</sup> United Kingdom, *Death Certification and Investigation in England, Wales and Northern Ireland: The Report of a Fundamental Review,* (Cm 5831, 2003). (Known as the Luce Report), Available at <a href="http://www.official-documents.co.uk/document/cm58/5831/5831.htmp">http://www.official-documents.co.uk/document/cm58/5831/5831.htmp</a>.

<sup>&</sup>lt;sup>596</sup> United Kingdom, Report of the Committee on Death Certification and Coroners, Cmnd 4810 (1971) 18.

<sup>&</sup>lt;sup>597</sup> Ibid 45. The review indicated that the inspection would fall short of a full extenuation examination of the naked body.

<sup>&</sup>lt;sup>598</sup> Ibid 54. The inquiry based this conclusion on the assumption that a viewing would take place in a mortuary. It concluded that this would cost £10 million to £15 million per year for England and Wales. In Australia, Medicare benefits are not payable for the issue of a death certificate: *Medicare Benefits Schedule*, 1 January 2005. Available at http://www7.health.gov.au/pubs/mbs/mbsnov04/index.html.

inquiry recommended that bodies of persons who have died should be viewed by a person with forensic skills in cases where there was 'uncertainty or anxiety'. 599

In contrast, the review conducted by Dame Janet Smith, known as the Shipman Inquiry, recommended that some external examination of every person who has died should take place. For deaths occurring in hospitals, the inquiry recommended that the whole body should be examined for signs of violence or neglect. For other deaths, the inquiry recommended that there should be an examination of the head, neck, and arms to the elbow.

The UK Home Office indicated in a brief position paper its policy directions on coronial law reform. While the paper does not specifically address the issue of whether a doctor who certifies a death should be required to view the body, a proposed requirement is that the doctor should specify when s/he last saw the person alive and why s/he is satisfied that s/he can certify the death accurately.

## Evidence received by the Committee

A number of stakeholders agreed with the Committee's conclusion that s 13(3)(b) of the Act, requiring a doctor to report a death to the coroner if the doctor does not view the body, was in conflict with s 37(1) of the *Births, Deaths and Marriages Registration Act 1996*, which authorises treating and covering doctors to complete MCCDs without examining the body in relation to deaths which are not reportable to the coroner.<sup>603</sup>

In its submission, VIFM stated that there was another inconsistency:

Section 13(3)(d) of the 1985 Act is also at odds with section 37(1) of the [*Births, Deaths and Marriages Registration Act 1996*]. This section infers that a doctor must have seen the deceased within 14 days of death to be able to complete a death certificate.<sup>604</sup>

VIFM submitted that both these sections should be repealed. In effect, this would mean that a doctor would no longer be required under the Act to report deaths where s/he did not view the body or where s/he did not see the person within 14 days of the person's death, thus removing the inconsistencies in the requirements in the two Acts.

<sup>600</sup> United Kingdom, *Death Certification and the Investigation of Death by Coroners* (Cm 5854, 2003). (The third report), 497.

<sup>602</sup> The Home Office (UK), *Reforming the Coroner and Death Certification Service: A position paper*, March 2004. Available at: http://www.archive2.official-documents.co.uk/document/cm61/6159/6159.pdf.

<sup>603</sup> See for example Victorian Institute of Forensic Medicine, *Submission no. 40*, 12; Medical Practitioners Board of Victoria, *Submission no. 56*, 3; Australian Medical Association, *Submission no. 38*, 2.

<sup>&</sup>lt;sup>599</sup> Ibid.

<sup>601</sup> Ibid.

<sup>604</sup> Victorian Institute of Forensic Medicine, Submission no. 40, 12.

However, stakeholders were divided on the issue of whether it is sufficient for doctors to certify deaths as unreportable deaths without being required to view or examine the body of the person who has died. The Coroner's Office indicated that it did not have a firm opinion on this issue. The State Coroner in his submission indicated that he did not have any opinion about whether the requirement to view the body should be legislative or remain a State Coroner's requirement for determination of cause of death. <sup>605</sup>

VIFM indicated to the Committee that there were a number of ways to approach this issue. The Institute informed the Committee that it stood by its previously issued guidelines with respect to the need to examine a body as part of the process of determining cause of death. However, VIFM indicated that it had an open mind about the necessity in the future for a full body examination for the purposes of death certification in all cases:

There are many instances in which a doctor can be properly satisfied with a diagnosis of a cause of death based on the medical history and the circumstances of the death without the need to make such an examination. However, it may be a prudent step to take in the post Shipman world. It will be an empty gesture if such an examination is not undertaken by a second medical practitioner, something which will have major logistical and resource implications. An intermediate position would take into account family satisfaction with the death certificate before requiring an examination of the body by a second practitioner.<sup>607</sup>

Associate Professor Ranson in his personal submission differed from VIFM and supported the view that there should be a legal requirement to examine the body, notwithstanding the administrative and operational difficulties such a requirement may pose:

It seems somewhat anomalous for a doctor to be able to sign a death certificate stating the cause of death when they have not examined the body. Clearly a medical practitioner with detailed knowledge of the patient's medical history may have a very good idea and indeed a reasonable belief as to the cause of death however, without the opportunity to examine the body the doctor cannot be assured that another untoward event (including criminal assault) has not occurred and in fact accounted for the death. Of course it is also true that a mere external examination of the body is unlikely to be sufficient to determine whether the suspected natural causes death on the basis of the medical history is in fact correct. But an external examination of the body would at least be able to exclude a number of significant external causes of death for example certain types of trauma. 608

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<sup>&</sup>lt;sup>605</sup> State Coroner's Office, Submission no. 70, 121.

<sup>&</sup>lt;sup>606</sup> Victorian Institute of Forensic Medicine, Submission no. 40, 13–14.

<sup>&</sup>lt;sup>607</sup> Ibid 13.

<sup>608</sup> David Ranson, Submission no. 19, 22.

He also indicated that he was aware of many cases where family members and or funeral directors have identified external features on a body that have resulted in the death being reported to the coroner despite the existence of a valid death certificate. 609

In relation to the place where an examination of a body should occur, Associate Professor Ranson considered that this would depend on the circumstances of the death but could occur at the place of death, if sufficient privacy could be obtained, or at a nearby funeral home. He also addressed the issue of who should carry out the examination. He advised that, if it was suggested that a forensic medical practitioner be involved in carrying out a more formal examination of the body, other arrangements would be needed, due to the shortage of forensic medical practitioners throughout Victoria. He did however consider that it would be possible to develop a new cadre of part-time forensic physicians to undertake the examinations. Associate Professor Ranson also considered that a review of the medical history of the patient would appear to be an essential ingredient in arriving at a reasonable cause of death because external examination of the body is unlikely on its own to reveal the natural disease causing the death in most cases.<sup>610</sup>

A number of other witnesses also indicated that they considered that an examination of the body was a necessary part of the death certification process. Ms Wilson told the Committee that she thought that doctors who wrote death certificates should be required to view the body because it is not possible for them to accurately certify the cause of death without such examinations. She did not consider that a requirement to view the body would be overly burdensome. Ms Heffey also considered that the legislation should require doctors to view a body before issuing a death certificate. She indicated that she had thought that this was already a requirement.

Corporate counsel Mr O'Shea told the Committee that Bayside Health would have no objection to mandatory examination of the body before certification of death. <sup>614</sup> He advised that:

it is the practice at Bayside Health to encourage covering junior medical staff to examine the body prior to certification of death, as stipulated under 13(3)(b).[...] However, should a doctor be unable to examine the body and the death not be in a reportable category, the practice followed is that stipulated under s 37(1) *Births, Deaths and Marriages Registration Act 1996.* This is a more efficient practice [...] in that it allows the death to be certified immediately and funeral

<sup>610</sup> David Ranson, Submission no. 19, 22.

<sup>609</sup> Ibid.

<sup>&</sup>lt;sup>611</sup> Beth Wilson, Health Services Commissioner, Victoria, *Minutes of Evidence*, *20 September 2005*, 178; Health Services Commissioner, Victoria, *Submission no. 62*, 10.

<sup>&</sup>lt;sup>612</sup> Health Services Commissioner, Victoria, Submission no. 62, 10.

<sup>613</sup> Jacinta Heffey, Submission no. 33, 10.

<sup>&</sup>lt;sup>614</sup> Bill O'Shea, *Minutes of Evidence*, 28 November 2005, 215.

arrangements to proceed in a timely manner. As the person's clinical diagnosis has already been documented, the practice is less subject to the risks outlined [in the discussion paper]. 615

The Royal Women's Hospital, Melbourne, considered that the inconsistency in the two Acts regarding the requirement to view the body was not a problem for public health services, as with all hospital deaths a medical practitioner views the body before completing part of the death certificate. However, the AMA in its submission identified instances in which doctors certifying deaths which occur in public hospitals may not view the body. The AMA advised that, when a patient dies during the night, the covering resident will only confirm that the patient is dead. The following day a member of the treating team will complete the death certificate on the basis of the medical records without necessarily going to the mortuary to view the body.

A number of medical witnesses, including the AMA, however did not consider that an examination of a body was necessary. The AMA submitted that it was unclear whether in the overwhelming majority of cases an external examination of the body by a clinician other than a forensic pathologist would yield any useful information. The MPBV noted the inconsistency in the requirements in the two Acts and stated that it preferred the requirement in the *Births, Deaths and Marriages Registration Act 1996* that doctors do not have to examine the body.

In relation to deaths in nursing homes, Ms Heffey submitted that there was a particular need for additional requirements:

With an ageing population the issue of "elder abuse" has been in the news recently. Elderly people living at home under the care of relatives may be particularly vulnerable to abuse. The abuse may contribute to the death eg. Failure to seek medical help in a timely manner, septicaemia from bed sores, being left in a draught, restrained in a way that restricts mobility (leading perhaps to deep vein thrombosis and pulmonary embolism.)

If a certifying doctor were required to examine the body of the deceased and the environment in which the death took place, and, in addition to the specifications included in the Home Office position, was required to include a statement to the effect that death from the certified cause was not reasonably preventable, this would help towards preventing death from neglect and abuse from carers. <sup>621</sup>

<sup>&</sup>lt;sup>615</sup> Bayside Health, Submission no. 46, 4.

<sup>&</sup>lt;sup>616</sup> The Royal Women's Hospital, Melbourne, Submission no. 18, 3.

<sup>&</sup>lt;sup>617</sup> Australian Medical Association, Submission no. 38, 2.

<sup>&</sup>lt;sup>618</sup> Shelley Robertson, *Submission no. 35*, 2; Australian Medical Association, *Submission no. 38*, 2; Medical Practitioners Board of Victoria, *Submission no. 56*, 3.

<sup>&</sup>lt;sup>619</sup> Australian Medical Association, Submission no. 38, 2.

<sup>620</sup> Medical Practitioners Board of Victoria, Submission no. 56, 3.

<sup>621</sup> Jacinta Heffey, Submission no. 33, 10.

Ms Caroline Storm, a former nurse, considered that an independent medical officer who did not provide medical services to the hostel or home where the death took place should view the unclothed body.<sup>622</sup>

VIFM also raised the issue of financial costs in relation to requiring doctors to view bodies as part of the death certification process. At present, under the Medicare Benefits Schedule (MBS), a doctor cannot claim a fee for certifying the cause of death. VIFM stated that it would support the proposal that a Medicare benefit be payable to a doctor who attends a dead patient for the purposes of certification, with different fee levels payable in instances where viewing the body was considered necessary. Dr Shelley Robertson also considered that doctors should be able to charge a fee for this service, with an appropriate Medicare rebate.

The Committee was interested in establishing whether a legal requirement that doctors view bodies when completing MCCDs would cause particular difficulties for doctors in regional Victoria, but it received no evidence on this issue. The Committee did however receive evidence which suggested that it was not necessary for a qualified doctor to undertake the examination. For example, the Nurses Board of Victoria suggested that qualified health professionals, including nurses, could view the body instead.

#### Discussion and conclusion

The Committee considers that there is merit in the proposal that, wherever practicable, a doctor should be required to undertake an external examination of the body when completing the MCCD. There may be occasions on which it is simply not possible for a doctor to make this kind of examination in a timely manner, and the Committee considers that in these instances a doctor should be able to justify why s/he is satisfied that s/he can certify the death accurately without examining the body.

Recommendation 25. That the *Births, Deaths and Marriages Registration Act* 1996 be amended so that, as part of the death certification requirements:

a) a doctor is required to undertake an external examination of the body when completing the medical certificate of the cause of death (MCCD), wherever this is practicable; and

<sup>622</sup> Caroline Storm, Submission no. 28, 2.

<sup>&</sup>lt;sup>623</sup> Medicare Benefits Schedule, 1 January 2005. Available at http://www7.health.gov.au/pubs/mbs/mbsnov04/index.html.

<sup>624</sup> Shelley Robertson, Submission no. 35, 2.

<sup>&</sup>lt;sup>625</sup> The Committee notes that the Committee secretariat invited the Rural Doctors Association and every regional hospital to make a submission to this inquiry. However, the Committee did not receive any submissions from these invitees.

<sup>626</sup> Nurses Board of Victoria, Submission no. 15, 3.

- b) where a doctor has not examined the body, the doctor is required to:
  - i) state on the MCCD why s/he is satisfied that s/he can certify the death accurately without examining the body; and
  - ii) indicate on the form that s/he is satisfied that the care and attention afforded to the person who died was reasonable and had no bearing on the death.

In relation to deaths occurring in nursing homes and other aged care facilities, the Committee notes that a high proportion of people receiving aged care services have a form of dementia such as Alzheimer's disease. Also, while other aged care recipients may be able to make competent decisions, their physical frailty may place them in a position of dependency on their carers. The Committee is of the view that such persons who are in need of a high level of care are especially vulnerable and that, therefore, their deaths require additional scrutiny. In these cases the Committee recommends that there be a mandatory requirement for a doctor, nurse or other health care professional to make an external examination of the body as part of the death certification process.

The Committee considers that this requirement should extend to the deaths of aged persons in aged care facilities, services or accommodation in receipt of a high level of care ('high care'). This would include aged persons whose physical, mental or social functioning was affected to such a degree that the person could not maintain himself or herself independently and at the time of death was residing in a high care residential aged care service (formerly known as a nursing home) under the Commonwealth's Residential Aged Care Programme. The Committee considers that the category should also include certain aged persons in low care residential aged care services (formerly known as hostels) where the person was receiving approved high care services, as well as aged persons who were receiving high care in respite care services.

The Committee is of the view that the category should also extend to older people who were living in supported accommodation which was provided on a private basis, such as Supported Residential Services. However, the Committee considers that it is unnecessary to include older people who were living in independent living units or serviced apartments in retirement villages because, unlike older people in aged care facilities, this group of people is not dependent on a high level of care.

The Committee considers that the person conducting the examination of the body should be an independent doctor who is not employed by or in receipt of a financial benefit or reward from either the owners of the nursing home or a beneficiary under the will of the person who died. A similar requirement already exists in relation to

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<sup>&</sup>lt;sup>627</sup> Fitzroy Legal Service Inc, *The Law Handbook*, 2006, 743.

<sup>628</sup> Ibid.

cremations. In these cases a second independent certifying doctor is required to examine the body, usually for a fee. <sup>629</sup> The Committee therefore considers that the adoption of a similar process in relation to the class of aged care deaths as outlined above would be appropriate and feasible. The Committee supports the view that it is appropriate that a doctor should be entitled to charge a fee for this professional service. The Committee considers that it is incongruous that, under the current MBS, only services relating to professional attendance on living patients attract a benefit, not examining a body for the purpose of certifying the cause of death.

Recommendation 26. That the *Births, Deaths and Marriages Registration Act* 1996 be amended so that, as part of the death certification requirements, an independent doctor undertakes an external examination of the deceased's body if the person, prior to his or her death, had resided at:

- a) a high care residential aged care service or accommodation under the Commonwealth Residential Aged Care Programme; or
- b) a low care residential aged care service where the person was receiving approved high care services under the Commonwealth Residential Aged Care Programme; or
- c) a respite care service where the person was receiving approved high care services under the Commonwealth Residential Aged Care Programme; or
- d) supported accommodation provided on a private basis such as Supported Residential Services.

Recommendation 27. That the State Government raise with the Commonwealth Government the need for death and cremation certificates to be recognised under the Medicare Benefits Schedule as services attracting Medicare benefits.

#### Deaths where the doctor cannot determine the cause

In the discussion paper, the Committee referred to a number of studies in Australia and the UK which indicated that there were problems with the accuracy of information recorded on death certificates, including major errors such as inaccurately

The Committee understands that there has been confusion among doctors and funeral directors concerning the fee schedule. See for example the Central Bayside Division of General Practice newsletter available at :www.centralbayside.com.au/publications/newsletters/September%202005.pdf. The Department of Human Services advised the Committee that, as the *Cemeteries and Crematoria Act 2003* does not regulate the fees charged by doctors, the fee was a matter which should be negotiated between the doctor and the funeral director: Email, Anne-Marie Greenfield, Senior Project Officer, Regulatory Compliance and Review Unit, Department of Human Services, to Committee Legal Research Officer, 7 June 2006.

representing the cause of death.<sup>630</sup> One small-scale study was undertaken in Victoria in 1995.<sup>631</sup> That study examined the completeness and accuracy of death certificates completed by doctors in non-metropolitan Victoria. Types of doctors in the study included Resident Medical Officers (RMOs)<sup>632</sup>, hospital doctors, specialist physicians, surgeons and GPs. It found that, overall, 27 percent of certificates inaccurately represented the cause of death, with a higher inaccuracy rate (51 percent) for RMOs.<sup>633</sup> In the discussion paper, the Committee asked whether the Act or guidelines needed to be more specific as to the degree of certainty required, in the light of problems with the accuracy of information recorded on MCCDs.

If a doctor is unable to determine the cause of death, s/he must refer the death to a coroner as a reportable death<sup>634</sup>. The Act does not however give doctors an indication of the degree of certainty required in their diagnosis. VIFM guidelines previously contained the following advice to doctors:

One does not need to know the diagnosis as a fact—if this was the standard, then every death would require an autopsy. The doctor should have that degree of confidence or comfort that s/he has whenever it is believed that a good diagnosis has been made.

The guidelines were updated in April 2006 and the new statement no longer contains this advice.

# Other Australian jurisdictions

Queensland is the only jurisdiction where there is a general requirement in the *Registration of Births, Deaths and Marriages Act* that a doctor be able to form an opinion as to the 'probable cause of death'. In all other jurisdictions, including Victoria, a doctor is required to notify the Registrar of 'the cause of death'. Arguably, this demands a higher degree of certainty than the Queensland requirement.

<sup>&</sup>lt;sup>630</sup> D Brumley, *Death Certification by Doctors in Non-Metropolitan Victoria*, (M Sc (Primary Health Care) Thesis, Flinders University of South Australia, 1995); T Weeramanthri and B Beresford, 'Death Certification in Western Australia — Classification of Major Errors in Certificate Completion' (1992) 16 (4) *Australian Journal of Public Health* 431, 431–4; B Swift and K West, 'Death Certification: An Audit of Practice Entering the 21<sup>st</sup> Century' (2002) 55 *Journal of Clinical Pathology* 275, 275–9; G Maudsley and EM Williams, 'Death Certification by House Officers and General Practitioners — Practice and Performance' (1993) 15 *Journal of Public Health Medicine* 192, 192–201. Cited in D Brumley, *Death Certification by Doctors in Non-Metropolitan Victoria*, 126.

<sup>&</sup>lt;sup>631</sup> D Brumley, *Death Certification by Doctors in Non-Metropolitan Victoria*.

<sup>&</sup>lt;sup>632</sup> RMOs are junior doctors at a hospital.

<sup>&</sup>lt;sup>633</sup> D Brumley, *Death Certification by Doctors in Non-Metropolitan Victoria*, 10.

<sup>&</sup>lt;sup>634</sup> Coroners Act 1985 s 13(3)(c).

<sup>&</sup>lt;sup>635</sup> Births, Deaths and Marriages Registration Act 2003 (QLD), s 30(1)(a), (b).

<sup>&</sup>lt;sup>636</sup> Births, Deaths and Marriages Registration Act 1996 s 37(1); Births, Deaths and Marriages Registration Act 1997 (ACT) s 35(1); Births, Deaths and Marriages Registration Act 1995 (NSW) s 39(1)(a); Births, Deaths and

# Evidence received by the Committee

VIFM did not consider it necessary to amend the Act to further define the degree of certainty required to certify the cause of death, as the Institute believed that it was an issue which should be addressed by ongoing training of doctors and by medical scrutiny of the death certification process. <sup>637</sup> Similarly, the Coroner's Office considered that:

a specific degree of certainty required for diagnosis in the Act or in State Coroner's guidelines or a change in the Guidelines issued to the medical profession through the Institute, the Medical Board and others will not advance this issue further.<sup>638</sup>

The MPBV considered that the VIFM guidelines offer appropriate and sufficient direction. However, a number of stakeholders indicated to the Committee that there were issues with both the guidelines and the Act.

Ms Heffey considered that the question of the degree of certainty of diagnosis needed to be clarified. She indicated that her view was that the requirement should be to state the 'probable cause(s) of death'. While she considered that the VIFM guidelines were sufficient in terms of nominating the cause of death, she also thought that the UK Home Office proposal that doctors be required to state why they can certify the death accurately should be adopted.

Dr Robertson took the view that the guidelines should emphasise the legal standard of the degree of certainty required concerning the cause of death, which is the balance of probabilities.<sup>641</sup>

Bayside Health also considered that the guidelines may need amendment:

It is our experience that junior staff are often unsure of the certainty of diagnosis required for the completion of the death certificate....We would welcome more specific guidelines.<sup>642</sup>

The Committee also received evidence from another medical stakeholder which may indicate that some GPs need a greater level of guidance from medically qualified advisors at VIFM. GPDV submitted that:

Marriages Registration Act 1996 (SA) s 36(3); Births, Deaths and Marriages Registration Act 1999 (TAS) s 35(1); and Births, Deaths and Marriages Registration Act 1998 (WA) s 44(1).

<sup>637</sup> Victorian Institute of Forensic Medicine, Submission no. 40, 14.

<sup>638</sup> State Coroner's Office, Submission no. 70, 124.

<sup>&</sup>lt;sup>639</sup> Medical Practitioners Board of Victoria, Submission no. 56, 3.

<sup>&</sup>lt;sup>640</sup> Jacinta Heffey, Submission no. 33, 9–10.

<sup>&</sup>lt;sup>641</sup> Shelley Robertson, Submission no. 35, 2.

<sup>&</sup>lt;sup>642</sup> Bayside Health, Submission no. 46, 4.

Some doctors have commented that staff at the Coroner's Office encourage them over the phone to sign the death certificate, guessing from the medical records as to a possible (likely) cause of death, when the doctor is not confident about the precise cause of death.<sup>643</sup>

However, Associate Professor Ranson in his personal submission advised the Committee that an individual doctor responsible for certifying and or confirming the cause of death can only do so at the level of their reasonable belief and that:

A "reasonable belief" as to the true cause of death would appear to be the only degree of certainty possible in our current death investigation system. This degree of certainty applies to the determination of cause of death on the completion of a death certificate where no autopsy was carried out. The determination of the medical cause of death by the forensic pathologist and the final cause of death given by the coroner (these are not necessarily the same cause of death for any given case) are all provided on a certainty level of reasonable belief.<sup>644</sup>

He considered that there will be situations where different doctors will have different reasonable beliefs as to a cause of death and even situations where coroners in turn may come to a different conclusion as to the cause of death.

In relation to the general guidance offered by VIFM, he considered that it represented a 'reasonable and balanced view'. However, he indicated that he did not agree with the first part of the guidance, 645 which previously stated:

One does not need to know the diagnosis as a fact-if this was the standard, then every death would require an autopsy.  $^{646}$ 

His disagreement with this was based on the understanding that even an autopsy is still based on the 'reasonable belief' of the practitioner involved and is not a procedure that can determine the cause of death as 'a fact':

The autopsy is often referred to as the "gold standard" of medical death investigation, with some justification given the depth of investigation it involves, but it cannot and does not resolve all questions that could arise in a death investigation. At many points during an autopsy professional medical experience is required to interpret observations and draw inferences and this is done using a basis of "reasonable belief" to justify the conclusions.<sup>647</sup>

He advised the Committee that there was little peer audit review of clinically determined causes of death, particularly in general practice, and he referred to the error rates in studies, which have varied between approximately 30 percent and 50

<sup>&</sup>lt;sup>643</sup> General Practice Division Victoria, Submission no. 40, 3.

<sup>644</sup> David Ranson, Submission no. 19, 23-4.

<sup>&</sup>lt;sup>645</sup> The guidelines were updated in April 2006, and this part of the statement is not included in that advice.

<sup>&</sup>lt;sup>646</sup> This was removed from the updated version on the Medical Practitioners Board of Victoria website in April 2006.

<sup>&</sup>lt;sup>647</sup> David Ranson, Submission no. 19, 23–4.

percent. The AMA also referred to error rates in its submission.<sup>648</sup> The association told the Committee that difficulties associated with completing death certificates were not limited to Victoria and that it was a worldwide problem in both English and non-English speaking countries.

**Table 2 - Comparative International Death Certification Error Rate.** 

UK (Swift & West 2002)	55 per cent of death certificates met minimum acceptable
WA (Weeramanthri1992)	16 per cent of death certificates had major errors
Canada (Myers 1998)	33 per cent of death certificates had major errors
Netherlands (Zumwalt 1987)	59 per cent of death certificates had errors in the cause of death
USA (Cina 1999)	37 per cent of death certificates had errors

Source: AMA Submission no.3.

#### Discussion and conclusion

The Committee considers that there is evidence which suggests that there is a level of confusion among some doctors concerning the degree of certainty required by doctors when certifying the cause of death. The Committee is concerned by this and also by the suggestion that some coronial staff in some instances may be encouraging doctors faced with uncertainty to attempt to give less than a considered medical opinion as to the cause of death. On this issue, the Committee agrees with VIFM that ongoing training for doctors and the introduction of medical scrutiny of the death certification process are important steps in further improving the accuracy of determining the real or probable cause of death, as recommended in chapter three. The Committee considers that a practical measure which may assist in this regard would be for VIFM and the Coroner's Office to further publicise the fact that doctors can and should consult a forensic pathologist at VIFM if there are lingering doubts concerning the cause of death in a particular case.

The Committee has considered Ms Heffey's suggestion that the Act be amended so that, where the doctor is unable to determine the probable cause of death, s/he must refer the death to a coroner as a reportable death. However, the Committee is of the view that such a provision may encourage some time-poor doctors to give a less considered opinion as to the cause of death, as opposed to encouraging them to engage in a more rigorous consideration of the cause of death. The Committee makes no recommendation for change in this instance.

The Committee also has concerns about the error rate in relation to the completion of death certificates. The Committee considers that, although the problem is not limited to Victoria, an error rate of between 30 percent and 50 percent indicates that there are serious problems with the effectiveness of the current system of death certification. The Committee considers that its recommendations in chapter three, including the introduction of medical scrutiny of the death certification process by

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<sup>&</sup>lt;sup>648</sup> Australian Medical Association, Submission no. 38, 3.

VIFM, are important measures towards improving the accuracy of information contained in MCCDs.

## Reviewable deaths

In 2004, legislation amended the *Coroners Act 1985* and introduced a new category of reviewable deaths which must be reported to the State Coroner.<sup>649</sup> This new law arose as a result of concerns regarding the appropriate identification of situations where more than one child of a family dies.<sup>650</sup> The ultimate purpose of the legislation is not however clearly stated in the amending legislation.<sup>651</sup>

The Act states that 'reviewable death' means a death:

- (a) where the body is in Victoria; or
- (b) that occurred in Victoria; or
- (c) the cause of which occurred in Victoria; or
- (d) of a child who ordinarily resided in Victoria at the time of death-

being a death of a second or subsequent child of a parent. 652

Specified persons are required to report these kinds of deaths to the State Coroner. A doctor who is present at or after the death of a child must, where that death is a reviewable death, report the death to the State Coroner as soon as possible. The Registrar of Births, Deaths and Marriages has a legal obligation to search the register of deaths (the register) to determine if the death of a child is a reviewable death and then must also search the register to establish if there are also any living siblings. If there are any living siblings, the Registrar must advise the State Coroner.

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<sup>&</sup>lt;sup>649</sup> Death Notification Legislation (Amendment) Act 2004. The obligation to report a reviewable death arises under s 13A. Doctors are required to report reviewable deaths, as is any person who has reasonable grounds to believe that a reviewable death has not been reported.

<sup>&</sup>lt;sup>650</sup>David Ranson, 'Multiple Child Deaths; A New Direction in Death Notification' (2004) 12 *Journal of Law and Medicine*, 157. See also Graeme Johnstone, Christine Nixon and the Department of Human Services, *Report into the System for Dealing with Multiple Child Deaths*, 2003. Available at www.dpc.vic.gov.au.

<sup>&</sup>lt;sup>651</sup> Death Notification Legislation (Amendment) Act 2004 s 1 states that the purpose of the legislation is to amend the Coroners Act and other Acts. It makes no reference to other purposes, such as child protection.

<sup>&</sup>lt;sup>652</sup> Coroners Act 1985 s 13(1): (definition of 'reviewable death'). The Act also defines 'parents', 'siblings' and 'child'

<sup>&</sup>lt;sup>653</sup> Coroners Act 1985 s 13A(2).

<sup>&</sup>lt;sup>654</sup> Births, Deaths and Marriages Registration Act 1996 s 49A.

<sup>&</sup>lt;sup>655</sup> Births, Deaths and Marriages Registration Act 1996 s 49A(2)(a).

There is also a general community duty to report reviewable deaths. Where a person believes on reasonable grounds that a reviewable death has not been reported to the State Coroner, that person is required to report the death to the State Coroner as soon as possible after becoming aware of the death. The State Coroner may also now refer certain reviewable deaths to VIFM.

Under the legislation, VIFM has legal obligations in relation to the health and safety of any living siblings and in relation to the health needs of the parents. It also has powers to investigate and to undertake follow-up action where necessary, including referring a family to a specialist medical service and notifying the Victorian Child Protection Service if this is considered appropriate. VIFM has appointed a Paediatric Liaison Coordinator to carry out investigations and assessments of the needs of families. The coordinator also explains the investigation and assessment process to the family and asks about the family's support needs.

From January 2005 to May 2006 there were 35 reviewable death notifications to the Coroner's Office, all of which have been referred to VIFM. Of these, 20 were referred by the Registrar of Births, Deaths and Marriages, eight were identified by coronial services staff and one was referred by Victoria Police. Medical practitioners referred the other six deaths; of these, five were referred by hospital doctors and one was referred by a GP.

## Evidence received by the Committee

In its submission VIFM provided the Committee with information on how the new reviewable deaths legislation was working in practice. 661 VIFM advised that, to July 2005, it received 11 referrals of reviewable death investigations from the State Coroner. Two of these cases involved the Victorian Child Protection Service at DHS. VIFM also advised the Committee that, as part of its implementation project, it had developed a procedural manual and communication strategy concerning VIFM's investigatory and assessment role. 662 According to VIFM, the communication strategy focuses on providing information to health professionals and government stakeholders.

<sup>657</sup> Coroners Act 1985 s 30C. This section provides that the State Coroner may refer reviewable deaths which are not reportable deaths to VIFM.

<sup>&</sup>lt;sup>656</sup> Coroners Act 1985 s 13A(1).

<sup>&</sup>lt;sup>658</sup> Coroners Act 1985 s 66(3); s 66A.

<sup>&</sup>lt;sup>659</sup> VIFM statement on reviewable deaths. Available at www.vifm.org./reviewable.html.

<sup>&</sup>lt;sup>660</sup> Email, Sue Higgs, Principal Registrar, State Coroner's Office, to Committee Legal Research Officer, 11 May 2006.

<sup>&</sup>lt;sup>661</sup>Victorian Institute of Forensic Medicine, *Submission no. 40*, 15–17. The State Coroner's submission did not address question seven from the discussion paper, concerning the effectiveness of the new category of reviewable deaths.

<sup>&</sup>lt;sup>662</sup> Available at www.vifm.org/reviewabledeaths.html.

In its submission VIFM highlighted a concern which VIFM's Manager of Medico-Legal Policy, Helen McKelvie, advised was an unintended consequence of the amendments. While the legislation clearly states what a reviewable death is, it makes no reference to the point at which VIFM's monitoring responsibilities in individual cases will cease:

VIFM's main concern with the reviewable deaths amendments to the 1985 Act lies with the open-ended responsibility VIFM has in monitoring the health and safety needs of surviving siblings of deceased children. The Act does not specify when this responsibility has been discharged and as the Act gives no age limit for siblings, it can be argued that VIFM should continue to monitor their needs until they reach adulthood or beyond. This is impossible to achieve and exposes VIFM to risk of criticism and liability.<sup>664</sup>

Associate Professor David Wells, Head of Clinical Forensic Medicine at VIFM, explained to the Committee the problems VIFM had encountered as a result:

we will have 86 people each year for whom we will be responsible for ongoing monitoring. In 10 years that will be in excess of 800 people—300 children. If we are going to have a responsibility in the ongoing management of these children and families and any subsequent children, this will have an enormous financial implication for the Institute.

Secondly, it has the potential to be extraordinarily intrusive for the families that we would be charged with monitoring, because how else does one monitor the health and wellbeing of surviving children and the health of a parent without a fairly conscious and careful monitoring of that family? Monitoring these families 7, 8, 10 years their health and welfare will be an intrusive and I think very distressing phase for many of these families. What we are asking is that we would like to see some form of legislative amendment to define the extent of our responsibilities to these families. That is essentially where we are at the moment, because at the moment the legislation provides no definition, and in many of these cases—and I am particularly referring to hereditary diseases or premature births—we do not see any role in following these families up long term. 665

Professor Cordner told the Committee that he considered VIFM's monitoring responsibility should:

Cease[...] once we have either reported the need for protection and/or reported to the State Coroner, who might then ask us to do something else, we are not activated until we are asked by the State Coroner to do something else. I think it would be fairly easy to say that that is when it terminates. 666

<sup>&</sup>lt;sup>663</sup> Helen McKelvie, *Minutes of Evidence*, 19 September 2005, 121.

<sup>&</sup>lt;sup>664</sup> Victorian Institute of Forensic Medicine, Submission no. 40, 17.

<sup>&</sup>lt;sup>665</sup> David Wells, *Minutes of Evidence*, 19 September 2005, 119.

<sup>&</sup>lt;sup>666</sup> Stephen Cordner, *Minutes of Evidence*, 19 September 2005, 121.

Associate Professor Ranson in his personal submission indicated that he had similar concerns:

Given that the vast majority of second or subsequent deaths of children in the family are the result of natural disease rather than any suspicious action on the part of parents it is easy to see how doctors will be confused as to why this new category of reviewable death has been created. The fact that these deaths are actively medically investigated by the Victorian Institute of Forensic Medicine who now have a medical responsibility not just towards the deceased but also towards the surviving children and the parents still remains relatively unknown. This medical duty of care that the Institute owes to surviving children and the parents involves the delivery of a health-care service that is currently unfunded and is likely to considerably increase with respect to health care provision costs involved. Because most of the deaths are in fact natural deaths the Institute is responsible for establishing and delivering primary healthcare investigative services and that is not a service provision that the medical profession generally associates with the forensic pathology community. 667

While Associate Professor Ranson accepted that the definition of reviewable deaths was remarkably clear and direct, he considered that this new category of reviewable deaths would lie outside the general knowledge of most doctors. He believed that there was therefore a need for a major educational and communication campaign and referred to various measures currently being undertaken by VIFM to educate health professionals. He also considered that it was the managerial responsibility of the State Coroner to engage in an active public relations process in order to increase community awareness of reviewable deaths.

Associate Professor Ranson indicated that he was also concerned that the purpose of the new legislation is not clearly stated in the Act:

I fear this will mean that medical practitioners who are convinced that the death of the second or subsequent child is not suspicious will not feel it needs to be reported. (Indeed I have identified a number of deaths obviously caused by major trauma which were not reported to the coroner simply because the doctor believed they were not suspicious and that the doctor believed the purpose of the coroner's jurisdiction was to deal with suspicious deaths.)<sup>669</sup>

Associate Professor Ranson also identified a problem in the mechanisms for identifying reviewable deaths which may impact on the effectiveness of the new provision:

The medical profession is entirely reliant upon the medical history provided to them by the child or the child's family and if this does not disclose the existence of a previous death of a child it is difficult to see how the medical practitioner can identify the existence of the reviewable death. Changes in the operation of the Registry of births deaths and marriages will assist in ensuring

<sup>667</sup> David Ranson, Submission no. 19, 25-6.

<sup>&</sup>lt;sup>668</sup> Ibid 25.

<sup>669</sup> Ibid.

that such deaths are subsequently identified, but in recent months the VIFM has come across a case where, because of a name change, a second child death was not identified in this way.<sup>670</sup>

Ms Helen Kane, Coordinator of Reproductive Loss Services at the Royal Women's Hospital, told the Committee that she believed the new legislation required a minor amendment to accommodate the special needs of women medically assessed as having a high risk pregnancy, such as women with a history of recurring miscarriages.<sup>671</sup> She explained to the Committee that the Royal Women's Hospital has a high incidence of perinatal death because of the hospital's high risk pregnancy group, including extremely premature babies as well as babies with chromosomal abnormalities and family medical conditions.<sup>672</sup> She submitted that a greater degree of discretion should be given to investigating officers to discontinue a review where it was certain that the death was due to a medically recognised genetic condition:

It should be at the discretion of the investigating officer to halt any investigation process when two or more children in the one family have died in circumstances where it is clear that the children have suffered from a medically certified, life threatening condition and this has a recognised recurrence rate within families. In other words, we would ask the Committee to accept that there are many families who suffer multiple deaths of babies and that there should be a list of criteria which might allow the investigating officer to exercise discretion so as to exclude cases from further investigation and causing the families additional grief at their recent loss—for example, extreme prematurity, babies born after 20 to 24 weeks gestation, those born with congenital heart disease et cetera.<sup>673</sup>

A final issue was raised by the Consultative Council on Obstetric and Paediatric Mortality and Morbidity (CCOPMM).<sup>674</sup> Section 22A of the Act states that:

A coroner may notify the Consultative Council on Obstetric and Paediatric Mortality and Morbidity of the particulars of the death of a child reported to a coroner.

While not only applicable to reviewable deaths this section was nevertheless inserted into the Act by the 2004 amendments. CCOPMM recommended that the wording of the Act be changed from 'may' to 'shall' to make it mandatory for the coroner to notify the CCOPMM of a child death, which it considered would enable it to better perform

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<sup>&</sup>lt;sup>671</sup> Helen Kane, *Minutes of Evidence*, 19 September 2005, 102.

<sup>&</sup>lt;sup>672</sup> According to the Reproductive Loss Coordinator, a number of specialist programs have been established to care for women who have been assessed as having high risk or problematic pregnancies, including the Maternal Fetal Medicine program and the Recurrent Miscarriage Clinic, which cares for women who have had three or more pregnancy losses. The Fetal Medicine Unit receives approximately 50 percent of referrals internally and 50 percent from other hospitals across Victoria: Email, Vivienne Raymant, Reproductive Loss Coordinator, Royal Women's Hospital, Melbourne, to Committee Legal Research Officer, 19 June 2006.

<sup>&</sup>lt;sup>673</sup> Helen Kane, *Minutes of Evidence*, 19 September 2005, 103.

<sup>&</sup>lt;sup>674</sup> Consultative Council on Obstetric and Paediatric Mortality and Morbidity, Submission No. 84,1.

its functions under the *Health Act 1958*.<sup>675</sup> These functions include the investigation of deaths of children in Victoria who die aged less than 18 years of age.<sup>676</sup>

#### Discussion and conclusion

The Committee shares the concerns expressed by VIFM and Associate Professor Ranson regarding the open-ended nature of VIFM's current legal responsibilities with regard to monitoring the health and welfare of living persons. The Committee accepts that in a number of reviewable death cases it would not be appropriate or indeed necessary for VIFM to monitor the health of living siblings for up to 18 years until the child reaches adulthood. The Committee recommends that the Act should be amended to clarify the period for which VIFM is charged with the task of monitoring the health and welfare of surviving siblings and the health of the parents of the child who died.

In addition the Committee recommends the amendment to the Act suggested by the CCOPMM, to make it mandatory for a coroner to notify the CCOPMM of a child death.

Recommendation 28. That, in relation to reviewable deaths, the *Coroners Act* 1985 be amended so that it specifies that the obligation of the Victorian Institute of Forensic Medicine to investigate, assess and instigate responses in relation to:

- a) the health or safety of a living sibling of a child who has died; and
- b) the health of a parent of a child who has died

ceases when the Victorian Institute of Forensic Medicine provides a report to the State Coroner on the action taken by it in relation to a reviewable death, unless the State Coroner requests that the Victorian Institute of Forensic Medicine undertake further investigations or assessments in relation to the death.

Recommendation 29. That section 22A of the *Coroners Act 1985* be amended to replace the word 'may' with 'shall'.

While the new category of reviewable deaths has been in operation since 1 January 2005 only, the Committee considers that the State Coroner, in conjunction with VIFM, should work towards the development of investigation standards for reviewable deaths. This would give investigators a structure within which to carry out investigations. It would also give a degree of guidance as to how sensitive investigations should be undertaken where there is an established medical history of inherited conditions which may have caused the deaths of more than one child in the same family. The Committee believes that this will address the concerns raised by Ms Kane.

<sup>&</sup>lt;sup>675</sup> Ibid.

<sup>&</sup>lt;sup>676</sup> Health Act 1958 s 162F.

Recommendation 30. That the State Coroner and the Victorian Institute of Forensic Medicine establish standards for the investigation of reviewable deaths.

# Other possible categories of reportable deaths

# Deaths in nursing homes

Approximately four percent of people over the age of 60 in Victoria live in residential aged care facilities (formerly known as nursing homes and hostels).<sup>677</sup> In Victoria, the death of a person in an aged care residential facility is not reportable if a doctor certifies the death as due to natural causes. The Committee's research however indicates that, in a number of international jurisdictions, nursing home deaths are reported to the coroner for further investigation. For instance, deaths which occur in nursing homes in Ontario, Canada, must be reported to the coroner in that jurisdiction.<sup>678</sup> The Committee understands however that, rather than investigate every reported nursing home death, the Chief Coroner has adopted the approach of investigating every 10th nursing home death.<sup>679</sup> Nursing homes are required to keep a death register and must refer every 10th death to the Coroner for further investigation. While the Chief Coroner is notified of all deaths in nursing homes, he will only investigate a particular death if it meets certain criteria.

In Ireland, the Coroners Rules Committee has recommended that all deaths in nursing homes should be reported as deaths 'in care'. 680

Elder abuse and the standard of care provided in nursing homes have been topics of recent debate in the media. There was increased community awareness concerning the prevalence of elder abuse following the Elder Abuse Prevention Project Report, which was released in December 2005. Approximately 13.5 percent of the Victorian population is aged over 65 years. In the discussion paper the Committee questioned whether the category of reportable deaths should include deaths in nursing homes.

<sup>&</sup>lt;sup>677</sup> Department of Human Services, 'Population Ageing in Victoria: A Snapshot of Victoria's Senior Population Aged 60 years and Over'. Available at www.dvc.vic.gov.au.

<sup>&</sup>lt;sup>678</sup> Coroners Act, RSO 1990, C37, s 10 (2.1).

<sup>&</sup>lt;sup>679</sup> Meeting, Dr Barry McClellan, Chief Coroner, Ontario, of 21 June 2005.

<sup>&</sup>lt;sup>680</sup> Ireland, Department of Justice, *Report of the Coroners Rules Committee*, 2003. Available at www.justice.ie.

<sup>&</sup>lt;sup>681</sup> See for example Margot O'Neill, 'Claims of Sexual Abuse at Victorian Nursing Home', *Lateline*, 20 February 2006; Peter Ellingsen, 'Scandal of the Elderly Who Go Hungry', *The Age*, 12 December 2005; Annabel Stafford, 'Homes Hold Deadly Secrets', *The Age*, 17 April 2006, 1; Annabel Stafford, 'Owners to Notify Aged Home Abuse', *The Age*, 11 April 2006, 6; Annabel Stafford, 'Four Homes for Elderly Fail Code', *The Age*, 7 June 2006.

<sup>&</sup>lt;sup>682</sup> Elder Abuse Prevention Project, *Strengthening Victoria's Response to Elder Abuse*, Office of Senior Victorians, December 2005. Available at www.seniors.vic.gov.au.

<sup>&</sup>lt;sup>683</sup> Australian Bureau of Statistics. Available at http://www.abs.gov.au/AUSSTATS.

## **Evidence received by the Committee**

While the Coroner's Office accepted that there was under-reporting of nursing home deaths, its submission did not endorse the mandatory reporting of all nursing home deaths. The Coroner's Office considered that most of these deaths would be reported under other proposed categories of reportable deaths referred to in the submission. On the other hand, VIFM indicated that the Institute would not be opposed to the mandatory reporting of all deaths occurring in nursing homes. VIFM indicated that mandatory reporting of nursing home deaths would have substantial resource implications for VIFM but that issues of priority in death investigation could be dealt with in an evidence based, collaborative way by an advisory coronial council.

A number of stakeholders also supported a requirement that nursing home deaths be reported to the coroner. <sup>687</sup> Ms Heffey provided the Committee with a detailed proposal as to how these kinds of deaths should be reported. She identified a number of ways in which the health of an elderly person may be compromised:

- carer's failure to seek medical help in a timely manner,
- septicaemia developing from bed sores, and
- restraint that restricts mobility (leading perhaps to deep-vein thrombosis and pulmonary embolism)<sup>688</sup>

She considered that all deaths in nursing homes and other aged care facilities should be included in a new category of 'notifiable deaths' in the following manner:

The General Practitioner responsible for signing the death certificate should, after examination of the body, forward to the Coroners Office a copy of the death certificate along with a statement in a prescribed form to the effect that he/she has viewed the body, examined the deceased's medical records and the records of the facility and is satisfied that the care and attention afforded to the deceased was reasonable and had no bearing on the death.

In the event that he/she is not able to make that statement, the death should be categorised as "a reportable death" 689

<sup>&</sup>lt;sup>684</sup> State Coroner's Office, Submission no. 70, 81.

<sup>&</sup>lt;sup>685</sup> Victorian Institute of Forensic Medicine, Submission No. 40, 13.

<sup>&</sup>lt;sup>686</sup> Ibid.

<sup>&</sup>lt;sup>687</sup> For example, Royal College of Nursing, Australia, *Submission no. 63*, 4; Victorian Legal Aid, *Submission no.* 34, 2; Jacinta Heffey, *Submission no.* 33, 9.

<sup>688</sup> Jacinta Heffey, Submission no. 33, 10.

dadinta Hericy, Gabringsion no. 33,

<sup>&</sup>lt;sup>689</sup> Ibid.

Associate Professor Ranson considered that the way in which nursing home deaths should be reported and investigated required careful analysis in light of particular issues associated with these deaths:

It is probable that there would be a great deal of concern expressed by families in respect of all deaths in nursing homes being reportable to the coroner without considerable reform of the coroner's death investigation process. The decision to proceed to palliative care for very frail elderly individuals, in the terminal stages of an illness, which has been taken by medical and nursing staff in full consultation and with the agreement of the family, is a common event in nursing homes. Whilst I am not suggesting that such decisions should not be subject to external review the nature of that review would have to be very carefully considered as it may well seem inappropriate from a community perspective to have such deaths investigated in the same manner by the coroner as an unknown death or a death from trauma or medical misadventure. 690

#### **Discussion and conclusion**

The Committee is concerned by the indication that deaths in nursing homes are under-reported. According to recent media reports, NCIS data shows that 63 nursing home residents died from unnatural causes in 2004, and this is also a cause for some concern. <sup>691</sup> Clearly, there is a need for a closer level of medical scrutiny of these deaths to ensure that deaths involving elder abuse do not go unnoticed.

In response to these concerns, the Committee considered whether there should be a mandatory requirement that all nursing home deaths be reported to the coroner. The Committee noted the potential for mandatory reporting requirements to cause additional stress for the grieving families of elderly people who died from natural or unpreventable causes. It had further concerns about the likely substantial resource implications of such a requirement. The Committee agrees with Associate Professor Ranson and VIFM that the way in which these deaths are monitored and investigated requires careful expert analysis.

The Committee suggests that one mechanism for monitoring nursing home deaths would be to adopt a system similar to the one implemented by the Chief Coroner in Ontario. The directors of nursing homes could be required to notify the Coroner of all deaths, but the Coroner's Office in conjunction with VIFM could decide which deaths require coronial scrutiny.

As noted earlier in the chapter, the current practice in Ontario is for the Chief Coroner to investigate every 10th death of which he is notified. A similar system appropriate for Victoria would need to be developed. In chapter five the Committee has recommended that the State Coroner be given the power to undertake a preliminary investigation into deaths, whether reported or not, to establish if they are reportable. The implementation of this recommendation would provide part of the legislative basis

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<sup>690</sup> David Ranson, Submission no. 19, 19-20.

<sup>&</sup>lt;sup>691</sup> Annabel Stafford, 'Homes Hold Deadly Secrets', *The Age*, 17 April 2006, 1.

for the system proposed here. A requirement that all deaths be notified to the coroner could be achieved by legislative or administrative means. Without specifying the exact details of such a system, the Committee recommends that the implementation of a similar system be considered.

The Committee considered that the class of institutions required to notify the coroner should be consistent with the class recommended in an earlier section of this chapter in relation to recommendation 26.

Recommendation 31. That the Coroner's Office and the Victorian Institute of Forensic Medicine implement a system in which the directors of certain aged care facilities are required to notify the coroner of the deaths of all residents, and that an appropriate agreed number of these notified deaths, but not less than 10 percent, be investigated by the State Coroner.

The category of institutions required to notify the coroner include:

- a) high care residential aged care services or accommodation under the Commonwealth Residential Aged Care Programme;
- b) low care residential aged care services where the person was receiving approved high care services under the Commonwealth Residential Aged Care Programme;
- c) respite care services where the person was receiving approved high care services under the Commonwealth Residential Aged Care Programme; and
- d) supported accommodation provided on a private basis such as Supported Residential Services.

# Deaths occurring in 'prescribed circumstances'

In the year after the Act commenced, the *Coroners Regulations* were enacted. <sup>694</sup> These regulations, which expired in 1996, included the following kind of death as a prescribed circumstance:

<sup>&</sup>lt;sup>692</sup> JG Norris, *The Coroners Act 1958 — A General Review* (1981) Recommendation 59(e), 40.

<sup>&</sup>lt;sup>693</sup> Coroners Act 1985 s 3(1) definition of 'reportable death', para (h).

<sup>&</sup>lt;sup>694</sup> Coroners Regulations 1986.

A death is also a reportable death when it occurs as a result of a negligent act or omission of any person. <sup>695</sup>

However, this regulation was disallowed in November 1986 on the recommendation of the Victorian Parliament's Legal and Constitutional Committee. That committee considered that the rule offended a parliamentary guideline because it was no more than an example of what constituted a reportable death as defined in the Act. For the commendation of the Victorian Parliament's Legal and Constitutional Committee.

Interestingly, the current regulations, which were enacted in 1996 to replace the 1986 regulations, did not include this prescribed circumstance or indeed any prescribed circumstance. 698

The reference to 'deaths occurring in prescribed circumstances' in the Act has caused a degree of confusion for some medical stakeholders. For instance, VCCAMM informed the Committee that it was confused by the reference in the Act to 'a death that occurs in prescribed circumstances' and asked the Committee to consider clarifying what is meant by the reference.<sup>699</sup>

### **Evidence received by the Committee**

The Coroner's Office considered this issue and submitted that the deaths of persons from certain occupational diseases should be prescribed as reportable deaths under the regulations to the Act.<sup>700</sup> The issue of whether deaths from occupational diseases should be reported to the coroner is examined in the next section of this chapter. However, it is relevant to note here that it appears that the State Coroner was able to require mandatory reporting of deaths from mesothelioma by making doctors and others aware of his view that the deaths were reportable under existing provisions of the Act.

It is not clear why the coroner chose this approach rather than making use of the regulations to designate mesothelioma as a prescribed circumstance.

Other witnesses considered that the power in the Act to make regulations should be used and that the regulations should specify which deaths from particular diseases

<sup>&</sup>lt;sup>695</sup> Coroners Regulations 1986 r 5.

<sup>&</sup>lt;sup>696</sup> Parliament of Victoria, Legal and Constitutional Committee, *Sixth Report to Parliament on Subordinate Legislation*, No. 122, November 1986, 3–6.

<sup>&</sup>lt;sup>697</sup> Ibid. According to the report, the Department of Justice advised that the regulation had been made to end doubts as to whether traffic collision deaths and workplace deaths were covered in the definition of 'reportable deaths'.

<sup>&</sup>lt;sup>698</sup> Coroners Regulations 1996. These regulations have been extended to 6 May 2007 by the Subordinate Legislation (Coroners Regulations 1996 - Extension of Operation) Regulations 2006 r 3.

<sup>699</sup> Victorian Consultative Council on Anaesthetic Mortality and Morbidity, Submission no. 22, 1.

<sup>700</sup> State Coroner's Office, Submission no. 70, 82.

should be reported because this would assist in clarifying which particular deaths should be reported to the coroner. For example, Austin Health submitted that:

there appears to be some uncertainty of what constitutes a preventable death that is attributed to a specific disease. For example, VIFM expects that deaths associated with mesothelioma be reported. Conversely, the same obligation does not exist for deaths relating to the misuse of alcohol or tobacco. Therefore, if deaths attributed to specific diseases are to be reported, then a clear list of disease states and accompanying rationales should be included in the guidelines to assist doctors' understanding. For instance, list disease states, such as mesothelioma, that may result from exposure to a specific toxin.<sup>701</sup>

#### Similarly, Victoria Police was of the view that:

rather than attempting to clarify particular diseases as reportable it may be more appropriate to make an application to have particular classes of otherwise 'natural diseases' classified as Prescribed Deaths. This provision already exists within the Act. Therefore, all Mesothelioma deaths could be a 'prescribed class' of death and as the need arises other classes may be sought to be included as prescribed.<sup>702</sup>

A contrary view was expressed by the Victorian Surgical Consultative Council, which did not think it would be helpful to report deaths from particular diseases. The Council however submitted that, if it was considered necessary to prescribe diseases, this should be dealt with in the regulations.<sup>703</sup>

#### Discussion and conclusion

The Committee considers that there is merit in the proposal that deaths of persons from certain diseases should be prescribed as reportable deaths under the regulations to the Act. While the existing power has not been used since the old regulations expired in 1996, it appears to the Committee that there is support for its retention. Further, the use of this power would be consistent with the preventative role of the coroner as it would allow for the monitoring of deaths resulting from emerging diseases or epidemics should the need arise.

As discussed earlier in the chapter, the Committee is of the view that the current categories of reportable deaths ought to be stated with a greater degree of clarity to enable doctors to be more fully informed of their reporting requirements. The Committee considers that the retention of the existing provisions facilitates this objective, and therefore it makes no recommendation for change.

Victoria i olice, oubiriissiori rio. 70, 5

<sup>&</sup>lt;sup>701</sup> Austin Health, Submission no. 45, 2.

<sup>&</sup>lt;sup>702</sup> Victoria Police, *Submission no.* 78, 3.

<sup>&</sup>lt;sup>703</sup> The Victorian Surgical Consultative Council, *Submission no. 21*, 1

## Occupational disease and workplace deaths

In all Australian jurisdictions, including Victoria, there is no category of reportable deaths specifically in relation to deaths associated with the workplace. These kinds of deaths are, of course, reportable if they fall under one of the general categories of reportable deaths discussed earlier in the chapter.

In October 2004 a specialist unit was established at the Coroner's Office to address work related deaths. The Work-Related Death Investigation and Resource Unit is:

supported by the Victorian WorkCover Authority with the aim of widening the scope, improving the quality and the coordination of work-related death investigations...<sup>704</sup>

Priority areas of investigation by the unit are identified by the coroner in partnership with the Victorian WorkCover Authority and at the unit's inception were specifically intended to include deaths associated with industrial toxins.

Dr Freckelton and Associate Professor Ranson have identified a number of instances which demonstrate that it is not always easy to determine whether a particular workplace death should be reported based on a MCCD which discloses an apparently natural cause of death:

- A death certificate states that the cause of death is cor pulmonale due to pulmonary fibrosis. Lung fibrosis can arise as a result of natural disease or as a result of exposure due to hazardous dusts such as asbestos or silica. This cause of death could then indicate that the person died as a result of an occupational or industrial disease; and
- A death from Legionnaires' disease. These deaths are due to pneumonia, a natural disease process. However, the disease may also been acquired from general exposure to the organism in its natural state in the environment. It could also be contracted as a result of an increased concentration of the organism in an air conditioning system which has not been appropriately serviced.<sup>705</sup>

#### International jurisdictions

A number of jurisdictions require occupational deaths to be reported to the coroner. In Ireland, the Coroners Rules Committee recommended that 'any death due to accident at work, occupational disease or industrial poisoning' should be classified as a reportable death.<sup>706</sup> Currently where the death resulted from any industrial disease, it is reportable.

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<sup>&</sup>lt;sup>704</sup> Media release, Victorian WorkCover Authority, 25 October 2004.

<sup>&</sup>lt;sup>705</sup> Ian Freckelton and David Ranson, *Death Investigation and the Coroner's Inquest* (2006) 167.

<sup>&</sup>lt;sup>706</sup> Ireland, Department of Justice, *Report of the Coroners Rules Committee*, 2003. Available at www.justice.ie.

The position in England and Wales is similar, with investigations required in relation to deaths caused by poisoning or disease, notice of which is required to be given under any Act (relating to workplace safety).<sup>707</sup> Coroners in England and Wales routinely investigate deaths from industrial disease:

industrial disease cases are by far the largest single verdict recorded (...) the great majority arise from exposure to asbestos or coal dust. (...) The proportion of verdicts of "industrial disease" returned by coroners has almost doubled in the last 10 years and in 1997 amounted to 1 836 verdicts.<sup>708</sup>

The position is also similar in Hong Kong. The death investigation system in that jurisdiction is derived from the English coronial system. The last review of coronial law was undertaken by the Law Reform Commission of Hong Kong in 1986. Following the review, new legislation was enacted in 1997 specifying the types of deaths which should be reported. The relevant legislation now includes a detailed ordinance, which provides that the following deaths be reported:

Any death of a person where-

- (a) an occupational disease, within the meaning of section 3 of the Employees' Compensation Ordinance (Cap 282), or pneumoconiosis, within the meaning of section 2(1) of the Pneumoconiosis (Compensation) Ordinance (Cap 360), caused the death; or
- (b) having regard to the nature of the last illness of the person, the medical cause of the death and the nature of any known occupation or employment, or previous occupation or employment, of the person, it is reasonable to believe that the death may be connected, either directly or indirectly, with any such occupation or employment.<sup>711</sup>

While there is a detailed provision in the legislation, it appears that some Hong Kong coroners take a restrictive view of how this legislation is to be interpreted. This occurred in relation to a 2003 inquest into the death of six health care workers who died from severe acute respiratory syndrome (SARS) after they had treated infectious patients at the hospital where they worked during a SARS outbreak.<sup>712</sup> The Hong Kong Coroner directed the jury to return a verdict of natural causes if it believed that

<sup>708</sup> C Dorries, *Coroner's Courts: A Guide to Law and Practice* (1999) 49. Cited in *Record of Investigation into a Death (Without Inquest)*, Case no. 1598/03, State Coroner's Office, Victoria, 8 July 2000. Available at <a href="https://www.coronerscourt.vic.gov.au">www.coronerscourt.vic.gov.au</a>.

<sup>&</sup>lt;sup>707</sup> Coroners Act 1988 (UK) s 8(3)(c).

<sup>&</sup>lt;sup>709</sup> Law Reform Commission of Hong Kong, *Report in Coroners*, 1986, 10.

<sup>&</sup>lt;sup>710</sup> Coroners Ordinance, (Hong Kong) Cap 504, s 2, Schedule 2.

<sup>&</sup>lt;sup>711</sup> Coroners Ordinance, (Hong Kong), Cap 504, s 2, Schedule 2, part 1, item 7.

<sup>&</sup>lt;sup>712</sup> SARS is a severe respiratory illness that is transmitted especially by contact with infectious material such as respiratory droplets or body fluids: www.nlm.nih.gov/medlineplus.

SARS was the cause of death.713 However, according to medical evidence, the respiratory masks supplied by the hospital filtered out only 95 percent of contaminants and were not as well fitting as other masks.714 The hospital limited workers to one mask for every 10-hour shift, which meant that workers had to clean and re-use masks after breaks. One of the health care workers, a nurse, was wearing the hospital issued mask when it slipped off while he was inserting a respiratory tube into a patient.715

### **Evidence received by the Committee**

As discussed earlier in this chapter, the Coroner's Office submitted that the deaths of persons from certain occupational diseases should be prescribed as reportable deaths under the regulations to the Act.716 In relation to which specific diseases should be prescribed as reportable deaths, the Coroner's Office considered that this should be determined by the Work-Related Death Investigation and Resource Unit, managed by VIFM:

This Unit will assist in providing advice to the State Coroner about the classes of occupational diseases that should be prescribed and help monitor any new occupational disease categories that also need to be reported.<sup>717</sup>

While VIFM was supportive of the proposal, it indicated that the question should be a public policy decision:

the question of whether deaths from mesothelioma and other slow-acting diseases attributable to industrial exposure to poisonous or otherwise dangerous agents should be reported to the coroner for investigation is one of public policy. Investigation of statistically significant numbers of these types of deaths could produce extremely important information and findings for use in a number of public health and legal arenas.

The above issue raises a larger question about how death investigation resources are expended and whether a more policy-driven approach could be taken to delineating which deaths are reported and what level of investigation is undertaken for different categories of deaths. 718

VIFM also indicated that the State Coroner's decision to have mesothelioma deaths reported had caused a number of difficulties for the Institute because the implementation of the initiative was not structured as a whole of government or community response.<sup>719</sup> As a result, many of the costs to VIFM, hospitals and families

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<sup>&</sup>lt;sup>713</sup> Jane Perry, 'Coroner Criticised Over Conduct of SARS Inquest' (2004) 329 *British Medical Journal* 1204.

<sup>&</sup>lt;sup>714</sup> Ibid.

<sup>&</sup>lt;sup>715</sup> Ibid.

<sup>716</sup> State Coroner's Office, Submission no. 70, 82.

<sup>&</sup>lt;sup>718</sup> Victorian Institute of Forensic Medicine, *Submission no. 40*, 10-11.

<sup>&</sup>lt;sup>719</sup> Ibid 11.

were neither identified nor funded. While VIFM acknowledged that the State Coroner acted entirely within his role when he undertook this initiative, the Institute noted that the initiative created increased workloads for VIFM staff. Without additional funding, this meant that VIFM was forced to spread finite resources more thinly.

To resolve these problems, VIFM endorsed:

formalising a public policy-driven approach to death investigation inclusive of, but external to the State Coroner, (thus avoiding a conflict of roles). Consideration should be given to the advisory "Coronial Council", as outlined in the United Kingdom Home Office Position Paper on "Reforming the Coroner and Death Certification Process". The Coronial Council could build upon the model of the Medical Advisory Group, which has been convened by the State Coroner and comprises representatives of medical colleges, SCO and VIFM.<sup>720</sup>

#### Discussion and conclusion

The Committee, like VIFM, considers that the issues concerning the way in which these kinds of deaths are reported and investigated requires further strategic and expert analysis and that this could most appropriately be undertaken by a coronial council as proposed by VIFM.<sup>721</sup> On advice from the council, and after due consideration of public policy implications by the Department of Justice, appropriate matters can then be included in the regulations as prescribed circumstances. Formalising the process in this way may address some of VIFM's concerns in relation to the imposition of increased workloads without corresponding increases in funding. A request to the government to amend the regulations would require funding implications to be specifically addressed.

Recommendation 32. That the proposed coronial council consider the following issues:

- a) whether particular workplace deaths, such as deaths from industrial diseases or deaths where employment or previous employment may have been connected with the death, should be reported to the coroner; and
- b) how such deaths should be reported and investigated.

# Community awareness of the requirement to report deaths

The Act requires the general public to report deaths to the coroner or the police in the following circumstances:

A person who has reasonable grounds to believe that a reportable death has not been reported must report it as soon as possible to a coroner or the officer in charge of a police station.

<sup>&</sup>lt;sup>720</sup> Ibid.

<sup>&</sup>lt;sup>721</sup> The Committee recommends the establishment of such a council in chapter nine.

Penalty: 10 penalty units.722

A person who has reasonable grounds to believe that a reviewable death has not been reported to the State Coroner as a reviewable death must report it to the State Coroner as soon as possible after becoming aware of the existence of that death.

Penalty: 10 penalty units. 723

The Act also imposes an obligation on carers to report the death of a person in care to a coroner:

The death of a person who was held in care immediately before death must be reported as soon as possible to a coroner by the person under whose care the deceased was held.

Penalty: 10 penalty units.724

In the discussion paper, the Committee questioned whether the general community was aware of the obligation to report notifiable deaths to the coroner.

### Other Australian jurisdictions

All jurisdictions impose general obligations to report notifiable deaths to a coroner.<sup>725</sup> In the ACT and Western Australia, unlike Victoria, the relevant legislation imposes a penalty on police officers who fail to comply with the obligation to report information to a coroner.<sup>726</sup> All jurisdictions also include deaths in custody as notifiable deaths.<sup>727</sup>

## Evidence received by the Committee

Associate Professor Ranson told the Committee that the majority of deaths were reported to the coroner by the police and doctors. In his experience, it is only occasionally that family members report deaths, and this may occur at the time of death or some months later. He also told the Committee that he has:

frequently come across situations where a family has commented to me that they did not realise that they could have reported the death to the coroner when they were concerned that medical staff or police did not intend to report the death. However, I do not know whether the community

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<sup>&</sup>lt;sup>722</sup> Coroners Act 1985 s 13(1).

<sup>&</sup>lt;sup>723</sup> Coroners Act 1985 s 13A(1).

<sup>&</sup>lt;sup>724</sup> Coroners Act 1985 s 13(5).

<sup>&</sup>lt;sup>725</sup> Coroners Act 1997 (ACT) s 77(1); Coroners Act 1980 (NSW) s 12A(1); Coroners Act 1996 (WA) s 17(1); Coroners Act 2003 (QLD) s 7; Coroners Act 1995 (TAS) s 19(1); Coroners Act 2003 (SA) s 28(1); Coroners Act 1993 (NT) s 12(2).

<sup>&</sup>lt;sup>726</sup> Coroners Act 1997 (ACT) s 77(2): the maximum penalty is six months' imprisonment; Coroners Act 1996 (WA) s 18(2): the maximum penalty is a \$1000 fine.

<sup>&</sup>lt;sup>727</sup> Halsbury's Laws of Australia, K Walker, *Coroners* [115–95] at 16 February 2005.

<sup>&</sup>lt;sup>728</sup> David Ranson, Submission no. 19, 28.

is generally aware that they have both the power and the obligation to report reportable deaths to the coroner. I suspect that the general public is largely unaware of this. <sup>729</sup>

A number of witnesses also stated that, in their experience, members of the public were unaware of the general obligation to report particular deaths. These witnesses included the Health Services Commissioner,<sup>730</sup> a pathologist based in regional Victoria,<sup>731</sup> a former coroner<sup>732</sup> and Victoria Police.<sup>733</sup> However, Victoria Police considered that the problem was often rectified once members of the public contacted police, emergency services or the health care system.

However, some witnesses considered that there was a level of community awareness regarding the obligation to report notifiable death. Ms Emilia Arnus, representing a number of constituents of East Yarra Province, indicated that the constituents who attended a meeting to discuss the Committee's discussion paper were aware of their obligation to report notifiable deaths and believed that the general community was also aware of it.<sup>734</sup>

The Committee also heard evidence from a number of family members who had reported the death of a relative directly to the coroner. For example, Ms Lorraine Long told the Committee about the circumstances surrounding the death of her mother, June Long.<sup>735</sup> Ms Long had a number of disturbing unresolved issues concerning the death of her mother at a Melbourne hospital. She told the Committee that she decided to contact the Coroner's Office herself.

Some witnesses, such as Ms Heffey, questioned the need for the general obligation provision:

It is my view therefore that this provision is of little value. I can think of no way in which this obligation could be publicised unless it arose out of an investigation which came to the notice of the coroner by a report and it became apparent that others knew of the death and failed to report it. The subsequent media publication of the coronial findings containing criticism of this failure might go some way to raising awareness but I imagine that most members of the general public would not foresee themselves ever being in this position and would guickly forget it.<sup>736</sup>

<sup>730</sup> Health Services Commissioner, Victoria, Submission no. 62, 4.

<sup>&</sup>lt;sup>729</sup> Ibid.

<sup>&</sup>lt;sup>731</sup> Patrick van der Hoeven, Submission no. 6, 2.

<sup>732</sup> Jacinta Heffey, Submission no. 33, 11–12.

<sup>733</sup> Victoria Police, Submission no. 78, 4.

<sup>&</sup>lt;sup>734</sup> Emilia Arnus, Submission 20, 3.

<sup>&</sup>lt;sup>735</sup> Lorraine Long, Supplementary Submission no. 7S2; Frank Diconi Submission no. 76.

<sup>&</sup>lt;sup>736</sup> Jacinta Heffey, Submission no. 33, 11–12.

Dr Robertson was of a similar view.<sup>737</sup> Both witnesses considered that this provision should be removed and replaced with a specific class reporting requirement. Ms Heffey considered that the class should include persons employed in the health system and the correctional system, funeral directors, and police officers, while Dr Robertson thought the category should be confined to medical and law-enforcement personnel.

The Committee received a number of submissions which addressed the question of who should be responsible for raising awareness of the requirement to report notifiable deaths. Witnesses such as Associate Professor Ranson considered that this was the State Coroner's role and that raising awareness should be more actively pursued:

Given that the coroner operates in a jurisdiction which is freed from most of the formalities surrounding the remainder of the adversarial legal system (with respect to procedure and rules of evidence) it is clearly open for coroners to engage in a much wider public range of communication activities designed to improve community knowledge of the work of the coroner. Indeed a variety of different court officials and quasi judicial office bearers engage in similar public relations activities in order to ensure that the community is aware of their role and the service they provide. Whilst advertising may be an uncomfortable area of activity for coroners it would appear that their jurisdiction cannot be effectively and efficiently operated without the community being more widely informed about their role. A clear statement in the legislation as to the purpose of the coroner's jurisdiction could certainly assist with this.<sup>738</sup>

Ms Wilson considered that it should be a function of the State Coroner to continue to raise public awareness. She submitted that this could be done through schools, clubs, television advertisements, newspaper articles and similar strategies. In the HSC's experience, the campaign would need to be continual and would need adequate resources to be successful.

The Coroner's Office briefly referred to the fact that the death certification process could be strengthened by regular education campaigns on the reporting of deaths and considered that the State Government should commit resources to a major education campaign targeting doctors in hospitals and nursing homes.<sup>740</sup> There was no indication in the submission as to who the Coroner's Office thought should be responsible for implementing the education campaign.

The Committee in the discussion paper also questioned whether the general community and the medical profession were aware of the new category of reviewable deaths. Two witnesses indicated that, as at July 2005, there were a few issues still to

<sup>737</sup> Shelley Robertson, Submission no. 35, 3.

<sup>&</sup>lt;sup>738</sup> David Ranson, *Submission no. 19*, 27-8.

<sup>&</sup>lt;sup>739</sup> Health Services Commissioner, Victoria, Submission no. 62, 4.

<sup>&</sup>lt;sup>740</sup> State Coroner's Office, Submission no. 70, 126.

be resolved.<sup>741</sup> Associate Professor Ranson believed that there was limited knowledge in the community and amongst health professionals regarding the new category and the reason that these deaths were now required to be reported.<sup>742</sup> He added that:

The introduction of reviewable deaths as a new special death category lies well outside the ordinary knowledge framework of most doctors when it comes to the workings of the coroner's jurisdiction and so raises a major educational and communication issue. The definition of reviewable deaths however is remarkably clear and direct. Barring some difficulties in determining what is meant by a family there should be little problem for the community and doctors in understanding which child deaths should be reported to the coroner for review.<sup>743</sup>

He considered that VIFM needed to re-educate the medical community regarding its role in the provision of health care services and medicolegal services, and he referred to the various activities VIFM has undertaken.<sup>744</sup>

VIFM also made a submission on this issue. It told the Committee that its communications strategy for reviewable deaths has not been directed towards the general public, as there was no real need for and no resources to run such a large campaign. However, VIFM proposed to seek funding to develop a brochure for families who experience the death of more than one child, which will explain the role of VIFM in a reviewable death investigation.

### Discussion and conclusion

Despite the absence of a detailed study surveying public awareness of the issues, the Committee considers that it can conclude, on the basis of the evidence it received, that the community is generally unaware of reporting requirements. Associate Professor Ranson and Ms Wilson, two witnesses who have considerable experience in the health sector and regular contact with families concerning health complaints, both reached this conclusion.

The Committee considers that the general provision requiring the reporting of certain deaths should be retained. In light of the under-reporting issue which it examined in chapter three, the Committee is of the view that the provision has the potential to provide a useful safeguard where a doctor fails to notify the coroner of a reportable death. Where a member of the public has concerns regarding the circumstances of a death, that person is able to directly approach the Coroner's Office if s/he is aware of the role and function of the office. In order for the provision to have practical effect, however, the community must be aware of their rights and obligations.

<sup>744</sup> Ibid 26.

<sup>&</sup>lt;sup>741</sup> See for example Eleanor Flynn, *Submission no.* 37, 3; Helen Kane, *Minutes of Evidence, 19 September 2005*, 107.

<sup>&</sup>lt;sup>742</sup> David Ranson, Submission no. 19, 25.

<sup>&</sup>lt;sup>743</sup> Ibid.

<sup>&</sup>lt;sup>745</sup> Victorian Institute of Forensic Medicine, Submission No. 40, 16.

The Committee is impressed by the Ontario Chief Coroner's efforts in this regard. It has been the practice of the Chief Coroner to maintain a high media profile and always to be accessible to families. It was reported to the Committee that, in the Ontario system, three coroners deliver approximately 30 lectures and presentations a month to groups of up to 100 people. The groups include industry associations, hospitals and high school students. The Chief Coroner also holds press conferences to publicise important coronial recommendations. He considers that all of these measures minimise the risk of a death going unreported, because there is general community awareness of the coroner's role and the requirement to report deaths.

The Committee therefore considers that it is important that the State Coroner be responsible for ensuring that the Coroner's Office's profile is raised through an ongoing community education campaign. This campaign should also include information about the new category of reviewable deaths.

Recommendation 33. That the *Coroners Act 1985* be amended to include, as a function of the State Coroner, the responsibility to provide ongoing education of the medical profession and the public, to increase awareness of the obligation to report reviewable and reportable deaths.

Recommendation 34. That the State Government provide ongoing funds to resource this function.

<sup>&</sup>lt;sup>746</sup> Meeting, Dr Barry McClellan, Chief Coroner, Ontario, of 21 June 2005.

# CHAPTER FIVE — DEATH INVESTIGATION

### **Definition of death**

In most cases the fact of death is readily determined by a doctor who carries out a series of tests to verify that a person is dead. The Act does not define 'death'. The Human Tissue Act 1982 however provides that:

For the purposes of the law of Victoria, a person has died when there has occurred—

- (a) irreversible cessation of circulation of blood in the body of the person; or
- (b) irreversible cessation of all function of the brain of the person.<sup>748</sup>

### Suspected deaths

A coroner may investigate reported cases of suspected deaths where a body has not been recovered or located.<sup>749</sup> This may occur following a police report of a missing person or in the aftermath of a mass fatality disaster where there could be problems with making sure that all bodies are located and identified.<sup>750</sup>

### **Disaster preparedness**

Disaster preparedness for coroners is currently an issue under consideration by the Standing Committee of Attorneys-General.<sup>751</sup> In 2005, Ministers agreed to review coronial legislation to ensure that coroners and other investigators are able to effectively respond to mass fatality disasters involving Australians both in Australia and oversees. As this review is currently underway, the Committee does not propose to conduct a similar review for this inquiry.

The Committee received two submissions which addressed the issue of mass fatality disaster investigation. The Committee invites the Victorian Government to consider

<sup>&</sup>lt;sup>747</sup> Ian Freckelton and David Ranson, *Death Investigation and the Coroner's Inquest* (2006) 135, 137. The authors point out that there is no uniform agreement on the criteria for life and death and cite examples of recent cases in Victoria involving the removal of life support systems and the need to seek Supreme Court declarations ordering the removal of life support.

<sup>&</sup>lt;sup>748</sup> Human Tissue Act 1982 s 41. See also s 26(7).

<sup>&</sup>lt;sup>749</sup> Coroners Act 1985 s 3. The definition of 'death' includes suspected death.

<sup>&</sup>lt;sup>750</sup> See Ian Freckelton and David Ranson, *Death Investigation and the Coroner's Inquest* (2006) chapter 8, for a detailed examination of mass fatality management.

<sup>&</sup>lt;sup>751</sup> Letter, Attorney-General Philip Ruddock to Committee Chair, 8 June 2005.

these submissions in the course of its review for the Standing Committee of Attorneys-General.<sup>752</sup>

### Missing persons

The procedures surrounding the investigation of missing persons have recently been the subject of a coronial inquest. Findings in the case of Matthew Bibby were handed down on 4 August 2006.<sup>753</sup>

Matthew Bibby died on 10 November 1996 and his body was recovered from the Yarra River on 16 November 1996. Mr Bibby was reported missing to police on 12 November 1996, but it was not until 2005 that a researcher working with the Police Missing Persons Bureau, who was reviewing files at the State Coroner's Office, noted similarities between files held by the two agencies. An exhumation was carried out and Mr Bibby was positively identified from dental records and DNA on 28 June 2005.754

As this case was handed down in the month before the Committee's final report was due to be tabled, the Committee has heard no evidence from stakeholders on its findings and implications. In addition, stakeholder evidence received on the issue of missing persons was provided to the Committee many months before the Bibby case was handed down and hence is not informed by the finding in this case. Stakeholder evidence is dealt with first below, followed by a discussion of the Bibby case and other recent developments.

### Evidence received by the Committee

In the discussion paper the Committee asked if there were any issues with the way suspected death cases were reported or investigated. Victoria Police expressed a concern in relation to reporting and investigating suspected deaths. According to Victoria Police, there are no objective criteria for police to use to determine when a missing persons case should be reclassified as a suspected death investigation and reported to a coroner:

Currently there are no timeframes in place as to when a 'missing person' becomes a 'suspected death' under the Act, and therefore requires reporting to the State Coroner. This leads to inconsistencies in how long after the person disappears that the Coroner is notified of a

<sup>&</sup>lt;sup>752</sup> David Ranson, Submission no. 19, 55; State Coroner's Office, Submission no. 70, 68.

<sup>&</sup>lt;sup>753</sup> Coroner's Case No. 3407/96. The coroner concluded that Mr Bibby died by drowning but could not determine precisely how he came to be in the water, whether by accident or otherwise. Mr Bibby was found to be depressed and drug affected at the time of the drowning.

<sup>&</sup>lt;sup>754</sup> Ibid 1–2.

'suspected death'. Victoria Police believes that a considered timeframe would provide helpful guidance in these matters.<sup>755</sup>

### Recent developments

After the identification of a number of cases where the records of missing persons had for years not been matched with unidentified bodies, the Office of Police Integrity (OPI) undertook an investigation. The *Report on Victoria Police Missing Persons Investigations* was released in May 2006. It noted that whilst:

initial inquiries concerned three specific complaints, inquiries revealed the existence of three other long-term Missing Person Reports that were also eventually matched to long-known unidentified remains. The discovery of these other cases during the early phase of the Office of Police Integrity investigation added weight to the concern that the cases were not isolated but symptomatic of wider procedural deficiencies.

. . .

the catalyst for the Missing Persons Bureau long-term missing person file review was the ...realisation that it has not in the past been aware of all unidentified remains found in Victoria. This situation had developed because contact between Victorian Police and the State Coroner's Office/Victorian Institute of Forensic Medicine had up to recent times been very much on an adhoc basis, with no formal system in place whereby the Missing Persons Unit was routinely made aware of all unidentified bodies discovered in Victoria.<sup>756</sup>

The report identified many aspects of police systems and procedure relating to missing persons which needed improvement. The area's lack of priority within Victoria Police and a consequent under-resourcing of the missing persons unit were identified as contributing factors. In relation to the Coroner's Office the report contained one recommendation, that:

Victoria Police undertake a comprehensive review of its missing persons and unidentified remains investigation policies, procedures and practices. The review should incorporate discussions with the State Coroner's Office and the VIFM, and an update of all relevant Victoria Police Manual Instructions.<sup>757</sup>

The report also recommended that Victoria Police:

<sup>&</sup>lt;sup>755</sup> Victoria Police, Submission no. 78, 8.

<sup>&</sup>lt;sup>756</sup> Office of Police Integrity, *Report on Victoria Missing Persons Investigations*, May 2006, as reported in Coroner's Case No. 3407/96, 9.

<sup>&</sup>lt;sup>757</sup> Ibid 15.

Examine the VIFM 'DAVID' [Disaster and Victim Identification Database] dental database and/or some other dental/DNA database, with a view to adopting and sharing the use of such a database with the VIFM. 758

The report notes that the Victorian Institute of Forensic Medicine (VIFM) uses the DAVID database to record all relevant dental data obtained from unidentified bodies received at the Coroner's Office mortuary, and that VIFM has offered the use of DAVID free of charge to Victoria Police. Noting that DNA records are also a major physical identification tool, the report states that a dental database is a much simpler and cheaper option.<sup>759</sup>

The report also advises that VIFM has provided Victoria Police with a fully costed proposal for an extensive identification computer database for intended joint use by the Coroner's Office/VIFM and Victoria Police. This database would include a range of identification tools, including odontology, DNA, anthropology and entomology.<sup>760</sup>

The Coroner's findings in the Bibby case (one of the cases investigated by OPI) reinforce many of the findings and recommendations of the OPI report. One recommendation impacts on the Coroner's Office:

Recommendation 1 The Victoria Police work with VIFM, the Coroner and the government to establish and maintain a state wide data system initially designed to record and match dental records of unidentified remains with dental records in Missing Persons Files. Eventually the database should also be capable of matching other relevant forensic information (DNA, photographs, etc).<sup>761</sup>

The findings also identify a need for a review of the way in which the Coroner's Office deals with these cases, and they direct a number of improvements, which include:

- improved data exchange between the Coroner's Office and Victoria Police;
- forensic samples or dental charting to be taken from all unidentified bodies prior to burial;
- requirement for an updated missing person report to be obtained before burial;
- Victoria Police Missing Persons Unit to be given access to NCIS for identification purposes;

<sup>&</sup>lt;sup>758</sup> Ibid.

<sup>&</sup>lt;sup>759</sup> Ibid 26.

<sup>&</sup>lt;sup>760</sup> Ibid.

<sup>&</sup>lt;sup>761</sup> Coroner's Case No. 3407/96, 13.

- regular audit to be undertaken to ensure all cases are dealt with according to correct procedure;
- three-monthly meeting between Victoria Police, the Coroner's Office and VIFM to review relevant issues;
- consideration to be given to the appointment of a liaison officer at the Coroner's Office to work with relevant agencies.<sup>762</sup>

In relation to reporting of suspected deaths, the Coroner identifies the following issues which need to be examined:

- the Coroner and Victoria Police to consider whether every case where a person is recorded as having been missing for a period of two years or more should be reported to the Coroner and a brief of evidence prepared by police, noting however that there may be some cases in which investigatory or other good reasons make this undesirable;
- cases where individuals have been reported as missing in circumstances of high risk should be the subject of regular meetings between the Coroner and the Head of the Missing Persons Unit and/or Homicide Squad to consider the reporting of a suspected death to the Coroner at an early stage.<sup>763</sup>

Finally, the Coroner suggests that an amendment to section 59A of the Act may be necessary to enable the reopening of inquests which have been finalised prior to July 1999. Amendments made at that time allowed the reopening of an inquest; however, the provisions did not have retrospective effect. The Bibby inquest was originally held in 1996 and, although it was determined that it could be reopened because an open finding had been made on the question of identity, there is also a contrary view that such a case should proceed first to the Supreme Court for the original inquest to be set aside.<sup>764</sup>

#### Discussion and conclusion

The cases discussed above have highlighted serious deficiencies in the systems at both Victoria Police and the Coroner's Office for dealing with missing person reports and unidentified bodies. Urgent action is clearly required, and the OPI report and the findings in the Bibby case outline a number of measures which will achieve substantial improvement in systems and outcomes. The Committee comments here only on those matters relevant to its current inquiry.

<sup>&</sup>lt;sup>762</sup> Ibid 18.

<sup>&</sup>lt;sup>763</sup> Ibid.

<sup>&</sup>lt;sup>764</sup> Ibid 16–7.

The Committee considers that each missing person case needs to be properly investigated, monitored and regularly reviewed for further evidence to determine if it should be reported to the Coroner as a suspected death. A legislative definition of 'suspected death' which is based on a specified period from when a person is reported missing does not involve an evidence-based determination of whether a missing person is possibly dead. However, the Committee believes that setting a maximum time after which a missing person case should be considered for referral to the Coroner would ensure that cases do not get lost in the system. The evidence presented above suggests that this has been far from an exceptional occurrence.

Therefore, the Committee recommends that Victoria Police and the Coroner's Office formally establish guidelines or a protocol for the reporting of missing persons to the Coroner. These should specify an appropriate period after which all missing person cases must be considered for referral to the Coroner. The guidelines should also require Victoria Police to regularly review all missing person cases in order to make an evidence-based determination as to whether it should report particular cases to the State Coroner. The Committee considers that the review process should be subject to the State Coroner's oversight so that the State Coroner can initiate a coronial investigation where s/he considers that a missing person case should be investigated as a suspected death.

The Committee notes the recommendations in the OPI report and Bibby findings which relate to database development and access for the relevant agencies. Whilst generally supporting the establishment of improved databases, as the information became available at such a late stage in the inquiry the Committee has had no opportunity to hear or solicit stakeholder views. Therefore, it does not believe it is in a position to make any specific recommendations.

Many of the other matters raised above relate to internal practices which are within the control of the Coroner's Office and for which directions for change have already been made in the Bibby case.

Finally, there is the issue of the possible need for the Act to allow the reopening of inquests finalised before July 1999. Again, this matter is one on which the Committee has no other stakeholder comment except that contained in the Bibby case. The Committee notes, however, the Coroner's comments that there are other cases for future inquests where the same legal circumstances already apply and that it is likely that the current review may uncover further cases. Based on these comments, the Committee considers that an amendment to clarify the law should be considered.

Recommendation 35. That Victoria Police and the Coroner's Office formally develop guidelines for the reporting of missing persons to the coroner.

<sup>&</sup>lt;sup>765</sup> Ibid 17.

Recommendation 36. That consideration be given to amending section 59A of the *Coroners Act 1985* to apply the provision retrospectively.

#### Stillbirth

An issue which is unresolved in Victoria is whether a stillbirth constitutes a death for the purposes of the Act. In the absence of a clear statutory provision or judicial decision, it remains unclear whether doctors are required to notify the Coroner when certain stillbirth deaths occur and also whether a coroner has the jurisdiction to investigate the stillbirth.

In general terms, a stillbirth refers to the birth of a dead foetus.<sup>766</sup> In 2004 there were 610 stillbirths in Victoria.<sup>767</sup> The leading cause of stillbirths was pregnancy termination (48 percent).<sup>768</sup> Other known causes of foetal death in this year included infection, hypertension, antepartum haemorrhage and foetal growth restriction.<sup>769</sup>

As discussed in chapter three, the Act requires doctors to notify a coroner when a reportable or reviewable death occurs. For all other deaths, the doctor must complete a MCCD and lodge this certificate with the Registrar of Births, Deaths and Marriages. For the purposes of death registration, the *Births, Deaths and Marriages Registration Act 1996* makes a distinction between perinatal death and deaths of persons aged 28 days or over. Still born child' is defined as:

a child of at least 20 weeks' gestation or, if it cannot be reliably established whether the period of gestation is more or less than 20 weeks, with a body mass of at least 400 grams at birth, that exhibits no sign of respiration or heartbeat, or other sign of life, after birth.<sup>773</sup>

Under the *Births, Deaths and Marriages Registration Act 1996*, a doctor is required to complete a Medical Certificate of Cause of Perinatal Death for any stillborn foetus which meets these legal requirements, including a foetus which was stillborn as a result of a termination procedure.<sup>774</sup>

<sup>771</sup> Births, Deaths and Marriages Registration Act 1996 s 37.

<sup>&</sup>lt;sup>766</sup> Definition of 'stillbirth', Medline plus, available at: www.nlm.nih.gov/medlineplus/mplusdictionary.html.

<sup>&</sup>lt;sup>767</sup> Consultative Council on Obstetric and Paediatric Mortality and Morbidity, Annual Report for 2004, incorporating the 43<sup>rd</sup> survey of perinatal deaths in Victoria, October 2005, xv.

<sup>&</sup>lt;sup>768</sup> Ibid. A total of 32 per cent of terminations were for psychosocial indications, while 16 per cent were for congenital malformations.

<sup>&</sup>lt;sup>769</sup> Ibid Figure 7: Causes of stillbirth, Victoria 2004.

<sup>&</sup>lt;sup>770</sup> Coroners Act s 13(3).

<sup>&</sup>lt;sup>772</sup> The Registry requires doctors to use two separate forms for certifying perinatal deaths and deaths of persons aged 28 days or over. See http://online.justice.vic.gov.au/servlet/bdm\_home.

<sup>&</sup>lt;sup>773</sup> Births, Deaths and Marriages Registration Act 1996 s 4, definition of 'still born child'.

<sup>&</sup>lt;sup>774</sup> Births, Deaths and Marriages Registration Act 1996 s 37(1); 12(5).

The *Births, Deaths and Marriages Registration Act 1996* definition of 'death' excludes stillbirth;<sup>775</sup> however, the *Coroners Act 1985* makes no reference to stillbirths, nor does it provide a comprehensive definition of 'death'.<sup>776</sup> The Act provides that a coroner has jurisdiction to investigate a 'death' if it appears to the Coroner that the 'death' is reportable.<sup>777</sup> It is therefore uncertain whether the Act gives a coroner the jurisdiction to investigate stillbirths as deaths and whether a doctor is required to report incidences of stillbirths to the Coroner.

Since the Act came into effect in 1985, the Coroner's Office has consistently taken the view that it does not have jurisdiction to investigate stillbirths, because there is no death to investigate.<sup>778</sup> This is because the death of a foetus occurs *in utero*, thus precluding it from being born as a living person. At common law stillbirths are excluded from a coroner's jurisdiction on the same basis.<sup>779</sup> It is the practice of the Office to cease an investigation when it becomes apparent on the available evidence that the case involves a foetus which did not live after the birth.<sup>780</sup>

The statement prepared by VIFM for doctors is consistent with the Coroner's Office interpretation of the limits on its jurisdiction. In the statement, doctors are advised that:

The law regards life as starting when there is an existence separate from the mother. Stillbirths and abortions, where there is no life or existence separate from the mother, are not reportable to the Coroner. ... If there is an existence separate from the mother, the Coroners Act applies and if the death fits one of the above categories, it should be reported.<sup>781</sup>

The ambiguity in the provision has however caused some controversy and, in one particular case in 2000, distress and harm to the privacy of a woman undergoing a pregnancy termination. In 2000 a doctor referred a woman who was 31 weeks pregnant to the Royal Women's Hospital. Her foetus was diagnosed with skeletal

<sup>&</sup>lt;sup>775</sup> Births, Deaths and Marriages Registration Act 1996 s 4, definition of 'death' and 'birth'.

<sup>&</sup>lt;sup>776</sup> Coroners Act s 3(1): definition of 'death'.

<sup>&</sup>lt;sup>777</sup> Coroners Act s 15(1).

<sup>&</sup>lt;sup>778</sup> Attachment to Letter, Rick Roberts, Registrar, State Coroner's Office, to Committee Legal Research Officer:

<sup>&#</sup>x27;Direction in Relation to Perinatal Death', by former State Coroner Hal Hallenstein, 3 March 2006.

<sup>&</sup>lt;sup>779</sup> Paul Matthews, *Jervis on the Office and Duties of a Coroner* (12<sup>th</sup> ed, 2002) 68.

<sup>&</sup>lt;sup>780</sup> See for example Coroner's Case No. 1389/05.

<sup>&</sup>lt;sup>781</sup> 'Doctors and Death: Certificates and Coroners', Stephen Cordner, Professor, Forensic Medicine, Monash University, Director of the Victorian Institute of Forensic Medicine, and Helen McKelvie, Manager, Medico-legal Policy and Projects, Victorian Institute of Forensic Medicine. Available at <a href="http://medicalboardvic.org.au">http://medicalboardvic.org.au</a>. As an aid to readers, the article is reproduced at appendix 5.

<sup>&</sup>lt;sup>782</sup> The Committee discusses this case in more detail in chapter eight.

dysplasia.<sup>783</sup> She was interviewed by a psychiatrist, who considered that she was acutely suicidal as a result of the diagnosis. Following counselling, the woman requested that the hospital perform a pregnancy termination.<sup>784</sup> The procedure, authorised by the hospital medical administrator, involved a termination of the pregnancy followed by an induced labour during which the foetus was stillborn.

Federal politician Senator Julian McGauran had lobbied to have the Coroner's Office investigate certain pregnancy terminations as reportable deaths. In this particular case, the State Coroner released documents from the coronial file to Senator McGauran, who then directly quoted from the documents in a public address to the Senate in 2002. This case illustrates the problems caused by the absence of a clear statutory provision indicating whether a coroner has jurisdiction to investigate stillbirths as deaths.

According to one report, several months after the termination the hospital's Chief Executive Officer reported the case to the State Coroner. Some 18 months after the termination, the Coroner's Office determined that it did not have jurisdiction to investigate. According to the Coroner who made the determination, it was her view that:

a death in utero is not a death under the Coroners Act, even if it was deliberately induced. Once a "foetus" is delivered alive, it becomes a life whose subsequent death may be reportable. 789

The ruling was criticised by a number of right to life campaigners and by the Catholic Archbishop of Melbourne, Dennis Hart.<sup>790</sup>

<sup>785</sup> See for example Commonwealth, *Parliamentary Debates*, Senate, 29 November 2000, 20 108 (Senator Julian McGauran): 'it is imperative that the coroner brings down a judgment as soon as possible so as to put a halt to the increasing number of late term abortions'. See also Commonwealth, *Parliamentary Debates*, Senate, 13 March 2002, 638–639 (Senator McGauran).

<sup>&</sup>lt;sup>783</sup> The diagnosis was that it was most likely achondroplasia — a genetic disorder disturbing normal growth of cartilage, resulting in a form of dwarfism: Lachlan J de Crespigny and Julia Savulescu, 'Abortion: Time to Clarify Australia's Confusing Laws', *The Medical Journal of Australia* (2004) 181 (4) 201.

<sup>&</sup>lt;sup>784</sup> Ibid 202.

<sup>&</sup>lt;sup>786</sup> Commonwealth, *Parliamentary Debates*, Senate, 13 March 2002, 638–639 (Senator McGauran).

<sup>&</sup>lt;sup>787</sup> Coroner's Case No. 2107/00.

<sup>&</sup>lt;sup>788</sup> Lachlan J de Crespigny and Julia Savulescu, 'Abortion: Time to Clarify Australia's Confusing Laws', *The Medical Journal of Australia* (2004) 181 (4) 202.

<sup>&</sup>lt;sup>789</sup> Jacinta Heffey, Submission no. 33, 7.

<sup>&</sup>lt;sup>790</sup> 'Prelate Questions Coroner', *Sunday Herald Sun*, 3 February 2002, 10. Archbishop Hart was invited by the Committee to make a submission to this inquiry: Letter, Dennis Hart, Archbishop of Melbourne, to Chair of Committee, 14 April 2005. The Committee however did not receive a submission from Archbishop Hart.

In 2000, in response to front-page media reports of the case,<sup>791</sup> the State Coroner sought legal advice from the Victorian Government Solicitor on the question of whether the Act gave jurisdiction to a coroner to investigate stillbirths.<sup>792</sup> According to the Acting Solicitor-General's opinion, section 15(1) of the Act did confer jurisdiction on the Coroner to investigate stillbirths.<sup>793</sup> In the legal opinion, the Acting Solicitor-General referred to section 4 of the Act, which abrogates a coroner's powers at common law. The Acting Solicitor-General considered that, as the common law position could not apply, he should examine the powers conferred on a coroner by the Act. He referred to part 6 of the Act, which gives a coroner jurisdiction to investigate fires. He noted that there does not appear to be any limitation on the type of fire which may be investigated. In addition, he reasoned that 'death' had not been made the subject of an express limitation for investigation purposes. In his view, 'death' could therefore encompass a stillbirth because:

The definition of "still birth" in the Concise Oxford Dictionary is—"birth of dead child". The phrase "still born" is defined—"born dead". The term "dead" is used. In my view those definitions confirm that "death" encompasses a still born child of the kind described in the publicity regarding the Royal Women's Hospital matter.<sup>794</sup>

The Acting Solicitor-General also referred to section 17(3) of the Act, which provides that a coroner may adjourn or decide not to hold an inquest where the coroner is satisfied that a person has been charged with *the murder, manslaughter, infanticide* or child destruction of the deceased. He concluded that the provision clearly recognised that a coroner has the power to hold an inquest into the death of an unborn child whose death may have been brought about by child destruction.<sup>795</sup>

The legal opinion, which was not followed by the State Coroner, can be questioned on a number of grounds. First, there is some doubt as to whether section 17(3) can be interpreted in this manner. The section was inserted into the Act in 1995, and the reference to child destruction has been described as 'a curiously obscure method of

<sup>&</sup>lt;sup>791</sup> See for example, Meghan Shaw and Darren Gray, 'Hospital Calls in the Coroner', *The Age*, 3 July 2000, 1–2.

<sup>&</sup>lt;sup>792</sup> Victorian Government Solicitor, *Memorandum for Mr Graeme Johnstone, State Coroner*, 7 July 2000. Copy provided to Committee Legal Research Officer by Principal Registrar Rick Roberts, 3 March 2006.

<sup>&</sup>lt;sup>793</sup> Ibid 2.

<sup>&</sup>lt;sup>794</sup> Ibid.

<sup>&</sup>lt;sup>795</sup> Section 10 of the *Crimes Act (1958)* in part provides:

<sup>(1)</sup> Any person who, with intent to destroy the life of a child capable of being born alive, by any wilful act unlawfully causes such child to die before it has an existence independent of its mother shall be guilty of the indictable offence of child destruction, and shall be liable on conviction thereof to level 4 imprisonment (15 years maximum).

<sup>(2)</sup> For the purposes of this section evidence that a woman had at any material time been pregnant for a period of twenty-eight weeks or more shall be prima facie proof that she was at that time pregnant of a child capable of being born alive.

implying a role for the coroner in relation to the investigation of child destruction'. <sup>796</sup> Dr lan Freckelton and Associate Professor David Ranson describe the reference to child destruction as a 'curious anomaly':

Oddly, though [the offences listed in s 17(3)] also include the offence of 'child destruction', an offence that of its essence related to the destruction of a foetus prior to its having any form of independent life. It is not clear why the coroner should have power to hold or recommence an inquest that he or she has no power to hold in the first place.<sup>797</sup>

Jacinta Heffey, the Coroner who made the ruling that the Coroner's Office did not have jurisdiction to investigate the stillbirth, has also rejected the Acting Government Solicitor's interpretation that section 17(3) conferred jurisdiction:

I am aware that the Government Solicitor took the view in the late term abortion case referred to above that this reference [to child destruction in section 17(3)(a)(i)] in effect conferred jurisdiction (or assumed jurisdiction under the Act) to investigate deaths in utero when the foetus was 28 weeks or more. I do not accept this as a matter of statutory interpretation. Such a significant addition to the meaning of a life whose death may be reportable should have been expected to be included in the definition section of the Act, rather than added to an amendment ten years after the Act was enacted.<sup>798</sup>

Second, in certain circumstances, as a matter of statutory interpretation, an ambiguity in a codifying Act will justify resort to the common law position. According to the Act's second reading speech, one of the major objects of the Act was to codify the law relating to coronial matters. Codification was a recommendation of the Norris review of the *Coroners Act 1985* in 1981. A codifying Act is said in theory to gather all the relevant statute and case law on a particular topic and then restate it in such a way that it becomes the complete statement of the law on that topic. However, on occasions such as this where an ambiguity exists — while the Act gives jurisdiction to a coroner to investigate certain deaths, it is unclear whether the Act confers jurisdiction to investigate the death of a foetus as well as the death of a person.

Mason J in *Sungravure Pty Ltd v Middle Eastern Airlines Airliban Sal* adopted the following approach where there was an ambiguity in a codifying Act:

<sup>&</sup>lt;sup>796</sup> Matthew Lynch and Helen McKelvie, 'The Coroner and the Unborn Child' (2000) *Journal of Law and Medicine* 8, 154.

<sup>&</sup>lt;sup>797</sup> Ian Freckelton and David Ranson, *Death Investigation and the Coroner's Inquest* (2006) 131.

<sup>&</sup>lt;sup>798</sup> Jacinta Heffey, Submission no. 33, 20.

<sup>&</sup>lt;sup>799</sup> D C Pearce and R S Geddes, *Statutory Interpretation in Australia* (5<sup>th</sup> ed, 2001) 224; *Stuart v R* (1974) 4 ALR 545, 555; *R v Barlow* (1997) 144 ALR 317, 329.

<sup>&</sup>lt;sup>800</sup> J H Kennan, Attorney-General, Coroners Bill, Second Reading Speech, 16 October 1985, 369.

<sup>&</sup>lt;sup>801</sup> John Norris, *The Coroners Act 1958 — A General Review* (1981) 12.

<sup>&</sup>lt;sup>802</sup> D C Pearce and RS Geddes, Statutory Interpretation in Australia (5<sup>th</sup> ed, 2001) 222.

Its meaning, therefore, is to be ascertained in the first instance from its language and the natural meaning of that language is not to be qualified by considerations deriving from the antecedent law (*Bank of England v Vagliano Brothers* [1891] AC 107 at 144–5; [1891–4] All ER Rep 93). An appeal to earlier decisions can only be justified if the language of the statute is itself doubtful or if some other special ground is made out, e.g. if words used have previously acquired a technical meaning.<sup>803</sup>

Dictionary definitions of the term 'death' and 'life' can be used to support both pro-life and pro-choice interpretations of when death is said to occur. However, it can also be argued that the term 'death' in the context of coronial law has acquired a technical meaning because the definition applies a medicolegal interpretation of when life and death is said to take place. At common law, a stillborn foetus is not considered a 'life in being' — a person with an independent existence. The test for when a foetus becomes a person for the purposes of criminal law in Victoria is similar:

A baby is fully and completely born when it is completely delivered from the body of its mother and it has a separate and independent existence in the sense that it does not derive its power of living from its mother. It is not material that the child may still be attached to its mother by the umbilical cord: that does not prevent it from having a separate existence. But it is required, before the child can be the victim of murder or manslaughter or infanticide, that the child should have an existence separate from and independent of its mother, and that occurs when the child is fully extruded from the mother's body and is living by virtue of the functioning of its own organs. 806

Thus it can be argued that, although the common law has been abrogated under the Act, the common law position in relation to a coroner not having jurisdiction to investigate stillbirths continues to apply because the meaning of 'death' acquired a technical meaning which still has application today.

### Position in other Australian jurisdictions

There is an absence of statutory and judicial authority in all jurisdictions except Queensland to indicate whether coronial jurisdiction extends to stillbirths. Section 12 of the Queensland *Coroners Act 2003* categorises a stillbirth as a death which is not to be investigated by a coroner, and the section provides that a coroner must stop an

<sup>&</sup>lt;sup>803</sup> Sungravure Pty Ltd v Middle Eastern Airlines Airliban Sal (1975) 5 ALR 147, 164.

<sup>&</sup>lt;sup>804</sup> For example, the *Macquarie Concise Dictionary* (2<sup>nd</sup> ed) defines death as 'the end of life', while 'life' is defined as the 'state or condition of existence as a human being'. See also the natural meaning interpretation of the provision by Professor Loane Skene, Director, Health and Medical Law Studies, University of Melbourne: 'It seems to me to be rather odd to think of the Coroner investigating a stillbirth because the role of the Coroner is to investigate deaths, and it seems to me rather odd that somebody should die before they're born'. The Law Report Transcript, Radio National, 18 July 2000. Available at <a href="https://www.abc.et.au/rn">www.abc.et.au/rn</a>.

<sup>&</sup>lt;sup>805</sup> Ian Freckelton and David Ranson, *Death Investigation and the Coroner's Inquest* (2006) 130.

<sup>&</sup>lt;sup>806</sup> R v Hutty [1953] VLR 338; [1953] ALR 689, Barry J, 339.

investigation if an autopsy reveals that the body is that of a stillborn child.<sup>807</sup> The Queensland Act also provides that only four sections of the Act apply to stillborn children. These provisions deal with autopsy, and control and disposal of the body.<sup>808</sup>

In other Australian jurisdictions, coroners have considered the question of whether their jurisdiction extends to stillbirths if or when they receive a report of a stillbirth. For example, in 2002 a South Australian coroner considered that he would not have jurisdiction to investigate a stillbirth because the common law position applied:

Whether as a matter of biology, philosophy, culture or religious doctrine an unborn foetus is properly to be regarded as a person, in my opinion as a matter of law an unborn foetus is not a person for the jurisdictional purposes of the Act. An unborn foetus becomes a person when it is fully extruded from the body of its mother. It follows, therefore, that while a coroner may hold an inquest into the cause or circumstances of the death of a person, he is not empowered to conduct an inquest into the cause and circumstances of the death of an unborn foetus, or to use another term, the death of a still-born child.<sup>809</sup>

### Stillbirth investigation in Victoria

The Consultative Council on Obstetric and Paediatric Mortality and Morbidity (CCOPMM) investigates all cases of stillbirths in Victoria which have been registered under the *Births, Deaths and Marriages Registration Act 1996*. Its Stillbirth Committee reviews complex or contentious cases and makes recommendations and judgements about potential contributing factors.<sup>810</sup>

The CCOPMM has the power to request that a report be submitted to it in the prescribed form for every stillbirth. The report must be provided by the relevant hospital, doctor or midwife depending on the place the birth took place and who was in attendance.<sup>811</sup> A person required to submit a report who fails to do so is guilty of an offence with a maximum penalty of five penalty points.<sup>812</sup>

Following amendments to the *Health Act 1958* by the *Death Notification Legislation* (Amendment) Act 2004, the CCOPMM may release information obtained in the

<sup>807</sup> Coroners Act 2003 (Qld) s 12(2)(c).

<sup>&</sup>lt;sup>808</sup> Coroners Act 2003 (Qld) s 96. The schedule 2 dictionary states that 'a stillborn child means a stillborn child as defined in the *Births, Deaths and Marriages Registration Act* (Qld) 2003'.

<sup>&</sup>lt;sup>809</sup> State Coroner's Office, South Australia, Ruling of Coroner Anthony Schapel, 18 September 2002 at 3.3. Available at www.courts.sa.gov.au.

<sup>&</sup>lt;sup>810</sup> Consultative Council on Obstetric and Paediatric Mortality and Morbidity (CCOPMM)—Overview <a href="https://www.health.vic.gov.au/perinatal/vpdcu/index.htm">www.health.vic.gov.au/perinatal/vpdcu/index.htm</a>. These cases are discussed in Consultative Council on Obstetric and Paediatric Mortality and Morbidity, Annual Report for 2004, incorporating the 43rd survey of perinatal deaths in Victoria, October 2005, 38.

<sup>811</sup> Health Act 1958 s 162G(2).

<sup>812</sup> Health Act 1958 s 162G(3).

course of performing its functions to a number of specified bodies or persons if it determines that it is in the public interest to do so.<sup>813</sup> There is no authority to make information public unless it is de-identified and general.

If the CCOPMM determines that the release of information would be in the public interest, it would only release information after careful consideration of the issues, including the need to encourage full and frank disclosures by health providers.<sup>814</sup> The CCOPMM cannot be compelled under any law to release information it holds.<sup>815</sup>

As an advisory body to the Minister of Health on maternal, perinatal and paediatric deaths, the CCOPMM also publishes an annual report which is publicly available and distributed to doctors, midwifes and hospitals.

The Victorian Perinatal Data Collection Unit (VPDCU) is a unit of the CCOPMM established as a population-based surveillance system to collect and analyse information on the health of mothers and babies. The aim of the unit is to contribute to improvements in maternal and child health.<sup>816</sup> The unit collects and analyses perinatal morbidity data, including information on obstetric conditions, procedures, outcomes, neonatal morbidity and birth defects. The unit also provides its epidemiological studies to hospitals and midwives allowing for state-wide comparisons of practice and outcomes. Under the *Health Act 1958*, the CCOPMM also has responsibilities in relation to providing information for the training of doctors and nurses in relation to the theory and practice of obstetrics.<sup>817</sup>

### **Submissions received by the Committee**

The Committee received six submissions on this issue. The Coroner's Office and Ms Heffey considered that the Act should specifically exclude stillbirths from the coronial jurisdiction. <sup>818</sup> While VIFM supported an amendment to the Act to clarify the issue, the submission did not consider whether the Act should include or exclude stillbirths. <sup>819</sup>

The Committee also received three submissions in favour of coronial investigation of stillbirths. The World Federation of Doctors Who Respect Human Life (Victorian

<sup>&</sup>lt;sup>813</sup> *Health Act 1958* s 162FB. These include the Medical Practitioners Board of Victoria, the Nurses Board of Victoria, the State Coroner and hospitals.

<sup>&</sup>lt;sup>814</sup> Consultative Council on Obstetric and Paediatric Mortality and Morbidity: www.health.vic.gov.au/perinatal/vpdcu/index.htm.

<sup>&</sup>lt;sup>815</sup> Health Act 1958 s 162H.

<sup>&</sup>lt;sup>816</sup> 'Victorian Perinatal Data Collection Unit (VPDCU) Overview', at www.health.vic.gov.au/perinatal/vpdcu/index.htm.

<sup>&</sup>lt;sup>817</sup> Health Act 1958 s 162F(1)(c).

<sup>818</sup> State Coroner's Office, *Submission no. 70*, 65–6; Victorian Institute of Forensic Medicine, *Submission no. 40*, 11–12; Jacinta Heffey, *Submission no. 33*, 7, 20.

<sup>819</sup> Victorian Institute of Forensic Medicine, Submission no. 40, 11–12.

Branch) submitted that all stillbirths involving medical treatment should be reportable so that a coroner may establish whether the stillbirth resulted from child destruction.820 The submission made reference to a fear that some stillbirths may be eugenically motivated.

Karyn and Andrew Kennedy advised the Committee that they made their submission from the standpoint of parents who had experienced the loss of a baby during childbirth. They submitted that the Victorian community would be better served if future amendments to the Act clarified the jurisdictional issues associated with stillbirth. Mr and Mrs Kennedy considered that the Act should extend the power of a coroner to investigate late-term stillbirth because stillbirth and neonatal death shared common causes, the most concerning of which were avoidable factors associated with the management of childbirth.

The CCOPMM submitted that there were some limited situations in which it considered that a coronial investigation into a stillbirth would be beneficial. These included where the stillbirth was greater than 32 weeks' gestation, was not caused by congenital malformation and occurred in the 24 hours before birth. The submission further suggested that a coronial investigation of a stillbirth should take place where the mother requests it or where resuscitation is attempted on a stillborn infant and fails. While Ms Heffey agreed that there was some value from a prevention point of view in empowering a coroner to investigate stillbirths resulting from medical mismanagement, she considered that the threshold issue was whether the death of a foetus is a death of a life in being and therefore reportable.

She indicated that she was opposed to including deaths in utero within the definition because:

(a)t common law a foetus is not a life in being. A statutory amendment to include a foetal death as being within the class of reportable deaths would mark a major departure from this. If my view were to be adopted, I consider that the Act should be amended to specifically exclude such a death to remove any doubt and to avoid controversy in the future.<sup>824</sup>

VIFM submitted that the current definition of a reportable death does not give the Coroner clear jurisdiction over cases involving adverse health events around pregnancy and birth.825 The Institute indicated that in the last few years there had been cases where confusion has arisen about whether the Coroner has jurisdiction. This had placed its pathologists in an awkward position in relation to conducting

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<sup>&</sup>lt;sup>820</sup> World Federation Of Doctors Who Respect Human Life (Victorian Division), *Submission no. 12*, 1.

<sup>821</sup> Andrew and Karyn Kennedy, Submission no. 30, 1–2.

<sup>&</sup>lt;sup>822</sup> Consultative Council on Obstetric and Paediatric Mortality and Morbidity, Submission no. 84, 1.

<sup>823</sup> Jacinta Heffey, Submission no. 33, 7.

<sup>824</sup> Ibid.

<sup>825</sup> Victorian Institute of Forensic Medicine, Submission no. 40, 11–12.

autopsies. The Coroner's Office submitted that the Act should define death as excluding stillbirth but made no further comment on this issue.<sup>826</sup>

Two stakeholders made submissions in relation to the reference in the Act to the offence of child destruction. Section 17(3) provides that a coroner may adjourn or decide not to hold an inquest where the coroner is satisfied that a person has been charged with child destruction. Ms Heffey considered that the reference to child destruction should be removed because it had led to the mistaken assumption that it conferred jurisdiction on a coroner to investigate foetal deaths, including late-term abortions.<sup>827</sup> Professor Stephen Cordner, Director of VIFM, agreed with Ms Heffey and told the Committee that if a coroner investigated abortions the Coroner's jurisdiction would be severely mired.<sup>828</sup> He therefore considered that the reference in the Act to child destruction should be removed.

#### Discussion and conclusion

The Committee notes the controversy and subsequent distress caused by the uncertainty surrounding coronial investigation of stillbirths. It is the Committee's view that the common law position in relation to a coroner not having jurisdiction to investigate stillbirths continues to apply despite section 4 of the Act which abrogates the common law. This is because the term 'death' in the context of coronial common law had acquired a technical meaning when the Act came into effect in 1985. The fact that the Act does not comprehensively define the meaning of 'death' indicates the legislative intention that the common law definition should apply. The Committee notes that it was only after the Act had been in place for 10 years that it was amended to make a reference to child destruction in section 17(3). The Committee agrees with Ms Heffey that this amendment does not confer jurisdiction on a coroner to investigate stillbirths.

To clarify the issue, the Committee therefore considers that the Act should clearly state the jurisdictional limits of a coroner's investigation into these deaths. This jurisdiction is consistent with all other jurisdictions in Australia since the introduction of the coronial system of death investigation.

While the Committee understands that a number of parents of stillborn babies may wish there to be an investigation into the causes of the stillbirth, the Committee notes that the CCOPMM undertakes a specialist review into the death of every registered stillbirth and presents its findings and recommendations in an annual report. While the CCOPMM itself recommended that in some cases a stillbirth be the subject of a coronial investigation, the Committee on balance decided that, rather that increasing the coronial jurisdiction, it would be more appropriate to reconsider the role, functions and powers of the CCOPMM to ensure that the Council can undertake a

<sup>826</sup> State Coroner's Office, Submission no. 70, 65-6.

<sup>&</sup>lt;sup>827</sup> Jacinta Heffey, Submission no. 33, 7.

<sup>828</sup> Stephen Cordner, Victorian Institute of Forensic Medicine, *Minutes of Evidence*, 19 September 2005, 131.

comprehensive stillbirth investigation. The Committee considered that the CCOPMM's specialist medical skills are essential in investigating issues relating to the medical management of pregnancy and birth and that it is best placed to continue this investigative role.

Recommendation 37. That stillbirths continue to be investigated by the Consultative Council on Obstetric and Paediatric Mortality and Morbidity and not the coroner, and that this be clarified in the *Coroners Act 1985*.

Recommendation 38. That the Department of Health review the role, functions and powers of the Consultative Council on Obstetric and Paediatric Mortality and Morbidity to determine whether they are adequate to undertake a comprehensive investigation of stillbirths.

The Committee is also of the view that the Act does not give a coroner the power to conduct an inquiry into child destruction, which involves the unlawful destruction of a foetus, because the jurisdiction extends only to the investigation of the death of a person. The Committee agrees with Dr Freckelton and Associate Professor Ranson that it is not clear why a coroner should have the power under section 17(3) to hold or recommence an inquest in relation to child destruction when s/he has no power to hold an inquest in the first place. Therefore, the Committee agrees with Ms Heffey and Professor Cordner that this is an anomaly which should be removed by amending the legislation.

Recommendation 39. That section 17(3) of the *Coroners Act 1985* which gives a coroner the discretion not to hold or recommence an inquest where a person has been charged with and convicted or acquitted of certain offences, be amended by removing the words 'child destruction' from the section.

# Powers to investigate deaths

In this section of the chapter the Committee examines the effectiveness of the existing powers available to a Coroner to investigate deaths.

# Preliminary power to investigate whether death is reportable

Under the Act a coroner has the power to investigate a death where it *appears* to the Coroner that the death *may* be a reportable death.<sup>829</sup> Some death investigations in effect require a coroner to make a preliminary investigation to establish if there are reasonable grounds to suspect that a reportable death has occurred. Examples include:

<sup>829</sup> Coroners Act s 15(1).

- an investigation to determine whether badly decomposed remains are recent human remains; and
- an investigation to obtain evidence to consider a request to investigate a death that was not originally reported to the Coroner as a reportable or reviewable death.

### **Evidence received by the Committee**

Ms Heffey raised the issue of the need for a specific provision regulating the way in which coroners conduct preliminary inquiries to establish whether the Coroner has jurisdiction to investigate a death.830 Ms Heffey referred to the Supreme Court decision of Clancy v West.831 In this case a family member made a request to the Coroner's Office to investigate the death of a relative who had died in a hospital. The hospital had not reported the death to the Coroner, because the death was not considered to be a reportable death. In order to establish whether the Coroner's Office had jurisdiction to investigate the death, the investigating coroner had to make preliminary investigations to establish whether the death was reportable. Ms Heffey cited the case as an example of the 'circular reasoning' that can occur in certain cases — a coroner must investigate a death to establish whether s/he has jurisdiction to investigate the death. Ms Heffey considered that this problem could be overcome by a provision which required or empowered a coroner to conduct a preliminary investigation in relation to every reported death to establish whether it was a reportable death. Ms Heffey also considered that this decision should be reviewable by the State Coroner at the first instance and then by the Supreme Court.

#### Discussion and conclusion

The Committee sees merit in Ms Heffey's suggestion that the Act contain a separate provision regulating the way in which a coroner investigates a death to establish whether the Coroner has jurisdiction to continue the investigation. While in many cases it will be obvious that a death is reportable, the Committee appreciates that there will also be instances in which a coroner is only able to establish if s/he has jurisdiction by conducting a preliminary investigation to obtain further evidence. Therefore, a provision which sets out how a preliminary investigation is to be conducted would be a useful additional provision for the Act.

Recommendation 40. That the *Coroners Act 1985* be amended to provide that:

a) where it appears to a coroner that a death may be a reportable death, a coroner may undertake a preliminary investigation of the death to establish whether the death is a reportable death;

<sup>830</sup> Jacinta Heffey, Submission no. 33, 19–20.

<sup>&</sup>lt;sup>831</sup> Clancy v West [1996] 2 VR 647. A summary of this case is included in the Committee's Coroners Act 1985 Discussion Paper at pages 47-8.

- b) a person may apply to the State Coroner for a review of a coroner's decision, following preliminary investigation, that a death is or is not a reportable death; and
- c) a person may apply to the Supreme Court for a review of the State Coroner's decision reviewing a coroner's decision that, following preliminary investigation, a death is or is not a reportable death.

### Warrant and warrant-like powers

In 2005 the Committee completed a separate inquiry into Victoria's warrant powers and procedures. The Committee established that there were over 80 Victorian Acts which currently authorise search warrants and that there were many inconsistencies in the terms of the warrants. In order to improve consistency, the Committee recommended the consolidation of Victorian search warrant powers and procedures into a single Search Warrants Act modelled on the New South Wales Search Warrants Act 1985. In its response to the Committee's recommendations, the State Government indicated in principle support for the recommendation.

Under the *Coroners Act 1985* a coroner has broad search and seizure powers. Without a warrant, a coroner may enter and inspect any place and take possession of anything relevant to the investigation and keep it until the investigation is finished.<sup>835</sup> Police officers may also exercise entry, inspection and seizure powers when authorised to do so by a coroner in writing.<sup>836</sup> While the regulations refer to the document authorising police to exercise these powers as a 'Coroner's authority to a member of the police force', the Committee in this report uses the term 'warrant'. This is because the authority is in fact a warrant.<sup>837</sup>

When exercising this power, a police officer is required to give a copy of the warrant to the owner or occupier of the place being searched. While it is an offence to hinder or obstruct a coroner or a person acting under a coroner's authority when exercising powers under the Act, this is not stated on the warrant.<sup>838</sup>

<sup>&</sup>lt;sup>832</sup> Victorian Parliament Law Reform Committee, *Warrant Powers and Procedures: Final Report* (2005). Available at www.parliament.vic.gov.au/lawreform.

<sup>833</sup> Ibid Recommendation 82.

<sup>&</sup>lt;sup>834</sup> Government of Victoria, *Government response to the Victorian Parliament Law Reform Committee's Warrant Powers and Procedures Final Report*, tabled 15 May 2006. Available at

http://www.parliament.vic.gov.au/lawreform.

<sup>&</sup>lt;sup>835</sup> Coroners Act 1985 s 26(1). The prescribed form is form 9, Coroners Regulations (1996), reg 22.

<sup>836</sup> Coroners Act 1985 s 26(3).

<sup>&</sup>lt;sup>837</sup> See for example the comments of Lord Wilberforce in *IRC V Rossminster Ltd* [1980] AC 952, 1000.

<sup>838</sup> Coroners Act 1985 s 60. The maximum penalty is three months' imprisonment.

The Act and Regulations do not currently include the safeguards recommended by the Committee in its inquiry into Victoria's warrant powers and procedures. Accordingly, the Act and Regulations have the following gaps:

- No requirement that police officers issue receipts for seized documents or physical evidence<sup>839</sup> and no legislative provision for the period within which exhibits must be returned following the completion of a death investigation;
- The form of the warrant does not provide information such as what persons in the place where the warrant is executed must do and consequences for not doing so, the rights of the persons and what they may do if dissatisfied with the warrant or the way in which it was executed;<sup>840</sup>
- No requirement that the Coroner's Office establish and maintain a search warrants register for searches carried out under the authority of a warrant or a warrant-like power.<sup>841</sup>

### Other Australian jurisdictions

All jurisdictions have similar powers; however, coroners in the ACT and Queensland may only exercise entry, search and seizure powers under warrant.<sup>842</sup> In the ACT a coroner may issue a warrant authorising a specified police officer to execute the warrant.<sup>843</sup> The warrant must state the reason it is issued, the particular hours during which entry is authorised and the date on which the warrant no longer has effect.<sup>844</sup> It must also include a description of the kinds of things the police are searching for, inspecting or seizing.<sup>845</sup> Police officers must also give a copy of the warrant to the owner or occupier of the premises.<sup>846</sup> When an inquiry is completed, a coroner is required to take all practical steps to return things seized under a warrant.<sup>847</sup>

<sup>&</sup>lt;sup>839</sup> Victorian Parliament Law Reform Committee, Warrant Powers and Procedures: Final Report (2005).

<sup>840</sup> Ibid Recommendation 47.

<sup>841</sup> Ibid Recommendation 18.

<sup>842</sup> Coroners Act 1997 (ACT) s 66; Coroners Act 2003 (Qld) s 13(3).

<sup>843</sup> Coroners Act 1997 (ACT) s 66(1), (2).

<sup>&</sup>lt;sup>844</sup> Coroners Act 1997 (ACT) s 66(4). The period of the warrant cannot extend beyond one month from the date of issue of the warrant.

<sup>&</sup>lt;sup>845</sup> Coroners Act 1997 (ACT) s 66(4)(c).

<sup>846</sup> Coroners Act 1997 (ACT) s 66(6).

<sup>847</sup> Coroners Act 1997 (ACT) s 67(6).

In Queensland, legislation sets out standard rules which regulate all police warrant powers. This legislation also authorises and regulates warrants issued by a coroner.<sup>848</sup> A coroner's search warrant must state a number of things, including:

- the death that the Coroner is investigating;
- the evidence that may be seized under the warrant;
- the hours during which the place may be entered; and
- the day and time the search warrant ends (not more than seven days after the search warrant was issued).849

The legislation sets out a detailed list of warrant powers, which include the following powers:

- the power to open locked places,
- the power to temporarily detain persons on premises being investigated; and
- the power to dig up land.850

For warrants issued by a coroner, a police officer does not have the following powers:

- the power to remove walls, ceiling linings or floors; or
- the power to do anything that may cause structural damage to a building.<sup>851</sup>

### **Evidence received by the Committee**

In the discussion paper the Committee asked if there were problems or issues of concern with the current powers of a coroner in relation to entry, search and seizure. Most stakeholders who considered this issue thought that, while a coroner has extremely wide search and seizure powers, the powers were necessary to enable a coroner to effectively carry out death investigations.<sup>852</sup> According to Associate Professor Ranson:

<sup>&</sup>lt;sup>848</sup> Police Powers and Responsibilities Act 2000 (Qld) s 371AD. Under warrants issued by a coroner, a police officer also has the powers set out in section 74(1)(a) to (e) and (g).

<sup>&</sup>lt;sup>849</sup> Police Powers and Responsibilities Act 2000 (Qld) s 371AD(2).

<sup>&</sup>lt;sup>850</sup> Police Powers and Responsibilities Act 2000 (Qld) s 74(1).

<sup>&</sup>lt;sup>851</sup> Police Powers and Responsibilities Act 2000 (Qld) s 74(3): the power to do anything that may cause structural damage may only be authorised by a Supreme Court judge.

<sup>&</sup>lt;sup>852</sup> Health Services Commissioner, *Submission no. 62*, 6; David Ranson, *Submission no. 19*, 37; State Coroner's Office, *Submission no. 70*, 159–160.

Coroners have some of the most effective powers with regards to investigation and the collection of evidence. ...In my experience coroners have been generally conservative in the way that they have exercised their investigative powers and this has been to the benefit of the jurisdiction. Where necessary coroners I believe have exercised their powers of search and seizure fearlessly. Examples of this being seen in; the collection of medical records of patients who are not deceased but whose records contain information that relate to a deceased person, the search and seizure of items within hospital treatment areas, correctional facilities and police facilities, the seizure of a 'Formula One' racing car and components and the seizure of laptop computers from officials from an overseas private company when they were about to return home with the results of their own private investigation into a major disaster involving fire and loss of life.<sup>853</sup>

The Coroner's Office referred to a number of cases in which vital evidence had been seized as justification for the retention of existing search and seizure powers:

the powers facilitate availability of files for the Coroner including medical files and Corrections files. For example, they were used in the investigation into a series of about 100 fires involving Mistral Fans. These powers have also been used to great advantage in cases like the Longford gas explosion and fire where the State Coroner's authority was used to seize the information that eventually assisted the Royal Commission.<sup>854</sup>

Two witnesses whose experience of the coronial system was as relatives of a person who died told the Committee that they believed that there was evidence which indicated that some hospital records had been tampered with. According to these witnesses, it was therefore vital that a coroner had broad powers in order to immediately retrieve evidence needed for a coronial investigation to prevent tampering. Mr Graeme Bond told the Committee that:

Medical records are tampered with after patients die. It is difficult to prove that. It has been shown in some cases and there is considerable evidence that there was some tampering with the medical history of my son after he died. There appear to be extra entries squeezed in between other entries in an entirely different handwriting in a way that suggests they were added at some later stage.<sup>856</sup>

However, Mr Bond believed that since his son had died in 1993 there had been a significant improvement in ensuring that the Coroner's Office gained prompt access to hospital records which ensured that the records could not be retrospectively altered.<sup>857</sup>

<sup>853</sup> David Ranson, Submission no. 19, 37.

<sup>854</sup> State Coroner's Office, Submission no. 70, 159–160.

<sup>&</sup>lt;sup>855</sup> Graeme Bond, Submission no. 48, 6–7, Minutes of Evidence, 22 August 2005, 2; Lorraine Long, Minutes of Evidence, 19 September 2005, 90; Medical Error Action Group, Submission no. 7S2, 5.

<sup>856</sup> Graeme Bond, Submission no. 48, 6-7, Minutes of Evidence, 22 August 2005, 2.

<sup>857</sup> Graeme Bond, Submission no. 48, 6-7.

Three witnesses raised specific issues with the exercise of search and seizure powers. Health Services Commissioner Beth Wilson advised the Committee that, while the Commission supported the retention of the current powers, she was aware that there had been problems for agencies where there had been a failure by the Coroner's Office to return medical files at the completion of cases. Ms Heffey stated that when she was a coroner there were demarcation issues with the federal Australian Transport Safety Bureau associated with transport related accidents, particularly aviation fatalities. Beta Wilson advised the Committee that, while the Commission supported the retention of the current powers, she was aware that there had been problems for agencies where there had been a failure by the Coroner's Office to return medical files at the completion of cases. Ms Heffey stated that when she was a coroner there were demarcation issues with the federal Australian Transport Safety Bureau associated with transport related accidents, particularly aviation fatalities.

The South Pacific Foundation of Victoria Inc (SPFV) advised the Committee that members of its community may attach spiritual and cultural importance to certain objects and places that may be subject to search and seizure by a coroner. SPFV submitted that these issues needed to be discussed with cultural liaison officers before a coroner initiated search and seizure processes. The needs of family members of a person whose death is the subject of a coronial investigation, and issues of cultural sensitivity are discussed in detail in chapter eight.

Victoria Legal Aid (VLA) expressed concern with a coroner's power to enter, search and seize property because VLA considered that the powers permitted serious infringement of civil liberties.<sup>861</sup> According to VLA:

Proper checks and balances are necessary to ensure that this power is exercised appropriately. This is particularly important when the evidence obtained may lead to criminal proceedings. VLA supports the ACT and Queensland approach, where Coroners may only exercise these powers under warrant.<sup>862</sup>

Victoria Police and other stakeholders made no comment on this issue.

#### Discussion and conclusion

The Committee accepts that there is a need for coroners to have broad investigation powers in order for them to undertake an effective investigation into a death. However, the Committee considers that police powers should also be subject to regulation and review to ensure that these powers are exercised consistently and fairly. This can be achieved by implementing some of the Committee's recommendations from its inquiry into warrant powers and procedures.<sup>863</sup>

<sup>&</sup>lt;sup>858</sup> Health Services Commissioner, Submission no. 62, 6.

<sup>859</sup> Jacinta Heffey, Submission no. 33, 13.

<sup>860</sup> South Pacific Foundation of Victoria, Submission no. 54, 10.

<sup>&</sup>lt;sup>861</sup> Victoria Legal Aid, Submission no. 34, 4.

<sup>862</sup> Ibid

<sup>&</sup>lt;sup>863</sup> In recommendations 62 and 65 of the warrants report the Committee considered that the requirement that receipts be issued for seized documents and legal professional privilege were issues which should be addressed within the proposed Search Warrants Act and not in primary legislation. See appendix 6.

In light of the observation by the Health Services Commissioner that hospitals have experienced occasional difficulties regarding the return of medical files following the completion of coronial inquiries, the Committee considers that there should be a provision regulating the return of coronial exhibits.

Recommendation 41. That the *Coroners Act 1985* be amended to provide that:

- a) the Coroner's Office is required to create and maintain a search warrants register and to record the information set out in recommendation 18 of the Victorian Parliament Law Reform Committee report *Warrant Powers and Procedures: Final Report;*
- b) the Coroner's Office is required to provide information about search warrants and warrant-like powers to persons in the place to be searched, as set out in recommendation 47 of the Victorian Parliament Law Reform Committee report *Warrant Powers and Procedures: Final Report*, and
- c) on the completion of an inquest or inquiry, a coroner must take all reasonable steps to give anything taken or seized, to the person whom the coroner reasonably believes to be legally entitled to it.

### Coroner's powers to direct police investigations

While Victoria Police assists coroners with coronial investigations, the role of police officers and the nature of their reporting relationship to coroners are not defined in the Act. The *Police Regulations Act 1958* only provides that, if requested by a coroner, the Commissioner of Police is required to direct that a sufficient number of police officers be present at an inquest.<sup>864</sup>

According to Victoria Police, the initial police role relating to death notification includes:

- attending the scene of a death and notifying the Coroner if the death is reportable or reviewable;
- notifying relevant investigators, authorities and relatives;
- ensuring the preservation and collection of physical evidence;
- arranging for the removal and identification of the body; and
- taking custody of the personal property of the person who has died.<sup>865</sup>

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<sup>&</sup>lt;sup>864</sup> Police Regulations Act 1958 s 18A.

<sup>&</sup>lt;sup>865</sup> Trevor Carter, Victoria Police, *Minutes of Evidence*, 5 December 2005, 265.

The next stage in which police are involved is the investigation phase. The Coroner's Office and Victoria Police agree that coronial investigations are carried out by the following police units:

- the State Coroner's Assistants' Unit in Melbourne, which is a special coronial police investigation unit; or
- local police based at police stations for most rural investigations and some Melbourne investigations; or
- specialist police investigation units, such as the Arson and Homicide Squads.

The investigation tasks undertaken by police include:

- obtaining expert and non-expert witness statements, and documentary evidence such as medical files from hospitals; and
- preparing the brief of evidence for the Coroner. This involves physically collating statements, photos and medical reports and reviewing evidence to assess whether further evidence is required. It also may include writing summaries of evidence and chronologies as well as arranging the service of witness summons for inquests where witnesses have declined to provide statements.

There appears to be a level of confusion as to who directs the police in their coronial investigations and to whom police officers report — the police officer in charge of the local police station/specialist police unit or the Coroner. While the Act permits coroners to authorise police officers to exercise entry, search and seizure powers, it does not give either the State Coroner or a coroner the power to direct the way in which police conduct the investigation. In effect, coroners do not have legal control over the death investigation process.

For example, a police officer may interview a witness in order to draft a statement or s/he may chose to accept a statement which has already been drafted by the witness. A coroner cannot direct the way in which a statement should be obtained, that a statement be obtained within a certain time frame or even that the police obtain further evidence where the coroner believes that this is required. While both the Coroner's Office and Victoria Police consider that a good working relationship exists between coroners and police, 868 with a coronial investigation which is effectively directed by Victoria Police evidence as to the cause of death may potentially be

<sup>&</sup>lt;sup>866</sup> This is discussed in further detail in the next section of this chapter.

<sup>&</sup>lt;sup>867</sup> Coroners Act 1985 s 26(3). Boronia Halstead, 'Coroners' Recommendations and the Prevention of Deaths in Custody: A Victorian Case Study', *Deaths in Custody, Australia, no. 10,* Australian Institute of Criminology (1995) 5. The Act does however require a police officer to report relevant information: s 14(2).

<sup>&</sup>lt;sup>868</sup> State Coroner's Office, Submission no. 70, 141; Victoria Police, Submission no. 78.

compromised. The Deputy State Coroner made comments on this in an inquest in Melbourne in 2003:

The deceased's family are highly critical of the police investigation of this incident, alleging that delays in obtaining statements, together with the paucity of information gathered from witnesses, the scene and the vehicles, all severely compromised an understanding of what occurred and any legal redress. ... The evidence satisfies me that there is merit in the criticism. The majority of statements were taken over five months after the incident and when taken, were unclear and lacked detail, such that all witnesses were recontacted to elicit further information. When this occurred in February and March 2002, they understandably found it difficult to recall specific details of the event. The investigation was not only deficient in respect to the statements obtained.<sup>869</sup>

The Deputy State Coroner was also critical of other aspects of the investigation:

There was little attempt to accurately record details of the accident scene, or secure and examine the implicated vehicles. No mechanical examination of the Ford was undertaken and the Nissan was not impounded pending its mechanical examination which took place 10 weeks after the incident. In addition, no report was obtained from a qualified accident reconstructionist.<sup>870</sup>

However, the State Coroner in a recent case considered that he was ultimately responsible for the quality of the investigation. Declaring himself the investigating coroner at the scene, he considered himself to be responsible for the overall carriage of the inquiry.<sup>871</sup>

### Law reform agencies

In 1991 the Royal Commission into Aboriginal Deaths in Custody (RCADC) was critical of the fact that coroners had not been given the legal power to require police officers to report to coroners. In its *National Report* the Commission recommended that coroners should be given this power, along with the power to give directions as to any additional steps the coroner desires to be taken in the investigation.<sup>872</sup> According to the Commission:

If coroners are to properly be held accountable for the standard of the inquests over which they preside, they must be in a position to ensure that the police investigations on which they are based are of a satisfactory quality and are promptly completed. ... The quality of inquests cannot

<sup>871</sup> Coroner's Case No. 201/02, 41.

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<sup>&</sup>lt;sup>869</sup> Coroner's Case No. 1114/01.

<sup>&</sup>lt;sup>870</sup> Ibid.

<sup>&</sup>lt;sup>872</sup> Royal Commission into Aboriginal Deaths in Custody, *National Report* (1991), vol 1; 4.5.6 and Recommendation 29.

be improved without establishing an integrated system with clear lines of responsibility flowing from the pivotal position of the coroner.<sup>873</sup>

The Australian Institute of Criminology (AIC) in a research study which looked at a Victorian case of a death in custody, has questioned the role of police officers in coroners' investigations into deaths in police custody:

There is likely to be either a perceived or actual conflict of interest which might interfere with either the public confidence in the investigatory process, or the actual conduct of the investigatory process. This question was specifically raised by a family member in one of the cases under discussion here, who directly challenged the credibility of the coronial process because she had no confidence in the capacity of police officers to investigate fellow officers impartially.<sup>874</sup>

The Committee also heard evidence from family members who were critical of police involvement in investigating police shooting deaths. This is discussed in the next section of the chapter.

### Other Australian jurisdictions

Unlike Victoria, three other Australian jurisdictions in line with the RCADC recommendation, give specific powers to coroners to enable them to direct police in coronial investigations. A coroner in New South Wales has the power to issue directions to police officers, while in Queensland it is the legal duty of police officers to comply with requests or directions of a coroner. In the Northern Territory, a coroner may give directions to a police officer for the purpose of investigating the death of a person held in custody or caused or contributed to by injuries sustained while being held in custody. Police officers are also required to comply with a lawful direction of a coroner. Property of the purpose of the purpose of investigating the death of a person held in custody. Police officers are also required to comply with a lawful direction of a coroner.

### **Evidence received by the Committee**

Conflicting views emerged from the evidence on the question of whether coroners currently have and should have the power to direct a police investigation for a coronial inquiry. In his submission to the Victorian Implementation Review of the Recommendations from RCADC, the State Coroner advised the review that a coroner

<sup>874</sup> Boronia Halstead, 'Coroners' Recommendations and the Prevention of Deaths in Custody: A Victorian Case Study', *Deaths in Custody, Australia, no. 10,* Australian Institute of Criminology (1995) 4.

<sup>&</sup>lt;sup>873</sup> Ibid 5.5.7–4.5.8.

<sup>&</sup>lt;sup>875</sup> Coroners Act 1980 (NSW) s 17C.

<sup>&</sup>lt;sup>876</sup> Police Powers and Responsibilities Act 2000 (Qld) s 371(1).

<sup>877</sup> Coroners Act 1993 (NT) s 25.

<sup>&</sup>lt;sup>878</sup> Coroners Act 1993 (NT) s 25(2). Failure to comply carries a maximum penalty of six months' imprisonment.

has the power to give directions to police.<sup>879</sup> This view was challenged by Senior Constable Susan Nolan of the State Coroner's Assistants' Unit, who told the Committee that she could not identify any provision which gave a coroner an actual power to direct the police in their investigations.<sup>880</sup>

Acting Commander Trevor Carter told the Committee that Victoria Police did not support the enactment of a provision enabling a coroner to direct police investigations:

Victoria Police suggests that, despite our assistance to the coroner, the coroner should not have the power to issue directions directly to investigating police. It is important for Victoria Police to remain independent from the coroner while assisting the coroner's office with its investigations. If the Coroner were provided with the power to direct police investigations, it would create the potential to hinder other competing interests for which police are accountable.<sup>881</sup>

Senior Constable Nolan explained to the Committee what Victoria Police viewed to be competing interests:

Primarily the competing interests would be that the police are investigating to determine if there are criminal offences involved, and if there are, then obviously there are obligations as to how that investigation will be conducted—the gathering of evidence, the relevant admissions and so on. So they have a very clear obligation to investigate from a criminal perspective. The coroners perspective is quite different from that and may not take into account the considerations that a criminal investigation would need to take into account. If the police were being directed purely down a coronial line, there would be the potential to miss, if you like, matters which are critical to a criminal investigation.<sup>882</sup>

Both Victoria Police and the Coroner's Office considered that in general there was a cooperative working relationship between police and coroners, and neither submission considered that a coroner should have the legislative power to direct the police in the investigation.<sup>883</sup> Instead, the Coroner's Office submitted that the Act should be amended to provide that, following a request by a coroner, the Commissioner of Police is to provide a sufficient number of police for a coronial investigation.<sup>884</sup> Acting Commander Carter told the Committee that the Act should be amended to specify the role of police in coronial investigations because this role was poorly understood by sections of the community:

<sup>&</sup>lt;sup>879</sup> Victorian Implementation Review of the Recommendations from the Royal Commission into Aboriginal Deaths in Custody, Review Report, Vol. 1, 2005, 467.

<sup>880</sup> Susan Nolan, Victoria Police, Minutes of Evidence, 5 December 2005, 267.

<sup>&</sup>lt;sup>881</sup> Trevor Carter, Victoria Police *Minutes of Evidence, 5 December 2005*, 265.

<sup>882</sup> Susan Nolan, Victoria Police, Minutes of Evidence, 5 December 2005, 266.

<sup>883</sup> State Coroner's Office, Submission no. 70, 142; Victoria Police, Submission no. 78, 5.

<sup>884</sup> State Coroner's Office, Submission no. 70, 142.

Such an amendment would alleviate difficulties that may arise for police, particularly in the health sector, where resistance is often experienced by police acting on behalf of the coroner due to a lack of understanding or clear statute as to the role of police in this context.<sup>885</sup>

Two other witnesses considered that the current arrangements in which police investigate deaths for the Coroner were adequate. Former coroner Jacinta Heffey told the Committee that:

The great value of the current Coroners Assistants Office is that the bulk of investigations into reportable deaths in Victoria are conducted by uniformed police members and the Coroners Assistants, being police officers themselves, are well acquainted with police procedures. They can advise the investigating police and request that the information to be provided to the Coroner conducting the investigation be along certain lines. I know of no difficulties being experienced in this regard.

With this resource available, in my view, it is not necessary to specifically empower Coroners to give directions to police officers.<sup>886</sup>

However, the Committee heard evidence from a number of other stakeholders who considered that there are problems with the way in which police carry out coronial investigations and that, therefore, there is a need for a coroner to have the power to direct the coronial investigation. Problems identified by stakeholders include:

- unacceptable delays by police in carrying out coronial investigations;
- poor quality police investigation of medical procedure related deaths; and
- a perceived conflict of interest where police officers are investigating deaths in which other police officers were involved (for example police shootings).

All legal stakeholders supported the need for coroners to have the legislative power to direct police investigations in relation to coronial inquiries. The Health Services Commissioner also agreed that coroners should have the power because they are ultimately responsible for the police investigation. Similarly, a number of

<sup>&</sup>lt;sup>885</sup> Trevor Carter, Victoria Police *Minutes of Evidence, 5 December 2005*, 266.

<sup>&</sup>lt;sup>886</sup> Jacinta Heffey, *Submission no. 33*, 16. Ian Freckelton told the Committee that he thought the 'challenge for the coroner is to ensure that she or he has the information which is necessary for an effective investigation, and by and large that seems to me to be accomplished': *Minutes of Evidence, 20 September 2005*, 206.

<sup>&</sup>lt;sup>887</sup> Victorian Bar, *Submission no. 81*, 7; Law Institute of Victoria, *Submission no. 58*, 4; Victorian Aboriginal Legal Service, *Submission no. 57*, 3; Federation of Community Legal Centres Inc, *Submission no. 55*, 8. Victoria Legal Aid made no submission on the discussion paper question.

<sup>&</sup>lt;sup>888</sup> Health Services Commissioner, Submission no. 62, 7.

constituents from East Yarra Province considered that a coroner should have the power to direct coronial inquiries.889

### Unacceptable delays in police investigations

Ms Kathleen Hurley told the Committee that her family was dissatisfied with the way her brother Gerard's death was investigated by the police. The Hurley family considered that the Coroner's Office did not exercise its authority towards the police adequately, and that this led to delays in obtaining witness statements and contributed to a poor-quality investigation which ultimately failed to establish the circumstances of Gerard's death. Ms Hurley told the Committee that Gerard died in a traffic collision in Melbourne in September 2003. She said that the Coroner's Office advised the Hurley family that it would provide a report on Gerard's death within eight to 10 weeks. The actual coronial investigation, which involved taking statements from persons who had witnessed the collision, was undertaken by a local police constable at a Melbourne police station. Ms Hurley outlined the problems the Hurley family had encountered with that investigation:

As the months went by, family members took to calling the Coroner's Office every four to six weeks to ask when we would receive the report. In the course of this process, we discovered that the Coroner's Office had sent out a number of "chasers" to the Nunawading Police station and the officer in questions, in order that he submit all the paper work for the report. ...It was not until [a family member] contacted the Sergeant in charge of Nunawading Police station who, after visiting the investigating officer's "locker" let [the family member] know that he had found three letters from the Coroner's Office, that the Police subsequently acted on the matter.<sup>891</sup>

The Hurley family considered that information in relation to Gerard's death should have been provided in a more professional manner. Ms Hurley told the Committee that her family was distressed by the length of time it took for the Coroner's Office to complete the report. The family waited 11 months to receive a three-page coronial report, which did not even refer to any independent witnesses' observations as to how the accident occurred. This led the Hurley family to question the quality of the investigation and its findings in relation to Gerard's death.

Mr Charandev Singh, Human Rights Advocacy Worker for the Federation of Community Legal Centres (FCLC), gave as an example of police delay in obtaining evidence for a coronial investigation the case of Villiami Tonginoa's death<sup>892</sup> in 2000 at the Maribyrnong Detention Centre in Melbourne:

<sup>889</sup> Constituents of East Yarra Province, Submission no. 20, 4.

<sup>&</sup>lt;sup>890</sup> Kathleen Hurley, *Submission no. 68*, 2. A copy of the record of investigation into the death is attached to the submission; Coroner's Case No. 2965/03.

<sup>891</sup> Kathleen Hurley, Submission no. 68, 2.

<sup>892</sup> Coroner's Case No. 4162/00.

After the death only three of the immigration detainees who witnessed the events were interviewed. It was a full five weeks before police returned to the immigration detention centre to interview other detainee witnesses. In the interim five weeks up to 17 eye witnesses, some of them key eye witnesses, were either removed from the detention centre to other states or removed from the country, and their evidence was not captured at all or was captured in only a very perfunctory way.

The video footage that ACM [Australian Correctional Management Pty Ltd] was taking of the whole day's event—and it would have captured the actual act of the leap—was not collected from ACM for 14 days by the police. It was actually held by the officer who was in charge of the overall events, and he was playing basketball in front of Villiami while Villiami was in a very distressed state. Only seconds of that is captured, and the final moment is not captured, or at least was not made available to the police, so that failure to collect that evidence is quite critical. It is key forensic and other evidence.<sup>893</sup>

Mr Singh told the Committee that the first two to three days after a death is the critical period for capturing evidence and that it was vital to the integrity and effectiveness of the investigation.

#### Lack of coroner involvement in early stage investigation

Mr Bond explained to the Committee that a coroner was only assigned to the investigation into his son's death a few weeks before the actual inquest.<sup>894</sup> In effect, it was the police and not the coroner who controlled the investigation. Mr Bond outlined the problems he encountered with the police investigation:

No one made any effort to get the medical history. I got some of that with an FOI request from the hospital. I did more investigating than anyone else. I sought to have the policeman investigating the case approach other potential witnesses at the hospital. He would not do it.<sup>895</sup>

Mr Bond told the Committee that, as a result, he was not able to identify witnesses other than those who were selected by the solicitors representing the hospital and doctors.<sup>896</sup>

## Method of obtaining witness statements

Other witnesses questioned the effectiveness of the method by which police officers obtained witness statements for coronial investigations. Unlike in criminal investigations, where it is the usual practice for a police officer to ask a prosecution witness a series of questions in order to produce a written statement so that it is

<sup>&</sup>lt;sup>893</sup> Charandev Singh, Federation of Community Legal Centres, *Minutes of Evidence*, 19 September 2005, 112.

<sup>894</sup> Graeme Bond, Minutes of Evidence, 22 August 2005, 4.

<sup>&</sup>lt;sup>895</sup> Ibid.

<sup>&</sup>lt;sup>896</sup> Ibid.

directed to the evidence, in coronial investigations police officers usually accept statements written by medical witnesses.

For example, the coronial investigation into Jason Bond's death was conducted by coronial police assistants, who sent written requests to the local police station for police constables to obtain statements from medical witnesses. Jason Bond's father, Graeme Bond, told the Committee that the practice amounted to the outsourcing of the investigation, which resulted in an incomplete investigation:

what in fact happens with these cases where there is a medico legal issue is that the solicitor representing the hospital and doctors approaches the policeman doing the investigation. The policeman is totally out of his depth. The solicitor kindly offers to get the witness statements for the policeman. The policeman accepts the offer. In doing so, he places the decision as to who will be a witness and what will be the content of their statement into the hands of the legal representatives of the hospital and doctors. It completely corrupts the investigation.<sup>897</sup>

Ms Lorraine Long from the Medical Error Action Group told the Committee that the practice of police accepting submissions which were drafted by hospital lawyers had resulted in hospital lawyers controlling the evidence which was presented at an inquest. She considered that this problem could be addressed if coroners did not permit statements to be drafted by hospital lawyers.

However, Victoria Police defended its method of obtaining statements in this manner:

When statements are being obtained, I am talking generally, from someone within the medical profession whether they be a psychiatrist or a doctor, they generally are given a briefing, if you like, of the sorts of issues we would like them to cover, and this is the advice we give to police members as well, and they then have the time to go away and write their report for the coroner.

It is not often the case where a police member is actually sitting down with someone of the medical profession taking a statement. Certainly that gives them the opportunity to put in whatever information they believe is necessary and to explain the background of that information. I do not think there are any restrictions placed on what information they can provide in their statements.

Certainly if there is a situation where a police member is taking a statement and they think the police member does not understand, which may very well be the situation, there is nothing to prevent them from going on and wanting to expand further on what they have put in the statement. I am not sure how that has become an issue. Certainly once we get to the point of an inquest we may have a range of experts who are providing an expert assessment of the medical or psychiatric history. There is a lot of opportunity to expand on what might be initially said.<sup>899</sup>

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<sup>&</sup>lt;sup>897</sup> Ibid.

<sup>898</sup> Medical Error Action Group, Submission no. 7, 14.

<sup>899</sup> Susan Nolan, Minutes of Evidence, 5 December 2005, 29.

#### Conflict of interest in police investigating police-related deaths

A number of stakeholders addressed the issue of whether there is an actual or perceived conflict of interest when police officers play a role in coronial investigations into:

- the death of a person who was in police custody;
- the death of a person who died in a police pursuit or other kind of police operation;
   and
- the death of a person who at the time of death was not in custody but where police
  officers had an involvement in the death (for example a police shooting).

The Victorian Aboriginal Legal Service Co-operative Ltd (VALS) agreed with the AIC research study that if police investigate for the Coroner in these circumstances there is likely to be a perceived or actual conflict of interest which might interfere with public confidence in the investigatory process.<sup>900</sup>

Family members who gave evidence to this inquiry confirmed this. According to Margrit and David Kaufmann, whose son Mark Kaufmann was shot by a police officer at the family home in Melbourne in January 2002, the fact that the police were investigating the actions of police added to their sense of grief and dissatisfaction with the coronial investigation. The Kaufmanns told the Committee that:

It is cold comfort that the coroner declared himself responsible at a time, when it was too late to change the investigation preceding the Inquest. In our view the investigation which took  $2\frac{1}{2}$  years to complete was no more than a collating of statements, because it all proceeded on the premise that the shooting was justifiable. Therefore we are adamant, that police should not investigate police.<sup>901</sup>

However, Acting Commander Carter from Victoria Police told the Committee that the police had carried out the investigation with integrity and that this was subject to coronial oversight:

Our processes are that in that sort of situation our ethical standards department has a very strong role in oversighting the way investigations are carried out. There is also the role of the coroner to oversight the investigation. Also at the moment if any issues arise the Office of Police Integrity has oversight and plays an investigative role as well. Although we have an initial response in terms of our investigation, there are a number of checks and balances in terms of our ethical standards to Parliament and the OPI. 902

<sup>902</sup> Trevor Carter, *Minutes of Evidence*, 5 December 2005, 267.

<sup>&</sup>lt;sup>900</sup> Victorian Aboriginal Legal Service, *Submission no. 57*, 3.

<sup>901</sup> Margrit and David Kaufmann, Submission no. 71, 4.

The Committee heard further evidence in relation to the issue of police investigating police-related deaths, and this is discussed in the next section of the chapter.

#### Discussion and conclusion

The Committee notes that the Coroner's Office and Victoria Police consider that there is a cooperative working relationship between police and coroners and that there is therefore no need for a coroner to have the power to direct police investigations. However, the Committee has a number of concerns with the current arrangements and considers that on occasion there may well be a need for coroners to have the legal authority to direct police officers in their inquiries.

While the Committee has not conducted an investigation into the overall standard of coronial investigations, it is aware of a number of cases in which the timeliness and quality of the police contribution to a coronial investigation may have been improved by empowering a coroner to give specific directions to police in the course of the investigation. The Committee notes the concerns expressed by the Hurley family, and Mr Singh and the comments made by the Deputy State Coroner<sup>903</sup> regarding delays in police investigations. While the Committee accepts that there are many instances in which police have conducted coronial investigations in an exemplary and timely manner, it considers that it is vital for coroners to have the power to direct police in order to obtain witness statements and other evidence within defined time frames. A coroner cannot claim that s/he is accountable, as the chief investigator, for the standard of an inquiry when that coroner does not have the power under the Act to direct that inquiry. The Committee considers that the power is particularly necessary in relation to coronial inquiries into deaths in police custody and deaths resulting from police actions in order to avoid the perception that there is a conflict of interest in police directing investigations into police-related deaths.

Most coronial investigations do not involve police investigations into criminal liability. The Committee does not accept that giving a coroner the power to direct police in a coronial investigation would necessarily compromise the independence of the police in their criminal investigations. However, the Committee is of the view that, without the power to direct, a coroner's ability to effectively investigate a death from a community safety and prevention viewpoint may be compromised. If a police officer is only directed to examine a death for the purposes of a criminal investigation, there is the potential to overlook lines of inquiry which are critical to a coronial investigation.

Recommendation 42. That the *Coroners Act 1985* be amended to provide that a coroner may give a police officer directions concerning investigations to be carried out for the purposes of an inquest or inquiry into a death or suspected death, whether or not the inquest or inquiry has commenced.

<sup>903</sup> Coroner's Case No. 1114/01. This case was discussed earlier in this chapter.

## Lawyers assisting inquiries

There is no provision in the Act requiring coroners to appoint lawyers to assist with an investigation. However, the Act does provide that a coroner may be assisted by a lawyer or the Director of Public Prosecutions (DPP) at an inquest. An example of a case in which the Coroner's Office was assisted by both senior and junior counsel from the private bar was in relation to the initial investigation and subsequent inquest into the death of a volunteer race marshal at the Grand Prix in Melbourne in 2001.

At inquests where a coroner has not appointed a lawyer as counsel assisting the coroner, the role is undertaken by police officers. The person assisting the coroner at an inquest is responsible for calling and questioning witnesses and in some instances asks witnesses questions on behalf of family members who do not have legal representation. 906

### Legal assistance in other Australian jurisdictions

The ACT is the only Australian jurisdiction which specifically requires coroners to appoint a lawyer to assist inquests into all deaths in custody.<sup>907</sup>

#### Law reform agencies

The RCADC made a specific recommendation that, in relation to Indigenous deaths in custody, the State Coroner should appoint a solicitor or barrister to assist the coroner conducting the inquiry. 908 The Commission further recommended that the lawyer's role should be to ensure that all relevant evidence is brought to the attention of the coroner and tested. 909 According to the Commission:

a solicitor or barrister should also be appointed as soon as practicable, and not later than fortyeight hours after receiving advice of the death. Immediate responsibility for ensuring that a full and adequate inquiry is conducted into the cause and circumstances of death should fall to that legal practitioner, subject to the direction of the coroner.

While police investigators may not immediately welcome such supervision, it is my opinion that, in time, its advantages will be appreciated. The removal of ultimate responsibility for the adequacy of investigations will also remove the prospect of allegations of bias. The broader scope of investigations designed to examine the duty of care owed by custodial authorities and

<sup>&</sup>lt;sup>904</sup> Coroners Act 1985 s 46(2).

<sup>905</sup> Coroner's Case No. 621/01.

<sup>&</sup>lt;sup>906</sup> Ian Freckelton and David Ranson, *Death Investigation and the Coroner's Inquest* (2006) 565.

<sup>&</sup>lt;sup>907</sup> Coroners Act 1997 (ACT) s 72.

<sup>&</sup>lt;sup>908</sup> Royal Commission into Aboriginal Deaths in Custody, *National Report* (1991), vol 1, Recommendation 26.

<sup>909</sup> Ibid recommendation 28.

to identify systemic failures are matters in which the advice of a legal practitioner will assist police and enhance the quality of their inquiries.<sup>910</sup>

The State Coroner has indicated that, because of a lack of resources, lawyers are not appointed at the early stage of an investigation. The current practice in relation to police-related deaths is that the DPP provides a lawyer to assist the Coroner when the brief of evidence is completed and a date for the inquest is determined. This lawyer will then assist the Coroner at the actual inquest. Assistance will usually include calling and examining witnesses and may sometimes include making submissions as to possible findings, closing address and preparing draft findings.

In 2005 the implementation review recommended that the Victorian Government provide adequate resources to appoint counsel to assist coronial investigations of Indigenous deaths in custody.<sup>914</sup>

#### **Evidence received by the Committee**

#### Initial investigation of police-related deaths

The Coroner's Office told the Committee that it was the usual practice to request assistance from the DPP for investigations into deaths 'involving police and some other sensitive or controversial matters'. The submission advised that:

there is no statutory bar to dealing with these professional requirements on a case-by-case basis and the State Coroner's Office does not seek statutory support for this investigatory machinery. However, the resources costs are an issue that require attention by Government.<sup>916</sup>

In his findings in relation to the police shooting death of Mark Kaufmann, the State Coroner referred to the RCADC recommendation that a lawyer be appointed to assist in the early stages of a death in custody inquiry as:

a sensible and practical solution in order to assist in developing a multi-disciplinary investigatory system to help look at these investigations from a number of perspectives.<sup>917</sup>

In his findings, the State Coroner made the following comments in relation to the advantages of appointing a lawyer in the early stages of a death investigation:

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<sup>&</sup>lt;sup>910</sup> Ibid 4.2.30–4.2.31.

<sup>&</sup>lt;sup>911</sup> Coroner's Case No. 201/02, 41.

<sup>&</sup>lt;sup>912</sup> Ibid.

<sup>&</sup>lt;sup>913</sup> Ian Freckelton and David Ranson, *Death Investigation and the Coroner's Inquest* (2006) 565.

<sup>&</sup>lt;sup>914</sup> Victorian Implementation Review of the Recommendations from the Royal Commission into Aboriginal Deaths in Custody, Review Report, Vol. 1 (2005) 305, recommendation 94.

<sup>915</sup> State Coroner's Office, Submission no. 70, 143-4.

<sup>&</sup>lt;sup>916</sup> Ibid.

<sup>&</sup>lt;sup>917</sup> Coroner's Case No. 201/02, 41.

At the beginning of the investigation into Mr. Kaufmann's death (at the scene) an issue was not canvassed (the issue of Mr. Kaufmann running past the police officer and being shot on his way to the front door of the house). Because of the general circumstances of the incident this was not thought to be an issue until raised by the family during the running of the inquest. Whilst an examination of the facts during the inquest phase of the investigation would tend to discount this theory, it has not been totally excluded. The State Coroner as the investigating coroner at the scene, and responsible for the overall carriage of the inquiry, did not consider this to be an issue until it was raised at the inquest. It is possible that the early assistance of a lawyer to help oversee the investigation phase might have identified and tackled this issue at a far earlier stage. Thus, in police related matters like shootings the Royal Commission recommendation for the early assistance of a lawyer working on behalf of the Coroner, has merit. 918

In her submission Ms Heffey advised the Committee that, in cases of police-related deaths, the Office of Public Prosecutions (OPP) routinely assists coroners. <sup>919</sup> She indicated that she did not anticipate that there would be any problems if the Act were amended to require a coroner to appoint a lawyer in these cases, because such an amendment would reflect the current practice of the Coroner's Office. Ms Heffey considered that these lawyers were independent of the police, and she did not believe that any issues concerning a perceived conflict of interest would be raised by appointing prosecution lawyers to assist a coroner with an investigation into police actions.

However, this was disputed by Mr Kaufmann, who gave evidence that in his son Mark's case a perceived conflict existed:

the lawyers from the OPP ... are in fact in a working relationship with the police on a day to day basis, and so to give the perception, if not the fact of further independence, then perhaps an outside investigator/lawyer, not associated in any way with the police or the police enforcement, might be an even more emphatic way of having that accountability. On the night the coroner comes, the homicide squad comes, they all have a look and have a chat amongst themselves and they more or less figure it out on the spot—in Mark's case they believed they had. These guys have been working together for umpteen years. 920

Mr Bill O'Shea of the Law Institute of Victoria (LIV) Council told the Committee that the LIV supported an arrangement in which there are two separate systems of investigation for police-related deaths — a criminal investigation conducted by a specialist police investigation unit, and an independent coronial investigation. He explained to the Committee how such a system could operate:

No one is suggesting that the homicide squad would not be involved in it. But it is a question of who would be involved for the Coroner in respect of assembling the brief of evidence into the death for the purposes of a coronial inquiry as opposed to a criminal file. There would be two

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<sup>&</sup>lt;sup>918</sup> Ibid.

<sup>919</sup> Jacinta Heffey, Submission no. 33, 16.

<sup>&</sup>lt;sup>920</sup> David Kaufmann, Minutes of Evidence, 22 August 2005, 63.

files. There would be a file for the homicide squad, which it would run; but there would be someone independently looking at the death for the coroner, who might well be able to shed light on the cause of the death, which is the Coroner's primary focus in terms of how to make recommendations for improvement, rather than who was the culprit. The Coroner has a different focus to the police. If the coroner could have the assistance of people who could look at that, then we think that would be better in the case of a police death. It might be a group of forensic pathologists or others that we could identify who could do it, or it could be a dedicated group of Victoria Police based at forensic services, as we have now, the sort of people who are the counsel assisting.<sup>921</sup>

## Investigation of deaths in custody

In his submission to the implementation review, the State Coroner advised that the RCADC recommendation that a lawyer be appointed to assist a coronial investigation within 48 hours after advice regarding a death in custody is received is not generally followed. However, he further advised the review that, on some occasions where an investigation is complex or where there is perceived potential for conflict, a barrister from the private bar or the OPP may be briefed to assist the inquiry. In other cases, due to lack of resources, the State Coroner's Assistants Unit oversees the investigations and assists the Coroner at the inquest.

Dr Freckelton also referred to the failure to appoint lawyers to assist at inquests as a resourcing issue:

It is up to coroners whether they procure legal assistance, but one of the fetters on that is whether they can pay for it, and that comes back to a further budgetary and resourcing issue. Quite a deal of the time the police who assist a coroner do an adequate task in facilitating the inquest, but it seems to me that there are occasions where police assistants fulfil the role of counsel assisting and take a reasonably passive role in that exercise, when someone with greater confidence and facility in advocacy could do a constructive job in enhancing the quality of the investigation. Were the coroner to have sufficient funds to more readily utilise experienced lawyers to assist her or him, that would be constructive. 923

Ms Heffey told the Committee that it was current practice at the Coroner's Office not to appoint a lawyer to assist a coroner in the investigation of the death of a non-Indigenous person who died in the custody of Corrective Services. <sup>924</sup> She told the Committee that she saw no reason that this practice should be changed. Ms Heffey did however note that the practice may cause problems in relation to the investigation of deaths in rural areas. This was due to the fact that, outside Melbourne, police

<sup>921</sup> Bill O'Shea, Minutes of Evidence, 28 November 2005, 172.

<sup>&</sup>lt;sup>922</sup> Victorian Implementation Review of the Recommendations from the Royal Commission into Aboriginal Deaths in Custody Review Report, Vol. 1, 2005, 466.

<sup>923</sup> lan Freckelton, Minutes of Evidence, 20 September 2005, 206.

<sup>924</sup> Jacinta Heffey, Submission no. 33, 16.

officers are not specifically assigned to assist coroners in a full-time capacity and may therefore not have the time to investigate a death in custody for the Coroner. Ms Heffey proposed that rural coroners should have access to a lawyer to assist with complex cases or any case considered to be beyond the skill or available time of the local police. 925

On the other hand, a number of witnesses considered that it was essential that a coroner have the ability to appoint lawyers to investigate deaths in custody in order to remove the perception that such an investigation involves a conflict of interest. Associate Professor Ranson told the Committee that he believed:

it is essential that coroners have the capacity to appoint and instruct lawyers to assist in the investigation of deaths in custody in order to avoid the risk of apprehended bias with respect to the role of police as investigators of deaths in police custody. The example of the State coroner of Queensland standing aside from the inquest into the recent death in custody on Palm Island, as a result of apprehended bias in relation to his work investigating police conduct some 10 years or so before, shows the potential strength of the apprehended bias issue.<sup>926</sup>

Mr Frank Guivarra, Chief Executive Officer at VALS, told the Committee that VALS supported the enactment of legislation similar to that in the ACT, which specifically requires a coroner to appoint a lawyer to assist inquests into deaths in custody.<sup>927</sup>

### Investigation of the deaths of on-duty police officers

While it did not accept that a police investigation of a police-related death amounted to a conflict of interest, Victoria Police did accept that a potential conflict existed in relation to police investigations into deaths of on-duty police officers. Acting Commander Carter told the Committee that the deaths of two on-duty police officers, Senior Constable Rennie Page and Senior Constable Tony Clarke, in 2005 were subject to coronial investigation and investigation by the Victorian WorkCover Authority. Acting Commander Carter told the Committee that:

(g)iven the potential for WorkCover prosecution against Victoria Police there could be a potential for conflict of interests with police conducting investigations into these deaths, as the outcomes of these investigations have a direct impact on the vulnerability of the organisation.<sup>928</sup>

Victoria Police suggested that these investigations should therefore be conducted by a non-police investigator.

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<sup>&</sup>lt;sup>925</sup> Ibid.

<sup>926</sup> David Ranson, Submission no. 19, 44.

<sup>&</sup>lt;sup>927</sup> Victorian Aboriginal Legal Service, Submission no. 57, 3.

<sup>&</sup>lt;sup>928</sup> Acting Commander Trevor Carter, Victoria Police, *Minutes of Evidence*, *5 December 2005*, 268.

#### Discussion and conclusion

The Committee is concerned by the evidence which suggests that the failure to appoint lawyers to assist with investigations is due to a resourcing issue. The Committee believes that there is a vital need for a coroner to appoint, as well as have the resources to appoint, a lawyer or other appropriately qualified person, depending on the circumstances of the case, to lead the investigation on behalf of the coroner in police-related deaths. This is to ensure that an independent investigation takes place. It is equally important that the families of persons who have died have confidence in the investigation process. This can only be achieved by the Coroner's Office being and being seen to be independent of the police.

The Committee notes the concerns expressed by David and Margrit Kaufmann, who did not consider it appropriate that OPP lawyers be appointed to investigate police-related deaths, but the Committee makes no recommendation as to the kind of lawyer who should be appointed to assist the Coroner. Instead, the Committee considers that appointments should be made on a case-by-case basis by determining whether a particular lawyer has or may be perceived to have a conflict of interest.

Recommendation 43. That the *Coroners Act 1985* be amended to provide that a coroner holding an investigation into a death in custody, a police-related death or a death of an on-duty police officer, must appoint a lawyer or other appropriately qualified person to assist the coroner at an early stage of the investigation and at an inquest, and that the State Government provide funding to the Coroner's Office to enable these appointments.

Recommendation 44. That the duties of the investigator, subject to the direction of the coroner are to:

- a) ensure that a full and adequate investigation is conducted into the cause and circumstances of the death; and
- b) ensure that at the inquest all relevant evidence is brought to the coroner and tested.

# Specialist investigators

While the Act requires certain persons to give information about a death to the Coroner,<sup>929</sup> the Act does not give the power to the State Coroner to appoint either police or other investigators to assist with a coronial investigation. Current practice at the Coroner's Office is that investigators are employed under a contract or on a fee-

<sup>&</sup>lt;sup>929</sup> Coroners Act 1985 s 14(1).

for-service basis. 930 A coroner does not have any power under the Act to direct the way in which an investigator carries out the investigation. 931

## **Assistance in other Australian jurisdictions**

In South Australia and the ACT, unlike other Australian jurisdictions, investigators may be appointed under the relevant Coroners Act. 932

## **Evidence received by the Committee**

Dr Freckelton questioned whether it was appropriate that deaths continue to be investigated with coroners acting in their traditional investigatory role:

At the moment a great deal of investigation is done by coroners. The question has to be asked—and it is something of an iconoclastic one—whether we really want our coroners doing the investigations, or whether we should not put the investigation functions of coroners at arms length from them. Having them do what lawyers tend to do pretty well, namely make decisions, make sure court hearings work well, write decisions and justify their reasoning. Instead, have an investigator, either within the Coroner's Court or perhaps within an Institute of Forensic Medicine, or an entity that we rename, doing the investigations, preparing the material for the Coroner and enabling the Coroner to be at arms length until the matter comes before her or him for decision-making. 933

Dr Freckelton considered that the advantage of such an investigation system would be that it would involve a team-based approach to investigation, recognising the limitations of the traditional individual-based approach.

Associate Professor Ranson in his personal submission told the Committee that there was an overwhelming need for the Coroner's Office to appoint full-time coronial investigators in specialist areas such as occupational health and safety, public health, and risk management. 934 Associate Professor Ranson submitted that:

The need for individuals with these skills is arguably greater than the need for seconded police officers or legal practitioners. This is because such technical specialist investigators would be able to provide the coroner with an investigation that is more tightly focused on identification of the relevant facts surrounding the death including technical issues relating to the identification of potential recommendations that could help to prevent such deaths in the future. Given the fact that coroners see the prevention role of their jurisdiction as being of paramount importance,

<sup>930</sup> David Ranson, Submission no. 19, 45.

<sup>&</sup>lt;sup>931</sup> In chapter seven the Committee discusses further the role of specialist investigators such as those located in the Clinical Liaison Service.

<sup>&</sup>lt;sup>932</sup> Coroners Act 2003 (SA) s 9; Coroners Act 1997 (ACT) s 59.

<sup>933</sup> Ian Freckelton, Minutes of Evidence, 20 September 2005, 205.

<sup>934</sup> David Ranson, Submission no. 19, 45.

anything that can be done to enhance the capacity of a coroner's investigation to identify preventable issues would seem to be worthy of consideration.<sup>935</sup>

He also considered that engaging investigators as employees of the Coroner's Office, as opposed to the current arrangement of engaging investigators on a contract basis, would reduce operating costs or at least not increase costs.

The Coroner's Office indicated that it supported a similar provision to that in the South Australian *Coroners Act* which provides a legislative mechanism for appointing investigators. 936

Victoria Police was the only stakeholder to indicate opposition to the appointment of certain kinds of investigators under the Act. Jenny Peachey, Director of Corporate Strategy and Performance for Victoria Police, advised the Committee that Victoria Police did not support individual appointments, because it would not be possible to appoint investigators to cover the entire ambit of expertise required. However, she indicated that it may be possible to appoint investigators to investigate certain classes of deaths, such as workplace deaths, which would require a multidisciplinary teambased approach.

#### Discussion and conclusion

The Committee considers that Dr Freckelton's proposal that consideration be given to re-examining the investigatory role of the Coroner is sound and warrants further analysis. Operational research into the current investigation work undertaken by full-time coroners based in Melbourne and part-time coroners in regional Victoria would need to be conducted to develop an understanding of the strengths and limitations of the current system.

On the basis of evidence available to this inquiry, the Committee considers that as an interim measure the effectiveness of the death investigation process could be improved by the appointment of specialist investigators under the Act. The Committee accepts the evidence that this would be a cost-effective way in which specialist investigators could assist coroners in investigating deaths.

Recommendation 45. That the *Coroners Act 1985* be amended to provide that a coroner may appoint a specialist investigator to assist with an investigation into a death. The duties of the investigator, subject to the direction of the coroner, are to:

<sup>935</sup> Ihid

<sup>936</sup> State Coroner's Office, Submission no. 70, 143.

<sup>937</sup> Victoria Police, Submission no. 78, 6.

<sup>&</sup>lt;sup>938</sup> Ibid.

<sup>&</sup>lt;sup>939</sup> Ibid.

- a) ensure that a full and adequate investigation is conducted into the cause and circumstances of the death; and
- b) identify any possible measures which may have prevented the death or similar deaths.

## State Coroner's function to issue guidelines for coroners

It is a statutory function of the State Coroner to issue guidelines to coroners to help them carry out their duties. 940 The Act also gives the State Coroner discretion to give directions to coroners about an investigation and the manner of conducting it. 941

Over 10 years ago an AIC case study on the Victorian Coronial system reviewed 16 coronial death-in-custody findings made by 10 city and rural coroners. <sup>942</sup> The study revealed the application of widely varying standards of acceptable custodial care from coroner to coroner, which in part:

blunts the effectiveness of the coronial process as a reliable means of identifying risk factors and developing remedial strategies. 943

When the discussion paper was published in April 2005, the Committee conducted research to establish:

- how many guidelines and investigation standards had been developed since the AIC study in 1995;
- how many of the guidelines were accessible on the Internet;
- the level of stakeholders' awareness of the existence of investigation standards and guidelines; and
- whether coroners were aware of the guidelines and whether they consistently applied the guidelines in their investigations.

The Committee's researcher was only able to publicly access one standard—'Coroner's Investigation Standard into Deaths from Falls'. The standard was only available at VIFM's website and not the Coroner's Office website.<sup>944</sup> Since April 2005,

<sup>941</sup> Coroners Act 1985 s 16. The section states that the State Coroner may give directions about an investigation into a death (other than an inquest) and the manner of conducting it.

944 The website is www.vifm.org.

<sup>&</sup>lt;sup>940</sup> Coroners Act 1985 s 7(e).

<sup>&</sup>lt;sup>942</sup> Boronia Halstead, 'Coroner's Recommendations and the Prevention of Deaths in Custody: A Victorian Case Study', in David McDonald (ed), *Deaths in Custody*, Australian Institute of Criminology (1995). Available at aic.gov.au.

<sup>&</sup>lt;sup>943</sup> Ibid 2.

the State Coroner has issued further guidelines. These guidelines are reproduced in the Coroner's Office submission but are not available on the Coroner's Office website. 945

The guidelines cover the following topics:

- Radiology Investigation Standard (undated draft version);
- Asbestos-related deaths (from 2004);
- Protocol for the Management of Skeletal Remains (undated); and
- Minimum Investigation Protocol for Heroin-related deaths (undated).

There is also a State Coroner guideline, which was issued in 2003, which deals with directions to coroners on when to hold an inquest.<sup>946</sup>

## Other Australian jurisdictions

Queensland and Western Australian State Coroners have a statutory requirement to issue guidelines and have fulfilled this requirement. In Queensland, legislation requires the State Coroner to issue investigation guidelines to ensure best practice in the coronial system'. Under the Coroners are required to comply with the guidelines to the greatest extent possible. Under the Coroners Act 2003 (Qld), the State Coroner of Queensland is required to report annually to the Attorney-General on the State Coroner's Guidelines and directions issued to coroners. The guidelines are publicly available at the Queensland State Coroner's website.

The Act also requires the State Coroner, when preparing the guidelines, to have regard to the recommendations of the RCADC that relate to the investigation of deaths in custody. The Queensland Guidelines give the following advice to coroners regarding the investigation of a death in custody:

<sup>&</sup>lt;sup>945</sup> State Coroner's Office, *Submission no. 70*, Appendix C. The guidelines can however be accessed on the Law Reform Committee's website at www.parliament.vic.gov.au/lawreform. While most of the guidelines are undated, it would appear that some of the guidelines were issued before 2005.

<sup>946</sup> State Coroner's Office, Submission no. 70, Appendix C, Ivii-Ix.

<sup>947</sup> Coroners Act 2003 (Qld) s 14; Coroners Act 1996 (WA) s 58.

<sup>948</sup> Coroners Act 2003 (Qld) s 14(1)(b).

<sup>949</sup> Coroners Act 2003 (Qld) s 14(4).

<sup>950</sup> Coroners Act 2003 (Qld) s 77.

<sup>&</sup>lt;sup>951</sup> The website is www.justice.qld.qov.au/courts/coroner/pdfs/quidelines.pdf.

<sup>&</sup>lt;sup>952</sup> Coroners Act 2003 (Qld) s 14(2); Royal Commission into Aboriginal Deaths in Custody, National Report (1991), vol 1.

In all cases investigation should extend beyond the immediate cause of death and whether it occurred as a result of criminal behaviour. It should commence with a consideration of the circumstances under which the deceased came to be in custody and the legality of that detention. The general care, treatment and supervision of the deceased should be scrutinised and a determination made as to whether custodial officers complied with their common law duty of care and all departmental policies and procedures and whether these were best suited to preserving the prisoner's welfare. Only by ensuring the investigation has such a broad focus as to identify systemic failures will a Coroner be given a sufficient evidentiary basis to discharge his/her obligation to devise preventative recommendations.<sup>953</sup>

The West Australian State Coroner is required by legislation to issue guidelines regarding the principles, practices and procedures of the coronial system. While the guidelines are not currently available on the Coroner's website, the State Coroner supports the practice of making the guidelines available on the website. While the guidelines are not as detailed as the Queensland guidelines, they give specific procedural guidance to coroners. For example, the guidelines require a coroner to:

- ensure that coronial staff complete the necessary paperwork, such as the distribution of information brochures to family members; and
- ensure that coronial staff have provided the next of kin with all information required by the Act.

Although it is not required under legislation, the New South Wales State Coroner issues guidelines to coroners. The guidelines, which are referred to as circulars, are not available on the Coroner's Office website but are distributed to all coroners in New South Wales. The circulars cover a wide range of topics, such as directions for removing the body of a person who has died in a rural nursing home and the complaints procedure in which rural coroners refer complaints concerning coronial investigations to the State Coroner.

While the ACT legislation does not require the State Coroner to issue investigation guidelines, it does contain additional provisions relating to the investigation of deaths

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<sup>&</sup>lt;sup>953</sup> State Coroner's Guidelines—Version 0 December 2003, Paragraph 7.2.

<sup>&</sup>lt;sup>954</sup> Coroners Act 1996 (WA) s 58. A copy of the guidelines was provided to the Committee by Dave Dent, Registry Manager, Coroner's Court, Western Australia.

<sup>&</sup>lt;sup>955</sup> Email, Dave Dent, Registry Manager, Coroner's Court, Western Australia, to Committee Legal Research Officer, 16 March 2006.

<sup>&</sup>lt;sup>956</sup> Letter, Naree Peters, Graduate Legal Officer, Office of the State Coroner, New South Wales, to Committee Legal Research Officer, 13 March 2006.

<sup>&</sup>lt;sup>957</sup> Email, Don McLennan, Manager, Coronial Services, New South Wales, to Committee Legal Research Officer, 15 March 2006. Mr McLennan provided copies of the circulars to the Committee.

<sup>&</sup>lt;sup>958</sup> New South Wales State Coroner, State Coroner's Circular no 51, 17 June 2005, 2.

<sup>&</sup>lt;sup>959</sup> New South Wales State Coroner, State Coroner's Circular no 54, undated, 2.

in custody. 960 A coroner must address issues such as quality of care, treatment and supervision if in the opinion of the Coroner these issues contributed to the cause of death. 961

#### **Evidence received by the Committee**

### Lack of comprehensive guidelines

A number of witnesses, including Victoria Police and former coroner Jacinta Heffey, noted the absence of comprehensive guidelines for coroners. According to Victoria Police:

Currently there are no 'all-encompassing and readily accessible' State Coroners Guidelines. There is some guidance provided from Supreme Court decisions, however these are not consistently applied. In general, guidelines are not accessible by the general public and are distributed on an ad-hoc and inconsistent basis. A guideline that is currently used is the recently developed Falls Investigation Standard, which is available to all police members investigating deaths. There is a further MOU between Victoria Police and WorkSafe. However, this last guideline was developed as a result of a finding, not a guideline, issued by a Coroner. There has also been a Fire Investigation Working Party that has developed Fire Investigation procedures. 962

A broad cross-section of stakeholders indicated that they were unaware that the Coroner's Office had either developed any investigation guidelines or used them in relation to investigations. These stakeholders included the Australian Council for Safety and Quality in Health Care (ACSQHC), medical negligence lawyers at legal firm Maurice Blackburn Cashman and Graeme Bond.<sup>963</sup>

#### Mr Bond told the Committee that he was:

not aware of the existence of such standards and have seen nothing that cause me to suspect their existence. ...I take a keen interest in coronial investigations into deaths related to the Mental Health System and yet am unaware of such guidelines. I think my lack of knowledge would indicate that there is little if any effort made to publicise such guidelines or standards if they even exist. 964

Ms Heffey informed the Committee that she was a full-time coroner from 1994 to March 2003 and that during that time the State Coroner had not developed any

<sup>&</sup>lt;sup>960</sup> Coroners Act 1997 (ACT) ss 69-76. The Committee was unable to establish whether the ACT Territory Coroner has issued guidelines. The Territory Coroner did not reply to the Committee's letter and emails. Guidelines do not exist in South Australia and Tasmania.

<sup>961</sup> Coroners Act 1997 (ACT) s 74.

<sup>&</sup>lt;sup>962</sup> Victoria Police, Submission no. 78, 5.

<sup>&</sup>lt;sup>963</sup> Maurice Blackburn Cashman, *Submission no. 42*, 5; Graeme Bond, *Submission no. 48*, 6; Australian Council for Safety and Quality in Health Care, *Submission no. 51*, 5.

<sup>964</sup> Graeme Bond, Submission no. 48, 6.

coronial guidelines in relation to investigations. Ms Heffey told the Committee that she strongly supported the development of investigation guidelines for coroners. Similarly, all stakeholders who considered this issue supported the development of comprehensive guidelines to ensure a consistent approach to death investigation. For example, Kerry Power, General Manager, Health Care, at the Transport Accident Commission (TAC) told the Committee that:

TAC supports the State Coroner establishing investigation standards and guidelines. Not only will these assist Coroners to carry out their duties but will also direct other stakeholders, whether in the health or road safety systems, as to the information and issues which will be investigated. 968

Stakeholders also identified a range of investigation standards which they considered the State Coroner needed to develop to ensure that the guidelines were comprehensive. In Associate Professor Ranson's opinion:

minimum investigation standards could be usefully developed in a wide variety of operational areas for the coroner. These would include a range of death investigation types and as well as internal operational procedures.<sup>969</sup>

ACSQHC offered the following advice to the Coroner's Office for the development of further guidelines:

The investigation of adverse events in health care is now recognised to be a specialised discipline that often requires multidisciplinary expertise and can be complex, time-consuming, and relatively expensive. The Root Cause Analysis technique that is now widely used is based on the understanding that many adverse events appear to be the result of simple individual errors or omissions, but on closer examination there are underlying system factors that have enabled the adverse event to occur, or have failed to prevent its occurrence when it was possible to do so.

The ACSQHC considers that the Coronial investigation standards should reflect these principles and techniques. Failure to apply appropriate specialist investigatory techniques can result in

<sup>&</sup>lt;sup>965</sup> Ms Heffey indicated in her submission that she did have access to some guidelines which were developed by the previous State Coroner, Hal Hallenstein.

<sup>966</sup> Jacinta Heffey, Submission no. 33, 14.

<sup>&</sup>lt;sup>967</sup> See for example Maurice Blackburn Cashman, *Submission no. 42*, 5; Disability Discrimination Legal Service, *Submission no. 29*, 7–8; David Ranson, *Submission no. 19*, 38–40; Transport Accident Commission, *Submission no. 50*, 7–9; Federation of Community Legal Centres Inc, *Submission no. 55*, 7; Graeme Bond, *Submission no. 48*, 6–8.

<sup>&</sup>lt;sup>968</sup> Transport Accident Commission, Submission no. 50, 7.

<sup>969</sup> David Ranson, Submission no. 19, 40.

inadequate conclusions that lay blame on individuals inappropriately, and fail to identify opportunities for system improvement. 970

The TAC also identified some investigations which it considered required guidelines and standards of investigation.<sup>971</sup> According to the TAC, standards and guidelines were required particularly in relation to:

- the conduct of autopsies following transport accidents;
- systemic road system issues;
- · public transport related investigations; and
- vehicle component failures.

The TAC indicated that it also supported the development of standards in relation to hospital and nursing home related deaths. Ms Alyena Mohummadany from the Disability Discrimination Legal Service (DDLS) told the Committee that there should be specific coronial guidelines in relation to the deaths of people with a disability. According to DDLS:

These guidelines should direct a coroner to look at whether the individual was receiving appropriate care and assistance in light of their particular needs. It has been the experience of the DDLS that people with a disability often do not have their needs appropriately met and are therefore at higher risk of discrimination and mistreatment.<sup>973</sup>

DDLS agreed with the AIC case study that the lack of guidelines or standards reduced the coronial system's ability to identify practices or procedures which may have caused a death.

## Lack of clarity in existing guidelines

Ms Heffey questioned whether the existing guidelines gave guidance to coroners on how an investigation should be conducted. Ms Heffey referred to the 'Coroner's Investigation Standard into Deaths from Falls'. She told the Committee that it was unclear to her whether the standards were directed to coroners, in terms of how to conduct an investigation, because the guidelines appeared to be directed to the institution at which the fall occurred. She questioned how these guidelines would assist rural magistrates in undertaking a coronial investigation:

<sup>&</sup>lt;sup>970</sup> Australian Council for Safety and Quality in Health Care, Submission no. 51, 5.

<sup>&</sup>lt;sup>971</sup> Transport Accident Commission, *Submission no. 50*, 7.

<sup>&</sup>lt;sup>972</sup> Disability Discrimination Legal Service, Submission no. 29, 7–8.

<sup>&</sup>lt;sup>973</sup> Ibid.

<sup>974</sup> Jacinta Heffey, Submission no. 33, 14.

in the Coroners Bench Book recently published and accessible to all magistrates on the JOIN system, the "falls" cases are routinely reviewed at the State Coroners Office at Melbourne and the hospitals are required to provide certain details "to the State Coroner". It is unclear as to how these guidelines inform rural magistrates. <sup>975</sup>

However, according to the Coroner's Office there are two purposes behind the development of the standards. The first purpose is to guide investigators, while the second purpose is to give:

encouragement to those at the sites of frequent relevant deaths to implement prevention and accountability protocols in anticipation of the questions they will be asked if a death occurs. 976

Ms Heffey however considered that the Queensland guidelines were a useful model. She considered that the Queensland guidelines:

are clearly directed to coroners to assist them in conducting investigations. I think this is an excellent procedure. It goes a long way towards achieving consistency of approach and generally promotes a high state-wide standard of investigation. The guidelines are practical and are true guidelines as to how to manage an investigation.<sup>977</sup>

## Lack of review system to ensure consistency in investigations

In the discussion paper the Committee questioned whether all coroners in Victoria were familiar with the standards and guidelines and whether they consistently used and applied them when investigating a death. Ms Vivienne Topp, a lawyer at the Mental Health Legal Centre (MHLC), told the Committee that there was a:

Lack of consistency in terms of the rigour with which different Coroners approach matters. There is a striking difference in the level of detail with which different findings are recorded and findings and recommendations made. 978

She provided a number of case studies to support this claim:

An example is a recent decision involving the death by suicide, of young man with a serious mental illness. He had been hospitalised for some time prior to his death and had expressed aversion to his treatment, particularly a deep fear of the proposed administration of ECT. This fear may have contributed to his death but did not come out in the coronial inquiry. Another example involved the death of [a] young man with serious mental illness who was on exceptionally high doses of psychiatric medication and died in hospital having obtained heroin whilst on leave. Toxicologists explored whether there was any interaction between the medication and heroin. Opinion was that there was not. There was however, no reference

<sup>&</sup>lt;sup>975</sup> Ibid 15.

<sup>&</sup>lt;sup>976</sup> State Coroner's Office, Submission no. 70, 134–5.

<sup>&</sup>lt;sup>977</sup> Jacinta Heffey, Submission no. 33, 15.

<sup>&</sup>lt;sup>978</sup> Mental Health Legal Centre, Submission no. 41, 2.

whatsoever to this issue in the finding. Whilst there was no interaction contributing to death, it would seem useful to summarize that aspect of the evidence for the community to properly understand the issue.<sup>979</sup>

The Committee queried whether coroners' investigations were reviewed to assess whether the standards and guidelines were consistently applied. The Coroner's Office advised that investigation standards were made available to all coroners in the *State Coroner's Practice Manual* but that the Coroner's Office did not review cases to establish if the guidelines were used by coroners. The Coroner's Office did not comment on the merits of conducting reviews and did not advise whether the State Coroner was likely to conduct reviews in the future.

Associate Professor Ranson, on other hand, identified the need for and the value of a review mechanism. In his personal submission, Associate Professor Ranson told the Committee that:

it is important to remember that the presence of standards or guidelines does not guarantee their usage. The production of such standards cannot usefully take place without there being an organised and managed process of case audit and review to ensure compliance and appropriate redevelopment of guidelines when needed. Identifying the relevant areas for investigation standards is problematic. This is an area where a Coroner's Advisory Council could have an important role to play.<sup>981</sup>

Associate Professor Ranson advised that he had examined completed coronial files but had not seen evidence of a quality management audit trail or evaluation in the records. He observed that:

continuous improvement systems are part of the quality management arrangements of many organisations. Although the State Coroner's Office takes part in the continuous improvement request system operated by the Victorian Institute of Forensic Medicine this largely relates to interactions between the State Coroner's Office and the Institute rather than including day-to-day internal operations of the Coroner's office in Melbourne or in regional Victoria. 982

The Health Services Commissioner considered that there should be more review of coronial investigations to assess whether the standards and guidelines are consistently applied.<sup>983</sup>

A number of stakeholders considered that consistency in the way coronial investigations are undertaken is vital to ensure a state-wide approach to death investigations. Associate Professor Ranson in his personal submission indicated that,

<sup>&</sup>lt;sup>979</sup> Ihid

<sup>980</sup> State Coroner's Office, Submission no. 70, 134–5.

<sup>981</sup> David Ranson, Submission no. 19, 38.

<sup>&</sup>lt;sup>982</sup> Ibid 39.

<sup>&</sup>lt;sup>983</sup> Health Services Commissioner, Submission no. 62, 5.

while the five full-time coroners in Melbourne were generally aware of the existing standards and guidelines, he was concerned about the rural magistrates' knowledge of these standards and guidelines. He told the Committee that regional magistrates were responsible for coronial investigations on a very infrequent and ad hoc basis. Associate Professor Ranson considered that the lack of everyday operational experience in managing death investigations put rural magistrates at a considerable disadvantage in terms of managing these investigations.

Mr Singh, Human Rights Advocacy Worker for the FCLC, told the Committee that, while the federation supported the introduction of comprehensive guidelines similar to the Queensland guidelines, it considered that other measures were needed to improve the effectiveness of investigations. In relation to deaths in institutional settings such as prisons and detention facilities, Mr Singh told the Committee that:

it is really important for memorandums of understanding or bilateral binding agreements to be set up between agencies responsible for institutions or where deaths have occurred and may continue to occur and the State Coroner's Office for the reason of improving consistency of investigations—whether they happen in the city, or rural and regional settings—improving the effectiveness in terms of setting out a very binding framework for collection of evidence, collection of witness evidence, collection of forensic evidence, time lines for collection of evidence and transparency of that evidence, and it provides an audit framework for investigators and, in the end, the inquest. 986

Mr Singh cited a death in custody case from 2000 as an example of why coronial investigation standards dealing with internal procedures for investigations are required. He told the Committee that, following the death of Villiami Tonginoa at the Maribyrnong Detention Centre in Melbourne, police did not begin to interview detainees who had witnessed the death until five weeks after it happened. By this time the Department of Immigration and Multicultural and Indigenous Affairs (DIMIA) had deported several material witnesses from Australia, and vital evidence may have been missed.<sup>987</sup>

### Lack of planning in developing guidelines

One witness, Associate Professor Ranson, referred to the lack of forward planning or a structured approach to the development of guidelines and standards as a major problem.<sup>988</sup> He told the Committee that:

there is no documented strategic direction or five-year business or strategic plan that the jurisdiction can point to and seek funding to support. Instead the production of these important

<sup>984</sup> David Ranson, Submission no. 19, 39.

<sup>&</sup>lt;sup>985</sup> Charandev Singh, *Minutes of Evidence*, 19 September 2005, 114.

<sup>&</sup>lt;sup>986</sup> Ibid.

<sup>&</sup>lt;sup>987</sup> Ibid 112.

<sup>988</sup> David Ranson, Submission no. 19, 39.

guidelines is based on an ad hoc approach that depends upon discovery of such a need during particular death investigations. 989

Associate Professor Ranson indicated that a Coroner's Advisory Council (discussed in chapter nine) could assist the State Coroner to develop a business or operational plan for the development of guidelines and standards to ensure the implementation of standards and guidelines which are effectively coordinated, resourced and managed.

## Guidelines not publicly accessible

In the discussion paper the Committee also questioned whether the public could readily access the State Coroner's guidelines and investigation standards and whether the investigation standards were publicised in any way. All stakeholders who specifically addressed this question considered that there was a need for publicly accessible guidelines. For example, Ms Beth Wilson, Health Services Commissioner, told the Committee that she considered that the guidelines should be open to public scrutiny. 990

The TAC indicated its concern that the State Coroner's guidelines and investigation standards were not easily accessible to the public or even to those familiar with the system. <sup>991</sup> The commission suggested that the guidelines should be made available on the Internet, along with brochures on the guidelines, which should be made available at the Coroner's Office and at regional Magistrates Courts. If easy-to-understand standards and guidelines were readily available, the TAC considered that they would help family members better understand the coronial processes.

Associate Professor Ranson told the Committee that, while groups consulted concerning the development of existing standards were generally aware of the standards, he was not aware that the standards were promoted beyond these groups. He suggested that there were a number of ways the standards could be promoted, including through electronic kiosk services.

The Coroner's Office made no response to these questions in its submission.

## RCADC recommendation not implemented

The Committee asked stakeholders for their views on whether the Act should specifically require coroners to have regard to the recommendations of the RCADC relating to the investigation of deaths in custody. The RCADC recommended that the State Coroner be responsible for developing guidelines and protocols which coroners

<sup>&</sup>lt;sup>989</sup> Ihid

<sup>&</sup>lt;sup>990</sup> Health Services Commissioner, Submission no. 62, 5.

<sup>991</sup> Transport Accident Commission, Submission no. 50, 8.

<sup>&</sup>lt;sup>992</sup> David Ranson, Submission no. 19, 38.

could refer to when conducting investigations into deaths in custody. 993 The Coroner's Office did not provide a response to this question. However, the State Coroner advised the implementation review in 2005 that he had not implemented this recommendation because 'protocols were not seen as appropriate'. 994

All other stakeholders who responded endorsed this RCADC recommendation. 
Associate Professor Ranson told the Committee that, while he believed that the Coroner's Office had in the past shown a high level of investigative control in relation to deaths in custody, he acknowledged that there may be the perception that the coronial supervision of investigations was limited. 
According to Associate Professor Ranson:

Enshrining in legislation key elements of an investigation into a death in custody may ensure that whoever is appointed as a coroner or State Coroner in the future will continue to apply a high standard of investigative supervision in relation to deaths in custody.<sup>997</sup>

Former coroner Ms Heffey submitted that she could see no difficulty with a provision in the Act specifically requiring coroners to have regard to the RCADC recommendations. She agreed with Associate Professor Ranson that in her experience:

all deaths in custody, in Melbourne at least, whether in police custody or under the Office of Corrections, are conducted thoroughly and in line with the recommendations proposed.<sup>998</sup>

She indicated that she had one qualification to her support for the provision requiring coroners to have regard to the recommendations:

I have some difficulty with Recommendation 35 (b) and (c). I do not believe that a coroner should be required to inquire into the lawfulness of the custody in circumstances in which a magistrate has ordered it (for example by refusing bail). Provided the custody involved the decision of individual police officers to place a person in custody (as opposed to a magistrate refusing bail), I

<sup>&</sup>lt;sup>993</sup> Royal Commission into Aboriginal Deaths in Custody, *National Report* (1991), vol 1; Recommendation 8.

<sup>&</sup>lt;sup>994</sup> Victorian Implementation Review of the Recommendations from the Royal Commission into Aboriginal Deaths in Custody, Review Report, Vol. 1, 2005, 463. The Committee has not been able to obtain a copy of the State Coroner's submission to the Review and is therefore unable to establish whether the State Coroner provided reasons as to why he thought protocols were inappropriate. In its report, the Implementation Review Team asked the State Coroner to elaborate on this response: Recommendation 79, 497.

<sup>&</sup>lt;sup>995</sup> Victorian Aboriginal Legal Service, *Submission no. 57*, 2–3; David Ranson, *Submission no. 19*, 38–40; Health Services Commissioner, *Submission no. 62*, 6–7; Disability Discrimination Legal Service, *Submission no. 29*; Jacinta Heffey, *Submission no. 33*, 4. Ms Heffey indicated that she had difficulty in relation to one recommendation. This is discussed further in this section.

<sup>996</sup> David Ranson, Submission no. 19, 40.

<sup>&</sup>lt;sup>997</sup> Ibid.

<sup>&</sup>lt;sup>998</sup> Jacinta Heffey, Submission no. 33, 15.

do not see any difficulty here. With these provisos, I foresee no difficulties with coroners in Victoria being required to have regard to these recommendations when investigating a death in custody of an aboriginal person. 999

On the other hand, DDLS told the Committee that a coroner should be required to investigate how a person came to be in prison and the appropriateness of that imprisonment. Such investigation was necessary, according to DDLS, because it would enable a coroner to assess the shortcomings of the justice system and community services. 1000

#### Discussion and conclusion

The Committee considers that there is a demonstrated need for the State Coroner to develop comprehensive investigation standards and guidelines in line with the statutory function of the office. The lack of guidelines or standards reduces the coronial system's ability to secure evidence and identify practices or procedures which may have caused a death. The Committee notes with some concern the absence of guidelines in relation to the investigation of deaths in custody. The case example provided by Mr Singh clearly demonstrates that there is an urgent need for guidelines to be developed.

A consistent state-wide death investigation system which promotes a best practice approach can only be achieved by providing coroners with relevant investigation standards and practical guidance on how to manage different kinds of death investigations. In this regard, the Committee endorses the comments made by Associate Professor Ranson that a strategic approach to the development of death investigation guidelines is needed.

The Committee agrees with Ms Heffey that the approach adopted in Queensland regarding the development of comprehensive guidelines is a best practice approach which should be adopted in Victoria. Similarly, the Committee considers that, as in Queensland, the Act should require coroners to have regard to the RCADC recommendations relating to the investigation of deaths in custody. The Committee notes Ms Heffey's concern regarding recommendation 35 — that she considers it inappropriate for coroners to investigate the lawfulness of the custody. However, the Committee considers that the words 'have regard to' require a coroner only to consider the recommendations. They do not require a coroner to necessarily apply the recommendations where a coroner considers that a particular recommendation is in the circumstances inappropriate. 1001

<sup>&</sup>lt;sup>999</sup> Ibid 15-16.

<sup>&</sup>lt;sup>1000</sup> Disability Discrimination Legal Service, Submission no. 29, 8.

<sup>&</sup>lt;sup>1001</sup> See for example D C Pearce and R S Geddes, Statutory Interpretation in Australia (6<sup>th</sup> ed, 2006) 364: The phrase 'have regard to' 'has been consistently interpreted to mean that a decision-maker must take account the matter to which regard is to be had and give weight to it as a fundamental element in making the decision. The

Recommendation 46. That the *Coroners Act 1985* be amended to provide that:

- a) in order to ensure best practice in the coronial system, the State Coroner must issue guidelines to all coroners about the performance of their functions in relation to investigations generally;
- b) when preparing the guidelines, the State Coroner must have regard to the recommendations of the Royal Commission into Aboriginal Deaths in Custody that relate to the investigation of deaths in custody;
- c) when investigating a death, a coroner must comply with the guidelines issued to the coroner to the greatest extent practicable.

Recommendation 47. That the guidelines outlined in Recommendation 12 be made available to the public and be available on the Coroner's Office website.

Recommendation 48. That the State Coroner's annual report contain all guidelines which were in operation during that year.

Recommendation 49. That the proposed Coroner's Advisory Council assist the State Coroner to develop guidelines and standards.

## Training for coroners

The Act does not require the State Coroner to implement a training programme for newly appointed coroners, nor does it require a coroner to undertake a training programme before being appointed as a coroner.

In 2004 and 2005 the Sir Zelman Cowen Centre at Victoria University in Melbourne hosted two training sessions for coroners. Topics at the one-day training session in 2005 included death investigation training, report writing and ethics for coroners. The next training programme is scheduled for 2007. 1003

In June 2006, the Attorney-General Rob Hulls requested that Crown Counsel Dr John Lynch conduct a review into options for compulsory continuing education for judges and magistrates.<sup>1004</sup> The review is expected to be completed later in 2006. In a recent letter to the Committee from the Department of Justice it indictated that discussions

weight to be given the matter, is however, for the decision-maker to determine, provided that the consideration of the matter is genuine'.

<sup>&</sup>lt;sup>1002</sup> 'Papers and Presentations 2005 — Coroners Training Programme'. Available at www.businessandlaw.vu.edu.au.

<sup>&</sup>lt;sup>1003</sup> Email, Sue Marshall, Business Manager, Sir Zelman Cowen Centre, Victoria University, to Legal Research Officer, 13 July 2006.

<sup>&</sup>lt;sup>1004</sup> Attorney-General Rob Hulls, 'Judges' Training a Boost to the Justice System: Hulls' (Press release, 12 June 2006). Available at www.dpc.vic.gov.au.

have begun with the Judicial College of Victoria about the development of further training opportunities for magistrates and coroners.<sup>1005</sup>

## **Evidence received by the Committee**

The discussion paper asked stakeholders if all newly appointed coroners, including rural coroners, participated in training. Responses from stakeholders indicated that such training was limited and that some coroners did not attend training. While the Coroner's Office submission did not provide a direct response, the State Coroner told the Committee that a number of rural coroners had attended two training courses. 1006

Associate Professor Ranson advised the Committee that he taught at the training courses and that many coroners did not attend the programme. In his view, it is preferable that potential coronial appointees undertake training, perhaps as a prerequisite for appointment as a coroner. Ms Heffey expressed concern with the level of training currently provided to rural coroners and relieving magistrates on circuits to rural and regional Victoria, describing it as inadequate.

The Coroner's Office acknowledged that more intensive training was required, given that the death investigation system required specialist skills. 1009 According to the submission:

it is becoming increasingly difficult for magistrates who have not worked regularly as coroners or have not had specific training in relation to coronial work to perform some of the specialist coronial functions. While recognising the value of professional development and training, that of itself is not the sole answer, as it takes many years to develop the necessary experience and understanding of the coronial jurisdiction.<sup>1010</sup>

A number of stakeholders also considered the issue of who should be responsible for providing training for coroners. The Health Services Commissioner thought that training could be provided through the Australian Institute of Judicial Administration, while VIFM considered that the State Coroner should oversee the training of all coroners.<sup>1011</sup> The Coroner's Office submission did not indicate who it considered should be responsible for training.

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<sup>&</sup>lt;sup>1005</sup> Department of Justice, *State Coroner's Office Improvement Project – Briefing for Victorian Parliament Law Reform Committee*, August 2006.

<sup>&</sup>lt;sup>1006</sup> Graeme Johnstone, *Minutes of Evidence*, 19 September 2005, 82.

<sup>1007</sup> David Ranson, Submission no. 19, 38.

<sup>&</sup>lt;sup>1008</sup> Jacinta Heffey, Submission no. 33, 14–16.

<sup>1009</sup> State Coroner's Office, Submission no. 70, 99.

<sup>&</sup>lt;sup>1010</sup> Ibid 100.

<sup>&</sup>lt;sup>1011</sup> Health Services Commissioner, *Submission no. 62*, 5; Victorian Institute of Forensic Medicine, *Submission no. 40*, 37.

#### Discussion and conclusion

The Committee notes that in recent years there has been an increased emphasis on the need for judicial training. Stakeholders in this inquiry have also recognised the need for coroners to undertake formal training in areas relevant to this increasingly specialised jurisdiction. Currently it is a statutory function of the State Coroner to provide guidelines for coroners. The Committee is of the view that it should also be a statutory function of the State Coroner to provide training to coroners. The structure of the training could be informed by the proposed Coronial Council (discussed in chapter nine) and the review currently being undertaken by the Victorian Crown Counsel.

Given that attendance at training is not mandatory, the Committee also considers that the State Coroner and the Chief Magistrate should work together to support and encourage coroners, and magistrates who act as coroners, to take advantage of the training opportunities available to them.

Recommendation 50. That the *Coroners Act 1985* be amended to provide that:

- a) it is a statutory function of the State Coroner to provide training to coroners.
- b) as part of the State Coroner's annual report, the State Coroner must provide a report indicating the training that coroners have attended during that year.

Recommendation 51. That the State Coroner and the Chief Magistrate work together to support and encourage coroners, and magistrates who act as coroners, to take advantage of the training opportunities available to them.

# Inquests

An inquest is a public hearing into the death of a person.<sup>1012</sup> According to the Coroner's Office, coroners complete over 90 percent of reported cases without holding an inquest.<sup>1013</sup> In these cases, the coroner's investigation is completed when the coroner delivers a written statement on the cause of death. The Coroner's Office refers to a finding made without an inquest as a chambers finding.

Details of where an inquest will take place must be published in a newspaper 14 days before the inquest unless the State Coroner directs that this not take place. <sup>1014</sup> The Coroner's Office also publishes details of upcoming inquests on its website.

In Melbourne, coroners hold inquests at the Coronial Services Centre at Southbank. The physical layout of the inquest hearing rooms in Melbourne is that of a traditional

<sup>&</sup>lt;sup>1012</sup> While inquests are usually held in public, a coroner also has the power to exclude members of the public from the inquest: *Coroners Act 1985* s 47(1).

<sup>&</sup>lt;sup>1013</sup> State Coroner's Office, Submission no. 70, 137.

<sup>&</sup>lt;sup>1014</sup> Coroners Act 1985 s 42.

formal courtroom — the Coroner sits at an elevated bench at the centre of the room and witnesses usually give evidence from a witness box. In rural and regional Victoria, coroners hear inquests at local Magistrates' Courts where criminal and civil trials take place.

## Purpose of an inquest

The purpose of an inquest is not defined in the Act. In the review of the *Coroners Act* (1958) in 1981, the Norris review considered that an attempt to determine the purpose of an inquest may help to indicate when a discretionary inquest is and is not necessary. Dame Janet Smith examined this issue in the Shipman Inquiry. She considered that the UK Act also did not clearly state the purpose of an inquest and referred to the coroners who gave evidence at that inquiry that there was a need for the purpose to be stated in the Act. She observed that:

the fact that the inquest had no defined purpose which the public can understand leads to difficulty and unrealistic expectations. 1017

Various commentators, including Dame Janet Smith along with stakeholders in this inquiry have identified the following purposes of an inquest:

- 1. To set the public mind at rest where there are unanswered questions about a reportable death; 1018
- 2. To conduct a public investigation into deaths which have or might have resulted from an unlawful act;1019
- 3. To provide public scrutiny of those deaths that occur in circumstances in which there exists a possibility of an abuse of power;<sup>1020</sup>
- 4. To improve the quality of the investigation where the facts around the death are unclear; 1021
- 5. To generate publicity which may result in further information about a death; 1022

<sup>&</sup>lt;sup>1015</sup> John Norris, *The Coroners Act 1958- A General Review* (1981) 70. The Norris review referred to five grounds of public interest which the Brodrick Committee identified in United Kingdom, *Report of the Committee on Death Certification and Coroners* (1971) Cm 4810 14.19-14.24.

<sup>&</sup>lt;sup>1016</sup> United Kingdom, The Shipman Inquiry Third Report: *Death Certification and the Investigation of Deaths by Coroners* (2003) Cm 5854, 213.

<sup>&</sup>lt;sup>1017</sup> Ibid 214.

<sup>&</sup>lt;sup>1018</sup> Domaszewicz v The State Coroner (2004) 11 VR 237.

<sup>&</sup>lt;sup>1019</sup> United Kingdom, The Shipman Inquiry Third Report: *Death Certification and the Investigation of Deaths by Coroners* (2003) Cm 5854, 215.

<sup>&</sup>lt;sup>1020</sup> Ibid.

<sup>&</sup>lt;sup>1021</sup> Coroner's Office, Victoria, "State Coroner's Guidelines: when to hold an inquest", 1 June 2003.

- 6. To test the credit of witnesses including their demeanour;1023
- 7. To provide a forum for natural justice because issues of fairness require a hearing to clarify facts, where a coroner may be critical of a party, or where an inquest may provide a reasonable opportunity for a party to present an explanation of how an incident occurred;<sup>1024</sup>
- 8. To enable interested parties to participate in the process and to suggest preventative measures and systemic improvements or other recommendations that may be deemed useful; 1025
- 9. To inform interested bodies and the public at large about deaths which give rise to issues relating to public health and safety and the prevention of avoidable death and injury.<sup>1026</sup>

## Evidence received by the Committee

lan Freckelton asked the Committee to consider whether the Act should set out more extensively the purposes of the holding of inquests. He also asked that the Committee consider the issue of:

recognising the utility and social advantage in inquiries and inquests being held to facilitate the avoidance of avoidable deaths in the future. 1028

#### Discussion and conclusion

The Committee believes that by clearly stating the purposes of an inquest in the Act, coroners, family members and the community will have a better understanding of why an inquest is or is not taking place. A person who is dissatisfied with the decision of a coroner not to hold an inquest, will also be in a more informed position as to whether s/he should appeal against that decision.

The Committee considered what purposes should be stated in the Act. After examining those suggested by both stakeholders and other commentators outlined above, the Committee concludes that there are three major purposes which should be stated in the Act.

<sup>&</sup>lt;sup>1022</sup> Ihid

<sup>&</sup>lt;sup>1023</sup> Stephen Cordner, Victorian Institute of Forensic Medicine, Minutes of Evidence, 19 September 2005, 130.

<sup>&</sup>lt;sup>1024</sup> State Coroner's Office, Submission no. 70, Appendix C, Ivii-Ix.

<sup>&</sup>lt;sup>1025</sup> Jacinta Heffey, Submission no. 33, 17-18.

<sup>&</sup>lt;sup>1026</sup> United Kingdom, The Shipman Inquiry Third Report: *Death Certification and the Investigation of Deaths by Coroners* (2003) Cm 5854, 215.

<sup>&</sup>lt;sup>1027</sup> Ian Freckelton, Minutes of Evidence, 20 September 2005, 207.

<sup>&</sup>lt;sup>1028</sup> Ibid.

The first purpose of an inquest is to provide public accountability for deaths occurring in contentious circumstances which demand that the investigation takes place in public. This incorporates the first three purposes in the list above. The second purpose of an inquest is an evidentiary purpose—to provide a superior method of eliciting and challenging evidence. This covers points four to seven above. The third purpose relates to the preventative and educative function of the jurisdiction. The inquest acts as a forum at which interested persons can contribute to the shaping of coronial recommendations aimed at preventing similar deaths. This has been recognised both in Victoria and in the UK and is referred to above at points eight and nine.

Recommendation 52. That the *Coroners Act 1985* be amended to provide that the purposes of an inquest are:

- a) to conduct a public investigation into a death which occurred in contentious circumstances in order to provide public accountability for the death;
- b) to provide an effective mechanism for eliciting and challenging evidence; and
- c) to provide a forum for interested persons to contribute to the development of coronial recommendations for the prevention of similar deaths.

## Scope of an inquest

In the Act the jurisdiction of a coroner to investigate a death is set out in section 15, which requires the investigation of all reportable deaths, and in section 15A in relation to reviewable deaths. The jurisdiction to hold an inquest is covered in section 17. The scope of both investigations and inquests is limited by section 19 which sets out what findings and comments a coroner may make.

- (1) A coroner investigating a death must find if possible-
  - (a) the identity of the deceased;
  - (b) how death occurred; and
  - (c) the cause of death; and

. . .

(2) A coroner may comment on any matter connected with the death including public health and safety or the administration of justice.

#### Case law and research

There is considerable case law which has considered the correct application of section 19. In *Commissioner of Police v Hallenstein*, Hedigan J commented:

A distinction is drawn between necessary findings and optimal comment. Section 19(1) is the charter for necessary findings. The findings defined ... are concerned with those findings historically essential to the discharge of the coroner's task, namely, identity of the deceased, contributors to the death, and the manner and cause of death. The scheme of the balance of the section is to confer on the coroner the freedom to comment about matters connected with the death, including public health and safety of the administration of justice. <sup>1029</sup>

In the case of *Harmsworth v State Coroner*, Nathan J comments:

A coroner's source of power of investigation arises from the particular death or fire. A coroner does not have general powers of enquiry or detection... the enquiry must be relevant, in the legal sense to the death or fire; this brings into focus the concept of 'remoteness'. 1030

These cases have established that the scope of an inquest is essentially to determine the matters set out in section19 (1), and that the power to comment contained in section 19(2) must be ancillary to, and relevant to, those matters.

The scope of an inquest would ideally be established at an early stage of the inquest and this is currently often what is done in practice.

#### Freckelton and Ranson comment:

Legal argument about matters such as the evidence to be adduced, and the scope of the inquiry, can form part of this early phase of an inquest proper. It is possible for a coroner to adjourn an inquest at any time for further investigations to be undertaken, and such adjournment may be for considerable periods of time. Occasionally a coroner will commence an inquests hearing within a day or so of a death and then adjourn the matter for several months for ongoing investigation. Such a procedure amounts to a virtual pre-hearing. It highlights the role of an inquest as an ongoing investigation. 1031

#### Queensland Coroner Act 2003

In Queensland, unlike other Australian jurisdictions, this procedure has been formalised in the *Coroners Act 2003*.

- 34 Pre-inquest conferences
- (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

<sup>1030</sup> [1989] VR 989, 996.

<sup>&</sup>lt;sup>1029</sup> [1996] 2 VR 1, 3.

<sup>1031</sup> Ian Freckelton and David Ranson, Death Investigation and the Coroner's Inquest (2006) 550.

- (ii) who may appear at the inquest; or
- (iii) which witnesses will be required at the inquest; or
- (iv) what evidence 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;16 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.

#### Discussion and conclusion

The Committee received little evidence in relation to problems or otherwise in determining the scope of inquests, other than in relation to the issue of expanding the preventative role of coroners. It could be argued that its recommendations contained in chapters seven and eight of this report to include as purposes of the Act: preventing deaths in similar circumstances from occurring in the future; and the accommodation of the needs of families and other associated with a death which is the subject of a coronial inquest, may have the effect of expanding the scope of an inquest.

As a matter of statutory interpretation a purpose or objects clause cannot change the clear language of a provision, however it may be used to assist in interpreting legislation.<sup>1032</sup>

Hence to ensure clarity and the efficient use of court time and resources, the Committee considers that the Queensland legislation would be a useful model to follow, and recommends such an amendment to the Act.

Recommendation 53. That the *Coroners Act 1985* be amended to include a provision modelled on the Queensland *Coroners Act 2003*, section 34, which allows a coroner to hold, and require attendance at, a pre-inquest conference.

# Mandatory inquests

The Act requires coroners to hold inquests for certain kinds of deaths which are connected with Victoria. Inquests are mandatory where:

<sup>&</sup>lt;sup>1032</sup> D C Pearce and R S Geddes, Statutory Interpretation in Australia (6<sup>th</sup> ed, 2006) 154-5.

<sup>&</sup>lt;sup>1033</sup> Coroners Act 1985 s 17(1): the body of the person who has died must be in Victoria, or it must appear to the Coroner that the death or the cause of the death occurred in Victoria.

- the Coroner suspects homicide; 1034
- the person who died was, immediately before death, a person 'held in care'; 1035
- the identity of the person who died is not known;<sup>1036</sup>
- the death occurred in 'prescribed circumstances';1037
- the Attorney-General or the State Coroner directs a coroner to hold an inquest, 1038 or
- the Supreme Court makes an order that an inquest take place.<sup>1039</sup>

## **Mandatory inquests in other Australian jurisdictions**

Inquests into certain deaths are mandatory in all jurisdictions, but the kinds of deaths which must be investigated at an inquest vary in each jurisdiction. In all Australian jurisdictions, including Victoria, all deaths in care or custody must be investigated at an inquest. <sup>1040</sup> In five of the eight jurisdictions, including Victoria, an inquest is mandatory where the Coroner suspects that a death may be due to homicide. <sup>1041</sup> Only two other jurisdictions besides Victoria require an inquest to be held where the identity of the person who has died has not been established. <sup>1042</sup>

An inquest is mandatory in the ACT when a person has been found drowned, dies in suspicious circumstances, or dies a sudden death, the cause of which is unknown. An inquest must also be held where a person dies after an accident where the cause

<sup>&</sup>lt;sup>1034</sup> Coroners Act 1985 s 17(1)(a). This is subject to section 17(3), which is discussed later in this chapter. A coroner with jurisdiction must hold an inquest, except if the Coroner makes a determination under s 17(3) not to hold an inquest.

<sup>&</sup>lt;sup>1035</sup> Coroners Act 1985 s 17(1)(b). The definition of 'in care' is discussed in chapter four.

<sup>&</sup>lt;sup>1036</sup> Coroners Act 1985 s 17(1)(c).

<sup>&</sup>lt;sup>1037</sup> Coroners Act 1985 s 17(1)(d). The Coroners Regulations 1996 do not currently list any prescribed circumstances.

<sup>&</sup>lt;sup>1038</sup> Coroners Act 1985 s 17(1)(e), (f).

<sup>&</sup>lt;sup>1039</sup> Coroners Act 1985 s 18(3).

<sup>&</sup>lt;sup>1040</sup> Coroners Act 1997 (ACT) s 13(1); Coroners Act 1993 (NT) s 15(1); Coroners Act 1980 (NSW) s 14B(1); Coroners Act 2003 (Qld) s 27; Coroners Act 2003 (SA) s 21(1); Coroners Act 1985 (Vic) s 24(1).

<sup>&</sup>lt;sup>1041</sup> Coroners Act 1997 (ACT) s 13(1); Coroners Act 1980 (NSW) s 14B(1)(a); Coroners Act 1995 (Tas) s 24(1); Coroners Act 1996 (WA) s 22(1).

<sup>&</sup>lt;sup>1042</sup> Coroners Act 1993 (NT) s 15(1); Coroners Act 1995 (Tas) s 24(1).

<sup>&</sup>lt;sup>1043</sup> Coroners Act 1997 (ACT) s 13(1)(b)-(d).

of death appears to be directly attributable to the accident or if the person dies and has not seen a doctor for three months before his or her death.<sup>1044</sup>

In both the ACT and New South Wales, unlike all other jurisdictions, coroners must hold inquests for certain kinds of deaths which occur during or after specified medical procedures. <sup>1045</sup> In New South Wales there are also other categories of deaths in which an inquest is mandatory. Inquests are mandatory where it appears to the Coroner that the manner and cause of the person's death has not been sufficiently disclosed or where it has not been sufficiently disclosed that the person has died. <sup>1046</sup>

## Law reform agencies

#### **RCADC**

In 1991 RCADC emphasised the importance of holding a public inquest in relation to every death in custody:

Only a public inquiry in the form of an inquest can present the opportunity for the ventilation of all relevant facts, for any suspicions to be aired and for the evidence to be tested. It is of great importance that the family of the deceased should be confident that such an opportunity will always be available to allay any anxiety or fears which they may have concerning the circumstances of death. A mandatory coronial inquest into every death in custody should be an elementary guarantee offered by the Australian legal system: justice must not only be done, it must be seen to be done.<sup>1047</sup>

## Human rights law

Since the *Human Rights Act 1998* (UK) was enacted in 2000, the UK Government has been required to conduct 'an effective investigation' into the death of a person who was in the custody of the state at the time of death. This is because the *Human Rights Act* requires UK courts and tribunals to give effect to the rights contained in the European Convention of Human Rights (the Convention), including the right to life. Under the Convention, the state has a positive obligation to protect life. As a consequence of that right, there is a procedural obligation to effectively investigate every death in the custody of the state where there may have been a breach of the obligation to protect life. In *R (Khan) v Health Secretary*, the Court of Appeal (Brooke, Waller and Clarke LJ) interpreted the article 2 procedural obligation as follows:

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<sup>&</sup>lt;sup>1044</sup> Coroners Act 1997 (ACT) s 13(h), (g).

<sup>&</sup>lt;sup>1045</sup> Coroners Act 1997 (ACT) s 13(1)(e); Coroners Act 1980 (NSW) s 14C.

<sup>&</sup>lt;sup>1046</sup> Coroners Act 1980 (NSW) s 14B(c), (d).

<sup>&</sup>lt;sup>1047</sup> Royal Commission into Aboriginal Deaths in Custody, *National Report* (1991), vol 1; 4.5.56.

<sup>&</sup>lt;sup>1048</sup> Paul Matthews, *Jervis on Coroners* (12th ed, 2002) 21-05.

<sup>&</sup>lt;sup>1049</sup> European Convention of Human Rights, 1950, article 2.

Where agents of a state bear potential responsibility for the loss of a human life, the state should provide a procedural mechanism whereby the cause of death may be investigated, and responsibility for the death ascertained, through an investigation held in public which must be both judicial and effective. <sup>1050</sup>

A legal opinion for the Luce Report in 2003 advised that inquiry that, in order for coroners to comply with the Convention rights, a full inquest should be conducted in relation to every death in custody or care of the state:

There are certain categories of death, such as deaths in custody, or where the deceased is particularly dependent on the care of others, where an obligation to hold an inquiry would be necessary in order to achieve proper accountability and transparency, regardless of the evidence of how the deceased died. Therefore, we would recommend that all forms of custodial death and situations where law enforcement agencies are involved in the circumstances surrounding the death should be subject to a full inquest as is currently the case. <sup>1051</sup>

In Victoria the *Charter of Human Rights and Responsibilities Act 2006* (the Charter) comes into operation on 1 January 2007, with some sections commencing on 1 January 2008. The Charter establishes a charter of human rights which may have an impact on the way deaths are required to be investigated under the Act. The main purpose of the Charter is to protect and promote human rights by, inter alia, imposing an obligation on all public authorities to act in a way that is compatible with human rights. Like the *Human Rights Act 1998* (UK), the Charter establishes the right to life. The Charter sets up a mechanism by which it will be a requirement that a statement of compatibility with human rights be tabled before the second reading speech for any bill. Any incompatibility must be identified and the nature and extent of the incompatibility must be stated. When the Charter comes into effect, any proposed amendments to the *Coroners Act 1985* will be subject to this regime.

### Evidence received by the Committee

The discussion paper asked stakeholders if there were any issues with the current categories of death for which an inquest must be held.

Two stakeholders questioned whether any category of death should attract a mandatory inquest. Ms Heffey considered that a coroner should have the discretion in

<sup>&</sup>lt;sup>1050</sup> R (Khan) v Health Secretary [2003] EWCA Civ 1129.

<sup>&</sup>lt;sup>1051</sup> United Kingdom, *Death Certification and Investigation in England, Wales and Northern Ireland: The Report of a Fundamental Review*, Cm 5831 (2003) Volume 2, Report 3 - Counsel on the compliance of Coroner's Courts with the European Convention of Human Rights 19.

<sup>&</sup>lt;sup>1052</sup> Charter of Human Rights and Responsibilities Act 2006 s 1(2).

<sup>&</sup>lt;sup>1053</sup> Charter of Human Rights and Responsibilities Act 2006 s 1(2).

<sup>&</sup>lt;sup>1054</sup> Charter of Human Rights and Responsibilities Act 2006 s 9.

<sup>&</sup>lt;sup>1055</sup> Charter of Human Rights and Responsibilities Act 2006 s 28.

every case to consider if an inquest is necessary, while forensic pathologist Dr Shelley Robertson referred to an inquest as a time and expense consuming exercise which needed to be justified on a case-by-case basis.<sup>1056</sup>

The Committee did not agree that the Coroner's discretion should be completely unfettered, as public accountability considerations require that certain deaths should always be subject to a public inquiry. A mandatory provision removes any risk of perceived bias in decisions not to investigate deaths which occur in particular circumstances, particularly deaths occurring in the care of the state.

## Mandatory inquests for deaths in custody and care

The Coroner's Office and Victoria Police submitted that there should not be mandatory inquests in relation to deaths in custody or care where it appears that the death was due to natural causes. <sup>1057</sup> This was also the view of Dr Robertson, who told the Committee that:

I do not see why, for example, where someone who is in care but has a documented history of heart disease and one day clutches his chest and falls to the floor should attract an inquest, when it is fairly obvious that the cause of death is ischaemic heart disease, unless there are other circumstances which would necessitate an inquest.<sup>1058</sup>

Ms Heffey agreed with this view. She told the Committee that it was preferable that an inquest not be required where the preliminary investigation revealed that the person had died from natural causes.<sup>1059</sup> According to Ms Heffey:

The purpose of such an investigation would be towards determining whether the deceased, a person whose autonomy by definition had been reduced, had received timely and adequate medical care. I see no value in running an inquest when no issue arises in this respect. They are rarely attended by family members and, if they do attend, there is so little material before the court that the hearing is concluded within five minutes. 1060

At the public hearings, the State Coroner advised the Committee that the rationale for restricting the categories in which inquests were mandatory was based on resources. However, Associate Professor Ranson cautioned against a resource-based approach used as the criteria to determine whether an inquest should take place. In his personal submission, Associate Professor Ranson was critical of a resource based approach, stating that:

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<sup>&</sup>lt;sup>1056</sup> Jacinta Heffey, Submission no. 33, 17–18; Shelley Robertson, Minutes of Evidence, 5 December 2005, 312.

<sup>1057</sup> State Coroner's Office, Submission no. 70, 138; Victoria Police, Submission no. 78, 6.

<sup>&</sup>lt;sup>1058</sup> Shelley Robertson, *Minutes of Evidence*, 5 December 2005, 312.

<sup>&</sup>lt;sup>1059</sup> Jacinta Heffey, Submission no. 33, 17–18.

<sup>&</sup>lt;sup>1060</sup> Ibid.

<sup>&</sup>lt;sup>1061</sup> Graeme Johnstone, Minutes of Evidence, 19 September 2005, 85.

should there be any risk that coroners in the future would feel it necessary to restrict the number of inquests due to financial constraints then the current categories of mandatory inquests should be maintained. 1062

Professor Stephen Cordner, Director of VIFM, considered that it would be a backward approach to limit the kinds of death in custody cases in which an inquest was mandatory. Professor Cordner told the Committee that:

It was interesting to see in the submission from the State Coroner's Office a recommendation that natural deaths in custody not be subject to an inquest. Personally, that is a direct contradiction to recommendations 11 and 12 of the report of the Royal Commission into Aboriginal Deaths in Custody. I was quite surprised to see it there. For those who die in custody from whatever cause there will be at least one relative who thinks the person was murdered. The ability to eyeball the officers and those involved with the custodial institution to see how they answer questions, to have the opportunity to ask the question themselves, I would have thought was a given in what our coronial system was there for—for families to have that sort of opportunity.<sup>1063</sup>

This view was supported by Professor David Wells, Head of Clinical Forensic Medicine at VIFM, who advised the Committee that he has been involved in developing a training program for doctors who practice custodial medicine. Professor Wells told the Committee that:

One would have to say that the service across the country has a considerable way to go to get to the same standard one would be able to access if one were outside the custodial system; so not only in quality of medical services but also in access to medical services and information there is a considerable distance to travel. The concept of having a natural death in custody being exposed to the sort of investigation that we currently have can only benefit in continuing that process much further. 1064

VALS considered that an Indigenous death in custody which authorities may have assumed to be from natural causes requires inquisitorial scrutiny to determine whether it was entirely due to natural causes. Mr Mike Zaccaro, a solicitor at VALS, told the Committee about the recent death of a client in custody to illustrate to the Committee the issues involved in conclusively determining whether a death was from natural causes:

Before [VALS client] went in [to custody] he was diagnosed with pancreatitis and an alcoholic problem, but from the information that has been passed to me he was given Panadol Forte. There will be questions asked as to how he died. Natural causes, a pancreatic problem, but why was he given the medication et cetera? The internal system may do its investigation and come

<sup>&</sup>lt;sup>1062</sup> David Ranson, Submission no. 19, 46.

<sup>&</sup>lt;sup>1063</sup> Stephen Cordner, Victorian Institute of Forensic Medicine, *Minutes of Evidence*, 19 September 2005, 130.

<sup>&</sup>lt;sup>1064</sup> David Wells, Victorian Institute of Forensic Medicine, *Minutes of Evidence*, 19 September 2005, 130.

<sup>&</sup>lt;sup>1065</sup> Greta Jubb, *Minutes of Evidence*, 5 December 2005, 294.

out with natural causes, but what is natural? You have to then ask the family members who know of his past condition and history and who visit him in prison, and that may require the inquisitorial process.<sup>1066</sup>

Other witnesses also considered that there was an ongoing need for all in-care deaths to be investigated at a public inquest. For example, Ms Caroline Storm told the Committee that all mental health patient suicide deaths should continue to be investigated at public inquests. She submitted that, when such deaths are investigated in a public forum, it may attract media scrutiny surrounding the suicide rate in this group of people. Ms Isabell Collins, Director, Victorian Mental Illness Awareness Council, told the Committee that in-care deaths should continue to be investigated at an inquest because she considered that there is an overall lack of rigour in the way the coronial system investigates in-care deaths. 1068

#### Discussion and conclusion

In considering whether every death in care should continue to be examined at inquest, the Committee considered the purpose of an inquest. These purposes were discussed earlier in this chapter. The Committee concluded that one of the purposes of an inquest is to ensure public accountability for deaths which occur in contentious circumstances. When a person dies in custody the death is by its very nature contentious because it occurs behind closed doors. It is therefore very important that these kinds of deaths are scrutinised in public to determine what did and did not cause them.

The importance of examining deaths in custody at inquest is recognised by all jurisdictions in Australia which currently require that any death in custody be examined at a mandatory inquest. The inquiry heard a considerable amount of evidence from a number of expert witnesses, including the Health Services Commissioner, VALS, the FCLC and Professor Wells, regarding the need for public scrutiny of the medical treatment available to persons who die in custody. The Committee therefore considers that all deaths in custody should continue to attract a mandatory inquest because there is a need for them to be scrutinised at a public inquiry to establish whether there are any issues associated with the medical management which may have caused the deaths.

Furthermore, the Committee is of the view that any amendment to the Act which changes the existing requirement that all deaths in custody be investigated at inquest may be inconsistent with the right to life identified in the *Charter of Human Rights and Responsibilities Act 2006*. This inconsistency will arise if the Charter is interpreted in the way the Convention has been interpreted in the UK, for example, to require that a coroner conduct an effective investigation into a death in custody at a public inquiry.

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<sup>&</sup>lt;sup>1066</sup> Mike Zaccaro, Minutes of Evidence, 5 December 2005, 294.

<sup>&</sup>lt;sup>1067</sup> Caroline Storm, Submission No. 25, 3.

<sup>&</sup>lt;sup>1068</sup> Isabell Collins, *Minutes of Evidence*, 19 September 2005, 97.

While inconsistency would not invalidate an amending Act, it is nevertheless clearly the intention of the Charter to ensure that incompatibility with human rights as defined in the Charter is kept to a minimum.

The Committee also considers that all deaths in care, whatever the presumed cause, should continue to be examined by the most thorough and public investigatory process and that the only way for this to occur is at an inquest. Dame Janet Smith concluded in the Shipman Inquiry that one of the purposes of an inquest is to provide public scrutiny of those deaths that occur in circumstances in which there exists a possibility of an abuse of power. The Committee agrees with that conclusion. Deaths in care which appear to result from natural causes should still continue to be examined at inquest, because any death occurring where a person has been deprived of their liberty or is dependent on the care of others needs to be examined in public to ensure a transparent review process.

## Mandatory inquests for suspected homicide deaths

An inquest is also mandatory for suspected homicide deaths.<sup>1069</sup> Ms Heffey submitted that, if an inquest into a homicide is to be mandatory, it should be limited to cases where the death or cause of death occurred in Victoria.<sup>1070</sup> Ms Heffey referred to the mandatory inquest she held into the death of a former Victorian resident, Max Green, who died in Cambodia in 1998. She told the Committee that this was an example of a case which did not warrant an inquest in Victoria:

His body was exhumed for an autopsy to take place to identify him so that Section 19 findings as to identity and cause of death could be made. Nobody had been charged with his murder and there were no known suspects. Short of bringing to Australia the investigating police from Cambodia, an inquest in Melbourne was never going to elucidate issues such as how the death occurred and who had killed him. A Chambers Finding, after investigation, would have sufficed, if even that was necessary.<sup>1071</sup>

Associate Professor Ranson made the comment that mandatory inquests in cases of suspected homicide may in practice appear to be illogical.<sup>1072</sup> However, in cases involving suspected homicide in which no offender has been identified, Associate Professor Ranson was of the view that most prudent coroners would convene an inquest to ensure that the most complete death investigation process was undertaken.

<sup>&</sup>lt;sup>1069</sup> Coroners Act 1985 s 17(1)(a).

<sup>&</sup>lt;sup>1070</sup> Jacinta Heffey, Submission no. 33, 17–18.

<sup>&</sup>lt;sup>1071</sup> Ibid.

<sup>&</sup>lt;sup>1072</sup> David Ranson, Submission no. 19, 46.

#### Discussion and conclusion

The Committee received very little evidence in relation to this issue. While it concludes that mandatory inquests should continue in relation to suspected homicide deaths, it notes the comments in relation to deaths occurring outside Victoria and suggests that this issue be considered further when the Act is amended. The Committee notes that jurisdictional issues associated with deaths occurring outside State or Territory boundaries are currently under consideration by the Standing Committee of Attorneys-General.<sup>1073</sup>

## Mandatory inquests to determine identity

Last, an inquest is mandatory where the identity of the person who died is not known.<sup>1074</sup> Ms Heffey submitted that, while an inquest may be the best way to generate public attention to establish the identity of an unknown person who has died, there is no reason for an inquest to be mandatory.<sup>1075</sup> No other stakeholder commented on this issue.

The inquest into Matthew Bibby, 1076 for which findings were handed down on 4 August 2006, as discussed earlier in this chapter, has focused attention on the need for improved practices between Victoria Police and the Coroner's Office in relation to missing persons and unidentified bodies. This follows a review by the OPI 1077 which investigated six cases where unidentified bodies had not been matched with missing person reports, resulting in the persons remaining unidentified for many years. Both the coronial findings and the OPI report make extensive recommendations for improved systems and better cooperation and coordination. The Committee has also made a recommendation that formal guidelines be established between the two agencies as to when a person reported missing to the police will be reported to the Coroner as a suspected death.

#### Discussion and conclusion

The Committee accepts that there may be other methods besides inquests by which the Coroner's Office may attract public attention in order to establish the identity of a person who has died. For example, in August 2005 Coroner Phil Byrne conducted a mandatory inquest into the death of an unidentified man who died in 2003. On the available evidence, the Coroner was unable to make a finding as to the man's

<sup>&</sup>lt;sup>1073</sup> Letter, Attorney-General Philip Ruddock to Committee Chair, 8 June 2005.

<sup>&</sup>lt;sup>1074</sup> Coroners Act 1985 s 17(1)(c).

<sup>&</sup>lt;sup>1075</sup> Jacinta Heffey, Submission no. 33, 17–18.

<sup>&</sup>lt;sup>1076</sup> Coroner's Case No. 3407/96.

<sup>&</sup>lt;sup>1077</sup> Office of Police Integrity, *Report on Victoria Missing Persons Investigations*, May 2006, as reported in Coroner's Case No. 3407/96.

<sup>&</sup>lt;sup>1078</sup> Coroner's Case No. 3072/03.

identity. The man's body was however identified after the Coroner's Office permitted a Victorian daily newspaper to publish a reconstructed colour photograph of the dead man's face. Following this publication, the man's former neighbours contacted police, and the Coroner's Office was then able to contact the man's relatives to confirm the man's identity.<sup>1079</sup> The Coroner re-opened the inquest in September 2005 and made a formal finding as to the man's identity.

Given the current deficiencies identified by the OPI report and the Bibby inquest in the practices for dealing with unidentified bodies, the Committee believes that inquests should remain mandatory. While not the only method available to the Coroner, they remain an important and powerful tool in identifying the bodies of unknown persons.

Recommendation 54. That the present categories of death investigations which attract mandatory inquests under the *Coroners Act 1985* be retained.

## Extension of current categories of mandatory inquests

While this question was included in the discussion paper, only two stakeholders provided comments, with one indicating that no extension was necessary. 1080

The TAC supported the extension of the categories to include mandatory inquests where a person dies after an accident where the cause of death appears to be directly attributable to the accident. According to the TAC, mandatory inquests may provide a better understanding of unknown systemic health care and personal care risks in the provision of long-term care to severely injured Victorians. The Committee understands these comments to relate to deaths which occur at a point in time significantly removed from the accident.

#### Discussion and conclusion

Based on the limited evidence provided, the Committee concludes that the proposed extension would be difficult to clearly delineate in legislation. It notes the existing discretionary power of the Coroner, discussed below, to undertake inquests where s/he considers it appropriate. The Committee believes that, rather than extending the categories, this discretionary power could be used in appropriate cases.

<sup>&</sup>lt;sup>1079</sup> Jo Chandler, 'The Mystery of 3072/03, the Body With No Name', *The Age* (Melbourne), 3 September 2005; Jo Chandler, 'The Lonesome Death of an Australian Everyman', *The Age* (Melbourne), 1 October 2005, 5.

David Ranson, *Submission no. 19*, 46. Associate Professor Ranson was of the view that there was little purpose to be served in extending the current categories of mandatory inquests. He told the Committee that an inquest was unlikely to result in new information about a death if a coroner was supported by specialist investigators and had access to reports and relevant witness statements.

<sup>&</sup>lt;sup>1081</sup> Transport Accident Commission, Submission no. 50, 10.

## Discretionary inquests

A coroner who has jurisdiction to investigate a death has the discretion to hold an inquiry if he or she believes it is 'desirable'. Also, any person may request a coroner to hold an inquest, provided that the coroner has jurisdiction to investigate the death. The State Coroner has issued guidelines to coroners on the kinds of cases in which coroners should hold an inquest. According to the guidelines, inquests should be held where:

a hearing is likely to improve the quality of the investigation (e.g. where the facts on the brief of evidence are unclear); or where publicity may result in additional information which might provide answers to the identity of the person who died, how the death occurred or the cause of death.

The guidelines state that a coroner should consider whether to hold an inquest where:

there is a localised or general public health or safety issue; or issues of fairness necessitate a hearing to clarify facts, where a coroner may be critical of a party, or where an inquest may provide a reasonable opportunity for a party to present an explanation of how an incident occurred.<sup>1085</sup>

In 2004–05, in approximately eight percent of Melbourne cases referred to the Coroner an inquest was held, while three percent of cases in rural and regional Victoria involved an inquest. The Committee was unable to establish the percentage of these cases which involved mandatory or discretionary inquests. This is because the Coroner's Office does not record this information on a case management system. 1087

#### Discretionary inquests in other Australian jurisdictions

In all jurisdictions a Coroner has a discretionary power to decide not to hold an inquest for certain death investigations. For instance, in the ACT a coroner may decide not to hold a hearing for certain categories of investigations if the cause and manner of the death are sufficiently disclosed and a hearing is unnecessary. A coroner in the ACT must not however dispense with a hearing if the coroner has

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<sup>&</sup>lt;sup>1082</sup> Coroners Act 1985 s 17(2).

<sup>&</sup>lt;sup>1083</sup> Coroners Act 1985 s 18(1).

<sup>1084</sup> State Coroner's Office, Submission no. 70, Appendix C, Ivii-Ix.

<sup>&</sup>lt;sup>1085</sup> Ibid

<sup>&</sup>lt;sup>1086</sup> Email, Sue Higgs, Principal Registrar, Coroner's Office, to Legal Research Officer, 18 July 2006.

<sup>&</sup>lt;sup>1087</sup> Sue Higgs advised that the statistical information could be provided but that it would involve a manual check of 4321 inquest files.

<sup>&</sup>lt;sup>1088</sup>Coroners Act 1997 (ACT) s 14(1); Coroners Act 1993 (NT) s 16(1); Coroners Act 1980 (NSW) s 14; Coroners Act 2003 (Qld) s 28; Coroners Act 2003 (SA) s 22(1)(a); Coroners Act 1996 (WA) s 22(2).

<sup>&</sup>lt;sup>1089</sup> Coroners Act 1997 (ACT) s 14(1).

reasonable grounds for believing that a person died in custody or as a result of or during an anaesthetic.<sup>1090</sup>

In Queensland the guidelines offer coroners the following advice:

The discretion to hold an inquest should be exercised with reference to the purpose of the Act and with regard to the superior fact finding characteristics of an inquest compared to the fault finding role of criminal and civil trials.<sup>1091</sup>

#### Law reform agencies

The Luce Report in England and Wales compiled a list of the kinds of deaths it considered should be investigated by inquest. <sup>1092</sup> In brief, they include the following:

- any traumatic workplace death in which industrial process or activity is implicated;
- any traumatic deaths occurring in public or commercial transport vehicles or vessels;
- any death of a child which the Coroner is unable to certify as being beyond reasonable doubt from natural disease without neglect or ill-treatment;
- any category of death reported where there is sufficient uncertainty or conflict of evidence over the cause or the circumstances of the death to justify the use of a forensic judicial process; and
- where there is a likelihood that a public judicial inquest will uncover important system defects or general risks not already known.

#### **Evidence received by the Committee**

In the discussion paper the Committee asked if there are any issues or concerns with the current criteria coroners use to determine if a discretionary inquest should be held. All stakeholders who commented on this issue indicated general support for the current criteria.

However, one stakeholder had a specific concern regarding the criteria used by rural and regional coroners to determine whether an inquest should be held. Former coroner Ms Heffey referred to what she regarded as the number of unnecessary inquests conducted in regional and rural Victoria. <sup>1093</sup> She told the Committee that she did not understand what criteria regional and rural coroners were using to determine

<sup>1091</sup> State Coroner's Guidelines — Version 0 December 2003. Paragraph 8.1.

<sup>&</sup>lt;sup>1090</sup> Coroners Act 1997 (ACT) s 14(2).

<sup>&</sup>lt;sup>1092</sup> United Kingdom, *Death Certification and Investigation in England, Wales and Northern Ireland: The Report of a Fundamental Review*, Cm 5831 (2003) 80.

<sup>&</sup>lt;sup>1093</sup> Jacinta Heffey, Submission no. 33, 17–18.

whether an inquest should be held, other than a 'misunderstanding of what is required to complete a coronial investigation'.<sup>1094</sup> Ms Heffey did however indicate that the explanation set out in the recently published *Coroners' Bench Book* was a useful guide for coroners to use when determining whether an inquest should be held.

Ms Heffey provided the Committee with a list of circumstances in which she considered an inquest should be held. According to Ms Heffey an inquest should be held:

- if there is no other way of receiving the information necessary to make the obligatory findings under section 19 of the Act;
- to test the evidence (both factual and expert) contained in the statements compiled as part of the coronial brief where this is deemed desirable for elucidation reasons;
- to require a person to give evidence who has refused to make a statement;
- to attempt to resolve factual conflicts in the evidence;
- to provide an opportunity for any party to cross-examine a witness whose evidence is critical of that party;
- to raise public awareness (or allay public concern) about issues of public health and safety and the administration of justice;
- to enable interested parties to participate in the process and to suggest preventative measures and systemic improvements or other recommendations that may be deemed useful.<sup>1095</sup>

Ms Wilson, Health Services Commissioner, supported the need for a coroner to have a discretionary power to decide not to hold an inquest. She told the Committee that:

Occasionally family members are so traumatised by a death they make unreasonable demands on agencies of accountability like the Coroner. A Coroner should have a discretionary power to hold or to dispense with holding inquests. This is particularly necessary where the Coroner is dealing with people who may be categorised as vexatious.<sup>1096</sup>

The Coroner's Office also referred to the need for coroners to be able to exercise the discretion where they consider that family members of the person who died have made unjustified demands for an inquest:

<sup>1095</sup> Ibid

<sup>&</sup>lt;sup>1094</sup> Ibid.

<sup>&</sup>lt;sup>1096</sup> Health Services Commissioner, Submission no. 62, 7–8.

Frequently, family members request an inquest in an attempt to use the coronial system as a further forum for acting out family conflicts and/or their general dissatisfaction with professional care of the deceased that is unrelated to their death.

The family requests are treated seriously but, when the evidence is complete or there is no relationship between their specific complaints and the death of their family member, the coroner may determine that there is nothing to be gained from an inquest. 1097

The Coroner's Office considered that the current arrangement, in which the decision whether to hold an inquest is determined by the investigating coroner according to the State Coroner's guidelines, should be retained.

Associate Professor Ranson indicated that he did not consider that there were any particular issues with the current criteria, advising the Committee that:

the sensitivity of coroners in Victoria to requests from parties with an interest in the death including the family for an inquest to be held usually means that such requests result in the coroner agreeing to an inquest. 1098

Maurice Blackburn Cashman agreed with Associate Professor Ranson that coroners are usually responsive to a request to investigate a death and hold an inquest where the firm's lawyers have raised issues of public interest associated with a death. 1099 Associate Professor Ranson also suggested that, if there was a need for greater clarity concerning the factors a coroner needed to consider in deciding whether to hold an inquest, this could be set out in the Act.

One stakeholder considered that the current criteria should be expanded. While the TAC indicated that it had no specific issues or concerns with the current criteria, it indicated its support for the Luce Report recommendation that traumatic deaths occurring in public or commercial transport vehicles be investigated at inquest. The TAC also submitted that:

Discretionary inquests might also be considered in circumstances where the Police Accident Investigation Unit or the survivors of an accident have issues about failures of safety components in a vehicle which is involved in an accident causing traumatic death. Examples might include malfunctioning airbags, unusual fires or seat failures.<sup>1101</sup>

Ms Heffey referred the Committee to an inconsistency in the Act:

<sup>&</sup>lt;sup>1097</sup> State Coroner's Office, Submission no. 70, 138–9.

<sup>&</sup>lt;sup>1098</sup> David Ranson, Submission no. 19, 47.

<sup>&</sup>lt;sup>1099</sup> Maurice Blackburn Cashman, Submission no. 42, 6.

<sup>&</sup>lt;sup>1100</sup> Transport Accident Commission, Submission no. 50, 10–11.

<sup>&</sup>lt;sup>1101</sup> Ibid 11.

In terms of the appeal process referred to in the question, the current discretion to hold an inquest is determined by whether the coroner "believes" it to be "desirable". The Supreme Court may order an inquest, on appeal, if "it is satisfied" that it "is necessary or desirable in the interests of justice". It is strange that the criteria are different. The coroner's discretion is subjective. The Appeal Court adopts an objective standard. <sup>1102</sup>

She told the Committee that she considered that the criteria for the Coroner's decision should be the same as the criteria applied by the Supreme Court.

Finally, one stakeholder, the Coroner's Office, submitted that a person's right of appeal to the Supreme Court following a coroner's refusal to hold an inquest should be removed. This is discussed in a later section of this chapter.

#### Discussion and conclusion

The Committee did not receive evidence that there are any major issues or concerns with the current criteria used to determine whether an inquest should be held, apart from the concern expressed by Ms Heffey that some rural and regional coroners did not seem to know when to convene an inquest. Earlier in this chapter the Committee discussed the purposes of an inquest. As a measure designed to promote a consistent state-wide approach to determining when an inquest should be held, the Committee considers that the Act should require coroners to have regard to the purpose of an inquest when considering whether to convene an inquest.

Recommendation 55. That section 17(2) of the *Coroners Act 1985* be amended to provide that, when determining whether an inquest is desirable, a coroner must have regard to the purposes of an inquest.

## Multiple-death inquests

The Act allows the State Coroner to direct that more than one death be investigated at the same inquest.<sup>1104</sup> According to the State Coroner, in recent years the identification of trends or patterns in deaths has resulted in a number of cases being heard together.<sup>1105</sup> Examples of the types of deaths where multiple-death inquests have been held include separate deaths involving the same make of car, tractor deaths on farms, the deaths of children in backyard swimming pools, and railway level crossing deaths.<sup>1106</sup>

<sup>&</sup>lt;sup>1102</sup> Jacinta Heffey, Submission no. 33, 19.

<sup>&</sup>lt;sup>1103</sup> State Coroner's Office, Submission no. 70, 139.

<sup>&</sup>lt;sup>1104</sup> Coroners Act 1985 s 43.

<sup>&</sup>lt;sup>1105</sup> G Johnstone, 'An Avenue for Death and Injury Prevention', in H Selby (ed), *The Aftermath of Death* (1992) 160.

<sup>&</sup>lt;sup>1106</sup> Ibid 165–70.

In 1993 former State Coroner Hal Hallenstein made the following comments in relation to the traditional coronial investigation approach to deaths by suicide:

Although every suicide is a Coroner's case, public death investigation is generally deficient in assisting the community to deal with the issue. In considering suicide Coronership has generally failed socially because of traditional legalistic process of being limited to one case at a time and, in that case, being restricted to narrow considerations of mechanism of death, the deceased's conduct and the deceased's intent.<sup>1107</sup>

He noted that this approach was changing in Victoria:

Coronership in Victoria has taken a fresh approach. A modern Coroners Act has produced in Coroner's process a civilian investigation relying on whoever may have expertise and for the purpose of public information and public learning with a view to preventing avoidable recurrence. A modern basis of Coroner's process is the ability to conduct a class investigation of many cases with common features.

Suicide is eminently suited to class investigation and is worthy of the best application possible of modern Coronership. 1108

## Multiple-death inquests in other Australian jurisdictions

Besides Victoria, multiple-death inquests are permitted by law in four other jurisdictions. 1109 In Queensland a coroner may investigate multiple deaths as follows:

The State Coroner may investigate, or direct a coroner to investigate, at an inquest—

- (a) a number of deaths that happened at different times and places, but which appear to have happened in similar circumstances; or
- (b) a number of deaths that happened at the same time and place.

Example of paragraph (a)--

The State Coroner may direct a coroner to investigate several deaths that are suspected of being caused by an overdose of methadone.<sup>1110</sup>

<sup>1109</sup> Coroners Act 1996 (WA) s 40; Coroners Act 1995 (Tas) s 50; Coroners Act 2003 (SA) s 21(3); Coroners Act 2003 (Qld) s 33. In the ACT the Chief Coroner may hold an inquiry into a disaster with the consent of the Attorney-General: Coroners Act 1997 (ACT) s 19.

<sup>&</sup>lt;sup>1107</sup> Hal Hallenstein, 'Coronership — The Practical Application of Law, Medicine, Science and Specialty Knowledge' (Presented at Law, Medicine and Criminal Justice Conference, Mariott Resort, Surfers Paradise, 6 to 8 July 1993) 20.

<sup>&</sup>lt;sup>1108</sup> Ibid.

<sup>&</sup>lt;sup>1110</sup> Coroners Act 2003 (Qld) s 33.

An example of a multiple-death inquest is that held into six separate deaths in South Australia in 1997.<sup>1111</sup> Coroner Wayne Chivell selected three deaths where the person who died had committed suicide while experiencing a severe schizophrenic illness. Three other deaths were also investigated, and these involved unlawful killings by people who were experiencing schizophrenia. The findings and recommendations were published together and received a considerable amount of media attention.<sup>1112</sup> Recommendations common to all six cases included the need for adequate documentation and record keeping and the important role of family members in providing information relevant to a diagnosis.

#### Multiple-death inquests in international jurisdictions

Ontario, Canada, like Victoria, also holds inquests into multiple deaths. The relevant legislation provides that, where two or more deaths appear to have occurred in the same event or from a common cause, the Chief Coroner may direct that one inquest be held into all of the deaths.<sup>1113</sup>

The Ontario Coroner's Court undertakes a number of thematic inquests which can take up to two or three months to complete. Inquiries have included an investigation of the deaths of cyclists in Toronto, factory safety standards, the use of bullet-proof vests, and the mental health system.

#### **Evidence received by the Committee**

The discussion paper asked stakeholders whether the Act should define criteria for the State Coroner to apply when s/he considers whether a multiple-death inquest should take place. While the Coroner's Office considered that the Act should not define the circumstances which warranted multiple-death inquests, three other stakeholders supported the introduction of a criterion.

The Coroner's Office told the Committee that the circumstances in which inquests should be joined 'do not lend themselves to general definition in the Act'.<sup>1114</sup> The submission indicated that the State Coroner's criterion is to 'sparingly' order multipledeath inquests where:

the deaths or fires all occurred in or arose from the same incident; or the costs will be significantly reduced if a multi-death or fire inquest is held; or the same public safety and prevention issues in the cases justify their amalgamation.<sup>1115</sup>

<sup>&</sup>lt;sup>1111</sup> Robert D Goldney, 'A South Australian Coronial Inquiry Into Suicide and Homicide' (2000) 8 (no. 2) *Australasian Psychiatry* 142–6.

<sup>&</sup>lt;sup>1112</sup> Ibid 142.

<sup>&</sup>lt;sup>1113</sup> The Coroners Act, RSO 1990, c 37, s 25(2).

<sup>&</sup>lt;sup>1114</sup> State Coroner's Office, Submission no. 70, 176.

<sup>&</sup>lt;sup>1115</sup> Ibid.

Ms Heffey submitted that to restrict the circumstances in which multiple-death inquests could take place would amount to an unacceptable restriction on a coroner's discretion. 1116 While she considered that there was great value in holding multiple inquests from the prevention point of view, not all deaths necessarily occur in the same time frame. Ms Heffey therefore considered that the Coroner's decision to convene a multiple-death inquest needed to take into account the views of the family of the person who died and the need to complete an inquiry without undue delay.

Associate Professor Ranson considered that the Coroner's decision to hold a multiple-death inquest was a procedural issue. However, he indicated that it might be prudent for the legislation to include provisions which outlined legal procedures involving a multiple-death inquest. He also considered that the Act could be amended to allow a right to object to the multiple-death inquest process, which could be appealed to the Supreme Court.

Four other witnesses considered that the Act should define the kinds of circumstances in which multiple-death inquests could occur.<sup>1118</sup> For example, Maurice Blackburn Cashman submitted that the provision should be defined in reasonably broad terms to allow, for example, a review of deaths in Victorian psychiatric institutions which raise the issue of misdiagnosis of medical illnesses. Ms Wilson submitted that a list of circumstances would provide coroners with guidance on the types of considerations that should be taken into account,<sup>1119</sup> while the TAC considered that criteria would promote a consistent approach.<sup>1120</sup>

Mr Jason Rosen from the Association for the Prevention of Medical Errors (APME) also supported a change to the Act requiring the State Coroner to consider criteria before deciding whether to hold a multiple-death inquest. APME submitted that the State Coroner should direct that a multiple-death inquest take place where it is reasonable and in the public interest. However, APME emphasised that the views of the senior next of kin were an important factor that a coroner should take into consideration.

#### Discussion and conclusion

The Committee believes that, although the Act should not unduly restrict the circumstances in which a multiple-death inquest is held, some criteria to guide the

<sup>&</sup>lt;sup>1116</sup> Jacinta Heffey, Submission no. 33, 22.

<sup>&</sup>lt;sup>1117</sup> David Ranson, *Submission no. 19*, 50.

<sup>&</sup>lt;sup>1118</sup> Maurice Blackburn Cashman, *Submission no. 42*, 6; Health Services Commissioner, *Submission no. 62*, 10; Transport Accident Commission, *Submission no. 50*, 12; Association for the Prevention of Medical Errors, *Submission no. 79*, 13–14.

<sup>&</sup>lt;sup>1119</sup> Health Services Commissioner, *Submission no. 62*, 10.

<sup>&</sup>lt;sup>1120</sup> Transport Accident Commission, Submission no. 50, 12.

<sup>&</sup>lt;sup>1121</sup> Association for the Prevention of Medical Errors, *Submission no.* 79, 13–14.

Coroner's decision would be appropriate. A multiple-death inquest has the potential to be a more effective means of identifying systemic problems than a single-death inquest. However, at present family members and other persons with a sufficient interest in a death or series of related deaths do not have procedural rights to request that a multiple-death inquest take place or to object to the convening of a multiple-death inquest.

The Committee is of the view that the Act should require the State Coroner to consider the wishes of persons with a sufficient interest on this issue. It is inconsistent that under the Act a person may request that a coroner hear an inquest into a single death but cannot make a similar request where two or more deaths appear to have resulted from a similar cause. As such the Committee recommends that the Act be amended to include a set of broad criteria which outline the circumstances in which a multiple-death inquest may be held, while retaining the coroner's discretion to decide on a case-by-case basis.

Recommendation 56. That the *Coroners Act 1985* be amended to provide:

- a) a set of broad criteria which outline the circumstances in which a multiple-death inquest may be held;
- b) that a person may ask the State Coroner to hold an inquest into a number of deaths that happened at different times and places but that appear to have happened in similar circumstances:
- c) that the State Coroner may investigate, or direct a coroner to investigate, at an inquest, a number of deaths that happened at different times and places but that appear to have happened in similar circumstances; and
- d) that, before deciding whether to convene a multiple-death inquest, the State Coroner must consider the views of persons with a sufficient interest regarding the merits of a multiple-death inquest.

## Relationship between inquest and possible criminal trial

Before the Act came into force in 1986, a coroner's inquest could also function as a committal hearing. Under the *Coroners Act 1958* a coroner had the authority to commit a person to the Supreme Court for trial on charges of murder or accessory before the fact to murder or manslaughter. This power was removed in 1986 when the current Act came into force. According to the second reading speech, the power to commit was removed because it was considered inconsistent with the function of a coroner:

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<sup>&</sup>lt;sup>1122</sup> Coroners Act 1958 s 15.

The coroner's primary duty has become the finding of the cause of death. In performing this function, the coroner's role is in essence inquisitorial, in that the coroner must discover all he or she can about the circumstances surrounding the death. It is inappropriate that the coroner should then be empowered to commit for trial a person believed to have caused the death.

The traditional legal protections available to an accused in committal proceedings are simply not available in the coronial jurisdiction. For these reasons, coroners will no longer commit for trial. 1123

Although it is not a requirement of the Act, it has been the practice of the Coroner's Office, where a person has been charged with an offence related to the death, to wait for the outcome of criminal proceedings before considering whether to hold an inquest into the death. The practice, while affording all the traditional legal protections to an accused person, may cause considerable delays, sometimes up to several years, before a coronial investigation can be finalised.

There are no statistics to indicate the average length of delay, as the State Coroner's Office has not established an adequate case management system. The Committee however notes that Springvale Monash Legal Service (SMLS) examined this issue in its submission and in their research found that, in relation to four workplace deaths, the average length of time from the date of the death to the inquest was three years and one month.<sup>1124</sup>

When the criminal process has been finalised, a Coroner has the discretion not to hold, continue or recommence a mandatory inquest where s/he is satisfied that a person has been found guilty or not guilty or has been acquitted of one of the following offences:

- murder;
- manslaughter;
- infanticide or child destruction;
- an offence under section 6B(2) of the Crimes Act 1958 (which relates to inciting or aiding suicide); or
- causing a death by the culpable driving of a motor vehicle.<sup>1125</sup>

The Act does not indicate what factors a coroner should consider when exercising this discretion to hold an inquest. For example, if a person has been acquitted of the crime of murder, should a coroner then hold an inquest to establish the cause of death? In

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<sup>&</sup>lt;sup>1123</sup> Mr Matthews, Minister for the Arts, Coroners Bill, Second Reading Speech, 21 November 1985, 2305–6.

<sup>&</sup>lt;sup>1124:</sup> Springvale Monash Legal Service, *Submission No. 13*, 4.

<sup>&</sup>lt;sup>1125</sup> Coroners Act 1985 s 17(3).

Domaszewicz v The State Coroner, Ashley J considered that an inquest following a criminal trial where a defendant has been acquitted should rarely be held:

There should be, I consider, the gravest consideration before a coroner embarks upon an inquest subsequent to acquittal if there is no cogent material pointing to an alternative suspect, or no clearly new and cogent facts or evidence. 1126

Ashley J did however indicate that an inquest would be desirable in the following circumstances:

Whether by reason of new facts, or in order to further explore the questions how the death occurred and the cause of death, and in that context the question whether some person other than the acquitted person contributed to the cause of death.<sup>1127</sup>

The State Coroner's guidelines on when to hold an inquest advise coroners that:

Generally, an inquest is not held after the completion of a criminal trial unless there is a public health and safety issue that requires further investigation or public hearing. In the event that the trial raises the prospect that other persons, not previously identified, have caused the death then further investigation and inquest may be required. 1128

## Position in other Australian jurisdictions

In the ACT, Queensland, South Australia, Tasmania and Western Australia, if the Coroner is advised before or during an inquest that a person has been charged with an indictable offence relevant to the death or fire then the Coroner must not proceed or must adjourn the inquest or inquiry.<sup>1129</sup> It is only after the criminal process has been finalised that a coroner may recommence the inquest.

In New South Wales a coroner may commence or continue an inquiry where a person has been charged, but the inquiry is restricted to establishing details such as the identity of the person who died and the date and place of his or her death. However, a coroner may commence a new inquiry after the criminal proceedings have been finalised. However, a coroner may commence a new inquiry after the criminal proceedings have been finalised.

<sup>&</sup>lt;sup>1126</sup> Domaszewicz v The State Coroner (2004) 11 VR 237, 255.

<sup>&</sup>lt;sup>1127</sup> Ibid.

<sup>&</sup>lt;sup>1128</sup> Coroner's Office, Victoria, State Coroner's Guidelines—When to Hold an Inquest.

<sup>&</sup>lt;sup>1129</sup> ACT Coroners Act 1997 s 58(3), (4); Coroners Act 2003 (Qld) s 29; Coroners Act 2003 (SA) s 21(2); Coroners Act 1995 (Tas) s 25; Coroners Act 1996 (WA) s 53(1).

<sup>&</sup>lt;sup>1130</sup> Coroners Act 1980 (NSW) s 19(1)(a).

<sup>&</sup>lt;sup>1131</sup> Coroners Act 1980 (NSW) s 20.

#### **Evidence received by the Committee**

#### Practice of suspending inquest for criminal proceedings

Two stakeholders raised the issue of whether an inquest should precede possible criminal proceedings. Associate Professor Ranson supported the current practice. He told the Committee that:

Given the broader power of the coroner's inquest to receive evidence that would be inadmissible in a criminal hearing it would be generally preferable for inquests not to be held prior to a planned criminal trial of a charged individual.<sup>1132</sup>

The Committee also heard from Ms Marion Stevens. Her son Patrick Stevens died in an underground mine at Kangaroo Flats, near Bendigo, in 2001. The inquest did not take place until 2005 because the Coroner's Office suspended its inquiry pending the outcome of a Department of Primary Industries investigation. Ultimately, this investigation resulted in a prosecution under the *Mineral Resources (Health and Safety) Regulations 1991* against the mine owner and its manager. Both defendants pleaded guilty to charges which involved the failure to provide a safe work site.

Ms Stevens told the Committee that there were a number of reasons that an inquest and criminal proceedings should occur at the same time:

I continue to find it a nonsense that a criminal matter be heard prior to an Inquest because witnesses may refuse to answer on the grounds they may incriminate themselves. I see no logical reason why the two matters cannot be concurrently conducted and that the coronial process may provide more information for any criminal proceedings. It would certainly relieve families of these excruciating four and five year waits.<sup>1133</sup>

The Coroner's Office did not comment on this issue in its submission.

#### Discussion and conclusion

The Committee is concerned by the evidence that some families are waiting up to four years for an inquest because coronial inquiries are suspended while criminal investigations are pending. Such delays undoubtedly contribute to the stress experienced by family members. The Committee discusses delays in coronial investigations and the impact this has on family members in detail in chapter eight.

Due to the absence of a proper case management system at the Coroner's Office, the inquiry was unable to obtain statistics which would indicate the average length of delays where inquests have been suspended due to criminal or workplace safety prosecutions. The need for a case management system to be developed is identified elsewhere in this report.

<sup>&</sup>lt;sup>1132</sup> David Ranson, Submission no. 19, 48.

<sup>&</sup>lt;sup>1133</sup> Marion Stevens, *Minutes of Evidence*, 22 August 2005, 29.

While recognising the need for some inquests to be delayed to afford procedural fairness to an accused person, the Committee considers that there is a need to conduct evidence-based research on this issue to investigate whether there are ways the criminal justice system can shorten the time it takes to complete matters in which coronial investigations are pending. It may, for instance, be possible for certain criminal matters to be given priority listing so as to enable a coronial inquiry to commence without extended delays. The Committee acknowledges however that there are many competing priorities to be considered in the case-listing process.

Recommendation 57. That the Coroner's Office undertake a research project examining the length of time it takes to complete a coronial death investigation when the investigation is suspended pending the outcome of related criminal proceedings, with a view to taking up this issue with Victorian courts.

# Circumstances in which an inquest should be held following criminal proceedings

Two witnesses indicated that there were a number of circumstances in which inquests should be held after the criminal justice system had completed its investigations. Ms Heffey told the Committee that to statutorily prohibit an inquest after an acquittal or conviction would remove valuable functions that often only an inquest can fulfil. 1134 She considered that, while there was in general no value in holding an inquest following a conviction or acquittal for murder, manslaughter or infanticide, there were a number of exceptions. In her submission she identified the following exceptions:

- 1. A situation in which the death is for other reasons, a "reportable death"; for example because the deceased was in prison. Issues such as prisoner supervision, protection for vulnerable prisoners, incident reporting etc. may all be significant systemic factors bearing on the death. Deaths by homicide or manslaughter of persons otherwise in the care and custody of the state may also warrant a coronial investigation and possibly inquest.
- 2. The second exception would be where the death can be seen as being contributed to by some preventative factors. For example, a woman who kills her new born child whilst suffering postnatal depression for which she is being inappropriately medicated. The outcome of an investigation into her medical management may have significant implications for public health and safety.
- 3. There may be value in conducting an inquest into a murder etc. after an acquittal. Such an inquest would be directed not towards re-testing the same evidence against the accused or the issues that have been considered by a jury, but towards raising public awareness in an effort to encourage someone to come forward who may be able to assist in determining how the deceased came by his/her death. So it should not take place to test whether the person acquitted did in fact cause the death. It should only occur in circumstances in which it can

<sup>&</sup>lt;sup>1134</sup> Jacinta Heffey, Submission no. 33, 18.

properly be regarded as an "unsolved case" and the investigating police seek an inquest as part of its own investigation. An inquest may be a good opportunity to publish the existence of a reward for information or to publish some features of the crime scene, for example, or other aspects which to that date had been withheld.<sup>1135</sup>

She considered that another exception could be where an accused is acquitted on the grounds of insanity. An inquest could serve a valuable purpose by examining whether the accused had been adequately managed by mental health professionals at the time s/he killed the person whose death was subject to coronial investigation.

Ms Heffey referred to the decision in *Domaszewicz v The State Coroner*.<sup>1136</sup> She told the Committee that, to overcome the difficulties presented by this case, section 19 could be amended by a new subsection to the effect that 'if a coroner determines to hold an inquest under section 17(3), a finding under section 19(1)(b) must not include a determination (where this is challenged) that a person previously found guilty or acquitted of causing the death actually caused the death'.<sup>1137</sup>

Associate Professor Ranson agreed with Ms Heffey that in some instances an inquest should be held after criminal proceedings are concluded. He told the Committee that there are very good reasons for inquests to be held following a conviction or acquittal, including the fact that, unlike that of a trial, the focus of a coronial investigation was not criminality but death prevention. Associate Professor Ranson gave an example to illustrate the point:

Take for example the hypothetical situation where a parent has been charged with the murder of their child and is subsequently acquitted or convicted. A coroner may well decide that it is inappropriate to hold an inquest after the completion of the criminal process. However, the criminal Court will have been focused on the question of criminality on the part of the defendant and will generally have had no interest in potential issues regarding social service provision in the area of child protection that may have contributed to the death. Conversely a coroner hearing an inquest into the child's death would have the capacity to review the conduct of child protection workers and the efficacy of the child protection system and make recommendations that could improve the safety of children in similar circumstances without addressing the criminal issues at all. Clearly this would be a very important outcome of a death investigation regardless of the outcome of the previous criminal trial. 1139

Associate Professor Ranson told the Committee that the Act did not provide guidance to a coroner on what factors the coroner should consider when exercising the discretion to hold an inquest following criminal proceedings. In his view:

<sup>&</sup>lt;sup>1135</sup> Ihid

<sup>&</sup>lt;sup>1136</sup> Domaszewicz v The State Coroner (2004) 11 VR 237.

<sup>&</sup>lt;sup>1137</sup> Jacinta Heffey, Submission no. 33, 21.

<sup>&</sup>lt;sup>1138</sup> David Ranson, Submission no. 19, 48–9.

<sup>&</sup>lt;sup>1139</sup> Ibid 49.

Given that coroners have repeatedly argued that the main benefit of their jurisdiction lies in its ability to reveal and expose the facts surrounding a death to public scrutiny and to ensure that possible ways in which the death could have been prevented are considered and promoted, these would appear to be the main factors that should govern the exercise of such discretions.

The existence of significant public or private concerns regarding the circumstances of a death particularly those involving the existence of a substantial hazard or risk in the community that may have led to or contributed to the death would appear to be the major factors that should influence the decision regarding the holding of an inquest.

No other stakeholder commented on this issue.

#### Discussion and conclusion

The Committee agrees that there are circumstances in which inquests held after the completion of criminal proceedings serve useful public safety and death prevention purposes that are not examined in the criminal justice system. While the State Coroner has issued guidelines to coroners which briefly refer to this issue, the Committee considers that existing guidelines could be expanded to provide coroners with a more detailed understanding of the types of cases which may benefit from the convening of an inquest after criminal proceedings have been finalised.

Recommendation 58. That the State Coroner issue guidelines to coroners regarding the circumstances in which a coroner should consider holding an inquest following the completion of related criminal proceedings.

#### Expansion of section 17(3) offences

As discussed earlier in this chapter, an inquest is mandatory where a coroner suspects homicide; however, a coroner has a discretion not to hold a mandatory inquest where a person has been acquitted or convicted of an offence listed in section 17(3). The TAC, the Coroner's Office and the Victorian Bar identified further offences which they considered should be added to the list in section 17(3). According to the TAC the offence of dangerous driving causing death<sup>1140</sup> should be included in section 17(3), while the Coroner's Office submitted that the offence of arson causing death<sup>1141</sup> should be included.<sup>1142</sup> The Victorian Bar told the Committee that the category of offences should be altered to include breaches of the *Occupational Health and Safety Act 2004*.<sup>1143</sup> According to the Bar:

<sup>&</sup>lt;sup>1140</sup> Crimes Act 1958 s 319.

<sup>&</sup>lt;sup>1141</sup> Crimes Act 1958 s 197A.

<sup>&</sup>lt;sup>1142</sup> Transport Accident Commission, Submission no. 50, 11–12; State Coroner's Office, Submission no. 70, 138.

<sup>&</sup>lt;sup>1143</sup> Victorian Bar, Submission no. 81, 9.

Individuals and bodies corporate frequently plead guilty to, or are found guilty of, such breaches where death is a consequence. In such circumstances, the finding of guilt of an offence under the Occupational Health & Safety Act is a clear statement of all of the statutory circumstances which the Coroner is obliged to find in relation to the death. It may be unnecessary to subject relatives and workers to the stress of an additional court hearing.<sup>1144</sup>

#### Discussion and conclusion

The offences listed in section 17(3) relate to the most serious criminal offences in the *Crimes Act 1958*, including murder, manslaughter, culpable driving causing death and infanticide. This is in contrast to the offences under the *Occupational Health and Safety Act*, which does not include an offence of industrial manslaughter. While the Committee sees merit in including the offences of dangerous driving causing death and arson causing death to the offences listed in section 17(3), the Committee does not consider that it is necessary to include offences under the *Occupational Health and Safety Act*. This is because an inquest where a person has been convicted or acquitted of a charge under the *Occupational Health and Safety Act* will not be mandatory and a coroner will in any event exercise his or her discretion as to whether an inquest should be held.

Recommendation 59. That section 17(3) of the *Coroners Act 1985* be amended to provide that if, in relation to the investigation of a death, a coroner is satisfied that one or more persons have been charged before a court with:

- a) dangerous driving causing death; or
- b) arson causing death;

and one or more of those persons has been found guilty of the offence or acquitted or found not guilty of the offence the coroner may—

- i) determine not to hold an inquest; or
- ii) adjourn the holding of an inquest which has already commenced; or
- iii) if an inquest has been adjourned, determine not to recommence the inquest.

## Rules of evidence at an inquest

A coroner holding an inquest is not bound by the rules of evidence. 1145 Under the Act a coroner may be informed and conduct an inquest 'in any manner the Coroner thinks

<sup>&</sup>lt;sup>1144</sup> Ibid.

<sup>&</sup>lt;sup>1145</sup> Coroners Act 1985 s 44.

reasonably fit'. 1146 However, the Act and the case law require a coroner to observe a number of rights and privileges in relation to witnesses and persons with standing.

#### Rights of persons with standing

Under the Act, 'a person with a sufficient interest' has the following rights:

- the right to appear at the hearing or be represented by a lawyer;<sup>1147</sup>
- the right to call, examine and cross-examine witnesses and to make submissions; and
- the right to access statements which the coroner intends to consider. 1149

The Act does not define what is meant by 'a person with a sufficient interest'. In *Barci v Heffey* Beach J considered that whether a person has a sufficient interest is a question of fact to be determined after a consideration of the circumstances surrounding the death.<sup>1150</sup> He identified the following persons as having sufficient interest:

- persons closely related to the person whose death is being investigated; and
- any person whose actions may have caused or contributed to the death, where there is a reasonable prospect that the Coroner may make a finding adverse to the interests of that person.<sup>1151</sup>

Beach J gave the following hypothetical examples where a person would have a sufficient interest:

if the deceased met his death during the course of his employment, his employer would have a sufficient interest justifying the grant of leave to appear and to be represented. One can envisage many relationships between the deceased and other persons which may entitle those other persons to appear at the inquest and be represented by counsel, eg the teacher of a

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<sup>&</sup>lt;sup>1146</sup> Coroners Act 1985 s 44.

<sup>&</sup>lt;sup>1147</sup> Coroners Act 1985 s 45(3). A non-lawyer may also represent a person if this is permitted by the Coroner. The right to legal representation is of course dependent on a person's ability to afford legal representation. The State Coroner's information booklet advises that usually a person will have to pay for a private solicitor; State Coroner's Office and Victorian Institute of Forensic Medicine, *When a Person Dies — The Coroner's Process*, 20.

<sup>&</sup>lt;sup>1148</sup> Coroners Act 1985 s 45(3). The Attorney-General also has these rights: s 45(2). The right to call witnesses includes the right to engage an expert witness such as an engineer, scientist or medical specialist to give evidence at an inquiry.

<sup>&</sup>lt;sup>1149</sup> Coroners Act 1985 s 45(1). 'Rules of evidence' refers to the complex body of case law and legislation relating to the sort of evidence that a court can hear (ie consider in finding guilt or civil liability) in a case.

<sup>&</sup>lt;sup>1150</sup> Barci v Heffey (Unreported, Supreme Court Of Victoria Practice Court, Beach J, 1 February 1995) 4.

<sup>&</sup>lt;sup>1151</sup> Ibid.

student killed whilst on a school excursion, the commanding officer of a soldier killed on a peacetime manoeuvre. 1152

There is no provision in the Act permitting specialist legal organisations to assist an inquest by advocating on behalf of the interests of the person who died in the role of public intervenor. However, in the discussion paper the Committee referred to Dr Freckelton's comment that the term 'sufficient interest' has generally been liberally interpreted by coroners. Dr Freckelton cited examples where coroners have permitted the Council for Civil Liberties and the Public Advocate to appear at inquests.

## Other Australian jurisdictions

All jurisdictions have a similar requirement of 'sufficient interest' to establish standing at an inquest. 1155 In Western Australia the *Coroners Regulations* include a list of persons who are considered 'interested persons' with procedural rights at an inquest. The Act provides that the list is not an exhaustive list of interested persons. 1156 The relevant regulation states:

The following persons are interested persons for the purposes of section 44(3) of the Act —

- (a) a spouse, de facto partner, child, parent or other personal representative of the deceased person;
- (b) any of the deceased person's next of kin under section 37(5) of the Act;
- (c) a beneficiary under a policy of insurance issued on the life of the deceased person;
- (d) an insurer who issued such a policy of insurance;
- (e) a person whose act or omission, or the act or omission of an agent or servant of that person, may in the opinion of the coroner have caused, or contributed to, the death of the deceased person;
- (f) a person appointed by an organization of employees to which the deceased person belonged at the time of death, if the death of the deceased person may have been caused by an injury received in the course of employment or by an industrial disease;
- (g) the Commissioner of Police appointed under the Police Act 1892.

<sup>&</sup>lt;sup>1152</sup> Ibid.

<sup>&</sup>lt;sup>1153</sup> For a discussion of the law relating to public interest intervention in Australia, see George Williams, 'The Amici Curiae and the Intervener in the High Court of Australia: A Comparative Analysis', (2000) 28 FLR 365.

<sup>&</sup>lt;sup>1154</sup> Ian Freckelton, 'Inquest Law', in H Selby (ed), *The Inquest Handbook* (1998) 9.

<sup>&</sup>lt;sup>1155</sup> Coroners Act 1997 (ACT) s 42; Coroners Act 1993 (NT) s 40(3); Coroners Act 1980 (NSW) s 32(1); Coroners Act 2003 (Qld) s 36(1)(c), (2); Coroners Act 2003 (SA) s 20(1)(b), (2); Coroners Act 1995 (Tas) s 52(4).

<sup>&</sup>lt;sup>1156</sup> Coroners Act 1996 (WA) s 44(3).

## International jurisdictions

The test for standing stated in the Ontario *Coroners Act* is whether a person is 'substantially and directly interested in the inquest'.<sup>1157</sup> Recent Canadian cases suggest that, in the past 15 years, both courts and coroners have given a wide interpretation to what is meant by this term. It has become increasingly common for coroners to grant standing to public interest advocacy groups who have no knowledge or connection with the person whose death is examined at the inquest, in order to better address issues relevant to the preventative function of the coronial system.

This was acknowledged by the Divisional Court of Ontario in *People First of Ontario v Niagara (Regional Coroner)* in 1992.<sup>1158</sup> In that case the court observed that a separate and wider function of the coronial system was becoming increasingly significant, which it referred to as 'the vindication of the public interest in the prevention of death by the public exposure of conditions which threaten life'.<sup>1159</sup>

Wenden J of the Provincial Court of Alberta made the following observation on how the test of standing in the Ontario *Coroners Act* has been interpreted by Ontario courts in recent years:

the cases also demonstrate that the preventative function of a fatality inquiry is now becoming as important as the investigative function. Standing is becoming more inclusive. Disparate groups with no obvious connection to the event are being given standing on the basis of a public interest and/or an expertise in areas that in some instances are peripheral to the matter under inquiry. Lastly the cases show that applications for standing are to be dealt with on a case by case basis, and all that need be demonstrated is either a direct or substantial connection, not both.<sup>1160</sup>

An example of a case in which an Ontario Coroner has applied a public interest test for standing in relation to public interest advocacy groups was the inquest into the death of Kimberly Rogers. At the time of her death during a heatwave in 2001, Ms Rogers was eight months pregnant and had been confined to her home because she had been sentenced to home detention. Her welfare payments had been cancelled but were later reinstated, though they were substantially reduced for three months. Her entitlement to pharmacy benefits had also been cancelled.

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<sup>&</sup>lt;sup>1157</sup> Coroners Act, RSO 1990, c 37, s 41(1).

<sup>&</sup>lt;sup>1158</sup> People First of Ontario v Niagara (Regional Coroner), 85 DLR (4<sup>th</sup>) 174, 184. See also *Black Action Defence Committee v. Huxter, Coroner* (1992) 11 OR (3<sup>rd</sup>) 641, in which Adams J observed that there will always be the possibility that those with a direct connection with the person who died might not be motivated or have the resources to pursue the preventative objects of the inquest. This case is discussed in detail in Ian Freckelton and David Ranson, *Death Investigation and the Coroner's Inquest* (2006) 567–8.

<sup>&</sup>lt;sup>1159</sup> People First of Ontario v Niagara (Regional Coroner), 85 DLR (4<sup>th</sup>) 174, 184.

<sup>&</sup>lt;sup>1160</sup> Re Pham (Public Fatality Inquiry), 2004 ABPC 24, para 47.

<sup>&</sup>lt;sup>1161</sup> Ontario, Coroner's Office, *Coroner's Ruling re Application for standing at the inquest into the death of Kimberly Rogers*, 19 September 2002. Available at http://dawn.net/Kimberly\_Rogers/ruling.html.

The Ontario Social Safety Network (OSSN) and the Steering Committee on Social Assistance (SCSA) applied for standing on a public interest basis. 1162 The Coroner, Dr David Eden, granted the application, finding that both groups met the legal test for public interest standing because they had:

a substantial and direct interest in the inquest by virtue of representing a group which shares a legal identity with the deceased and will be acutely affected by jury recommendations, and which has a unique or almost unique expertise that will offer the jury a valuable perspective that other wise would not have come forward... 1163

Dr Eden identified the specific area of interest to which standing was limited:

The development of recommendations regarding welfare legislation and administration, as it applies to persons in circumstances similar to those of Ms Rogers, excluding the process for criminal prosecutions related to welfare legislation. 1164

Following the inquest the coroner's jury made a number of recommendations, including a recommendation directed to the Government of Ontario to ensure that adequate housing, food and medication is provided to a person serving a sentence of home detention.

#### Evidence received by the Committee

Four stakeholders addressed the issue of standing. The MHLC and the FCLC submitted that standing to appear at an inquiry should be extended. 1165 Mr Singh from the FCLC raised the issue of whether the test for standing should be extended to include a public interest element, as in Ontario:

The test for standing under the act is not a public interest test. It is a sufficient interest test. ... It has been an interpretation of the sufficient interest to encapsulate the unique perspectives, experiences and contributions that parties can make to an inquest. It is either a matter that the sufficient interest test is interpreted liberally under the standing rules, or that a public interest test be added to the test for standing, so they are the two mechanisms by which additional parties may become involved. 1166

<sup>&</sup>lt;sup>1162</sup> The OSSN is an advocacy and advisory organisation for people on low incomes; the SCSA advocates for social security recipients.

<sup>1163</sup> Ontario, Coroner's Office, Coroner's Ruling re Application for standing at the inquest into the death of Kimberly Rogers, 19 September 2002. Available at http://dawn.net/Kimberly\_Rogers/ruling.html.

<sup>&</sup>lt;sup>1164</sup> Ibid.

<sup>&</sup>lt;sup>1165</sup> Mental Health Legal Centre, Submission no. 41, 2; Charandev Singh, Minutes of Evidence, 19 September 2005, 116-17; Pauline Spencer, Minutes of Evidence, 19 September 2005, 114.

<sup>&</sup>lt;sup>1166</sup> Charandev Singh, *Minutes of Evidence*, 19 September 2005, 116–17.

Ms Pauline Spencer from the FCLC referred to the Kew Cottages fire inquest in 1997<sup>1167</sup> and told the Committee that at this inquiry the Villamanta Legal Service was able to assist the State Coroner with its expertise in the area of intellectual disability. <sup>1168</sup> She told the Committee that:

The organisations that are working on the ground in these areas have a lot of information and knowledge about the systemic issues that often underpin the deaths and also in the follow-ups then are often involved in key players having those recommendations implemented — to have them involved all the way through so that you are getting recommendations that are solid and that are going to be able to be acted upon is very important.<sup>1169</sup>

In terms of what was required to modernise the Act, Ms Spencer emphasised that it was important to consider public interest standing and intervenor status. She told the Committee that:

Numerous organisations work in a range of areas that have expertise and knowledge that can be brought to the table. If our ultimate goal is to prevent deaths, then their expertise is crucial in bringing out the issues in the coroner's inquest and asking the right questions and raising the knowledge that they have, and bringing that to the table.<sup>1170</sup>

Ms Topp, a lawyer at the MHLC, submitted that standing ought to extend to specialist advocacy organisations that could assist a coroner in establishing all the circumstances of a person's death, including issues of public concern surrounding the death.

The LIV endorsed the view of the MHLC, which submitted that independent experts should be able to assist the Coroner at an inquest into the death of a person with a psychiatric disability.<sup>1171</sup> According to the LIV:

A coronial inquiry provides a forum for the trauma and pain suffered by the family or carer of a deceased person to be recognised. However, they also provide a forum for discovering all of the facts surrounding a tragic death and must ensure that all issues are thoroughly explored. The involvement of a family or carer of a deceased person with a psychiatric disability is often complicated by tensions and unresolved issues of conflict with the deceased. This can prevent the family or carer from representing the intentions and experiences of the deceased. 1172

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<sup>&</sup>lt;sup>1167</sup> In 1996 nine men with cognitive impairments died in a fire at Kew Residential Services in Melbourne.

<sup>&</sup>lt;sup>1168</sup> Pauline Spencer, *Minutes of Evidence*, 19 September 2005, 114.

<sup>&</sup>lt;sup>1169</sup> Ibid 116–17.

<sup>&</sup>lt;sup>1170</sup> Ibid 114.

<sup>&</sup>lt;sup>1171</sup> Mental Health Legal Centre, Submission no. 41, 1.

<sup>&</sup>lt;sup>1172</sup> Law Institute of Victoria, Submission no. 58, 6.

Finally, the TAC suggested that, while there were many instances in which coroners considered that statutory authorities had sufficient interest in an inquest, the Act should provide guidance as to what needs to be shown to demonstrate the interest.<sup>1173</sup>

#### Discussion and conclusion

In Victoria, as in Ontario, there is increasing recognition of and emphasis on the preventative role of the Coroner. The traditional focus of an inquest has been on providing answers to the questions surrounding how a person died. It is therefore appropriate that a person wishing to establish standing must have a sufficient connection with the person who died. However, an equally important function of a modern inquest is the making of recommendations aimed at preventing further deaths of a similar nature. Giving legislative recognition to this role is a key recommendation of this inquiry, which the Committee discusses in chapter seven.

The focus of the preventative function is not on answering questions about how a person died. The function's focus is broader, with an emphasis on public safety. It examines what happened to an individual in the past with a view to protecting the community in the future. The Committee therefore considers that the test for standing should not be exclusively based on establishing a direct interest in the particular death. It should also include a public interest test so that specialist groups are able to call and cross-examine witnesses and make submissions on possible recommendations aimed at preventing similar deaths.

Recommendation 60. That the *Coroners Act 1985* be amended to provide that, in determining whether a person has a sufficient interest for the purposes of section 45 of the Act, a coroner must consider whether:

- a) it is in the public interest; and
- b) it is consistent with the purposes of the Act;

for the person to call, examine and cross-examine witnesses and make submissions at an inquest.

#### Privilege against self-incrimination

Although it is not stated in the Act, the longstanding common law privilege against self-incrimination applies at a coronial inquest.<sup>1174</sup> This means that a witness may choose not to answer a question where it can be established that the answer may

<sup>&</sup>lt;sup>1173</sup> Transport Accident Commission, Submission no. 50, 18–19.

<sup>&</sup>lt;sup>1174</sup> Re O'Callaghan (1899) 24 VLR 957. Followed in R v The Coroner; Ex parte Alexander [1982] VR 731, 35.

tend to expose that person to a criminal conviction, despite section 46(1)(c) of the Act, which gives a coroner the power to order a witness to answer questions.<sup>1175</sup>

While a coroner does not have a statutory duty to warn witnesses of their right to choose not to answer such questions, it is the practice of the Coroner's Office not to call a witness who is likely to be implicated in a serious crime. However, if a witness is called but is not aware of the right and gives self-incriminating evidence, there is a possibility that the evidence may be used in later criminal proceedings against the witness. 1177

The privilege against self-incrimination may also be waived in part or in full by a witness. The Committee heard evidence that some witnesses at inquests, including doctors in medical procedure related deaths, choose to waive the privilege and give their evidence at the inquest. On the other hand, the Committee heard evidence that there were instances where witnesses could have provided information in relation to a death but chose not to provide it for a coronial investigation because of concerns that their evidence could be used against them in later proceedings. The part or in full by a witness.

There are various rationales for the rule against self-incrimination. The rule is seen as offering protection against a potential abuse of power in the criminal justice system:

Because of its resources, the State has a considerable advantage in putting its case against most citizens. Most people dealing with the State are at a substantial organisational, monetary and knowledge disadvantage. In addition, there is considerable potential for internal corruption and misuse of its powers if they are not strictly regulated and controlled.<sup>1180</sup>

Another rationale for the continued existence of the rule is that the privilege is akin to a human right, as opposed to a mere rule of evidence. This was acknowledged by the High Court of Australia, which has described the privilege as being in the nature of a human right, designed to protect individuals from oppressive methods of obtaining

<sup>&</sup>lt;sup>1175</sup> J D Heydon, *Cross on Evidence* (6<sup>th</sup> ed, 2000) para 25065.

<sup>&</sup>lt;sup>1176</sup> R v The Coroner; Ex parte Alexander [1982] VR 731.

<sup>&</sup>lt;sup>1177</sup> R v Coote [1861-73] All ER Ext 1113. However, note section 57(3) of the Coroners Act, which provides that a record of evidence given in a coronial inquest cannot be used in a later proceeding as evidence of a fact unless the evidence comes under one of the exceptions in section 55AB of the Evidence Act 1958. There is however no prohibition in relation to derivative use of evidence. Unlike in Victoria, a UK coroner has a duty to inform a witness of the right to claim the privilege: Coroners Rules 1984 (UK), rule 22(2).

<sup>&</sup>lt;sup>1178</sup> George Doland Ltd v Blackburn Robson Coates & Co [1972] 3 All ER 959 at 962; [1972] 1 WLR 1338 per Geoffrey Lane J; Barilla v James [1964-65] NSWR 741; (1964) 81 WN (Pt 1) (NSW) 457 at 475 per Asprey J.

<sup>&</sup>lt;sup>1179</sup> Victoria Police Submission no. 78, 7; State Coroner's Office, Submission no. 70, 78.

<sup>&</sup>lt;sup>1180</sup> Australian Law Reform Commission, *Evidence*, Report No. 26, 1985, vol 1, 487.

<sup>&</sup>lt;sup>1181</sup> Accident Insurance Mutual Holdings Ltd v McFadden and Another (1993) 31 NSWLR 412 per Kirby P at 420– 1.

evidence of their guilt for use against them. The rule is given statutory recognition in the *Crimes Act 1958*. Under this provision an accused person cannot be compelled to give evidence at his or her criminal trial. Section 26 of the *Evidence Act 1958* confirms the rule. However section 29 of the Act has been construed as an erosion of the privilege because the section is expressed in terms appropriate only for a claim to privilege on trial before a court.

The rule was referred to by the Chief Justice of the Victorian Supreme Court in 1899 as the 'first principle of our law that nobody shall be called upon to contribute to his or her own conviction'. Chief Justice Madden upheld the right of a witness to refuse to give evidence before a coroner in relation to an inquest into the death of a baby because the witness may have been rendered liable for prosecution for failing to register her child-care business under the *Infants Life Protection Act 1898*. The traditional common law privilege against self-incrimination in relation to the present Act was recognised by the Victorian Supreme Court in *R v The Coroner; Ex parte Alexander*. This is the leading case on the entitlement of a witness at an inquest to decline to answer questions on the basis of the privilege against self-incrimination.

Another rationale for the rule is that the privilege against self-incrimination is necessary to protect the quality of evidence. It has been argued that it is more likely that a person may give false evidence if s/he is required to give self-incriminating evidence to avoid future prosecution:

A witness will often prefer to lie than to expose himself to criminal prosecution; the threat of perjury penalties is less directly threatening than the threat of prosecution for the commission of a criminal offence.<sup>1191</sup>

While the idea that a person should be compelled to give answers which expose them to the risk of prosecution is considered probably still repellent to public opinion, 1192 the

<sup>&</sup>lt;sup>1182</sup> Environmental Protection Authority v Caltex (1993) 178 CLR477, at 508 per Mason CJ and Toohey J.

<sup>&</sup>lt;sup>1183</sup>Crimes Act 1958 s 184.

<sup>&</sup>lt;sup>1184</sup> See the discussion in Ian Freckelton and David Ranson, *Death Investigation and the Coroner's Inquest* (2006) 583–5, concerning the application of the rule in *Weissensteiner v The Queen* (1993) 178 CLR 217 regarding the probative value of unsworn testimony which has not been subject to cross-examination.

<sup>&</sup>lt;sup>1185</sup> Evidence Act 1958 s 26.

<sup>&</sup>lt;sup>1186</sup> J D Heydon, *Cross on Evidence* (6th ed, 2000) para 25170.

<sup>&</sup>lt;sup>1187</sup> Re O'Callaghan (1899) 24 VLR 957, at 967 per Madden CJ.

<sup>&</sup>lt;sup>1188</sup> R v The Coroner; Ex parte Alexander [1982] VR 731 at 35.

<sup>&</sup>lt;sup>1189</sup> Ian Freckelton and David Ranson, *Death Investigation and the Coroner's Inquest* (2006) 580.

<sup>&</sup>lt;sup>1190</sup> Queensland Law Reform Commission, *The Abrogation of the Privilege Against Self Incrimination*, Report No. 59 (2004) 27.

<sup>&</sup>lt;sup>1191</sup> Australian Law Reform Commission, *Evidence*, Report No. 26 (1985) vol 1, 487.

<sup>&</sup>lt;sup>1192</sup> J D Heydon, *Cross on Evidence* (6<sup>th</sup> ed, 2000) para 25140.

argument has been advanced that the privilege against self-incrimination should be limited. The privilege has been criticised on two grounds. First, it has the potential to undermine the purpose of the justice system by frustrating access to valuable evidence about the commission of an alleged offence.<sup>1193</sup> This argument has been advanced in relation to the claiming of the privilege by potential witnesses at inquests.<sup>1194</sup> Second, the privilege may give rise to the perception that the rights of an accused person are afforded priority over the 'rights' of a complainant.<sup>1195</sup> This argument was advanced by a number of family members who made submissions to this inquiry.<sup>1196</sup>

There are a number of privileges closely related to the rule against self-incrimination. They include:

• **Penalty privilege**: a person may refuse to answer questions or provide information, on the basis that to do so may expose that person to a civil penalty. The privilege has been applied to a number of actions, including actions involving exposure to dismissal from the police service. It is unclear whether the penalty privilege applies to non-judicial proceedings. However, two law reform agencies have recommended that the privilege should extend to non-judicial proceedings. This is in contrast to the dissenting view of Kirby J in *Rich v ASIC*, in which he considered that the penalty privilege — unlike the privilege against self-incrimination, which was reflected in universal principles of human rights — was a privilege of lower priority. I200

<sup>&</sup>lt;sup>1193</sup> I Dennis, 'Instrumental Protection, Human Right or Functional Necessity? Reassessing the Privilege Against Self-incrimination' (1995) 54 *Cambridge Law Journal* 355.

<sup>&</sup>lt;sup>1194</sup> See for example Ian Freckelton, 'Inquest Law' in H Selby (ed), *The Inquest Handbook* (1998) 11; State Coroner, Victoria, A Police Pursuit Related Inquest: Findings No. 822/02, 1821/02, 1823/02; 29 January 2004. Available at <a href="https://www.coronerscourt.vic.gov.au">www.coronerscourt.vic.gov.au</a>. See also *Decker v State Coroner of New South Wales* [1999] NSWSC 369.

<sup>&</sup>lt;sup>1195</sup> I Dennis, 'Instrumental Protection, Human Right or Functional Necessity? Reassessing the Privilege Against Self-incrimination' (1995) 54 *Cambridge Law Journal* 359.

<sup>&</sup>lt;sup>1196</sup> See for example Margrit and David Kaufmann, *Submission no. 71*, 5–6; Caroline Storm, *Submission No. 25*, 5.

<sup>&</sup>lt;sup>1197</sup> Police Service Board v Morris (1985) 156 CLR 397.

<sup>&</sup>lt;sup>1198</sup> See for example *Rich v ASIC* (2004) 209 ALR 271, per Gleeson CJ, Gummow, Hayne, Callinan and Heydon JJ at 278–9. While the case did not involve the determination of this question, the majority of the High Court left the question open.

<sup>&</sup>lt;sup>1199</sup> Australian Law Reform Commission, *Principled Regulation* — *Federal Civil and Administrative Penalties in Australia*, Report No. 95, Recommendation 18; Queensland Law Reform Commission, *The Abrogation of the Privilege Against Self Incrimination*, Report No. 59, 2004, 195: the QLRC recommended that the privilege apply in the absence of an express provision to the contrary.

<sup>1200</sup> Rich v ASIC (2004) 209 ALR 271, 309.

- Use immunity and derivative use immunity: the common law privilege against self-incrimination extends to protection against the risk of self-incrimination by both direct evidence and indirect evidence. The rule came to be extended beyond answers which might directly incriminate a witness to answers which might be used as a step towards obtaining evidence against the witness.<sup>1201</sup>
- **Documentary evidence**: while the common law privilege does not extend to physical evidence 1202 such as body samples or DNA, it does extend to documents required to be produced by an individual (but not a corporation). 1203 An issue in relation to this inquiry which requires consideration is whether the privilege attaches to certain hospitals' internal investigation documents referred to as root cause analysis (RCA) reports. 1204 Hospitals do not usually release these reports to the Coroner's Office and, similarly, it is not the practice of the Coroner's Office to request that a hospital release such documents. 1205 However, the Committee is aware of two cases in which hospitals have made a copy of the RCA report available to the Coroner's Office. 1206 In another case the lawyers representing a family at an inquest sought the release of documents which were discussed at a mortality and morbidity hospital review. 1207 In that case the Deputy State Coroner made a ruling that the documents were protected by public interest immunity and therefore did not make an order requiring the hospital to produce the documents at the inquest. 1208

The privilege against self-incrimination is not absolute and may be abrogated by statute:

If the legislature thinks that...the public interest overcomes some of the common law's traditional consideration for the individual, then effect must be given to the statute which embodies this policy. 1209

Various provisions in Victoria modify the scope of the privilege a witness may claim, including:

<sup>&</sup>lt;sup>1201</sup> R v The Coroner; Ex parte Alexander [1982] VR 731, per Gray J at 735.

<sup>&</sup>lt;sup>1202</sup> Sorby v The Commonwealth (1983) CLR 281 per Gibbs CJ at 292.

<sup>&</sup>lt;sup>1203</sup> Environmental Protection Authority v Caltex (1993) 178 CLR 477. Another kind of privilege may however be claimed, such as legal professional privilege.

<sup>&</sup>lt;sup>1204</sup> RCA is discussed in detail in Ian Freckelton and David Ranson, *Death Investigation and the Coroner's Inquest* (2006) 643.

<sup>&</sup>lt;sup>1205</sup> Coroner's Case No. 2390/03, 4.

<sup>&</sup>lt;sup>1206</sup> Coroner's Case Nos. 2390/03 and 1906/04.

<sup>&</sup>lt;sup>1207</sup> Coroner's Case No. 3578/96.

<sup>&</sup>lt;sup>1208</sup> But see *Royal Women's Hospital v Medical Practitioners Board of Victoria* [2006] VSCA 85 (20 April 2006). In this case it was found that the hospital records of a patient could not be protected by public interest immunity as the immunity was limited to decision-making at the highest government levels and therefore not applicable.

<sup>&</sup>lt;sup>1209</sup> Rees and Anor v Kratzman (1965) 114 CLR 63, per Windeyer J at 80.

- section 184 of the Crimes Act 1958;
- section 105 of the Victorian Civil and Administrative Tribunal Act 1998;
- section 39 of the Major Crime (Investigative Powers) Act 2004;
- Section 39 of the Transport Act 1983;
- Section 51 of the Seafood Safety Act 2003;
- Section 63F of the Nurses Act 1993;
- Section 154 of the Occupational Health and Safety Act 2004;
- Section 63G of the Medical Practice Act 1994;
- Section 19F of the Dangerous Goods Act 1985;
- Section 86PA of the Police Regulations Act 1958; and
- Section 138 of the Road Safety Act 1986.

In December 2005 the Victorian Law Reform Commission (VLRC), along with the Australian Law Reform Commission (ALRC) and the New South Wales Law Reform Commission (NSWLRC), considered whether to recommend that the uniform *Evidence Act* of the Commonwealth, New South Wales and Tasmania be implemented in Victoria. The model section abrogates the privilege against self-incrimination but provides for the granting of a certificate to exclude the admission of that evidence against the witness in any other legal proceeding. This is discussed in more detail later in this chapter.

#### Other Australian jurisdictions

In South Australia the position is similar to that in Victoria, although the privilege against self-incrimination is stated in the Act.<sup>1211</sup> In all other jurisdictions, unlike in Victoria, the relevant legislation specifically provides that self-incriminating evidence must be given at an inquest but that it is not admissible as evidence against that witness at later proceedings other than a prosecution for perjury.

In these jurisdictions the relevant legislation permits witnesses to object to answering incriminating questions. 1212 However, in these jurisdictions, unlike in Victoria and South

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<sup>&</sup>lt;sup>1210</sup> Australian Law Reform Commission, NSW Law Reform Commission, Victorian Law Reform Commission, *Review of the Uniform Evidence Acts*, ALRC Report No. 102 (2005); Queensland Law Reform Commission, *A Review of the Uniform Evidence Acts*, Report No. 60 (2005) 303.

<sup>&</sup>lt;sup>1211</sup> Coroners Act 2003 (SA) s 23(5).

<sup>&</sup>lt;sup>1212</sup> Coroners Act 1993 (NT) s 38(1); Coroners Act 1980 (NSW) s 33; Coroners Act 2003 (Qld) s 39(1); Coroners Act 2003 (SA) s 3(5)(a); Coroners Act 1996 (WA) s 47(1).

Australia, the Coroner has the power to require the witness to answer if the Coroner determines that it is in the interests of justice or in the public interest to do so.

While the common law privilege against self-incrimination has therefore been abrogated, these statutes also provide protective mechanisms for witnesses. While a witness may be required to give self-incriminating evidence, the legislation provides that the evidence cannot later be used in proceedings against that witness.<sup>1213</sup>

In all of these jurisdictions, except Queensland, a coroner gives a witness a certificate to this effect. <sup>1214</sup> In New South Wales a coroner may issue a certificate certifying that the evidence, as well as evidence derived from that evidence, is inadmissible at criminal or civil proceedings. This section was inserted into the New South Wales Act in 2000 following the claim of privilege against self-incrimination by a geologist who was a material witness at an inquest into the deaths of 18 people in a landslide at Thredbo in 1997. <sup>1215</sup>

The legislation is expressed in the following terms:

s.33AA Privilege in respect of self-incrimination

- (1) This section applies if a witness at an inquest or inquiry held by a coroner who is a Magistrate objects to giving particular evidence on the ground that the evidence may tend to prove that the witness has committed an offence or is liable to a civil penalty.
- (2) The coroner is to cause the witness to be given a certificate under this section in respect of the evidence if the objection is overruled but, after the evidence has been given, the coroner finds that there were reasonable grounds for the objection.
- (3) If the coroner is satisfied that the evidence concerned may tend to prove that the witness has committed an offence or is liable to a civil penalty but that the interests of justice require the witness to give the evidence, the coroner may require the witness to give the evidence. If the coroner so requires, the coroner is to cause the witness to be given a certificate under this section in respect of the evidence.
- (4) In any proceedings in a NSW court (within the meaning of the Evidence Act 1995):

<sup>&</sup>lt;sup>1213</sup> Coroners Act 1993 (NT) s 38(2), (3); Coroners Act 1980 (NSW) s 33AA; Coroners Act 2003 (Qld) s 39(3); Coroners Act 1996 (WA) s 47(2) and s 47(3).

<sup>&</sup>lt;sup>1214</sup> In the ACT and Tasmania certificates are granted under the *Evidence Act 1995* (Cth) s128 (for the ACT) and the *Evidence Act 2001* (Tas) s 128.

<sup>&</sup>lt;sup>1215</sup> Mr Kevin Moss, Parliamentary Secretary, Courts Legislation Amendment Bill, Second Reading Speech, 30 May 2000, 6107. The case which prompted the amendment was *Decker v State Coroner of New South Wales* [1999] NSWSC 369. It is discussed in detail in Ian Freckelton and David Ranson, *Death Investigation and the Coroner's Inquest* (2006) 581.

- (a) evidence given by a person in respect of which a certificate under this section has been given, and
- (b) evidence of any information, document or thing obtained as a direct or indirect consequence of the person having given that answer, cannot be used against the person. However, this does not apply to a criminal proceeding in respect of the falsity of the evidence.
- (5) A certificate under this section can only be given in respect of evidence that is required to be given by a natural person.

The Committee sought to establish whether the certification process under section 33AA of the NSW *Coroners Act* had caused concern. The Law Society of New South Wales did not express any general concern with the operation of section 33AA.<sup>1216</sup> However, the Society did comment on a specific difficulty that emerges where a witness is not legally represented. The Society submitted that:

a witness should not be asked in the witness box if they waive the privilege against self incrimination if they are not separately represented. It should be the role of Counsel assisting or another nominated person to explain what the privilege actually means. If this is not the role of Counsel assisting, it should be the duty of the Coroner to ensure that a witness has had independent legal advice from another source.<sup>1217</sup>

The Coronial Service in New South Wales indicated to the Committee that the Service does not keep statistics on the number of section 33AA certificates it issues and that there is no standard direction given to witnesses who make an application for a certificate. 1218

Coroners in New South Wales do not necessarily issue a certificate in every instance where a witness objects to answering questions. For example, in the 2004 inquest into the death of a 17-year-old boy during a police operation in Redfern, the State Coroner excused a key witness, who was a police officer involved in the operation, from giving evidence. The excusal was granted on the basis that, if the officer were required to give evidence, a section 33AA certificate would not exempt the evidence from being used at any subsequent police disciplinary proceedings.

At the inquest into the death of Dianne Brimble, 1220 a person of interest Mr Mark Wilhelm argued that he should not have to appear on grounds of possible self

<sup>&</sup>lt;sup>1216</sup> Email, Jo Kummrow, Lawyer, Law Institute of Victoria, to Committee Legal Research Officer, 23 January 2006.

<sup>&</sup>lt;sup>1217</sup> Ibid.

<sup>&</sup>lt;sup>1218</sup> Ibid.

<sup>&</sup>lt;sup>1219</sup> New South Wales Coroner's Case No. 287/04. Available at <a href="https://www.lawlink.nsw.gov.au">www.lawlink.nsw.gov.au</a>. See also Charandev Singh, *Minutes of Evidence*, 19 September 2005, 117.

<sup>&</sup>lt;sup>1220</sup> Ms Brimble died of an overdose of the drug Gamma-hydroxybutyrate on a cruise ship the Pacific Sky, in September 2002.

incrimination. The Coroner, however, ruled that he must appear and if he refused to give evidence on the grounds of self-incrimination, she would consider issuing him an immunity certificate.<sup>1221</sup>

In Queensland a simpler procedure has been adopted, which does not rely on the granting of a certificate for a witness to be afforded protection against self-incriminating evidence being used at a later proceeding. The provision also provides protection against derivative evidence being used in criminal proceedings against a witness:

#### 39 Incriminating evidence

- (1) This section applies if a witness refuses to give oral evidence at an inquest because the evidence would tend to incriminate the person.
- (2) The coroner may require the witness to give evidence that would tend to incriminate the witness if the coroner is satisfied that it is in the public interest for the witness to do so.
- (3) The evidence is not admissible against the witness in any other proceeding, other than a proceeding for perjury.
- (4) Derivative evidence is not admissible against the witness in a criminal proceeding.
- (5) In this section—

derivative evidence means any information, document or other evidence obtained as a direct or indirect result of the evidence given by the witness.

Partly in response to the change in the law in New South Wales, the Northern Territory introduced similar coronial legislation to amend the privilege against self-incrimination:

In view of the legislative developments in other states and territories which have modified the classic common law privilege against self-incrimination, and in view of the clear intention in coroners acts that the coroner should carry out a thorough investigatory process, we consider that these amendments are in the public interest, and will enhance the administration of justice in the Northern Territory.

The making of sensible recommendations in relation to public health or safety, or the administration of justice, may also be frustrated where medical practitioners refuse to answer questions on the basis of self-incrimination. It may be that in these cases, the concern for these witnesses may not be that he or she may be charged with a criminal offence, but that civil or disciplinary proceedings may result from the giving of the evidence. It is important to emphasise

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<sup>&</sup>lt;sup>1221</sup> The Australian, 23 June 2006. The case is part heard with hearing dates set for September, November and December 2006.

<sup>&</sup>lt;sup>1222</sup> Coroners Act 2003 (Qld) s 39.

that the effect of the amendment is not to provide an indemnity from prosecution or protection against civil action or disciplinary action. The witness could still be charged with a criminal offence following the inquest, or investigations taken with regard to civil or disciplinary action. It is just that the actual evidence given to the coroner cannot be used in subsequent proceedings.

The policy behind the amendment is to get to the truth. The policy is, therefore, better fulfilled by extending the protection afforded by a certificate and should extend to all proceedings. As inquests are generally held in open court, and evidence and findings are not generally the subject of suppression orders, if a confession is reported in the press, the guarantee of a fair trial will be eroded. This is particularly so in a small community such as the Territory. For that reason, I also emphasise that the act does contain discretionary powers in the coroner to suppress evidence in an appropriate case. 1223

## International jurisdictions

In the UK the relevant rules provide that a witness is not obliged to answer any question which tends to incriminate that person. The rules, unlike the Victorian Act, also require a coroner to inform a witness of the right to refuse to answer incriminating questions. The Canadian province of Ontario has similar provisions protecting the right to refuse to answer questions that may incriminate, and requiring the coroner to ensure that the witness is informed of this right.

This is in contrast to the standard practice in Victoria, which is not so much to advise the witness of the privilege in relation to certain questions but rather to allow the witness to refuse to answer any questions at all where it is likely that the witness will be implicated in a serious crime.<sup>1227</sup>

## Law reform agencies

The abrogation of the privilege against self-incrimination has been considered by a number of law reform agencies in the general context and in relation to coronial law. Some of these agencies have recommended the retention of the privilege, while others have considered that in some circumstances the removal of the privilege is justified.

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<sup>&</sup>lt;sup>1223</sup> Dr Toyne, Coroners Amendment Bill 2001, Second Reading Speech, 28 November 2001, Parliamentary Record No. 2.

<sup>&</sup>lt;sup>1224</sup> Coroners Rules 1984 (UK), rule 22(1).

<sup>&</sup>lt;sup>1225</sup> Coroners Rules 1984 (UK), rule 22(2).

<sup>&</sup>lt;sup>1226</sup> Coroners Act, RSO 1990, c 37, s 42.

<sup>&</sup>lt;sup>1227</sup> Ian Freckelton and David Ranson, Death Investigation and the Coroner's Inquest (2006) 579.

<sup>&</sup>lt;sup>1228</sup> See for example Australian Law Reform Commission, *Evidence*, Report No. 38, 1987, 120, which recommended the retention of the privilege; Victorian Law Reform Commission, *Implementing the Uniform Evidence Act Report*, 2006.

In 1991 a RCADC regional report on individual deaths in custody considered the abrogation of the privilege in the coronial context. Commissioner O'Dea referred to a number of death in custody inquests in which police officers had declined to give evidence on the grounds that their evidence may be self-incriminating. Commissioner O'Dea stated in the report that such incidents were clearly frustrating to the Coroner. He considered that it was appropriate that the traditional common law privilege be retained, given that at the time coroners still retained the power to commit a person for trial. However, he recommended that the Coroner's power to commit be abolished and that the privilege against self-incrimination be abrogated because it would enhance a coroner's ability to find out what happened in relation to a death. The removal of the privilege was to be compensated for by providing a statutory prohibition on the use of the evidence at any future criminal or civil proceeding. The suggested section provides:

A statement or disclosure made by any witness in the course of giving evidence before a coroner at an inquest is not admissible in evidence against that witness in any civil or criminal proceedings in any court other than a prosecution for perjury in the giving of such evidence. 1232

The abrogation of the privilege against self-incrimination by statute was examined in detail by the Queensland Law Reform Commission (QLRC) in 2004. The commission concluded that there were only two bases on which abrogation of the privilege was justified:

- the public interest to which the information that would be compelled by abrogation of privilege relates is sufficiently important; or
- the provision of the compelled information is required in compliance with a legislative regulatory system to which the individual has voluntarily subjected himself or herself. 1234

In relation to the public interest element, the commission considered that abrogation of the privilege is justified only if the information to be compelled concerns an issue of

<sup>1231</sup> This was not the case in Victoria, where the power of a coroner to commit for trial was removed by the 1985 Act.

<sup>&</sup>lt;sup>1229</sup> Royal Commission on Aboriginal Deaths in Custody, *Regional Report of Inquiry Into Individual Deaths In Custody In Western Australia* (1991) Commissioner Hon D J O'Dea.

<sup>&</sup>lt;sup>1230</sup> Ibid 6.4.6.

<sup>&</sup>lt;sup>1232</sup> Royal Commission on Aboriginal Deaths in Custody, *Regional Report of Inquiry into Individual Deaths in Custody in Western Australia* (1991) vol 2, Commissioner Hon D J O'Dea, 6.4.6.

<sup>&</sup>lt;sup>1233</sup> Queensland Law Reform Commission, *The Abrogation of the Privilege Against Self Incrimination,* Report No. 59, 2004.

<sup>&</sup>lt;sup>1234</sup> Ibid 53–4.

major public importance that has a significant impact on the community in general or on a section of the community.<sup>1235</sup> For example:

an inquiry or investigation into allegations of major criminal activity, organised crime or official corruption or other serious misconduct by a public official in the performance of his or her duties might justify the abrogation of the privileges. Abrogation might also be justified where there is an immediate need for information to avoid risks such as danger to human life, serious personal injury or damage to human health, serious damage to property or the environment, or significant economic detriment, or where there is a compelling argument that the information is necessary to prevent further harm from occurring.<sup>1236</sup>

Even if the abrogation is justified on one of these grounds, the Commission considered that a proposed abrogation provision may not necessarily be appropriate in a particular act. The following were identified by the Commission as relevant factors which should be taken into consideration:

- whether the information that an individual is required to give could not reasonably be obtained by any other lawful means;
- if alternative means of obtaining the information exist, the extent to which the use
  of those means would be likely to assist in the investigation in question; and
  whether resort to those means would be likely to prejudice rather than merely
  inconvenience the investigation.
- the nature and extent of the use, if any, that may be made of the information as evidence against the individual who provided it;
- the procedural safeguards that apply;
- whether the extent of the abrogation is no more than is necessary to achieve the purpose of the abrogation.

The commission also recommended that derivative use immunity should not be granted unless there are exceptional circumstances which justify the extent of its impact.<sup>1237</sup>

The abrogation of the privilege in relation to inquests was considered by the Northern Territory Law Reform Committee (NTLRC) in 2001. The NTLRC observed that in the coronial jurisdiction the perception seemed to prevail that its proceedings were

<sup>1237</sup> Ibid 104.

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<sup>&</sup>lt;sup>1235</sup> Ibid 54.

<sup>&</sup>lt;sup>1236</sup> Ibid.

<sup>&</sup>lt;sup>1238</sup> Northern Territory Law Reform Committee, *Report on Privilege Against Self-Incrimination*, Report No. 23, 2001. Available at www.nt.gov.au.

hampered by the privilege. It referred to the submission made by a Northern Territory Coroner who contended that it:

is particularly frustrating to the next of kin and in many cases has the effect of preventing them from coming to terms with the death of their loved one. They have the apprehension that essential evidence is being held back from them. It is something that may have the effect of undermining general public confidence in the coronial process itself.<sup>1239</sup>

In its report the NTLRC examined the differences between a judge and a coroner and the rules of evidence, referring to the fact that:

a Coroner is in a very different position from a judge. He is an investigator with powers to call witnesses and act very much like a continental judge to find the facts—an investigator rather than an arbiter. ...

If the Coroner is not so constrained and indeed has a specific duty to seek out the facts for himself, surely therefore the argument is strong that, if the investigation of those facts necessarily impinges upon criminal activity, he must have the power to investigate that criminal activity in order to discharge his duty effectively. 1240

In view of the clear intention in the Northern Territory *Coroners Act* that a Coroner should carry out a thorough investigatory process, and the legislative amendments made to the privilege in most other Australian coronial jurisdictions, the NTLRC supported similar amendments to the Territory Act.<sup>1241</sup>

The abrogation of the privilege against self-incrimination in the coronial context was also considered in the UK by the Luce Inquiry. The Luce Inquiry sought expert legal advice on the various procedures by which a witness could be compelled to give evidence at an inquest but which ensured that the evidence could not be used in subsequent criminal proceedings against that witness. 1242 The legal opinion concluded that, given that the nature of an inquest is to find out the cause of death, as opposed to ascribing fault to a particular party, there was some justification for questioning the need to allow the privilege of self-incrimination to extend to inquests. 1243 The opinion identified the following possible procedural measures by which the privilege could be modified:

<sup>&</sup>lt;sup>1239</sup> Ibid 7–8.

<sup>&</sup>lt;sup>1240</sup> Ibid.

<sup>&</sup>lt;sup>1241</sup> Ibid 10.

<sup>&</sup>lt;sup>1242</sup> Anthony Heaton-Armstrong and Brett Weaver, 'Privilege Against Self Incrimination: An Overview', Unpublished report to the United Kingdom Fundamental Review of Death Certification and the Coroner Services in England, Wales and Northern Ireland, Cm 5831 (2003).

<sup>&</sup>lt;sup>1243</sup> Ibid 8.

- Complete embargo: all information given to an inquest can only be used at the inquest and for no other proceedings. 1244
- Limited embargo within coroner's discretion: the privilege to remain available but only in specific circumstances. The witness could be required to answer all questions truthfully and in as much detail as possible, but where an issue as to self-incrimination arises the coroner could warn the witness that s/he should choose whether s/he waives the privilege. If s/he does so then the answer will be admissible in evidence against him or her, but if not then s/he cannot be compelled to answer the question.<sup>1245</sup>
- Compulsory disclosure in confidence: it could be possible to ensure that there is a statutory duty of full disclosure in relation to inquests. The statute could be framed in such a way as to give effect to the general principle that, where disclosure is given compulsorily for a specific and limited purpose, it is subject to a duty of confidentiality.<sup>1246</sup>
- The Bloody Sunday model: a system based on the Bloody Sunday inquiry, <sup>1247</sup> in which an undertaking would be given by a coroner that no information that arises at the hearing will be used in a subsequent proceeding, to ensure that all witnesses provide truthful testimony without fear of reprisals. <sup>1248</sup>
- Compulsory disclosure under limited embargo: when there is an issue of self-incrimination the coroner would be required to explain to the witness (a) the right to object to answer the question on the grounds of self-incrimination the witness would then be obliged to truthfully answer the question, but any evidence given in relation to the question could not be used in any criminal or disciplinary proceedings and (b) the entitlement to waive the right to object to a self-incriminating question.<sup>1249</sup>

The legal opinion given to the Luce Inquiry considered that the best option was either the Bloody Sunday inquiry model or the compulsory disclosure under limited embargo:

<sup>1245</sup> Ibid 10.

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<sup>&</sup>lt;sup>1244</sup> Ibid 9.

<sup>&</sup>lt;sup>1246</sup> Ibid 11.

<sup>&</sup>lt;sup>1247</sup> In 1972, during a disturbance in Derry following a civil rights march, members of the British Army fired shots which killed 14 people. An initial inquiry into the deaths was held in 1972. A second inquiry into the deaths was established in 1998 and is yet to table its final report: <a href="https://www.bloody-sunday-inquiry.org">www.bloody-sunday-inquiry.org</a>.

<sup>&</sup>lt;sup>1248</sup> Anthony Heaton-Armstrong and Brett Weaver, 'Privilege Against Self Incrimination: An Overview', Unpublished report to the United Kingdom Fundamental Review of Death Certification and the Coroner Services in England, Wales and Northern Ireland, Cm 5831 (2003) 12.

<sup>&</sup>lt;sup>1249</sup> Ibid 14.

The advantage of the Bloody Sunday model is that it ensures that witnesses are able to give full testimony to all the relevant facts without fear of criminal reprisals directly arising from such testimony and ensures that the witness does give evidence or face possible adverse inferences from their failure to do so. The disadvantage of this system is that the blanket embargo that arises is very similar to the complete embargo situation and may not be in the public interest.

The compulsory disclosure under limited embargo has the advantage that it avoids any such blanket embargo whilst still ensuring that witnesses are either compelled or encouraged to give full and frank testimony to the court. The protection against self-incrimination remains but only to a limited extent. The only disadvantage with such a system would be that it has the potential to be a complicated procedure but, as it is a set procedure, guideline directions could be provided to ensure a consistency of approach.<sup>1250</sup>

In conclusion, the report considered that the preferred option was the compulsory disclosure under limited embargo system because it provided the benefits of the Bloody Sunday model without the difficulties arising from the blanket embargo. A caveat on this was that clear, unambiguous statutory provisions and directions for witnesses would be required to ensure that the system was not unduly complex.

The Luce Inquiry endorsed the limited embargo system as a recommendation in its report. The inquiry also recommended that a standard written direction be prepared so that coroners could read the direction to a witness when an issue of self-incrimination arose. This measure would ensure that consistent and accurate advice was given to all witnesses.

Dame Janet Smith did not examine the question of self-incrimination at the Shipman Inquiry, as she thought that it was a difficult subject which required detailed consideration. 1253

As discussed earlier in this chapter, the uniform evidence law review recently considered whether to recommend that the uniform *Evidence Act* of the Commonwealth, New South Wales and Tasmania be implemented in Victoria. A model section abrogates the privilege against self-incrimination but provides for the granting of a certificate to exclude the admission of that evidence against the witness in any other legal proceeding.

<sup>1251</sup> Ibid 15.

<sup>&</sup>lt;sup>1250</sup> Ibid 13-14.

<sup>&</sup>lt;sup>1252</sup> United Kingdom, *Death Certification and the Coroner Services in England, Wales and Northern Ireland: a Fundamental Review*, Cm 5831 (2003) 106.

<sup>&</sup>lt;sup>1253</sup> United Kingdom, The Shipman Inquiry Third Report: *Death Certification and the Investigation of Deaths by Coroners* (2003) Cm 5854, 213.

<sup>&</sup>lt;sup>1254</sup> Australian Law Reform Commission, NSW Law Reform Commission, Victorian Law Reform Commission, *Review of the Uniform Evidence Acts*, ALRC Report No. 102 (2005) Queensland Law Reform Commission, *A Review Of The Uniform Evidence Acts*, Report No. 60 (2005) 303.

The process of issuing a certificate in exchange for the giving of self-incriminating evidence was based on a model adopted in the ACT Court of Petty Sessions. An ALRC report noted that magistrates had used the procedure around 25 times a year, resulting in useful additional information being obtained from witnesses.<sup>1255</sup>

## Section 128(2) provides:

Subject to subsection (5), if the court finds that there are reasonable grounds for the objection, the court is not to require the witness to give that particular evidence, and is to inform the witness:

- (a) that he or she need not give the evidence; and
- (b) that, if he or she gives the evidence, the court will give a certificate under this section; and
- (c) of the effect of such a certificate.

#### Section 128(5) states:

If the court is satisfied that:

- (a) the evidence concerned may tend to prove that the witness has committed an offence against or arising under, or is liable to a civil penalty under, an Australian law; and
- (b) the evidence does not tend to prove that the witness has committed an offence against or arising under, or is liable to a civil penalty under, a law of a foreign country; and
- (c) the interests of justice require that the witness give the evidence;

the court may require the witness to give the evidence.

In its discussion paper the inquiry noted that members of the judiciary had expressed concerns with procedural issues in relation to section 128:

Judges, in particular, told the Inquiry that the process under s 128 is cumbersome and hard to explain to witnesses. They also argued that the necessity to invoke the process in relation to each question is clumsy. 1256

In its joint report the ALRC, along with the VLRC and NSWLRC, considered that the best way to clarify the procedure under section 128 was by simplifying the order in which the process of certification was outlined in the section:

<sup>&</sup>lt;sup>1255</sup> Australian Law Reform Commission, *Evidence (Interim)*, ALRC Report 26, 1985, 861.

<sup>&</sup>lt;sup>1256</sup> Australian Law Reform Commission, New South Wales Law Reform Commission and Victorian Law Reform Commission, *Review of the Uniform Evidence Acts*, ALRC Discussion Paper 69, NSWLRC DP 47, VLRC DP (2005) [13.223]–[13.226], see Proposal 13–9 and Question 13–2.

This would involve moving the current s 128(5), where the court may require the witness to give evidence, closer to s 128(2), where the witness makes the objection. In addition, rather than the current practice, where a certificate is required to be issued for each question, the Commissions support the view that 'particular evidence' under the section should be defined to include 'evidence both in response to questions and evidence on particular topics'. 1257

Rather than including a requirement that a judge inform a witness of their rights and how the section operates, the commissions concluded that it would be simpler for the section to provide:

- that the witness may object to giving the evidence on the grounds of selfincrimination or that it would make the witness liable to a civil penalty;
- that the court will determine whether or not that claim is based on reasonable grounds;
- if the claim is reasonable, that the court can then tell the witness that s/he may choose to give the evidence or the court will consider whether the interests of justice require that the evidence be given;
- if the evidence is given, either voluntarily or under compulsion, that a certificate will be granted preventing the use of that evidence against the person in another proceeding. 1258

The QLRC indicated that, if Queensland were to consider adopting the uniform *Evidence Act* generally, consideration should be given to adoption of the uniform *Evidence Act* without adopting this certificate based provision. The QLRC considered that section 128 is inconsistent with recommendations contained in its report on the abrogation of the privilege against self-incrimination in that it does not provide that the witness may waive the immunity that is conferred in respect of the evidence given. <sup>1259</sup>

## Evidence received by the Committee

Witnesses were divided on the question of whether a change to the law limiting a person's right to claim the privilege against self-incrimination was justified. In general, most medical and legal stakeholders argued for the retention of the privilege, while the Coroner's Office, Victoria Police, medical error action groups and family members submitted that a change was justified because it was in the public interest that valuable evidence be obtained which could improve safety and prevent further deaths.

<sup>&</sup>lt;sup>1257</sup> Australian Law Reform Commission, NSW Law Reform Commission, Victorian Law Reform Commission, *Review of the Uniform Evidence Acts*, ALRC Report No. 102 (2005) 15.106.

<sup>&</sup>lt;sup>1258</sup> Ibid 15.107.

<sup>&</sup>lt;sup>1259</sup> Queensland Law Reform Commission, *A Review of the Uniform Evidence Acts*, Report No. 60,QLRC (2005) 294-295.

Legal stakeholders arguing for the retention of the privilege based their objections on a number of grounds. The LIV submitted that the public interest in preserving the privilege, insofar as it related to a tendency to expose the person to a criminal conviction, outweighed any public interest in waiving it for the purposes of coronial inquests. 1260 Similarly, the Victorian Bar strongly opposed a change, arguing that:

(t)he privilege against self incrimination has been continually eroded, with questionable benefits, if any, flowing from the erosion. There is no justification for removing the privilege in the Coroner's context. 1261

VLA also argued against the abrogation of the privilege, referring to a High Court of Australia decision which described the privilege as:

one of the bulwarks of liberty. History, and not only the history of totalitarian societies, shows that all too frequently those who have the right to obtain an answer soon believe that they have a right to the answer they believe should be forthcoming. Because they hold that belief, often they do not hesitate to use physical and psychological means to obtain the answer they want. The privilege against self-incrimination helps to avoid this socially undesirable consequence: McHugh J in RPS v R (2000) 199 CLR 620. 1262

Unlike all other stakeholders, VLA argued that the privilege should be strengthened. VLA submitted that this could be achieved by enshrining it in the Act and providing coroners with appropriate training about the nature and effect of the privilege. VLA considered that there were a number of problems currently faced by witnesses who claimed the privilege at an inquest, including negative media reporting when a witness exercised the right to object to giving evidence. VLA provided the Committee with the following case study:

A client's husband and child died. The Coroner considered the possibility the deaths resulted from a failed suicide pact between the client and her husband. The bereaved client was too distressed to give evidence. The Coroner required formal submissions from counsel about the right to silence before excusing the client from giving evidence. In his findings, the Coroner made adverse comments about client's reliance on the privilege and drew negative inferences based on her silence. The comments and inferences were published in media reports implying that the client was 'guilty'. 1263

Three medical stakeholders also opposed a change but did not articulate reasons for their opposition. 1264 Austin Health advised the Committee that, while the hospital

<sup>1263</sup> Ibid.

<sup>&</sup>lt;sup>1260</sup> Law Institute of Victoria, Submission no. 58, 4.

<sup>&</sup>lt;sup>1261</sup> Victorian Bar, Submission no. 81, 9–10.

<sup>&</sup>lt;sup>1262</sup> Victoria Legal Aid, Submission no. 34, 5.

<sup>&</sup>lt;sup>1264</sup> Nurses Board of Victoria, Submission no. 15, 2; Royal Women's Hospital, Melbourne, Submission no. 18, 2; Australian Medical Association, Submission no. 38, 3.

supported principles of open disclosure, it opposed the removal of the privilege on the grounds that health professionals should continue to have appropriate legal rights. Similarly, the Australian Nursing Federation argued that the privilege should remain because it was common for nurses to be required to give evidence at coronial inquiries and that witnesses at inquests should be afforded the same rights as other witnesses in courts. Former coroner Ms Heffey and Health Services Commissioner Ms Wilson also voiced their opposition to an erosion of the privilege in the coronial context, referring to the privilege as a fundamental right. 1267

A number of stakeholders who argued against the abrogation of the privilege against self-incrimination also voiced concerns in relation to the introduction of a certificate-style provision such as section 33A of the New South Wales Act. Ms Heffey expressed her concerns in the following terms:

I have always had difficulty with the NSW legislation in this respect. The privilege against self-incrimination is a fundamental right. I do not accept that a "certificate" is an acceptable way around this. Is it combined with suppression of the press to report? It would bring the whole justice system into disrepute if a person could openly admit to a crime of murder at an inquest but not suffer any repercussion. ...Whilst it would be a useful tool to get to the truth of an unlawful death, (as would be the case if the police could insist that a person respond to answers in a record of interview) this is an unassailable right that no inquest investigation should be able to circumvent.<sup>1268</sup>

#### VLA expressed similar concerns:

The negative consequences of overriding the privilege cannot be remedied by providing a certificate that the incriminating information is not admissible in any subsequent proceedings. ...Further, inquests are held in open Court. Members of the public and media frequently attend. The certificate does not prevent the incriminating information being disclosed to others or published by the media. In some cases, the socio-economic consequences that result from this disclosure are as significant as criminal penalties. 1269

Similarly, Jack Forrest QC told the Committee that the Victorian Bar strongly opposed any suggestion that the privilege against self-incrimination be 'whittled down in any way, even with the issue of a certificate', arguing that:

<sup>&</sup>lt;sup>1265</sup> Letter, Margaret Way, Director, Strategy, Risk and Clinical Governance, Austin Health, to Committee Executive Officer, 13 December 2005, 1; Austin Health, *Submission no. 45*, 6.

<sup>&</sup>lt;sup>1266</sup> Australian Nursing Federation, Victorian Branch, Submission No. 39, 1.

<sup>&</sup>lt;sup>1267</sup> Jacinta Heffey, *Submission no.* 33, 23; Beth Wilson, Health Services Commission, *Minutes of Evidence*, 20 September 2005, 178. Ms Wilson told the Committee that she had made a mistake in her submission and that she now thought that the privilege against self-incrimination was 'a fundamental human right enshrined in our law, and I think it should continue to be applicable in coronial proceedings'.

<sup>&</sup>lt;sup>1268</sup> Jacinta Heffey, Submission no. 33, 23.

<sup>&</sup>lt;sup>1269</sup> Victoria Legal Aid, Submission no. 34, 5.

Once you start tinkering with it, whether by certificates or otherwise, it places them in a position of jeopardy, even if the evidence cannot be used against them [subsequently]. It gives the prosecution or investigating authority a whole gamut of information which it would not have had previously, and that information has been obtained in the course of a coronial inquest...<sup>1270</sup>

## VLA agreed with the Bar on this point, submitting that:

Although the information itself cannot be used directly, it can be used to uncover other fresh evidence, which will be admissible. 1271

On the other hand, the LIV considered that with an appropriate indemnity the privilege could be waived with respect to liability to civil penalty and that a suitably modified version of the NSW legislation could be adopted. Mr O'Shea of the LIV told the Committee that the LIV did not support the waiver of the privilege with a certificate of indemnity in relation to criminal liability. However, he acknowledged that it was often difficult to draw a distinction between criminal and civil liability at an inquest:

Often coronial inquiries can be enmeshed with criminal and civil liability and it is very difficult to say that you can compel a witness to give evidence in respect of civil liability but not criminal. If the witness claimed only that there was a civil liability and therefore wished not to give evidence, perhaps that might be fair enough if it was the call of the witness, but inevitably it can give rise to problems if the evidence strays into the criminal area.<sup>1274</sup>

Mr O'Shea expressed concerns in relation to the extent of the protection which would be afforded by a certificate and queried whether it would provide immunity from prosecution in relation to Commonwealth offences. This was a concern he reiterated in his capacity as corporate counsel for Bayside Health. Another concern he expressed on behalf of Bayside Health centred on the need to clarify the law governing requirements to produce certain documents, such as RCA reports, for a coronial investigation in relation to a death at a hospital:

If the reports that are prepared, such as the root cause analysis, were given qualified privilege, the need to deal with that issue would largely have disappeared because you would have full and frank disclosure in the RCAs and any other reports that were written, and a person could then be cross examined in the box, I guess, on their report. And if the report is privileged, the extent to which self incrimination arises will be much less.

<sup>&</sup>lt;sup>1270</sup> Jack Forrest, Victorian Bar, *Minutes of Evidence*, 5 December 2005, 284 and 286.

<sup>&</sup>lt;sup>1271</sup> Victoria Legal Aid, Submission no. 34, 5.

<sup>&</sup>lt;sup>1272</sup> Law Institute of Victoria, Submission no. 58, 4.

<sup>&</sup>lt;sup>1273</sup> Bill O'Shea, *Minutes of Evidence*, 20 September 2005, 169.

<sup>&</sup>lt;sup>1274</sup> Ibid.

<sup>&</sup>lt;sup>1275</sup> Ibid 172.

<sup>&</sup>lt;sup>1276</sup> Ibid 216.

I think the problem is that at the moment fear of civil liability, not to mention criminal liability—for example, a breach of the Health Services Act or the Mental Health Act could involve criminal liability—is a big inhibitor to medical staff giving full and frank disclosures in RCAs. It is a major issue. The doctors do not say it all the time because it has not arisen too often.

It is not often that a coroner has asked for a root cause analysis to be produced. Earlier this year we almost ended up in the Supreme Court arguing that point on one particular coronial. In the end we decided to release it rather than stop the coronial and go off to the Supreme Court and argue the case. It does need to be clarified. If a case like that was argued and the result was that an RCA was deemed to be available for public disclosure, there would be a huge backlash among the medical profession in terms of their willingness to cooperate. It is a major issue for them.

It does not matter that you tell them that it is not admissible or in terms of apologies that apologies are not admissible. If they believe that what they say can be used against them, they just will not cooperate. Their insurers, if no one else, will tell them not to cooperate. The MDAV, the VMIA and whoever else insures them will tell them, 'If this is going to expose us to liability because of what you have to say, you should not cooperate. Do not participate in that RCA if it is going to become public'.

Mr O'Shea advised the Committee that an RCA is not like a routine hospital document that only contains factual information which would be released under Bayside Health's policy of open disclosure:

An RCA is more than just facts: it is really getting to the root cause of why that person died. It might be, for example, that there are not enough nurses on duty on weekends in a psych ward; or it might be that one registrar in a psych ward on a Sunday is not enough. Arguably that is an admission of liability by the hospital—that is, failure of a duty of care. That exposes it. It is more than just factual; it goes to cause and it goes to opinions, and that is where you have this conflict between open disclosure which deals with facts and straying from that into opinions. So it can inhibit open disclosure for the fear that you will go too far. 1277

Other witnesses, such as the Coroner's Office, the TAC, Victoria Police, Associate Professor Ranson and Dr Freckelton, considered that the abrogation of the privilege against self-incrimination with a certificate or general protection provision was justified on the ground that it would enable a coroner to fulfil the statutory function of making informed findings on the cause of a death. <sup>1278</sup> Dr Freckelton acknowledged that it was a fraught and difficult issue and something on which reasonable people differ. However, he supported the introduction of a certificate provision:

<sup>&</sup>lt;sup>1277</sup> Ibid.

<sup>&</sup>lt;sup>1278</sup> Victoria Police, *Submission no. 78*, 7; Transport Accident Commission, *Submission no. 50*, 13–14; David Ranson, *Submission no. 19*, 57. See also the submissions of the Association for the Prevention of Medical Errors, *Submission no. 78*, 14; Mark Cannon, Springvale Monash Legal Service, *Minutes of Evidence*, *20 September 2005*, 137; Constituents of East Yarra Province, *Submission No. 20*, 5.

There is a great deal to be said for that in respect of inquests in that it happens not seldom that those who know most about how a death occurred avail themselves of the privilege against self incrimination, entirely understandably seeking to protect themselves against the potential for the preferring of indictable charges. But that deprives the coroner of the capacity to set the record straight and to make findings as to the circumstances of death in an informed and constructive way. It is highly problematic in terms of the efficacious discharge of a coroner's functions and it seems to me regardless of what is done in terms of the extension of the uniform evidence legislation to Victoria, it would be constructive to create a certification process for coroners so they could compel the giving of evidence by persons who have relevant information to impart, provided that the protection were given of that evidence not being able to be used against those persons in future civil or criminal proceedings. 1279

The State Coroner has advocated for the removal of the common law privilege in a number of his coronial recommendations. Following an inquiry which concerned the deaths of three men in a car crash during a police pursuit in which two police invoked the privilege and did not give evidence, he made the following comment in the inquest findings:

a general comment may be made that without the (oral) evidence and resultant questioning of the police directly involved in an incident, the dilemma is that valuable information may not be gathered. This information could potentially lead to better identification and understanding of the factors operating in the incident under investigation and also ensure that potential improvements in safety for police, the public and offenders are not missed.<sup>1280</sup>

In his recommendations the State Coroner requested that consideration be given in the review of the Act to adopting a provision similar to section 33AA of the New South Wales Act.<sup>1281</sup> However, in the Coroner's Office submission, the State Coroner indicated that a better option would be to adopt a Queensland-style provision because that provision afforded a general protection to witnesses which was not dependent on the granting of a certificate, as required under the New South Wales *Coroners Act.*<sup>1282</sup>

Two witnesses referred to the public interest element in abrogating the right to claim the privilege. Associate Professor Ranson submitted that, unlike a criminal or civil trial, an inquiry was a fact-finding exercise which was arguably designed to minimise the risk of harm to the whole community. He argued that, therefore, in the coronial setting, the potential for public good should outweigh the possibility of private harm

<sup>&</sup>lt;sup>1279</sup> Ian Freckelton, *Minutes of Evidence*, 20 September 2005, 206.

<sup>&</sup>lt;sup>1280</sup> Coroner's Case No. 822/02; 1821/02; 1823/02; 34. Available at www.coronerscourt.vic.gov.au.

<sup>&</sup>lt;sup>1281</sup> Ibid. See also Coroner's Case No. 434/04.

<sup>&</sup>lt;sup>1282</sup> State Coroner's Office, *Submission no. 70*, 86. The Coroner's Office submission also contained a suggested provision which could be incorporated into the Act. The suggested provision replicates the wording of the Queensland provision.

<sup>&</sup>lt;sup>1283</sup> David Ranson, Submission no. 19, 57.

because no individual was on trial for their conduct or behaviour. Similarly, Mr Rosen of APME submitted that:

there are two competing interests—the public interest in ascertaining the true circumstances of a reportable death, and the private interest in remaining silent when facing a criminal charge. It is highly unlikely that a doctor or nurse will be charged with a criminal offence even if grossly negligent conduct resulted in death. Still, health providers might disingenuously frame a privilege argument with a real view to avoid disclosing information that may be used against them in professional disciplinary proceedings. And the Victorian Coroner as well as the Victorian Police have observed that many relevant witnesses have been excluded from giving evidence based on their possible exposure to minor statutory criminal offences. This severely frustrates the ability of the coroner to identify the factors that led to the medical error and caused the death. 1284

Mr Rosen considered that the major objections to the abrogation of the right could be addressed by the use of media suppression orders if the Coroner believes it is likely to prejudice the fair trial of an accused person. Other measures that Mr Rosen suggested could be used to overcome objections included the use of in camera evidence and a prohibition on the derivative use of evidence in relation to criminal proceedings. This could be combined with a discretionary power to compel witnesses to answer questions at an inquest. He submitted that, if these necessary safeguards were incorporated into the provision, abrogation of the privilege would be justified because it would permit the Coroner's Office to properly fulfil its preventative role. 1285

APME submitted that the best approach would be for Victoria to adopt a provision similar to section 39 of the *Coroners Act 2003* (Qld), with an additional provision stating that such evidence may be heard in camera.<sup>1286</sup>

An argument for abrogating the privilege was advanced by a number of family members on the ground that the privilege may give rise to the perception that the rights of witnesses are afforded priority over establishing the cause of the death. This was the opinion of Ms Storm following her experience at the inquest into the death of her daughter Anne:

I know only of my experience at Anne's inquest. Such a privilege in no way ensured that the truth was told by all medical staff. 1288

This view was shared by Margrit and David Kaufmann who attended their son Mark's inquest: 1289

<sup>1286</sup> The suggested wording of the provision is set out at page 17 of the submission.

<sup>&</sup>lt;sup>1284</sup> Association for the Prevention of Medical Errors, *Submission no.* 78, 14.

<sup>&</sup>lt;sup>1285</sup> Ibid 16.

<sup>&</sup>lt;sup>1287</sup> See also I Dennis, 'Instrumental Protection, Human Right or Functional Necessity? Reassessing the Privilege Against Self-incrimination' (1995) 54 *Cambridge Law Journal* 359.

<sup>&</sup>lt;sup>1288</sup> Caroline Storm, Submission No. 25, 5.

The Coroner's power to summon and order a witness under oath is enormously diluted by the "right to silence". This has a huge effect on the family, not to have the person who shot Mark even questioned at all publicly.

This gives the perception, that this witness is not accountable and also the perception of bias and protection of [the] main 'wrong doers'. It also gives the perception of lack of truth and meaning of the coronial process. It is nonsensical that the cause of our child's death cannot be tested or properly inquired into during the very process for that purpose.<sup>1290</sup>

The frustration experienced by family members when principal witnesses claim the privilege against self-incrimination and do not give evidence was acknowledged by the State Coroner at the public hearings for this inquiry.<sup>1291</sup>

#### Discussion and conclusion

The Committee considers that the issue of whether the abrogation of the privilege against self-incrimination at inquests is justified is indeed a vexed question. While the Committee considers that the privilege may operate as a serious impediment to a coroner's ability to discover why a person died and make recommendations aimed at preventing future deaths, the Committee appreciates that there are understandable reasons that a witness at an inquest would choose to invoke the common law privilege. In the present system, if a witness either is unaware of the right or decides to waive the right and gives evidence then that person is potentially exposed to the consequences of having that evidence used against them in criminal and civil proceedings as well as being reported in the media. This may have an impact on a person's professional and personal reputation as well as their livelihood and liberty. While a coroner no longer has the power to commit a person to stand trial, the Act requires a coroner to make a report to the DPP if the Coroner believes that an indictable offence has been committed in connection with the death. 1292 Removing a witness's right to claim the privilege without conferring statutory safeguards which effectively prevent those consequences from occurring will not necessarily support a coroner's 'ability to get to the truth'. This is because some witnesses may remain fearful of those consequences and may therefore not give a truthful account of the circumstances which led to the death.

The Committee is of the view that the criteria recommended by the QLRC should be used when considering whether a statutory abrogation of the privilege is justified. This test is used to determine whether abrogation is in the public interest. The Commission considered that abrogation of the privilege is justified in relation to evidence which touches on issues of major public importance which have a significant impact on the

<sup>&</sup>lt;sup>1289</sup> Margrit and David Kaufmann, Submission no. 71, 5–6.

<sup>&</sup>lt;sup>1290</sup> Ibid.

<sup>&</sup>lt;sup>1291</sup> Graeme Johnstone, *Minutes of Evidence*, 19 September 2005, 78.

<sup>&</sup>lt;sup>1292</sup> Coroners Act s 21(3).

community in general or on a section of the community. The Commission considered that, for example, abrogation could be justified where there was an immediate need for information to avoid risks such as danger to human life or serious personal injury or where there is a compelling argument that the information is necessary to prevent further harm from occurring.

Applying this criterion in relation to self-incriminating evidence at inquests, the Committee considers that in many cases it could be successfully argued that the abrogation of the privilege is justified in order for a coroner to establish the facts surrounding a person's death and to make recommendations to prevent future deaths and injuries. The Committee is however mindful of the fact that there also may be particular cases in which the abrogation of the privilege may not be justified because there may no longer be an immediate need for the evidence in order to prevent further danger. For example, if an inquest takes place several years after a death it may be successfully demonstrated that measures such as system changes have already been implemented which ensure that further deaths or injuries will not occur. As such the Committee considers that there is some justification for abrogating the privilege against self-incrimination at inquests but that this should be determined by the application of a public interest test which needs to be applied to the individual circumstances of each case.

The Committee is also of the view that a number of statutory provisions are required in order to ensure that a witness is encouraged to give a full and frank disclosure of the circumstances surrounding a death. A witness should be entitled to give self-incriminating evidence without fear that it will later be tendered at a federal or state criminal trial or a civil proceeding. Safeguards should extend to a prohibition on the use of derivative evidence at a later proceeding, and this is provided for in the model legislation which the Committee proposes to recommend. Other measures include applying the coroner's discretion to hear the self-incriminating evidence in camera under the general power contained in section 46 and an order restricting the publication of self-incriminating evidence under section 58.

The Committee considers that, while a certificate-based system would require the Coroner's Office to complete paperwork in order for a witness to be provided with the certificate, it has the advantage of encouraging reluctant witnesses because they would be provided with tangible proof that particular evidence given at an inquest may not be tendered at later proceedings. In the interests of national consistency in the laws of evidence, consideration should therefore be given to adopting a provision based on the uniform evidence law provision. The Committee believes that the amendments recommended by the ALRC, NSWLRC and VLRC in the *Uniform Evidence Law Report 2005* should also be incorporated into the provision, as these recommendations simplify the procedures and will assist witnesses' understanding of both their rights and how the certificate system operates. Under the uniform evidence

<sup>&</sup>lt;sup>1293</sup> See uniform *Evidence Act* s 128(7).

law provisions the certificate extends to both state and federal proceedings, thus alleviating concerns expressed by the LIV that the certificate may not apply to federal proceedings.

The Committee notes the concern expressed by the New South Wales Law Society regarding the operation of the certificate system in that state. At present there is no requirement that a witness be given direction or the opportunity to obtain independent legal advice about objecting to answering self-incriminating questions. The Committee considers that such concerns may be addressed by the introduction of a requirement that a coroner be required to read a standard direction to witnesses when an issue of self-incrimination arises which informs the witness of their rights, including the right to seek legal advice and to request that the evidence be heard in camera. Furthermore, the Committee considers that, as in the UK, a coroner should have a duty to inform a witness of the right to object where it appears to the coroner that a person has been asked a question which may tend to incriminate the witness.

Recommendation 61. That the *Coroners Act 1985* be amended to include a provision modelled on section 128 of the uniform *Evidence Act*, incorporating recommendation 15-7 of the *Uniform Evidence Law Report 2005*, which requires that section 128 of the uniform *Evidence Act* should apply where—

- a) a witness objects to giving evidence either to a particular question, or
- b) a class of questions;

on the grounds that the evidence may tend to prove that the witness has committed an offence against or arising under an Australian law or a law of a foreign country or is liable to a civil penalty under such law.

Recommendation 62. That the section referred to in recommendation 61 is to provide that:

- a) the coroner is to determine whether or not that claim is based on reasonable grounds;
- b) if the coroner is so satisfied, the coroner must inform the witness that the witness may choose to give the evidence or the coroner will consider whether the interests of justice require that the evidence be given;
- c) the coroner may require that the witness give the evidence if the interests of justice so require, but the coroner must not do so if the evidence would tend to prove that the witness has committed an offence against or arising under a law of a foreign country or is liable to a civil penalty under a law of a foreign country; and
- d) if the evidence is given, either voluntarily or under compulsion, a certificate is to be granted preventing the use of that evidence against the person.

Recommendation 63. That the *Coroners Act 1985* be amended to include a provision which provides that, in considering whether the interests of justice require that the evidence be given, a coroner must consider whether there is a compelling argument that the information is necessary to prevent further harm from occurring.

Recommendation 64. That the *Coroners Act 1985* be amended to provide that, where it appears to the coroner that a witness has been asked a question which tends to incriminate the witness, the coroner is required to inform the witness of:

- a) the right to object to answering the question because the evidence would tend to incriminate the witness but that the coroner may overrule the objection if the coroner considers that it is in the interests of justice for the witness to give evidence;
- b) the right to obtain independent legal advice; and
- c) the right to make an application to the coroner that the evidence be heard in camera or that the coroner place a restriction on the reporting of that evidence.

Recommendation 65. That the *Coroners Act 1985* be amended to include a provision requiring the State Coroner to issue standard written directions for coroners and witnesses advising witnesses of their rights in relation to giving evidence at an inquest, the section to provide that:

- a) the directions are to be used by coroners when an issue of self-incrimination arises at an inquest; and
- b) a copy of the directions is to be provided to all persons who are summoned to give evidence at an inquest at the same time as the summons is served on the person.

## Legal professional privilege

The Committee did not receive evidence in relation to this issue. However, the Committee notes the comments made by the VLRC in its recent report *Implementing the Uniform Evidence Act*.<sup>1294</sup> The commission was of the view that it was desirable for issues surrounding legal professional privilege to be determined according to the uniform *Evidence Act* privilege provisions so that lawyers, police and magistrates did not have to deal with separate sets of privilege rules for criminal and coronial matters.<sup>1295</sup>

<sup>&</sup>lt;sup>1294</sup> Victorian Law Reform Commission, *Implementing the Uniform Evidence Act Report*, 2006, 43–4.

<sup>&</sup>lt;sup>1295</sup> Victorian Law Reform Commission, *Implementing the Uniform Evidence Act*. The Commission considered that a provision in the *Coroners Act* could be modelled on section 106 of the *Victorian Civil and Administrative Tribunal Act 1998* or proposed section 131A of the uniform *Evidence Act*.

## **Natural justice**

In addition to the rights set out in the Act, the High Court of Australia in *Annetts v McCann* extended the rights of persons with a sufficient interest. The case is important because it held that a coroner has a duty to comply with the rules of natural justice. The decision confirmed a common law right that a person with a sufficient interest has a right of reply where a coroner is considering making a finding which is adverse to the interests of that person.

In *Annetts v McCann* a coroner held an inquest into the deaths of two boys who were found dead in the West Australian desert. The boys had been working as jackeroos on a station owned by a pastoral company. The Coroner granted the boys' parents the right to representation at the hearing; however, towards the end of the inquest the Coroner declined to hear submissions from the parents' legal representatives.

The High Court held that the Coroner's grant of representation created a legitimate expectation that the Coroner would not make a finding adverse to the interests which the parents represented without giving them the opportunity to be heard in opposition to that finding.

#### Position in Victoria

While the ruling in *Annetts v McCann* is observed at inquests in Victoria, there is no provision in the Act regulating the way in which the principles of natural justice apply to coronial death investigations.

## Position in other jurisdictions

Three jurisdictions, unlike Victoria, have enacted provisions enshrining the right to natural justice in the legislation. In Western Australia the *Coroners Act* requires that a person whose interests may be subject to an adverse finding must be given an opportunity to make submissions against the making of such a finding. <sup>1298</sup> In the ACT a more detailed provision regulates the process by which a coroner must observe a person's rights to natural justice:

55 Adverse comment in findings or reports

(1) A coroner shall not include in a finding or report under this Act (including an annual report) a comment adverse to a person identifiable from the finding or report unless he or she has, prior to the making of the finding or report, taken all reasonable steps to give to the person a copy of the proposed comment and a written notice advising the person that, within a

<sup>&</sup>lt;sup>1296</sup> Annetts v McCann (1990) 97 ALR 177.

<sup>&</sup>lt;sup>1297</sup> Ibid 179. See also *Harmsworth v The State Coroner* [1989] VR 989, 994.

<sup>&</sup>lt;sup>1298</sup> Coroners Act 1996 (WA) s 44(2).

specified period (being not more than 28 days and not less than 14 days after the date of the notice), the person may—

- (a) make a submission to the coroner in relation to the proposed comment; or
- (b) give to the coroner a written statement in relation to it.
- (2) The coroner may extend, by not more than 28 days, the period of time specified in a notice under subsection (1).
- (3) Where the person so requests, the coroner shall include in the report the statement given under subsection (1) (b) or a fair summary of it. 1299

New Zealand has also enacted a detailed provision in its *Coroners Act 2006* which regulates the way in which coroners may make comments in relation to living persons and persons who have died and corporations. The relevant subsection provides:

- (1) A coroner may, in the course of, or as part of the findings of, an inquiry, comment on the conduct, in relation to the circumstances of the death concerned, of any person.
- (2) The coroner must not comment adversely on a dead person without,—
  - (a) indicating an intention to do so; and
  - (b) adjourning the inquiry for at least 5 working days; and
  - (c) notifying every member of the person's immediate family who during the adjournment requests the coroner to do so of the proposed comment; and
  - (d) giving every such member a reasonable opportunity to be heard, either personally or by counsel, in relation to the proposed comment.
- (3) The coroner must not comment adversely on any living person, corporation sole, body corporate, or unincorporated body without
  - (a) taking all reasonable steps to notify the person, corporation or body of the proposed comment; and
  - (b) giving the person, corporation or body a reasonable opportunity to be heard, either personally or by counsel, in relation to the proposed comment. 1300

<sup>&</sup>lt;sup>1299</sup> Coroners Act 1997 (ACT) s 52.

<sup>1300</sup> Coroners Act 2006 (NZ) s 48.

## Law reform agencies

In *Director of National Parks and Wildlife v Barritt*, Kearney J made an observation about the desirability of the introduction of procedural rules to regulate coronial inquest procedure.<sup>1301</sup>

Dr Freckelton and Associate Professor Ranson have also commented on this issue. According to the authors:

Arguably, the Western Australian ACT and New Zealand provisions simply represent good and fair coronial practice and should be implemented in practice elsewhere. 1302

## Evidence received by the Committee

The Coroner's Office submitted that a person's right to natural justice was well protected by common law and that therefore a specific statutory provision was unnecessary. Associate Professor Ranson indicated that, while he thought the principles of natural justice ought to apply to the coronial system of investigation, he queried whether the principles which were constructed and developed in an adversarial system needed to be modified for a coronial system, which is based on an inquisitorial process. However, he recognised that because the coronial system operated within the adversarial legal system the principles may still need to apply.

#### Discussion and conclusion

The Committee considers that procedural rules regulating the way in which the principles of natural justice apply would be a useful addition to the Act. This would ensure that the principles are applied in a consistent way and would also provide certainty to persons concerned about procedural issues associated with the right. While the ACT provision could be used as an appropriate model, the Committee considers that there should be further consultation among stakeholders to consider this issue in more detail, as the Committee did not receive any evidence from stakeholders regarding the form that procedural rules should take.

In chapter seven the Committee considers coronial recommendations and adverse comments in more detail and makes a recommendation in relation to adverse coronial findings. The recommendation proposes that the Act be amended to require coroners proposing to comment adversely on any living person to take all reasonable steps to notify the person of the proposed comment and give the person a reasonable opportunity to be heard in relation to the proposed comment.

<sup>&</sup>lt;sup>1301</sup> Director of National Parks and Wildlife v Barritt (1990) 72 FLR 1, 17.

<sup>&</sup>lt;sup>1302</sup> Ian Freckelton and David Ranson, *Death Investigation and the Coroner's Inquest* (2006) 590.

<sup>&</sup>lt;sup>1303</sup> State Coroner's Office, Submission no. 70, 174.

<sup>1304</sup> David Ranson, Submission no. 19, 51.

# **Appeal rights**

In this section of the chapter the Committee examines the legislative framework which governs the way in which a person may appeal certain decisions made by a coroner, such as the refusal to grant a request for an inquest. The section also considers the appeals process in relation to review of coronial findings and recommendations. The appeals process in relation to objections to autopsy is considered in detail in chapter eight.

# Appeal against inquest finding

Any person may apply to the State Coroner or Supreme Court for an order that some or all of the findings of a coroner's inquest are void. Findings are the decisions which the coroner is required to make under section 19(1) of the Act. The section provides that:

- (1) A coroner investigating a death must find if possible—
  - (a) the identity of the deceased; and
  - (b) how death occurred; and
  - (c) the cause of death; and
- (d) the particulars needed to register the death under the Births, Deaths and Marriages Registration Act 1996.

There is a restriction in the Act on what a coroner can include in the finding. The finding must not include any statement that a person is or may be guilty of an offence.<sup>1306</sup>

The Supreme Court may declare that some or all of the findings of the inquest are void and may order a new inquest or that the inquest be reopened to re-examine the findings. The Supreme Court may make such an order only if it is satisfied that—

- (a) it is necessary or desirable because of fraud, consideration of evidence, failure to consider evidence, irregularity of proceedings or insufficiency of inquiry; or
- (b) there is a mistake in the record of the findings; or
- (c) it is desirable because of new facts or evidence; or
- (d) the findings are against the evidence and the weight of the evidence. 1308

<sup>&</sup>lt;sup>1305</sup> Coroners Act 1985 ss 59(1), 59A(1).

<sup>&</sup>lt;sup>1306</sup> Coroners Act 1985 s 19(3).

<sup>&</sup>lt;sup>1307</sup> Coroners Act 1985 s 59(2).

The words 'consideration of evidence' were examined by the Supreme Court in *Anderson v Blashki*, where Gobbo J described it as an 'unclear, somewhat incomprehensible phrase'.<sup>1309</sup> He concluded that a coroner's consideration of evidence must involve an error of law or misdirection of fact.<sup>1310</sup> In a later case, Hedigan J agreed that there were difficulties in establishing what was meant by the phrase and concluded that the language of the section empowers the court, having considered the relevant evidence, to set aside a finding if it is 'necessary or desirable'.<sup>1311</sup>

The State Coroner also has jurisdiction to review the finding of a coroner's inquest, but not if the Supreme Court has already refused to make an order based on the same or substantially the same grounds of evidence.<sup>1312</sup> The State Coroner may order that some or all of the findings of the inquest are void, and s/he may reopen or direct another coroner to reopen the inquest and re-examine any finding.<sup>1313</sup> However, the grounds on which the State Coroner can make an order are more limited than the grounds on which the Supreme Court can make an order. The State Coroner may only make an order if s/he is satisfied that there is a mistake in the record of the findings or where it is desirable because of new facts or evidence.<sup>1314</sup>

The State Coroner's power under this section is limited to cases where an inquest has taken place — the power of the State Coroner does not extend to reviewing a coroner's findings made on investigation without inquest. This is discussed in the next section of the chapter.

## Position in other Australian jurisdictions

As in Victoria, all other jurisdictions have statutory rights of appeal to the Supreme Court, except Queensland, where the right of appeal is to the District Court. <sup>1316</sup> In that jurisdiction the District Court may set aside a finding if it is satisfied that—

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new evidence casts doubt on the finding; or
the finding was not correctly recorded; or
there was no evidence to support the finding; or
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<sup>1308</sup> Coroners Act 1985 s 59(3).
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<sup>&</sup>lt;sup>1309</sup> Anderson v Blashki [1993] 2 VR 89, 92.

<sup>&</sup>lt;sup>1310</sup> Ibid.

<sup>&</sup>lt;sup>1311</sup> Chief Commissioner of Police v Hallenstein [1996] 2 VR 1, 13.

<sup>&</sup>lt;sup>1312</sup> Coroners Act 1985 s 59A(4).

<sup>&</sup>lt;sup>1313</sup> Coroners Act 1985 s 59A(2).

<sup>&</sup>lt;sup>1314</sup> Coroners Act 1985 s 59A(3).

<sup>&</sup>lt;sup>1315</sup> Domaszewicz v The State Coroner (2004) 11 VR 237.

<sup>&</sup>lt;sup>1316</sup> The District Court of Queensland is largely the equivalent of the Victorian County Court.

the finding could not be reasonably supported by the evidence. 1317

The Western Australia and Northern Territory provisions are identical to the Victorian grounds of appeal. <sup>1318</sup> Tasmania recently modified the grounds of appeal to those set out below:

- (a) the inquest was or may have been tainted by fraud; or
- (b) the inquest was not sufficiently thorough or was compromised by evidentiary or procedural irregularity; or
- (c) there were mistakes in the record of the findings; or
- (d) new facts or evidence affecting the findings have come to light; or
- (e) the findings were not supported by the evidence; or
- (f) there is another compelling reason to reopen the inquest. 1319

In New South Wales and the ACT the grounds of appeal are couched in identical terms:

By reason of fraud, rejection of evidence, irregularity of proceedings, insufficiency of inquiry, discovery of new facts or evidence or otherwise, it is necessary or desirable in the public interest or the interests of justice that the inquest or inquiry be quashed and that another inquest or inquiry be held ...<sup>1320</sup>

South Australia has a very general ground of appeal. The Supreme Court in South Australia may rehear a matter if it is in the interests of justice.<sup>1321</sup>

# **Evidence received by the Committee**

In the discussion paper the Committee asked stakeholders whether the Supreme Court was the most appropriate jurisdiction to hear appeals under the *Coroners Act*. Three stakeholders considered that the Supreme Court should continue to have jurisdiction to hear coronial appeals because it was the most appropriate appellate court. For example, Associate Professor Ranson considered that the Supreme Court was the most appropriate appeals forum because its jurisdiction was essentially

<sup>&</sup>lt;sup>1317</sup> Coroners Act 2003 (Qld) s 50(5).

<sup>&</sup>lt;sup>1318</sup> Coroners Act 1996 (WA) s 52; Coroners Act 1993 (NT) s 44.

<sup>&</sup>lt;sup>1319</sup> Coroners Act 1995 (Tas) s 58A.

<sup>&</sup>lt;sup>1320</sup> Coroners Act 1980 (NSW) s 47(2); Coroners Act 1997 (ACT) s 93(1)(b).

<sup>&</sup>lt;sup>1321</sup> Coroners Act 2003 (SA) s 27(5).

<sup>&</sup>lt;sup>1322</sup> Victorian Bar, *Submission no. 81*, 11; David Ranson, *Submission no. 19*, 53; Health Services Commissioner, *Submission no. 62*, 9.

unfettered.<sup>1323</sup> Both Associate Professor Ranson and Ms Heffey submitted that there should be a two-tier appeal process — an initial appeal to the State Coroner, followed by a further right of appeal to the Supreme Court.<sup>1324</sup>

Mr Bond told the Committee that, while he appreciated the need for appeals to be adjudicated in an authoritative appellate court, he recognised that:

the Supreme Court is an expensive forum and this makes for a powerful deterrent for many with legitimate concerns not to pursue such an appeal. 1325

He suggested that a possible solution is to provide for a process where persons with a substantial case should be granted legal aid for the costs of a Supreme Court appeal. Mr Bond thought that the issue of whether a case had merit could possibly be determined by a court appointed lawyer.

## **Discussion and conclusion**

While recognising the costs involved in Supreme Court appeals, the Committee considers that it is important that a person's right to review by a superior judicial body be retained. The issue of assistance with legal costs is discussed in chapter eight. The Committee considers that there is some merit in having an appeals process in which a person's initial right of review is to the State Coroner and then to the Supreme Court. However, a problem with this system is that the State Coroner also acts as a coroner. In cases where the State Coroner acts as the initial decision maker by investigating a death at an inquest and making findings, the State Coroner is unable to review his or her own findings and section 59 of the Act permits a person to appeal directly to the Supreme Court. However, the section is not limited to appeals from the findings of the State Coroner — where a coroner has conducted an inquest a person may appeal against some or all of the findings directly to the Supreme Court without first being required to appeal to the State Coroner. The Committee considers that there may be additional delays and possible extra legal costs if there were a mandatory requirement that such cases be reviewed by the State Coroner at first instance. As such, the Committee does not consider that there is compelling argument in favour of changing the current appeal process.

# Appeals against chambers findings

As discussed above, section 59A of the Act provides that a person may apply to the State Coroner for an order that a coroner's inquest findings are void, but there is no similar appeal process in relation to a coroner's findings made without inquest (chambers findings). In *Domaszewicz v The State Coroner* the State Coroner exceeded his jurisdiction by erroneously invoking section 59A and ordering that an

<sup>&</sup>lt;sup>1323</sup> David Ranson, Submission no. 19, 53.

<sup>&</sup>lt;sup>1324</sup> David Ranson, Submission no. 19, 53; Jacinta Heffey, Submission no. 33, 24.

<sup>1325</sup> Graeme Bond, Submission no. 48, 10.

inquest take place following an application to review the findings made by the Deputy State Coroner, who had conducted an investigation without inquest. Ashley J however determined that in this case there was another relevant source of power which the State Coroner had not identified but which nevertheless gave the State Coroner the power to hold an inquest:

In my opinion there was an available jurisdictional basis—via the interaction of ss 17(1)(a) and 18(1)—which authorised the Coroner to hold an inquest into Jaidyn Leskie's death; and, so far as was necessary, to void contrary findings made by the Deputy State Coroner.<sup>1327</sup>

## **Evidence received by the Committee**

The Committee asked stakeholders if the power of the State Coroner should be extended to include a specific power to review coroners' chambers findings. The Coroner's Office submission briefly referred to this question, suggesting that there was a need for 'legislative clarity'. Ms Wilson, Health Services Commissioner, and Associate Professor Ranson supported an extension in the power. Associate Professor Ranson submitted that:

Assuming that the State Coroner had the appropriate senior judicial status it would seem prudent and reasonable for appeals against a coroner's finding made with or without inquest to be reviewable at first instance by the State Coroner and for such a review to be mandatory before an appeal could be heard by the Supreme Court. This should not remove the ability for further appeals to be subsequently dealt with by the Supreme Court but it would streamline the coronial death investigation process and help to establish a framework by which the State Coroner was seen to operate at a more senior judicial level. This would reinforce the supervisory role of the State Coroner and allow indirectly for a process of quality assurance and case audit to be developed.<sup>1330</sup>

#### Discussion and conclusion

Under the Act a person seeking a review of a coroner's chambers finding must first ask the coroner to conduct an inquest and then apply to the Supreme Court if this request is refused. This is in contrast to cases which have been investigated at inquest. In these cases a person may make a direct request to the State Coroner for a review of the findings. It is inconsistent that there are different appeal processes for review of chambers findings and inquest findings. The Committee considers that the State Coroner should have a specific power to review coroners' chambers findings in line with the existing section 59A power, which permits the State Coroner to review inquest findings.

1328 State Coroner's Office, Submission no. 70, 39.

<sup>1326</sup> Domaszewicz v The State Coroner (2004) 11 VR 237.

<sup>1327</sup> Ibid 248

Clate Colonel & Chice, Cabinicolon no. 10, co.

<sup>&</sup>lt;sup>1329</sup> Health Services Commissioner, Submission no. 62, 10; David Ranson, Submission no. 19, 53.

<sup>1330</sup> David Ranson, Submission no. 19, 53.

Recommendation 66. That section 59A of the *Coroners Act 1985* be amended to provide that a person may apply to the State Coroner for an order that some or all of the findings made without inquest are void.

## Appeals against a decision not to hold an inquest

Any person may request that a coroner hold an inquest, provided the coroner has jurisdiction to investigate the death. <sup>1331</sup> If a coroner refuses the request, the coroner must give written reasons for the refusal to both the person making the request and the State Coroner within a reasonable time after receiving the request. <sup>1332</sup>

A person may appeal to the Supreme Court for an order that an inquest be held — but the person must first wait for three months from the date of his or her request before s/he can bring the appeal:1333

- 18. Application for inquest into death
- (2) If, after the expiry of 3 months from the date a person requests a coroner to hold an inquest into a death, the coroner has not—
- (a) agreed to hold the inquest or asked another coroner to do so; or
- (b) refused the request and given his or her reasons in writing to the person and the State Coroner—

the person may apply to the Supreme Court for an order that an inquest be held. 1334

The Supreme Court may make an order that an inquest be held if it is satisfied that it is necessary or desirable in the interests of justice. 1335

The decision in *Clancy v West*<sup>1336</sup> illustrates circumstances the Court may not regard as 'necessary or desirable'. In this case the Court of Appeal rejected a family member's request that an inquest be held, finding that the Coroner was justified in regarding the request as neither necessary nor desirable in the interests of justice. After the evidence was reviewed the real motive for the request for an inquest was revealed as continuing a family dispute as to the validity of the will. The Court

<sup>&</sup>lt;sup>1331</sup> Coroners Act 1985 s 8(1).

<sup>&</sup>lt;sup>1332</sup> Coroners Act 1985 s 18(1)(b).

<sup>&</sup>lt;sup>1333</sup> Coroners Act 1985 s 18(2); Mohamed Abdur Rouf v Graeme Douglas Johnstone (sued in his capacity as State Coroner), Supreme Court of Victoria–Court of Appeal (Unreported, Winneke, P., Charles and Buchanan, JJA, 14 December 1999).

<sup>&</sup>lt;sup>1334</sup> Coroners Act 1985 s 18(2).

<sup>&</sup>lt;sup>1335</sup> Coroners Act 1985 s 18(3).

<sup>1336</sup> Clancy v West [1996] 2 VR 674.

commented in its reasons for its decision that 'both the Coroner and the Supreme Court should be astute to prevent the misuse of an inquest for such a purpose'. 1337

## **Evidence received by the Committee**

The Coroner's Office submitted that a person's right of appeal to the Supreme Court following a coroner's refusal to hold an inquest should be removed. No other stakeholder supported this view. According to the Coroner's Office:

Frequently, family members request an inquest in an attempt to use the coronial system as a further forum for acting out family conflicts and/or their general dissatisfaction with professional care of the deceased that is unrelated to their death.

The family requests are treated seriously but, when the evidence is complete or there is no relationship between their specific complaints and the death of their family member, the coroner may determine that there is nothing to be gained from an inquest.<sup>1339</sup>

The Coroner's Office submitted that review of the decision not to hold an inquest should therefore remain within the coronial system except where matters of law are concerned. The submission indicated that it is not appropriate for the Supreme Court to review decisions not to hold inquests. The appropriate review mechanism, according to the Coroner's Office, is a review by the State Coroner. Where the State Coroner is the original decision maker the Coroner's Office considered that the appropriate person to review this decision was the Deputy State Coroner.

Former coroner Ms Heffey did not support this view. According to Ms Heffey, the Act should require that, on request, the State Coroner should review the decision of the coroner who has decided not to hold an inquest and should make a decision as to whether an inquest should be held.<sup>1340</sup> She considered that this decision should be reviewable by the Supreme Court.

The Victorian Bar referred the Committee to an inconsistency in the Act. According to the Bar, on a strict interpretation of section 18(3) if a coroner has refused to hold an inquest and given written reasons there can be no application to the Supreme Court. The Bar explained that:

The section 18(3) power in the Supreme Court to order an inquest is unlimited. However application to the Supreme Court for an order that an inquest be held is, on the face of section 18(2), limited. The difficulty is that the first ground in sub-section (a) of section 18(2) is joined with the second ground. For the person to be able to apply to the Supreme Court, the coroner

<sup>1337</sup> Clancy v West [1996] 2 VR 674, 656.

<sup>&</sup>lt;sup>1338</sup> State Coroner's Office, Submission no. 70, 138–9.

<sup>1339</sup> State Coroner's Office, Submission no. 70, 138-9.

<sup>&</sup>lt;sup>1340</sup> Jacinta Heffey, Submission no. 33, 19.

<sup>&</sup>lt;sup>1341</sup> Victorian Bar, Submission no. 81, 16.

has to have *neither* agreed to hold an inquest *nor* "refused the request and given his or her reasons in writing to the person and the State Coroner". 1342

#### Discussion and conclusion

The Committee does not consider that it is appropriate that a person's right to appeal to the Supreme Court following a coroner's refusal to hold an inquest should be removed. It is important that a person have access to a superior court so that decisions of the Coroner's Office be subject to judicial oversight. The Committee considers that a system in which the decisions of the State Coroner were subject to review by his or her Deputy State Coroner would be inappropriate because it would effectively deny a person's existing right to have a decision reviewed by a superior court.

The Committee agrees with the Bar that there is an inconsistency in section 18(3). On a strict interpretation, the section seems to imply that a person may not appeal to the Supreme Court where a coroner has refused to hold an inquest but has given reasons for the refusal within the time frame specified in the subsection. The Committee considers that the subsection should therefore be redrafted to remove this inconsistency.

Recommendation 67. That section 18(3) of the *Coroners Act 1985* be amended so that it states with a greater degree of clarity that, if a coroner refuses a request to hold an inquest and gives reasons in writing for the refusal, a person may apply to the Supreme Court for an order that an inquest be held.

# Appeals against recommendations and comments

Under the Act a person cannot apply for an order that a coroner's recommendation or comment is void — applications to the State Coroner and the Supreme Court are limited to applications for orders that a finding is void. 1343 It is uncertain whether an applicant could successfully apply to the Supreme Court for an administrative law remedy such as *certiorari* to quash a recommendation or comment made by a coroner. 1344

# **Evidence received by the Committee**

One stakeholder submitted that coroners' recommendations and comments should be reviewable by the Supreme Court. 1345 The Victoria Bar submission referred to the

<sup>1343</sup> Coroners Act 1985 s 59, 59A.

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<sup>&</sup>lt;sup>1342</sup> Ibid 15–16.

<sup>&</sup>lt;sup>1344</sup> Ian Freckelton and David Ranson, *Death Investigation and the Coroner's Inquest* (2006) 691. See also *Director of National Parks and Wildlife v Barritt* (1990) 72 FLR 1.

<sup>1345</sup> Victorian Bar, Submission no. 81, 11.

Northern Territory Supreme Court decision of *Director of National Parks and Wildlife v Barritt*, which considered whether there was an administrative law power to review recommendations made by coroners in the Northern Territory. 1346 According to the Bar, the issue of whether there is a power in Supreme Courts to quash comments and recommendations remained unresolved.

The Bar submitted that the Supreme Court should have the power because recommendations can have very significant financial consequences for persons to whom recommendations are directed. The Bar gave the Committee an example:

a coroner may comment on a vehicle involved in a fatal accident, and recommend modification of such vehicle. First, the manufacturer has no right to see, or make submissions in relation to, the coroner's adverse comment.<sup>1347</sup>

While accepting that a coroner's recommendation is not binding or enforceable, the Bar submitted that it should nevertheless be reviewable because coroners' recommendations may be widely circulated and may damage an individual's career and reputation. The Bar further submitted that the Supreme Court should have the power to review because the comment and recommendation made by a coroner may be wrong:

The manufacturer's decision not to make the modification may be wholly reasonable. However, evidence to that effect after the event, and the explanation that it was not possible to obtain review of the coroner's comment and recommendation earlier or, indeed, at all, are unlikely to diminish the force of the coroner's previously unchallenged comment in the eyes of the jury.<sup>1348</sup>

#### Discussion and conclusion

The Committee does not consider that a specific provision in the Act permitting the Supreme Court to review coronial comments and recommendations is warranted. While accepting that some coronial findings are widely distributed and may be on some level influential in prompting manufacturers to consider product modifications, the Committee cannot accept that there is merit in affording a statutory right to review recommendations because in any event recommendations are legally unenforceable. If a person is dissatisfied with a coroner's comments or recommendations, it may be possible to apply for an appropriate administrative law remedy. To date it would appear that no person in Victoria has attempted to seek such an order.

In chapter seven the Committee makes a recommendation which it considers will alleviate some of the concerns expressed by the Victorian Bar that persons with a sufficient interest in an investigation are unable to make submissions in relation to proposed adverse comments and recommendations. The recommendation proposes

<sup>&</sup>lt;sup>1346</sup> Ibid 12.

<sup>&</sup>lt;sup>1347</sup> Ibid.

<sup>&</sup>lt;sup>1348</sup> Ibid.

that the Act be amended to require coroners to give such persons an opportunity to respond in relation to proposed adverse comments and a right to respond after recommendations have been made.

The Committee considers that it would be undesirable for family members to face the prospect of having these kinds of issues litigated in the Supreme Court. After a coroner has made a finding on the cause of death, the family of the person whose death was investigated should, ideally, be able to consider that the investigation has been completed. The recommendation in chapter seven therefore strikes a balance between the family's need to finalise legal proceedings and the need for persons to be heard in relation to proposed recommendations.

# CHAPTER SIX — INDEPENDENT INVESTIGATION OF FIRES

A coroner's jurisdiction extends to the investigation of both fatal and non-fatal fires. Since the Great Fire of London in 1666, there has been legislation which empowers coroners to conduct inquests into fires regardless of whether a death is involved. <sup>1349</sup> In this chapter, the Committee examines the circumstances in which a coroner may investigate and hold inquests into fires, focusing on the non-fatal fire jurisdiction. A comparison is made with the other Australian jurisdictions which permit coroners to investigate fires.

# Investigations of fires

Under section 31 of the Act, a coroner has jurisdiction to investigate fires which have a territorial connection with the state. The fire must occur in, or partly in, Victoria. 1350

The coroner may investigate such fires if he or she believes it is desirable or where the Metropolitan Fire Board or the Country Fire Authority (CFA) requests an investigation. The Attorney-General may direct a coroner to investigate a fire, and the State Coroner can also direct another coroner to hold an inquest into a fire. Further, a member of the public may request a coroner to investigate a fire. If the coroner refuses the request, he or she must give reasons in writing to the person requesting the investigation and to the Attorney-General. Not all fire investigations are dealt with by coroners, who will generally investigate a fire where there are significant public health and safety concerns, or where they are requested or directed to do so in accordance with the above provisions.

The investigation of fires requires sophisticated professional expertise. <sup>1355</sup> In Victoria, fires are routinely investigated by the Metropolitan Fire and Emergency Services

Peter Thatcher, 'Fire!', in Hugh Selby (ed), *The Aftermath of Death* (1992) 132. In 1860 it was held that a coroner had no jurisdiction to inquire into the origin of a fire; however, the very next year jurisdiction to inquire into the cause and origin was given to coroners in NSW by legislation: *R v Herferd* (1860) 3 E & E 115, cited in lan Freckelton and David Ranson, *Death Investigation and the Coroner's Inquest* (2006) 650.

<sup>&</sup>lt;sup>1350</sup> Coroners Act 1985 s 31(1).

<sup>&</sup>lt;sup>1351</sup> Coroners Act 1985 s 31(1).

<sup>&</sup>lt;sup>1352</sup> Coroners Act 1985 s 31(2).

<sup>&</sup>lt;sup>1353</sup> Coroners Act 1985 s 32(1).

<sup>&</sup>lt;sup>1354</sup> Coroners Act 1985 s 32(2).

<sup>1355</sup> State Coroner's Office, Submission no. 70, 166.

Board (MFESB), the CFA, the Department of Sustainability and Environment, the Victorian Forensic Science Centre, the Victoria Police Arson Squad, the Office of Gas Safety and Worksafe Victoria. 1356 These agencies cooperatively investigate fires where appropriate under a memorandum of understanding between the agencies called the Victorian Fire Investigation Policy and Procedures. 1357 Following the Longford gas explosion and fire, the Royal Commissioners commented that:

The Victorian Fire Investigation Policies and Procedures, published by the Department of Justice in March 1998, established policies and procedures for the co-ordination of the various agencies with obligations or interests relating to the investigation of fires. The agencies were the Victoria Police, the Department of Conservation and Natural Resources, the Country Fire Authority, the Metropolitan Fire Brigade, the State Forensic Science Laboratories and, more recently, the Victorian Workcover Authority. There is a steering committee chaired by the State Coroner. Immediately following the explosion and fire at Longford on 25 September 1998, the Coroner established a task force to investigate the incident. Those involved were the Arson Squad from the Victoria Police, the Country Fire Authority and the Victorian Workcover Authority. The Arson Squad took the lead and the investigation was co-ordinated by Detective Senior Sergeant Hughes. Forensic experts were engaged...Their roles were co-ordinated by Inspector Willis of the Victorian Forensic Science Centre... 1358

When requested, the specialist fire investigation agencies referred to above will investigate fires on behalf of the State Coroner. Conversely, the Metropolitan Fire Service and the CFA can request coronial involvement in a fire investigation. 1359

# Inquests into fires

Under section 34 of the Act a coroner who has jurisdiction to investigate a fire may hold an inquest if that coroner believes it is desirable. 1360 A coroner must hold an inquest if the State Coroner or the Attorney-General directs that an inquest take place. 1361

A member of the public may request a coroner to hold an inquest into a fire. 1362 If the application is refused, the person has a right of appeal to the Supreme Court, which, as for death inquest appeals, may only be commenced three months after the initial

<sup>&</sup>lt;sup>1356</sup> Ibid.

<sup>&</sup>lt;sup>1357</sup> Victorian Fire investigation Policy and Procedures, 5 December 2003; cf Victorian Fire investigation Policy and Procedures, 17 November 1999. available at:

http://www.cfa.vic.gov.au/about/documents/fire\_inv\_policy.pdf.

<sup>&</sup>lt;sup>1358</sup> Sir Daryl Dawson and Mr Brian Brooks, The Esso Longford Gas Plant Accident: Report of the Longford Royal Commission (Victorian Government Printer, 1999) 246.

<sup>1359</sup> State Coroner's Office, Submission no. 70, 167.

<sup>&</sup>lt;sup>1360</sup> Coroners Act 1985 s 34(3).

<sup>&</sup>lt;sup>1361</sup> Coroners Act 1985 s 34(1), (2).

<sup>&</sup>lt;sup>1362</sup> Coroners Act 1985 s 35(1).

request to the coroner.<sup>1363</sup> The Supreme Court may make an order for an inquest to be held if it is satisfied that it is necessary or desirable in the interests of justice.<sup>1364</sup>

# Findings, comments and recommendations

Section 36(1) of the Act provides that a coroner must make the following findings, where possible:

- (a) the cause and origin of the fire; and
- (b) the circumstances in which the fire occurred; and
- (c) the identity of any person who contributed to the cause of the fire. 1365

As is the case with death investigations, a coroner may comment on any matter connected with the fire, including public health or safety or the administration of justice. Similarly, a coroner must not include in a finding or comment any statement that a person is or may be guilty of an offence. 1367

Further, as is the case in relation to deaths, a coroner may make recommendations to any Minister or public statutory authority on any matter connected with a fire which the coroner investigated, including public health or safety or the administration of justice. <sup>1368</sup> In addition, a coroner may report to the Attorney-General on a fire which the coroner investigated. <sup>1369</sup>

The Committee notes that sections 36(1)(b) and (c) are inconsistent with the findings which a coroner must make under section 19 in relation to death investigations. First, as discussed in chapters five and seven of this report, following the repeal of section 19(1)(e), coroners are no longer required to establish the identity of any person who contributed to a death. The Committee considers that the same policy reasons which led to the removal of section 19(1)(e) may be applied to section 36(1)(c). As will be discussed below, the State Coroner has recommended that the provision be repealed.

<sup>&</sup>lt;sup>1363</sup> Coroners Act 1985 s 35(2).

<sup>&</sup>lt;sup>1364</sup> Coroners Act 1985 s 35(3).

<sup>&</sup>lt;sup>1365</sup> Coroners Act 1985 s 36.

<sup>&</sup>lt;sup>1366</sup> Coroners Act 1985 s 36(2).

<sup>&</sup>lt;sup>1367</sup> Coroners Act 1985 s 36(3).

<sup>&</sup>lt;sup>1368</sup> Coroners Act 1985 s 37(2).

<sup>&</sup>lt;sup>1369</sup> Coroners Act 1985 s 37(1).

<sup>&</sup>lt;sup>1370</sup> Coroners Act 1985 s 19.

<sup>&</sup>lt;sup>1371</sup> Freckelton and Ranson have commented, 'Probably by oversight, this latter obligation persists in respect of fires, although it was removed in 1999 in respect of deaths': Ian Freckelton and David Ranson, *Death Investigation and the Coroner's Inquest* (2006) 652.

Further, the Committee notes that section 36(1)(b) enables a coroner to inquire into the 'circumstances' of a fire, in addition to the issue of causation referred to in section 36(1)(a). This is also inconsistent with the wording of the provisions of section 19. These include the requirement under section 19(1)(b) that a coroner find if possible 'how death occurred'. There has been uncertainty in Australia as to the meaning of 'how' in this context, particularly following the decision of the Victorian Court of Appeal in *Keown v Khan*, '1372 in which Callaway JA held that 'how' means or at least includes 'by what means', without stating further what this should include. '1373 However, recent authorities in the UK and Queensland have held that 'how' means 'by what means and in what circumstances'. '1374 Freckelton suggests that it is 'extremely likely' that these decisions will be followed in future in Australia. '1375 If so, the differences in the wording used in section 19(1)(b) and 36(1)(b) would be less meaningful. The Committee notes by way of comparison that the requirement to make a finding as to the circumstances of a fire has recently been removed from the New South Wales legislation, which will be discussed below.

# Powers of investigation

Under the Act a coroner has extensive powers of investigation in relation to fires.

A coroner investigating a fire has the power to restrict access to the place where the fire occurred (unlike the position in relation to death scenes). The coroner may put up a prescribed notice at that place. A person must not, without good reason, enter or interfere with any area to which access is restricted by a coroner.

Further, as is the case in relation to death investigations, a coroner investigating a fire has extensive powers of entry, inspection (search) and possession (seizure). Section 41 provides that a coroner who has jurisdiction to investigate a fire may, 'with any help thought fit':

- (a) enter and inspect any place and any thing in it; and
- (b) take a copy of any document relevant to the investigation; and
- (c) take possession of any thing which the coroner reasonably believes is relevant to the investigation and keep it until the investigation is finished.<sup>1377</sup>

<sup>&</sup>lt;sup>1372</sup> [1999] 1 VR 69, 76.

<sup>&</sup>lt;sup>1373</sup> Ian Freckelton and David Ranson, *Death Investigation and the Coroner's Inquest* (2006) 638.

<sup>&</sup>lt;sup>1374</sup> R v Coroner for the Western District of Somerset; ex parte Middleton [2004] WLR 800 (House of Lords); and Atkinson v Morrow [2005 QCA 353, [13] (Queensland Court of Appeal).

<sup>&</sup>lt;sup>1375</sup> Ian Freckelton and David Ranson, *Death Investigation and the Coroner's Inquest* (2006) 638.

<sup>&</sup>lt;sup>1376</sup> Coroners Act 1985 s 40.

<sup>&</sup>lt;sup>1377</sup> Coroners Act 1985 s 41.

The coroner may only exercise these powers if he or she reasonably believes it is necessary for the investigation. The coroner also has the power to authorise a member of the police force to enter and inspect a specified place and any thing in it, and to take a copy of specified documents or classes of documents or to take possession of specified things or classes of things.

# Other jurisdictions

In all jurisdictions except Queensland and Western Australia, a coroner has the jurisdiction to hold inquests or inquiries into the causes and origins of fires. <sup>1378</sup> In Queensland, where a non-fatal fire has a significant impact or causes serious injury, the Queensland Fire and Rescue Service's Fire Investigation Research Unit now investigates the fire in conjunction with the Police Service. <sup>1379</sup> In Western Australia, the causes of non-fatal fires are investigated by the Fire and Emergency Services Authority. <sup>1380</sup> By way of comparison, the Committee notes that recent major bushfires in northwest Victoria were investigated by the Victorian Emergency Services Commissioner (ESM).

The Tasmanian legislation is similar to that of Victoria; however, in Tasmania a coroner may also investigate explosions. A coroner has jurisdiction to investigate a fire or explosion that occurs in the State if the coroner believes it is desirable to do so, and a coroner must investigate a fire or explosion if the Attorney-General or a Chief Magistrate directs that an investigation be held. Other persons must have standing to request an investigation. This means that only a person whom the coroner considers has a 'sufficient interest' in relation to a fire or explosion may request a coroner to investigate. As is the case in Victoria, coroners in Tasmania must find, if possible, the cause and origin of a fire or explosion, the circumstances in which it occurred and the identity of any contributing persons. 1383

In the ACT, a coroner is required to hold an inquiry into the cause and origin of a fire that has destroyed or damaged property if requested to do so by the Attorney-General, or if the coroner is of the opinion that such an inquiry should be held. 1384 However, unlike in Victoria, apart from the Attorney-General, only property owners or occupiers whose property is destroyed or damaged may request an investigation into

<sup>&</sup>lt;sup>1378</sup> Butterworths, *Halsbury's Laws of Australia* (at 16 February 2005) 115 Coroners [115-275].

<sup>&</sup>lt;sup>1379</sup> Email, Greg Reynolds, Area Director, Kemp Place Fire Station, Queensland, to Committee Legal Research Officer, 18 March 2005.

<sup>&</sup>lt;sup>1380</sup> See www.fesa.wa.gov.au.

<sup>&</sup>lt;sup>1381</sup> Coroners Act 1995 (Tas) s 40.

<sup>&</sup>lt;sup>1382</sup> Coroners Act 1995 (Tas) s 42(1).

<sup>&</sup>lt;sup>1383</sup> Coroners Act 1995 (Tas) s 45(1).

<sup>&</sup>lt;sup>1384</sup> Coroners Act 1997 (ACT) s 18(1).

a fire.<sup>1385</sup> The Chief Coroner must also cause an inquiry to be held into the cause and origin of a disaster if requested to do so by the Attorney-General.<sup>1386</sup>

In the Northern Territory, a coroner has jurisdiction to investigate a disaster if it occurs in or partly in the Territory. Disaster' is defined as including a fire that causes substantial loss of property, or injury to persons or property. Disasters may be referred to the coroner by the Attorney-General for investigation. A coroner who has jurisdiction to investigate a disaster may, 'if the coroner thinks fit', hold an inquest. The coroner is required to find, if possible, the cause and origin of the disaster and the circumstances in which the disaster occurred.

In South Australia the Coroner's Court must hold an inquest if the State Coroner determines that it is necessary or desirable to do so, or the Attorney-General so directs, to ascertain the cause or circumstances of a fire or accident that causes injury to persons or property. 1391

In New South Wales, a coroner has jurisdiction to investigate fires and explosions that have destroyed or damaged property in that state.<sup>1392</sup> Inquiries can be dispensed with if the cause and origin of the fire is disclosed, unless the coroner has been requested to hold an inquiry by the New South Wales Fire Brigades, the Commissioner of the NSW Rural Fire Service, the Minister or the State Coroner.<sup>1393</sup>

Following a recent review of the New South Wales Act, the power of a coroner in that State to inquire into the 'circumstances' of a fire was removed, on the basis that:

Investigations have become protracted and time-consuming because the unlimited scope of the fire jurisdiction given to New South Wales coroners sees the Coroner go beyond finding the cause and origin of the fire and inquiring into the circumstances of the fire.

The interpretation of the term "circumstances" as contained in the Coroners Act 1980 has tended to be broad, resulting in lengthy and wide-ranging police coronial investigations, adding to the time victims, property owners, firefighters and the public must wait for an outcome...

<sup>&</sup>lt;sup>1385</sup> Coroners Act 1997 (ACT) s 18(2).

<sup>&</sup>lt;sup>1386</sup> Coroners Act 1997 (ACT) s 19. In the ACT, 'disaster' is defined broadly in section 3 to mean an occurrence in the Territory due to natural or other causes that: (a) caused or threatened to cause loss of life or property, injury or distress to persons or damage to the environment, or (b) in any way substantially endangered the safety of the public in part of the Territory.

<sup>&</sup>lt;sup>1387</sup> Coroners Act 1993 (NT) s 28.

<sup>&</sup>lt;sup>1388</sup> Coroners Act 1993 (NT) s 3.

<sup>1389</sup> Coroners Act 1993 (NT) ss 29 and 30.

<sup>&</sup>lt;sup>1390</sup> Coroners Act 1993 (NT) s 34(b).

<sup>&</sup>lt;sup>1391</sup> Coroners Act 2003 (SA) s 21(1)(b)(iv).

<sup>&</sup>lt;sup>1392</sup> Coroners Act 1980 (NSW) s 15(1).

<sup>&</sup>lt;sup>1393</sup> Coroners Act 1980 (NSW) s 15(2), (3).

After considering the submissions to the review and the results of subsequent consultation, the Government is of the view that delays in holding coronial fire inquiries could best be avoided by clarifying the scope of the inquiry to the cause and origin of the fire rather than the broader and less easily defined term, "circumstances". 1394

The Committee considers that similar arguments could be made in relation to section 36(1)(b) in the Victorian Act, although witnesses to this inquiry did not raise any concerns in relation to the power to inquire into 'circumstances'. The Committee also notes that the amending legislation in New South Wales recognised that there will be circumstances in which a broader inquiry could be considered to be in the public interest. Accordingly, the parties who are able to request that a coroner conduct an inquest also have the discretion to request that a coroner hold 'a general inquiry concerning a fire or explosion' — in other words, a broader inquiry into the circumstances of a fire. 1396

# **Evidence received by the Committee**

There was debate among witnesses in relation to whether the jurisdiction of coroners to investigate non-fatal fires should be retained; however, the weight of the evidence received by the Committee favoured such retention.

The Coroner's Office referred in its submission to various cases where its jurisdiction in relation to non-fatal fires has led to public health and safety initiatives being implemented. For example, the Coroner's Office stated that the work in the late 1980s and early 1990s which resulted in the compulsory installation of residential smoke detectors was enabled by both the death and fire jurisdictions. It cited the following as current (in 2005) examples of the potential safety use of the jurisdiction: investigations into the Wilson's Promontory fire, the Bogong Village fire, and a series of arson related fires in school buildings, which involved looking at how the fires occurred as well as safety and warning systems.

The Coroner's Office cited the 1997 Dandenong Ranges Fires inquest as a particularly relevant example of the usefulness of the non-fatal fire jurisdiction. The Coroner's Office submitted that, although the fires involved the deaths of three residents in one fire (Ferny Creek), there was a series of other fires in the area, each having particular characteristics. The non-fatal fire jurisdiction enabled all of these

<sup>&</sup>lt;sup>1394</sup> New South Wales, Coroners Amendment Bill, Second Reading Speech, Legislative Assembly, 29 October 2003 (Mr Graham West, Parliamentary Secretary, on behalf of Mr Bob Debus).

<sup>&</sup>lt;sup>1395</sup> Coroners Act 1980 (NSW) s 15B. The Committee notes that the State Coroner may, instead of directing another coroner to hold the inquiry, hold the inquiry himself or herself: s 15B(5).

<sup>&</sup>lt;sup>1396</sup> New South Wales, Coroners Amendment Bill, Second Reading Speech, Legislative Assembly, 29 October 2003 (Mr Graham West, Parliamentary Secretary, on behalf of Mr Bob Debus).

<sup>&</sup>lt;sup>1397</sup> State Coroner's Office, Submission no. 70, 167.

<sup>&</sup>lt;sup>1398</sup> Ibid.

fires to be considered in a joint inquest, from which a number of lessons emerged. The results included the development of a unique fire warning system for Ferny Creek and assistance in the development of the 'Model of Fire Cover for Victoria'.<sup>1399</sup> The Coroner's Office submitted that, without the ability to look more broadly at the other fires, a number of safety issues could not have been considered, such as fire refuges and emergency shelters, individual risk assessments in areas of high fire risk, review of the approach to risk management and fire preparedness, communication, and road access to fires. The inquest also cited the findings, comments and recommendations of the then Deputy State Coroner's inquest into a major fire at Warrandyte in 1991.<sup>1400</sup>

The State Coroner submitted that, while there are a number of agencies in Victoria other than the Coroner's Office which investigate fires,

there is no independent co-ordinating body with power and authority to investigate and promulgate lessons from serious fires about causation, prevention and public safety, particularly the safety of fire fighters in risky situations such as bush fires.<sup>1401</sup>

Therefore, the Coroner's Office recommended that Part 6 of the Act continue to provide coronial jurisdiction to investigate non-fatal fires, particularly where issues of public health and safety arise.<sup>1402</sup>

Despite recommending that the jurisdiction be retained, the Coroner's Office recommended certain changes to the necessary findings in relation to fires. The Coroner's Office submitted that, in its view, the necessity to find if possible 'the identity of any person who contributed to the cause of the fire' under section 36(1)(c) should be deleted from the Act. However, it did not recommend any change to the requirement under section 36(1)(b) to find 'the circumstances in which the fire occurred'. The Coroner's Office also submitted that a new finding should be introduced, namely 'whether or not the fire was a preventable fire'. The Committee notes that it has already discussed the proposal of introducing such a finding in relation to death investigations in chapter seven. The Committee concluded that such a proposal would have serious disadvantages and it considers that the same arguments are applicable in relation to the fire investigation jurisdiction.

Associate Professor David Ranson submitted that the non-fatal fire jurisdiction is 'anachronistic and unnecessary'. Associate Professor Ranson acknowledged that

<sup>&</sup>lt;sup>1399</sup> Office of the Emergency Services Commissioner, 'Model of Fire Cover for Victoria' (May 2001).

<sup>&</sup>lt;sup>1400</sup> Ibid 167–8.

<sup>&</sup>lt;sup>1401</sup> Ibid 168.

<sup>&</sup>lt;sup>1402</sup> Ibid.

<sup>&</sup>lt;sup>1403</sup> Coroners Act 1985 s 36(1)(c).

<sup>&</sup>lt;sup>1404</sup> Coroners Act 1985 s 36(1)(b).

<sup>&</sup>lt;sup>1405</sup> State Coroner's Office, Submission no. 70, 169.

<sup>&</sup>lt;sup>1406</sup> David Ranson, Submission no. 19, 56.

the Coroner's Office has played a major role in improving community safety with respect to fire danger, commenting that the investigative powers of the Coroner meant that many issues have been able to be addressed that otherwise may not have been addressed by non-coronial fire investigation agencies. Associate Professor Ranson observed that the coroner's fire jurisdiction appears to be a reflection of the significance of fire in causing frequent personal injury and property damage. However, he pointed out that coroners do not have jurisdiction to investigate other non-fatal scenarios that might cause personal injury or property damage, such as non-fire related explosions or mechanical failures of bridges and buildings. He emphasised the importance of coroners investigating fatal fires and said that:

Where a fire or other destructive scenario causes death it is of course appropriate that the coroner investigates the death and I believe that such a death investigation should include a broad ranging investigation of the circumstances of the fire or other destructive event that led directly or indirectly to the death.<sup>1407</sup>

Associate Professor Ranson observed that in practice the coroner rarely investigates non-fatal fires and by agreement with the fire authorities applies a filtering process to identify the few relevant non-fatal fires that might have a broader public interest and require coronial investigation. He commented that in many other situations where individuals may be harmed the coroner only has jurisdiction where a death occurs, and he considered that this causes little difficulty in most situations. Associate Professor Ranson submitted that, given the current small volume of coronial activity with respect to non-fatal fires, it is difficult to justify the retention of this jurisdiction. He suggested the following alternative:

Perhaps the coroner's fire jurisdiction could be reduced to those fires scenarios which the coroner currently considers it important to investigate. They could be defined within the category of reportable incidents and could perhaps include other scenarios where destructive events occur that could be associated with major public concerns, property damage, personal injury or death.<sup>1408</sup>

The Committee noted earlier that section 31 of the Act gives a coroner discretion to investigate fires if 'the coroner believes it is desirable to do so', 1409 but, as Associate Professor Ranson himself has observed, at present non-fatal fire investigations are held infrequently. 1410 The State Coroner has suggested that the provision be amended to include the words 'the coroner believes it is desirable to do so on the grounds of public health and safety', 1411 which would perhaps have the effect of reducing the fire jurisdiction as suggested by Associate Professor Ranson. However, the Committee

<sup>&</sup>lt;sup>1407</sup> Ibid.

<sup>&</sup>lt;sup>1408</sup> Ibid.

<sup>&</sup>lt;sup>1409</sup> Coroners Act 1985 s 31.

<sup>&</sup>lt;sup>1410</sup> David Ranson, Submission no. 19, 56.

<sup>1411</sup> State Coroner's Office, Submission no. 70, 169.

considers that coroners are likely to exercise the existing discretion to investigate on such grounds. This is not to say that the exercise of the discretion has been without controversy. In relation to the second part of Associate Professor Ranson's suggestion, the Committee will refer briefly to the issue of whether the Act should enable investigation of other destructive non-fatal events later in this chapter.

In its submission the ESM supported the retention of the coroner's power to investigate non-fatal fires.<sup>1413</sup> The ESM submitted that the coroner's investigatory role forms part of a collaborative approach to fire investigation and prevention, and that the coroner brings to investigations an element of objectivity and independence that may assist the community to understand the entire circumstances surrounding a fire.<sup>1414</sup> The broad jurisdiction of the coroner also enables a wider investigation into a fire which encompasses an investigation into the failure or quality of systems and procedures that had a connection with a fire.<sup>1415</sup>

The ESM considers that the coroner's ability to investigate non-fatal fires enables, and forms a part of, a collaborative and holistic approach to fire investigation and prevention. The ESM noted that the coroner generally investigates a fire where there are significant health and public safety concerns, and in the case of a non-fatal fire would do so with the involvement of VIFM and in collaboration with the CFA, the Metropolitan Fire Brigade (MFB) and Victoria Police. The ESM submitted that the ability to investigate non-fatal fires is consistent with the preventative role of the coroner, since non-fatal fires still have the potential to harm the safety of the Victorian community. Further, investigating non-fatal fires provides the coroner with the opportunity to learn from the fire with a view to preventing similar fires and avoiding deaths in future. 1417

In contrast, Volunteer Fire Brigades Victoria (VFBV), an association which represents the Victorian Rural Fire Brigades Association and the Victorian Urban Fire Brigades Association, the combined membership of which includes approximately 58 000

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<sup>&</sup>lt;sup>1412</sup> The Victorian Farmers Federation has expressed dissatisfaction with the State Coroner's decision to investigate the fire at Wilson's Promontory in contrast to his decision not to investigate the alpine bushfires of January and February 2003: Victorian Farmers Federation, 'Stock and Land – Looking into the Fire' (August 25 2005), available at

http://www.vff.org.au/index.php?id=118848.

<sup>&</sup>lt;sup>1413</sup> Emergency Services Commissioner, Submission no. 74, 6.

<sup>&</sup>lt;sup>1414</sup> Emergency Services Commissioner, *Submission no. 74*, 6–7. A corollary is that coronial investigations are seen to be independent inquiries: see for example Milanda Rout, 'Coroner Probes Prom Fire' *Herald Sun* (Melbourne), Wednesday 17 August 2005, 12.

<sup>&</sup>lt;sup>1415</sup> Emergency Services Commissioner, *Submission no. 74*, 7.

<sup>&</sup>lt;sup>1416</sup> Ibid.

<sup>&</sup>lt;sup>1417</sup> Ibid.

volunteers, submitted that the jurisdiction of coroners to investigate non-fatal fires should be removed.<sup>1418</sup>

VFBV considers that the State should establish a separate authority responsible for the investigation of non-fatal fires, adopting the current role of coroners in this area. The new centralised entity would have the capacity to establish and develop a database in relation to fires and 'become pre-eminent in fire investigation research and analysis'. VFBV suggested that this entity would have an investigative arm comprising experts in the field and other key stakeholders, and would have the capacity to sit as a board of inquiry which could call evidence, make findings on the evidence and make such findings public. VFBV considered that, due to the expertise of the board, such inquiries would be more focused and more efficient in terms of cost and time than coronial proceedings. The new entity would have a permanent specialist role in fire investigation and prevention as well as an ongoing capacity to perform tasks such as analysing and reporting on fire management activities and improving fire response and attack.

#### VFBV also submitted:

we respectfully are of the view that this alternative forum we have proposed will likely reduce trauma experienced by many of our volunteers who have in the past had to live with, wait for and then endure Coronial style inquests.<sup>1423</sup>

During the public hearings Mr Peter Davis, executive officer of VFBV, commented on the trauma experienced by volunteers during the inquest into the Linton fires, noting that many had received counselling prior to and after the inquest and that VFBV had lost some of its volunteers due to their experience of attending the inquest. Mr Davis told the Committee that VFBV accepts the need for an inquest in the case of a death, but that in non-fatal cases coronial investigations have a similarly daunting effect on volunteers. He told the Committee that one of the main concerns of volunteers was that they might say something self-incriminating. The Committee Chair asked Mr Davis whether he supported the protection that would accompany the abrogation, proposed in this inquiry, of the privilege against self-incrimination, namely the introduction of a statutory protection against such evidence being used in future

<sup>&</sup>lt;sup>1418</sup> Volunteer Fire Brigades Victoria, Submission no. 36.

<sup>&</sup>lt;sup>1419</sup> Ibid 2.

<sup>&</sup>lt;sup>1420</sup> Ibid 3.

<sup>&</sup>lt;sup>1421</sup> Ibid 3, 6.

<sup>&</sup>lt;sup>1422</sup> Ibid.

<sup>&</sup>lt;sup>1423</sup> Ibid.

<sup>&</sup>lt;sup>1424</sup> Peter Davis, Volunteer Fire Brigades Victoria, *Minutes of Evidence*, 5 December 2005, 271–2.

proceedings. Mr Davis suggested that this would 'certainly be much easier on volunteer witnesses'. 1425

The MFESB considers that the coronial system should maintain the ability to investigate non-fatal fires. The MFESB submitted that while the MFESB investigates non-fatal fires, the *Coroners Act 1985* enables issues of public health and safety to be raised at a higher level. The MFESB noted that close liaison between the MFESB and the State Coroner has produced success in major public safety campaigns, such as the introduction of childproof cigarette lighters, sprinkler systems for supported residential accommodation, the recall of Mistral fan heaters, prison mattress fire testing and a review of the safety of computer monitors. The MFESB observed that the *Victorian Fire Investigation Policy and Procedures* clearly defines the roles and responsibilities of the MFESB in the conduct of both coronial and noncoronial investigations. The MFESB submitted that this policy has been 'tried and proven over many years' and that the removal of the coroner's ability to investigate fires would have a major impact on this policy. The MFESB in the coroner's ability to investigate fires would have a major impact on this policy.

Commander Ian Hunter, manager of the fire investigation and analysis unit of the MFB, told the Committee that the MFB supports the retention of the power of coroners to investigate non-fatal fires. He cited a number of reasons for this support. For example, the MFB considers that, despite its own powers in relation to gathering evidence, there are times when coroners' powers of entry, search and seizure in relation to fire investigations 'provide very strong backup and support'. The MFB also considers that the jurisdiction of coroners in this area, while used infrequently, is an important public safety tool:

What I think is inevitably missed is that the coroner might investigate one non-fatal fire a year...The perception that the coroner will investigate all non fatal fires is not correct. What we want to see is the power for him to investigate a non fatal fire left in the Act. We do not want to lose it. It is a tool that is sitting there. It is a tool for the government as far as public safety goes. It is there. It would be a tragedy if we lost it. 1431

Commander Hunter also emphasised the capacity of coroners to publicise issues of public safety:

The Coroners Act provides a high level means of publicising public safety issues. The fire services — the CFA and MFB — have spoken about childproof cigarette lighters for years.

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<sup>&</sup>lt;sup>1425</sup> Ibid 272.

<sup>&</sup>lt;sup>1426</sup> Metropolitan Fire and Emergency Services Board, Submission no. 52, 1.

<sup>&</sup>lt;sup>1427</sup> Ibid.

<sup>&</sup>lt;sup>1428</sup> Ibid.

<sup>&</sup>lt;sup>1429</sup> Ian Hunter, Metropolitan Fire Brigade, *Minutes of Evidence*, *5 December 2005*, 277.

<sup>&</sup>lt;sup>1430</sup> Ibid 276.

<sup>&</sup>lt;sup>1431</sup> Ibid 277.

Something comes up in the Coroners Court and is reported in the media, which we can then support, and we have a good chance of success. A good chance of not achieving that is when it is left with the fire services, because the best you can do is virtually a media release, and all of us know that you can put media releases out, but the media does not necessarily publish them, or if it is not a newsworthy item compared to the other day's events, it is not going to go anywhere. The coroner gives us the higher level of support. 1432

Commander Hunter cited other examples where the non-fatal fire jurisdiction had led to improved safety measures, including:

- The establishment of a registration system for quality assurance and control at major hazard facilities following the fire at Coode Island.<sup>1433</sup>
- The introduction of licensing requirements for LPG installations in vehicles following a series of fires resulting in non-fatal injury.<sup>1434</sup>

Commander Hunter told the Committee that, in addition to influencing changes within the broader community, coroners also play a role in influencing change within the fire services that would not occur if certain events were investigated 'in house'. For example, while fire services had considered fitting warning devices for low levels in water tanks on fire-fighting vehicles, the cost of upgrading the entire fleet of vehicles was high in the context of the overall budget. He submitted that it was the role of the Coroner following the Linton inquest that provided the impetus for change within the fire service.

Another important issue raised by Commander Hunter was that the role of the coroner is an integral part of the collaborative investigative system formed under the *Victorian Fire Investigation Policy and Procedures*. <sup>1436</sup> Commander Hunter stated that this policy provides extremely clear, concise and simple protocols for the investigation of fires, based on a team approach. The policy arose from the successful Coode Island fire investigation and was designed to avoid duplication of investigative work. Commander Hunter stated that the policy was instrumental in the successful investigation of the Esso Longford fire, in circumstances where there was a strong risk that key evidence and personnel would leave the country.

Commander Hunter stated that, under the team approach, the coroner builds the team and does not have to conduct the investigation, 'but the best possible information comes back to him'. 1437 Commander Hunter submitted:

<sup>1433</sup> Ibid.

<sup>&</sup>lt;sup>1432</sup> Ibid.

<sup>&</sup>lt;sup>1434</sup> Ibid 278.

<sup>&</sup>lt;sup>1435</sup> Ibid 277.

<sup>&</sup>lt;sup>1436</sup> Ibid 278.

<sup>&</sup>lt;sup>1437</sup> Ibid.

The fire investigation policy is unique in Australia. We have had people from overseas approach us to see if it can be worked — from the United States and from England. The policy is tried and proven. It is almost like the Emergency Management Act. When the emergency services and the parties get together, all of a sudden it just starts running and that is it. The removal of the power of the coroner to investigate fires would have a major impact on the successful operation of this policy — there are no two ways about it — because he is the peak of it, if you like. We believe the combination of the coronial system, the policy and skilled fire investigators in all fire services negates the need for the creation of a new entity. We do not support that. 1438

These comments directly contradict the proposal of the VFBV that a separate fire investigation authority be created. Commander Hunter added that the Australasian Fire Investigation Group has a very effective data analysis and sharing system which has resulted, for example, in national product recalls of faulty ceiling exhaust fans following rapid feedback from every state in relation to a series of fires. Further, he stated that the policy allows the bringing together of fire investigation expertise from the various agencies in a way that obviates the need for a separate entity.

Finally, Commander Hunter addressed the criticism that coronial investigations are slow at reaching conclusions and making them available to the community. <sup>1441</sup> In his view this is not necessarily a relevant concern. First, he considers that there is a potential trade-off between the speed and the quality of an investigation. He observed that a large amount of work is required in relation to certain fire investigations, noting that the Coroner's Office is not unique in having delays and comparing these to the delays that occur within the court system. He emphasised that such investigations involve long-term and large-scale issues of community safety, stating that:

the ultimate aim is to be able to protect the public, and that should not be put at risk for the sake of getting something out there as quickly as possible.<sup>1442</sup>

Commander Hunter told the Committee that often problems were well recognised prior to findings being released, and that his involvement with Victorian agencies had shown that they take a proactive approach to safety issues and do not wait for the results of an inquest to implement safety measures, adding that:

The inquest is actually, I suppose you would say, the closing act of the event. It is the formal examination of the facts and the handing down of findings.<sup>1443</sup>

<sup>1439</sup> Ibid.

<sup>&</sup>lt;sup>1438</sup> Ibid.

<sup>&</sup>lt;sup>1440</sup> Ibid 279.

<sup>&</sup>lt;sup>1441</sup> Ibid.

<sup>&</sup>lt;sup>1442</sup> Ibid.

<sup>&</sup>lt;sup>1443</sup> Ibid.

The CFA also supports the retention of the Coroner's jurisdiction to inquire into non-fatal fires. It submitted that:

Although this jurisdiction is not often exercised, its retention is important because of the independence and transparency of the Coroner's role. 1444

Mr Neil Bibby, Chief Executive Officer of the CFA, pointed out that successful safety measures such as mandatory residential smoke alarms and sprinkler systems in nursing homes had come about as a result of fatal and non-fatal fire investigations, and he suggested that if the jurisdiction were restricted to fires that resulted in deaths, the body of available knowledge about fires would be reduced. He told the Committee that in a number of instances the role of the coroner had been of significant benefit to the CFA and other fire services in terms of implementing safety regulations and standards in response to fires where there had been no actual deaths but a high probability that deaths would occur. He Bibby told the Committee that the jurisdiction should be retained because of the coroner's authority in relation to implementation of recommendations. In relation to the problem of delays in investigations, Mr Bibby suggested that the coronial system needs improved case management systems but that delays are primarily a resource issue.

# Investigations into non-fatal events other than fire

In the discussion paper the Committee asked stakeholders whether the scope of a coroner's powers of investigation should appropriately include the power to investigate disasters. The Committee received limited evidence supporting the extension of the non-fatal fire jurisdiction to include other types of non-fatal disaster events such as floods and earthquakes. Mr Bob McDonald, executive officer of VFBV, suggested, as was submitted by Associate Professor Ranson, that it is anachronistic for coroners to investigate non-fatal fires but not other natural disasters in Victoria. Rather than viewing the inconsistency as justifying an extension of the non-fatal fire jurisdiction to include disasters, Mr McDonald considers that it demonstrates a need to remove the jurisdiction. Taking the opposite perspective, Mr Bibby accepted that there was a logical inconsistency in coroners not being able to look at other non-fatal events in the emergency management sphere, and he suggested that this was a matter for practical assessment in terms of the workload of the coroner and the potential advantages that would flow from investigating events other than fires. 1450

<sup>&</sup>lt;sup>1444</sup> Country Fire Authority, Submission no. 31, 1.

<sup>&</sup>lt;sup>1445</sup> Neil Bibby, Country Fire Authority, *Minutes of Evidence*, *5 December 2005*, 299.

<sup>&</sup>lt;sup>1446</sup> Ibid 297.

<sup>&</sup>lt;sup>1447</sup> Ibid 299.

<sup>&</sup>lt;sup>1448</sup> Ibid 300.

<sup>&</sup>lt;sup>1449</sup> Bob McDonald, Volunteer Fire Brigades Victoria, *Minutes of Evidence*, *5 December* 2005, 273.

<sup>&</sup>lt;sup>1450</sup> Neil Bibby, Country Fire Authority, *Minutes of Evidence*, 5 December 2005, 299.

# **Discussion and conclusion**

The Committee considers that the jurisdiction of coroners to investigate non-fatal fires should be retained. The weight of the evidence received by the Committee supports such a proposal. While the Committee accepts that the jurisdiction of coroners to investigate non-fatal fires, in contrast to other non-fatal events which pose a risk to the safety of Victorians, is arguably anachronistic from a theoretical perspective, there are pragmatic reasons why the jurisdiction should be retained.

It is clear to the Committee that in cases involving important issues of public health and safety the coroner is able to play a leading and coordinating role in fire investigations under the effective system encapsulated in the *Victorian Fire Policy and Procedures*. The coroner's extensive powers of entry, search and seizure are also viewed as important in certain fire investigations. Further, the role of the coroner provides a necessary element of independence to major fire investigations. It has also been suggested that the coroner's ability to publicise safety issues and to encourage the implementation of recommendations cannot be as readily achieved by the fire investigation authorities. The Committee considers that the evidence of a well-functioning team approach to fire investigations under the current system, of which the coroner is an integral part, militates against any recommendation that the coroner's jurisdiction be removed and given to a separate authority.

The Committee agrees with the recommendation of the State Coroner that section 36(1)(c) of the Act, which requires a coroner to find 'the identity of any person who contributed to a fire', should be repealed. The Committee has noted that the equivalent provision in relation to death investigations was repealed in 1999. The policy reasons for the removal of section 19(1)(e) were articulated by the Victorian Parliament upon the introduction of the amending legislation and have been referred to in other parts of this report.<sup>1451</sup> The Committee's view is that the legislative inconsistency between the required findings in relation to death and fires needs to be addressed, and that the policy rationale for the removal of such a finding in relation to deaths can also be applied in relation to fires.

While the Committee did not receive evidence in relation to section 36(1)(b), which requires a coroner to make a finding as to 'the circumstances in which the fire occurred', the Committee has noted above that the wording of this provision is also inconsistent with the findings required in relation to deaths. Recent decisions by the courts in other jurisdictions suggest that the required finding in section 19(1)(b) as to 'how death occurred' may in future be interpreted in Victoria as meaning 'by what means and in what circumstances'. Hence the extent of the inconsistency may be limited; however, the Committee considers that this issue should be considered when the legislation is redrafted.

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<sup>&</sup>lt;sup>1451</sup> See for example chapter 7.

Finally, the Committee received insufficient evidence on the question of whether the scope of a coroner's jurisdiction should be expanded to include disasters. Accordingly, the Committee considers that such a recommendation would be inappropriate.

Recommendation 68. That the jurisdiction of coroners under the *Coroners Act* 1985 to investigate non-fatal fires be retained.

Recommendation 69. That section 36(1)(c) of the *Coroners Act 1985* be repealed.

# CHAPTER SEVEN — THE CORONER'S ROLE IN PREVENTION OF DEATH AND INJURY

We speak for the Dead to protect the living. 1452

This is the motto of the State Coroner's Office, Victoria, and the Coroner's Office in Ontario, Canada. In recent years both jurisdictions have actively adopted a preventative role in coronial investigations. This involves identifying patterns in fatal accidents, diseases and practices and making recommendations to prevent similar deaths and improve safety.

In this chapter the Committee reviews the existing mechanisms which allow a coroner to make recommendations aimed at preventing future deaths and injuries. The Committee compares the system in Victoria with the systems and legislation in other jurisdictions. This includes an examination of the effectiveness of the current Victorian system.

Several components of the coronial system need to be analysed in relation to its role in preventing death and injury, including:

- the purposes and provisions of the current Act
- identifying similar kinds of death
- the power of coroners to comment and make recommendations
- the need for improved implementation of recommendations and for responses to them to be monitored
- the effectiveness of recommendations in preventing death and injury

Finally, the Committee will consider the merits of alternative systems, in particular the system adopted in Ontario.

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<sup>&</sup>lt;sup>1452</sup> Attributed to Thomas D'arcy McGee, a 19th-century Irish-Canadian politician.

<sup>&</sup>lt;sup>1453</sup> The State Coroner, Graeme Johnstone, has been described as 'probably Australia's most cogent and passionate advocate of the prevention role for coroners', Justin Malbon, 'Institutional Responses to Coronial Recommendations' (1998) 6 *Journal of Law and Medicine* 35, 39.

# Prevention as a purpose of the Act

[I]f prevention of deaths is not now regarded as the main purpose to be served by inquests, the inquiry becomes of little value.<sup>1454</sup>

The benefits to the wider community of a death investigation system which focuses on the prevention of further death or injury have been recognised for a long time. The above quotation, for instance, is from a statement made by William Brend in 1915. However, this recognition is not universal, and it is only the work of dedicated individuals that has resulted in prevention becoming a focus for contemporary coronial systems. <sup>1455</sup> In Victoria much of the progress in this area may be attributed to the work of the State Coroner, Mr Graeme Johnstone, and his predecessor, Mr Hal Hallenstein. <sup>1456</sup>

Another leading jurisdiction in the area of prevention is Ontario. In 1978 Dr Bennett, the Deputy Chief Coroner of Ontario, observed that the purpose of a coroner's inquest:

is not to name, blame or determine responsibility, but to allow the community to review the circumstances surrounding deaths that appear preventable. An effort is made to obtain recommendations which might prevent a similar death in the future ... the ultimate objective of each investigation is to gain knowledge to prevent similar deaths. To be successful there must be co-operation and communication at every level of involvement.<sup>1457</sup>

In Victoria in 1981 the Hon John Sir Norris QC stated in his review of the *Coroner's Act 1958*:

It is well understood that in establishing the cause of death the coroner (or his jury) may in particular cases serve further purposes. This may also be the case in the establishment of the cause and origin of a fire. The major further purpose to be served is safety.<sup>1458</sup>

In 1995, in a case study of coroners' recommendations and the prevention of deaths in custody, Ms Boronia Halstead commented that:

Coroner's 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 an

<sup>&</sup>lt;sup>1454</sup> William A Brend, *An Inquiry into the Statistics of Deaths from Violence and Unnatural Causes in the United Kingdom* (1915) 67.

<sup>&</sup>lt;sup>1455</sup> David Ranson, Victorian Institute of Forensic Medicine, *Minutes of Evidence*, 28 November 2005, 241.

<sup>&</sup>lt;sup>1456</sup> Victorian Institute of Forensic Medicine, Submission no. 40, 3, 18.

<sup>&</sup>lt;sup>1457</sup> R C Bennett 'The Changing Role of the Coroner' (1978) 118 CMA Journal 1133.

<sup>&</sup>lt;sup>1458</sup> John Norris, *The Coroners Act 1958 – A General Review* (1981) 134.

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. 1459

The preventative role of the State Coroner has also been affirmed recently by the Attorney-General of Victoria:

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 re-occurrence of similar deaths or accidents in the future. This role is an important and valuable one for improving the safety of the community.<sup>1460</sup>

The Committee supports the Attorney-General's view that prevention of death and injury is a proper focus for the coronial system, as has been discussed in chapter two. While the UK has retreated from allowing coroners to make comments directed towards prevention, it cannot be doubted that, in Victoria — as in other Australian jurisdictions and overseas in places such as Ontario and New Zealand — prevention is now recognised as a valuable purpose to be served by the coronial system.

However, at present the preventative role of coroners is not recognised expressly as a purpose of the *Coroners Act 1985*. Section 1 provides that:

The purpose of this Act is to -

- (a) establish the office of State Coroner;
- (b) require the reporting of certain deaths;
- (c) set out the procedures for investigations and inquests by coroners into deaths and fires;
- (d) establish the Victorian Institute of Forensic Medicine. 1461

Further, the Act does not include the making of recommendations to prevent deaths from similar circumstances in future as a listed function of the State Coroner, 1462 nor does the jurisdiction of coroners include investigating or holding inquests into deaths for the purpose of making such recommendations. 1463 The findings which a coroner can make do not include whether a death was preventable. 1464 However, the preventative role of coroners is enabled by provisions of the Act enabling a coroner to

<sup>&</sup>lt;sup>1459</sup> Boronia Halstead, 'Coroner's Recommendations Following Deaths in Custody', in Hugh Selby (ed), *The Inquest Handbook* (1998) 186.

<sup>&</sup>lt;sup>1460</sup> Attorney-General's Justice Statement, 'New Directions for the Victorian Justice System 2004–2014', 25 May 2004, 46.

<sup>&</sup>lt;sup>1461</sup> Coroners Act 1985 s 1.

<sup>&</sup>lt;sup>1462</sup> See section 7 of the Coroners Act 1985, which sets out a list of the functions of the State Coroner.

<sup>&</sup>lt;sup>1463</sup> Coroners Act 1985 ss 15, 18.

<sup>&</sup>lt;sup>1464</sup> Coroners Act 1985 s 19(1).

make comments and recommendations in relation to a death s/he investigates, as will be discussed below.

Section 19 of the Act provides, under the heading 'Findings and comments of coroner', that a coroner investigating a death must find, if possible:

- (a) the identity of the deceased; and
- (b) how death occurred; and
- (c) the cause of death; and
- (d) the particulars needed to register the death under the *Births, Deaths and Marriages Registration Act 1996.*<sup>1465</sup>

Thus the formal findings of a coroner are confined to issues related to the manner and cause of death. The role of the coroner is primarily an inquisitorial, fact-finding function, rather than one of apportioning guilt. The determination of civil or criminal liability is not a responsibility of the coroner. These are matters for other jurisdictions. The Committee notes that under the former section 19(e) coroners were obliged to find the identity of any person who *contributed to the cause of death*. However, due to the potential of this provision to blur questions of factual causation with questions of culpability, it was repealed in 1999. 1466 For example, if a person committed suicide by leaping in front of a train, a coroner would have to find that the train driver contributed to the cause of death, even though there may have been nothing that the train driver could have done to avoid the death. 1467 No matter how the Coroner sought to explain that the finding was about the legal definition of the causal chain, the finding of 'contribution' was likely to cause confusion, 1468 which could result in inaccurate media reporting and unwarranted damage to professional reputations. 1469

However, despite the limited scope of findings, under section 19(2) a coroner may comment on any matter connected with the death, including public health or safety or the administration of justice. Further, under section 21 a coroner may also report to the Attorney-General on any death that s/he has investigated, and s/he may make recommendations to any Minister or public statutory authority on any matter connected with a death which s/he investigated, including public health or safety or

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<sup>&</sup>lt;sup>1465</sup> Coroners Act 1985 s 19(1).

<sup>&</sup>lt;sup>1466</sup> Coroners (Amendment) Act 1999 s 10(b).

<sup>&</sup>lt;sup>1467</sup> Jan Wade, Attorney-General, Second Reading Speech, Coroners (Amendment) Bill, Legislative Assembly (25 March 1999) 185, 186.

<sup>&</sup>lt;sup>1468</sup> State Coroner's Office, Submission no. 70, 49.

<sup>&</sup>lt;sup>1469</sup> See for example *Keown v Khan* (Unreported, Supreme Court of Victoria, BC9801478, Ormiston, Callaway and Batt JJA); see also Elizabeth Kennedy, 'Reform of the Coroners Act – A Fair Go All Round', *Law Institute Journal* (March 1999), 11.

<sup>&</sup>lt;sup>1470</sup> Coroners Act 1985 s 19(2).

the administration of justice.<sup>1471</sup> These provisions will be discussed again later in this chapter.

Using these powers the coroner can and often does make critical comments about the conduct of persons or agencies in relation to a death, or about identified system failures, and can make recommendations so that the lessons learnt or problems identified from a particular case can be used as the basis for preventative measures in future. However, the current legislation views this role as ancillary to the investigation of deaths, and a discretionary one at that. The result is that the making of comments or recommendations designed to prevent future deaths in similar circumstances depends on the initiative of the particular coroner. For a range of reasons, at present only a few Victorian coroners make use of their power to make recommendations, as will be discussed later in this chapter.

# Other jurisdictions

While a number of other Australian jurisdictions give coroners the power to make comments and recommendations, the legislation in most other jurisdictions does not refer to prevention as being a purpose of the relevant Act or one of a coroner's main roles or functions. However, this comparison is of limited value, since Queensland is the only state other than Victoria in which the purposes or objects of the legislation are formally prescribed.

The *Coroners Act 2003* (Qld) formally recognises the preventative role of coroners as one of the purposes of the legislation:

- 3. The object of this Act is to -
- . . .
- (d) help to prevent deaths from similar causes happening in the future by allowing coroners at inquests to comment on matters connected with deaths, including matters related to –
- (i) public health or safety; or
- (ii) the administration of justice. 1472

Similarly, in New Zealand section 3 of the *Coroners Act 2006* contains a useful model for legislative recognition of the role of prevention:

- 3 Purpose of this Act
- (1) The purpose of this Act is to help to prevent deaths and to promote justice through –

<sup>&</sup>lt;sup>1471</sup> Coroners Act 1985 s 21(2).

<sup>1472</sup> Coroners Act 2003 (Qld) s 3.

- (a) investigations, and the identification of the causes and circumstances, of sudden or unexplained deaths, or deaths in special circumstances; and
- (b) the making of specified recommendations or comments (as defined in section 7) that, if drawn to public attention, may reduce the chances of the occurrence of other deaths in circumstances similar to those in which those deaths occurred.

The Act also provides that coroners' inquiries have three purposes:

- to establish, as far as possible, that a person has died, the person's identity, when and where the person died, the causes of the death and the circumstances of the death; and
- to make specified recommendations or comments that, in the coroner's opinion, may, if drawn to public attention, reduce the chances that other deaths will occur in circumstances similar to those in which the death occurred; and
- to determine whether the public interest would be served if the death were investigated by other investigating authorities in the performance or exercise of their functions, powers or duties, and to refer the death to them if satisfied that the public interest would be served by their investigating it in the performance of their functions, powers or duties.<sup>1473</sup>

# Evidence received by the Committee

Witnesses generally attested to the central role of the Coroner in the prevention of deaths and fires in Victoria. Several submissions contained variations of the following observation:

The Coroner is in a unique position to learn from deaths and fires to promote the safety of all Victorians and facilitate the prevention of future deaths and fires.<sup>1474</sup>

The State Coroner's Office submitted that, in order to achieve the public safety and prevention role identified by the Attorney-General, section 1 of the *Coroners Act* should be amended 'to ensure there is no further dispute' about the jurisdiction of coroners in this area.<sup>1475</sup> The State Coroner's Office submitted that the wording of the Queensland provision in this regard is useful but that it should be supplemented by a reference to the National Coroners Information System (NCIS) data collection and analysing process. The Committee discusses the NCIS later in this chapter. Thus one of the specified purposes of the Act should be to:

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<sup>&</sup>lt;sup>1473</sup> Coroners Act 2006 (NZ) s 4(2).

<sup>&</sup>lt;sup>1474</sup> Office of the Emergency Services Commissioner, Submission no. 74, 8.

<sup>1475</sup> State Coroner's Office, Submission no. 70, 54.

help to prevent deaths or fires from similar causes happening in the future by collecting and analysing data and enabling coroners to comment and make recommendations about certain matters connected with deaths or fires, including matters related to —

- (i) public health or safety; or
- (ii) the administration of justice. 1476

Mr Johnstone told the Committee that the work of the State Coroner's Office is increasingly directed towards looking at the systems behind reportable deaths, and that this focus is gradually being fostered within the investigatory culture of police and other relevant agencies. Mr Johnstone also told the Committee that the vast majority of injury-related incidents in Victoria are not investigated in a systematic way. There is generally no investigation of an incident which leaves a person with a severe disability unless the incident is the subject of a compensation claim. This means that the coronial system is particularly important in the area of injury prevention. 1478

Similarly, the Victorian Institute of Forensic Medicine (VIFM) stated in its submission that the current system in Victoria has had considerable influence in preventing death and injury and is considered to be leading the way in Australia, if not internationally. However, VIFM submitted that legislative recognition of the role of prevention is necessary to meet the community expectation, which VIFM strongly endorses, 'that we learn from past incidents'. VIFM noted that a common refrain of those who have lost family members is that they want to ensure that 'this doesn't happen to anyone else'. VIFM submitted that, until the preventative role of the coroner is recognised in the Act, some coroners will continue to treat cases in isolation, believing that it is not within their scope or ability to comment on trends and patterns to highlight preventable aspects of deaths. 1482

Further, VIFM strongly supports the role of coroners being expanded so that, during an investigation, coroners must consider any previous fatalities which have occurred in similar circumstances. This would ensure that individual fatalities, notwithstanding the different factors and circumstances inevitably involved, would be less likely to be dealt with in isolation, thus increasing the possibility that certain

<sup>&</sup>lt;sup>1476</sup> Ibid 58.

<sup>&</sup>lt;sup>1477</sup> Graeme Johnstone, *Minutes of Evidence*, 19 September 2005, 78.

<sup>&</sup>lt;sup>1478</sup> Ibid 71.

<sup>&</sup>lt;sup>1479</sup> Victorian Institute of Forensic Medicine, *Submission no. 40*, 18.

<sup>&</sup>lt;sup>1480</sup> Ibid 19.

<sup>&</sup>lt;sup>1481</sup> Ibid.

<sup>&</sup>lt;sup>1482</sup> Ibid.

<sup>&</sup>lt;sup>1483</sup> Ibid.

trends or patterns will be identified, and enabling preventative recommendations to be developed.<sup>1484</sup>

Associate Professor David Ranson, Deputy Director of VIFM, told the Committee that the focus on prevention by the State Coroner's Office is 'rather ad hoc and external to the legislation'. He observed that successes to date depended in part on a 'cult of personality' because the preventative function is not prescribed by the legislation. He cited the 'tremendous work' done by Mr Johnstone in terms of advancing prevention and expressed concern that if the coroners at the office were to change, 'we run the risk of losing some of the gains we have made in the last 10-15 years'.<sup>1485</sup>

During the public hearings for this inquiry Dr Ian Freckelton recommended to the Committee:

that thought be given to setting out more extensively the purposes not just of the legislation but of the holding of inquests, specifically this time recognising the utility and social advantage in inquiries and inquests being held to facilitate the avoidance of avoidable deaths in the future, thereby specifically recognising the prophylactic role of the coroner system as it is presently functioning.<sup>1486</sup>

However, the submission by the Victorian Bar cautioned against any departure from the limitations on the power of coroners to make comments and recommendations defined by the courts in cases such as *Harmsworth v The State Coroner*<sup>1487</sup> (which will be discussed later in the chapter). The courts have viewed such powers as incidental to the investigation of particular reportable deaths rather than an independent basis for inquiry. The Victorian Bar submission appears to imply that, if prevention were recognised as a purpose of the Act, this would undermine the notion that comments and recommendations must relate to a particular death investigation:

Even a Royal Commission is limited by terms of reference. There is a real danger in the suggestion to abrogate the Harmsworth principle that the Coroner would assume the role of a standing Royal Commissioner at large. 1489

The Victorian Bar considers that the Act strikes an important balance between the responsibility of a coroner and the executive arm of government, such that, while a coroner may make recommendations to a Minister or public statutory authority, it is

<sup>&</sup>lt;sup>1484</sup> Ibid.

<sup>&</sup>lt;sup>1485</sup> David Ranson, Victorian Institute of Forensic Medicine, *Minutes of Evidence*, 28 *November* 2005, 241.

<sup>&</sup>lt;sup>1486</sup> Ian Freckelton, *Minutes of Evidence*, 20 September 2005, 207.

<sup>&</sup>lt;sup>1487</sup> Harmsworth v State Coroner [1989] VR 989.

<sup>&</sup>lt;sup>1488</sup> Victorian Bar, Submission no. 81, 17–19.

<sup>&</sup>lt;sup>1489</sup> The submission states that some members of the Bar take a contrary view, although 'the majority view amongst those who practise in the Coroner's jurisdiction' is that the principles in *Harmsworth* should be retained: ibid 18.

the responsibility of the Minister or public statutory authority to decide what action should be taken.<sup>1490</sup> Part of that balance, according to the Victorian Bar, is that the coroner's power to comment and make recommendations is not an independent function of the Act.<sup>1491</sup> Rather, as was held in *Harmsworth*, the power is 'inextricably connected with, but not independent of, the power to enquire into a death or fire for the purpose of making findings'.<sup>1492</sup>

The Medical Practitioners Board of Victoria (MPBV) submitted that a public health function should be formalised as part of the coronial role in relation to both a coroner's functions and the purposes of holding inquests, noting that this has been done in New Zealand.<sup>1493</sup>

A number of witnesses submitted that making the preventative role of coroners a function of the Act would assist in the protection of the vulnerable groups in the community that they represent. For example, the Disability Discrimination Legal Service submitted that:

Making the preventative role of Coroners a function of the Act would ensure greater protection for prisoners with disabilities.<sup>1494</sup>

Finally, a number of family members of people whose deaths had been the subject of coronial investigation submitted that the Act should be amended to identify the prevention of deaths as one of its main purposes.<sup>1495</sup>

#### Discussion and conclusion

The Committee considers that the role of the coronial system has evolved increasingly towards the prevention of death and injury and that this role has been recognised for a considerable time in Victoria. The Committee considers that the coronial system has a greater purpose to serve than acting as a 'safety valve' for society to answer groundless suspicions about a death by bringing out the truth. Since the jurisdiction is no longer concerned with determining questions of civil or criminal responsibility, it cannot be doubted that one of its most valuable remaining functions is to identify risks to the public health and safety of the community and to make recommendations designed to prevent similar events in the future.

<sup>1491</sup> Ibid 18–19.

<sup>&</sup>lt;sup>1490</sup> Ibid 18.

<sup>&</sup>lt;sup>1492</sup> Harmsworth v State Coroner [1989] VR 989, 996.

<sup>&</sup>lt;sup>1493</sup> See Coroners Act 1988 (NZ) s 15(1)(b); Coroners Act 2006 (NZ) s 47(3), (4).

<sup>&</sup>lt;sup>1494</sup> Disability Discrimination Legal Service, *Submission no. 29*, 13.

<sup>&</sup>lt;sup>1495</sup> Graeme Bond, *Submission no. 48*, 12; Anne Anderson, *Submission no. 43*, 5; Marion Stevens, *Submission no. 49*, 5.

<sup>&</sup>lt;sup>1496</sup> R C Bennett, 'The Changing Role of the Coroner' (1978) 118 CMA Journal 1133.

The Committee therefore agrees with the State Coroner's Office that section 3 of the Coroners Act 2003 (Qld) should be used in amended form as a model for the Victorian Act in recognising as one of its purposes the prevention of deaths in similar circumstances happening in the future. The Committee considers that the Queensland provision should be used as a model except insofar as it only identifies this purpose for coroners at inquests, since matters that go to inquest represent a minority of cases.<sup>1497</sup>

Finally, the Committee has considered the recommendation by the State Coroner's Office that the Act identify the collection and analysis of data by coroners as a part of this preventative purpose. The Committee's view is that the recognition of prevention as a purpose of the Act is sufficient to facilitate the collection and analysis of data by the Coroner's Office and does not need to be separately identified as a purpose of the Act. The Committee notes that data collection and analysis is essential to prevention work and will require the cooperation of a number of agencies, as will be discussed below.

Recommendation 70. That section 1 of the *Coroners Act 1985* be amended to provide that a purpose of the Act is to help to prevent deaths or fires in similar circumstances happening in the future by allowing coroners to comment and make recommendations on matters connected with deaths or fires, including matters related to public health and safety or the administration of justice.

# Preventing suicide deaths of people involved in the mental health system

The Committee received compelling and disturbing evidence from the family members of several people whose deaths from suicide followed recent release from a mental health facility. The evidence suggested that existing coronial investigations of these deaths are inadequate. Due to the number of such cases brought to the Committee's attention and the perception by many families that prevention issues in cases involving mental health clients are not being sufficiently addressed, the Committee here sets out in some detail the main aspects of the evidence provided.

The criticisms which emerged, in part from confidential submissions, can be grouped into the following basic areas:

 Lack of available research concerning potential correlations between treatment or care given in the mental health system and subsequent suicide

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<sup>&</sup>lt;sup>1497</sup> The Committee also considers that the new provision should refer to both comments and recommendations. This is because in Victoria, coroners are able to make comments and recommendations, both of which may be of a preventative nature: *Coroners Act 1985* ss 19, 21. By contrast, section 46 *Coroners Act 2003* (Qld) gives the legislation in Queensland gives coroners power to comment but does not refer to recommendations, which is reflected in the wording of section 3.

- Inadequate investigations by police working as coroner's assistants who lack the
  expertise required to investigate complex medicolegal matters and who often rely
  on witness statements gathered by solicitors representing the hospital and doctors
- Failure by coroners and police to secure medical files and other documentation from uncooperative hospitals in a timely and thorough manner
- Undue reliance by coroners upon independent expert witnesses, who often have undisclosed close professional associations with treating doctors
- Apparent inability of many coroners to understand complex medicolegal matters
- Inequality of legal representation, leading to inadequate exploration of the circumstances surrounding the death
- Apparent unwillingness of coroners to criticise the mental health system, and existing restrictions on the scope of their power to make comments
- Weak and overly general recommendations by coroners
- Lack of follow-up on recommendations or lack of obligation of agencies to respond to them

Some of these concerns are addressed in other chapters of the report. Concerns raised by family members relating to the way coronial investigations of health care matters are conducted have been discussed in chapter five. The concerns of witnesses about inequality of legal representation are discussed in chapter eight.

This chapter will address concerns about the use and availability of epidemiological research for identifying similar kinds of death, and about the effectiveness of coronial recommendations, the need to monitor their implementation and the need for an obligation that agencies respond to them. Some of the family members affected by this issue requested that their submissions be kept confidential. The Committee is able to refer to the submissions of Ms Caroline Storm and Mr Graeme Bond, who both provided their evidence on the record.

# Evidence received by the Committee

Ms Storm, whose daughter Anne killed herself shortly after discharge from a hospital, stated in her submission that there has been an increase in suicides of clients of the mental health system and expressed concern that this information is already available but has not been made public.<sup>1498</sup> In her submission Ms Storm referred to the evidence of an expert witness called by the hospital at the inquest into her daughter's death; the expert witness suggested that it was not uncommon practice in the mental health

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<sup>&</sup>lt;sup>1498</sup> Caroline Storm, Submission no. 28, 7.

system for clients to be discharged even when believed to pose a potential risk to themselves or others.

Ms Storm referred to a study undertaken by the Office of the Chief Psychiatrist in conjunction with the Coroner's Office, which to date has not been publicly released but was described in a 2004 media report of an interview with Dr Ruth Vines, Director, Mental Health, Department of Human Services. 499 According to the media report, the research examined 5800 suicide deaths that occurred in Victoria between 1992 and 2002, finding that 1837 involved people who had had contact with the public mental health system at some time. Almost 1200 of the patients had a history of admissions to hospital. Of these, almost half killed themselves within a year of their discharge, and one in five committed suicide within five weeks of leaving hospital. 1500 These figures have been compared<sup>1501</sup> to a study published in 2000 which identified 629 people with a history of public sector psychiatric service use who committed suicide between 1989 and 1994, and found that 125 of these deaths might have been prevented if services had responded differently. 1502 Ms Storm emphasised the importance of the more recent research being made public in order to demonstrate the suicide rate of clients of the mental health system. Ms Storm expressed the view in her submission that:

The death increase is known and kept from public knowledge. 1503

Ms Storm submitted that, on the face of the new figures, it is possible to deduce that there has been a significant increase in client suicides from 1995 to 2002. 1504

In response to an inquiry, Dr Vines informed the Committee Chair that, as the person who carried out the research had moved to another position, the research had not

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<sup>&</sup>lt;sup>1499</sup> Liz Porter, 'Suicide a Risk After Hospital', *The Sunday Age* (Melbourne), 12 December 2004, 7.

<sup>&</sup>lt;sup>1500</sup> These figures have been confirmed to the Committee: Letter, Ruth Vines, Director, Mental Health, Department of Human Services, to Committee Chair, 15 March 2006.

<sup>&</sup>lt;sup>1501</sup> Liz Porter, 'Suicide a Risk After Hospital', *The Sunday Age* (Melbourne), 12 December 2004, 7; Peter Ellingson, 'Suicide Alarm Among Mentally III', *The Sunday Age* (Melbourne), 24 July 2005, 6.

Philip Burgess et al, 'Lessons from a Comprehensive Clinical Audit of Users of Psychiatric Services Who Committed Suicide', (200) 51 (12) *Psychiatric Services* 1555. This audit was commissioned by the Victorian government, and the auditors were given ministerial exemption to access confidential clinical records and match these against coronial investigations into suicide cases. See also Jasmin Kim-Westerndorf, 'Youth Suicide and Mental Health Services', *Victorian Parliamentary Internship Research Report* (2005), which contains a study of each coronial finding on the suicides of people 30 years old and under, between 2002 and 2003. The research found that 17 percent had significant interactions with mental health services, and it identified inadequacies in the treatment of those patients. See Kate Legge, 'Mental Health Failings Linked to 42 Suicides', *The Australian* (Sydney), 19 July 2005, 5,

<sup>&</sup>lt;sup>1503</sup> Caroline Storm, Submission no. 28, 7.

<sup>&</sup>lt;sup>1504</sup> Ibid.

been completed.<sup>1505</sup> The Committee was provided with a confidential draft of the report, and it was advised that there were difficulties in relation to the statistical analyses and that the report's conclusions should be viewed as preliminary.<sup>1506</sup> However, Dr Vines stated that, partly as a consequence of this work, additional funding was provided to mental health services in 2005–06 to support discharge planning and improved communication between mental health services and primary care services. Dr Vines expressed the hope that the department would be able to carry out similar work in collaboration with the State Coroner's Office in the future.

Mr Bond, whose son Jason killed himself in 1993 shortly after discharge from a hospital, was one of a number of family members who were assisted at the time by a pro-bono legal assistance scheme provided by the Law Council of Australia to aid the Human Rights and Equal Opportunity Commission (HREOC) following the release of the Burdekin Report in 1993. Mr Bond told the Committee that the cases funded under this scheme were evaluated for merit by a consultant to HREOC and judged to illustrate severe problems with the mental health system. He stated:

Despite this, only one of the cases I am aware of produced an outcome which was at all critical of the Mental Health System and its appalling treatment of a young man. (Case No 3921/92). The remainder of the cases I am aware of, including that of my son (Case No 1098/93) resulted in what can only be described as derisory findings that failed to even dimly comprehend the issues involved and deal with them.

I have since been a keen observer of Coronial inquests and felt a cold anger at the lost opportunities to identify significant issues of public safety and well being and make significant recommendations on them.<sup>1508</sup>

However, Mr Bond considered that some coroners 'appear to have done an excellent job and come to grips with very real issues that are of vital public interest'. Mr Bond stated in his submission that coroner Wendy Wilmoth had identified in earlier cases many of the issues present in his son's case and had made recommendations to the Department of Human Services well before the events leading to Jason Bond's death, but that these appeared to have had no effect. 1509

Mr Bond considers that general patient safety in the health care system is the prevention area which the coronial system deals with least well. In his view a major

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<sup>&</sup>lt;sup>1505</sup> Letter, Ruth Vines, Director, Mental Health, Department of Human Services, to Committee Chair, 15 March 2006.

<sup>&</sup>lt;sup>1506</sup> One problem highlighted was that there may have been a degree of double counting due to the way in which people are noted on the case register.

<sup>&</sup>lt;sup>1507</sup> Human Rights and Equal Opportunity Commission, *Human rights and mental illness – Report of the National Inquiry into Human Rights of People with Mental Illness* (1993) (the Burdekin Report).

<sup>&</sup>lt;sup>1508</sup> Mr Graeme Bond, Submission no. 48, 6–9, 12.

<sup>&</sup>lt;sup>1509</sup> Ibid 2.

obstacle is that coroners do not have investigators with sufficient skills and knowledge, which tends to result in the 'outsourcing' of a large part of the investigation to solicitors for the hospital and doctors.<sup>1510</sup>

Mr Bond was also concerned that coronial recommendations are not implemented:

As a general rule it seems that coronial recommendations are treated with indifference by government departments and agencies. It is as if they disappear into a departmental shredder or a dusty pigeon hole.<sup>1511</sup>

#### He added:

There needs to be a defined open and transparent process for coronial recommendations to be assessed by such organisations, within a reasonable time frame, and the actions proposed by the department or agency reported back to the coroner and interested parties as well as being accessible to the general public. Tabling of both the recommendations and proposed actions in Parliament would assist in the process of public exposure but is insufficient on its own.<sup>1512</sup>

#### Research and coronial recommendations

The Committee notes that the adequacy of mental health services has been the subject of a number of inquiries at both national and state level, and that any such assessment would be well beyond the scope of this inquiry. The Committee also notes that there is some debate among mental health experts regarding the extent to which the mental health system is able to prevent suicide. However, what emerged from submissions is a concern that the correlations between treatment and care received by clients within the mental health system and subsequent suicides still need to be explored thoroughly by the coronial system. Further, these correlations must be publicised to highlight this problem to relevant government departments and the broader community. Given that existing studies have found that the risk of suicide for clients of the mental health system is highest within the first five weeks after discharge — quite apart from the disturbing experiences of the family members who gave evidence to the Committee — this concern is not surprising.

Dr Freckelton, in the Myers Oration 2005, reviewed recent international analyses of data concerning premature death among persons with psychiatric disorders and

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<sup>&</sup>lt;sup>1510</sup> Ibid 12–13.

<sup>&</sup>lt;sup>1511</sup> Ibid 12.

<sup>&</sup>lt;sup>1512</sup> Ibid.

<sup>&</sup>lt;sup>1513</sup> See for example Victorian Auditor-General's Office, *Mental Health Services for People in Crisis* (2002), available at <a href="http://www.audit.vic.gov.au/reports">http://www.audit.vic.gov.au/reports</a> par/agp8100.html; Senate Select Committee on Mental Health, *A National Approach to Mental Health – from Crisis to Community – First Report*, Parliament of Australia (2006); Senate Select Committee on Mental Health, *A National Approach to Mental Health – from Crisis to Community – Final Report*, Parliament of Australia (2006). The latter reports are available at <a href="http://www.aph.gov.au/senate/committee/mentalhealth">http://www.aph.gov.au/senate/committee/mentalhealth</a> ctte/.

noted limitations in official records.<sup>1514</sup> Dr Freckelton then identified, by reference to NCIS data, a substantial number of coronial recommendations arising from inquests into such deaths between 2000 and 2005, and concluded that:

the subject matter of coroner's recommendations has been extremely diverse, spanning provision of psychiatric care; decision-making about discharge, leave and apprehension of absconding patients, procedures and protocols; and the need for improved knowledge, additional research and additional facilities. What characterises the recommendations is a clear attempt to explore underlying issues, structures and practices that may have contributed to deaths, which otherwise may have been avoided or at least postponed.<sup>1515</sup>

Further, he observes that the aggregation of coroners' recommendations on the NCIS database in respect of psychiatric deaths (which had not been done previously, due to the inaccessibility of coroners' decisions) reveals that:

the community, through the coroner's courts, has expended a great deal of money, care and attention on analysing the circumstances in which significant numbers of psychiatrically unwell patients have died. It has also identified a plethora of constructive steps which could be taken to reduce the incidence of such deaths.<sup>1516</sup>

However, Dr Freckelton then makes the point that it is not known to what extent such proposals for reform, research and review have been implemented. This is because there is no obligation on the entity to which they are directed to respond to them, let alone put them into operation. Another reason put forward by Dr Freckelton is the limited capacity of coroners to perform the research required to monitor implementation:

It has become apparent that the funding for coroner's offices is modest indeed, limiting their research capacities. A result is that it is unknown (save by anecdote) how common it is for coroner's recommendations and comments to be implemented.<sup>1517</sup>

He considers that this is especially unsatisfactory in the context of psychiatric deaths, given the range of thoughtful and diverse recommendations which relate to the treatment and resources available to people with life-threatening vulnerabilities:

It is important for the community to know which proposals are not implemented and the associated reasons. The reasons may be sound, or they may not be, but the families of the deceased and the community generally should be informed of them.<sup>1518</sup>

<sup>&</sup>lt;sup>1514</sup> Ian Freckelton, 'The Myers Oration 2005: Untimely Death, Law and Suicidality' (2005) 12 *Psychiatry, Psychology and Law* 2.

<sup>&</sup>lt;sup>1515</sup> Ibid 274.

<sup>&</sup>lt;sup>1516</sup> Ibid.

<sup>&</sup>lt;sup>1517</sup> Ibid 275.

<sup>&</sup>lt;sup>1518</sup> Ibid.

Dr Freckelton considers that the imposition of mandatory response obligations, such as those which exist in the ACT and the Northern Territory, would enable evaluation of the effectiveness of the contemporary role of coroners and enable the community to assess whether the recommendations put forward by coroners are informed, appropriate and worthy of implementation. He suggests that, while imposing such obligations would change the place of coroners within both the legal and public health systems, 'it may well be that it would transform coroners into entities of real, ongoing relevance'.<sup>1519</sup>

Dr Freckelton also comments on the need for available research into the incidence of psychiatric deaths to be utilised more effectively in coronial hearings:

The indications in the coroner's findings and recommendations between 2000 and 2005 are that inadequate research information about the incidence and aetiology of the deaths of persons with psychiatric disorders is informing coroner's hearings. There is a need for the evolving knowledge basis of suicide and self-harm, insofar as it relates to persons with psychiatric disorders, to be communicated effectively to legal hearings. <sup>1520</sup>

He also considers that better awareness and further research are also needed for a range of decision makers in the mental health system:

the particular risks that are becoming apparent, both from the research literature and from the information emerging in coroner's inquests, should influence clinical decision-making by psychiatrists and other mental health personnel about matters such as release from involuntary status, provision of leave, transfer from inpatient to community care status and provision of care during the period shortly after release from compulsory hospitalisation. This is an area in which there is potential for more informed decision making that may, in turn, save lives.<sup>1521</sup>

Dr Freckelton considers that members of mental health review boards also need to be alerted to knowledge in this area, stating that 'there is much that could lend greater sophistication and sensitivity to their decision-making from coroner's decisions (as well as the clinical literature) about patients who have died from suicide'. 1522

Finally, Dr Freckelton makes the observation that more research is required in relation to suicides by people with mental illnesses in order to understand the issue and generate community awareness, as suggested to the Committee by Ms Storm:

there is a need for epidemiological analysis of the incidence of suicide amongst those with psychiatric disorders within Australia so that the phenomenon can be better identified and understood. For that to be accomplished, a preliminary challenge is resolution of the disjunction

<sup>1520</sup> Ibid 276.

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<sup>&</sup>lt;sup>1519</sup> Ibid.

<sup>&</sup>lt;sup>1521</sup> Ian Freckelton, 'The Myers Oration 2005: Untimely Death, Law and Suicidality' (2005) 12 *Psychiatry,* 

Psychology and Law 2, 276.

<sup>&</sup>lt;sup>1522</sup> Ibid.

between correlations of completed suicides and mental illness and official government figures. Only when the data are reliable and can be studied more effectively is there likely to be appropriate community pressure for government to take those steps which evidence discloses can be taken to reduce this tragic category of deaths. Those who have already passed away and the families who continue to grieve for them deserve the compilation of such data, the effective integration of clinical knowledge into coroner's decisions, and informed governmental and clinical responses so as to address the tragedy of premature deaths of persons with psychiatric disorders. 1523

#### Discussion and conclusion

The issues identified here, in particular the need for data to be collected, analysed and made public, and the need for recommendations to be effective, responded to and monitored, are addressed in the remainder of this chapter.

# Identifying similar kinds of deaths

The ability of coroners to determine whether there are patterns in the circumstances surrounding a number of deaths is crucial to its function of identifying risk factors which may be preventable in future. In this part of the chapter the Committee will discuss ways in which similar kinds of deaths are identified, including death certification and reporting, the NCIS, and the various research units which review the data obtained from death investigations for the purpose of identifying areas of risk and possible prevention.

# Death certification and reporting

There are obvious limitations to the ability of coroners to identify similar kinds of deaths if deaths which are 'reportable' under the Act are under-reported. Dr Freckelton and Associate Professor Ranson note that a recent study undertaken at a number of public hospitals in Victoria has identified an 'unreported but reportable' death rate of approximately 60 percent, which demonstrates a potentially huge deficit in the number of cases that have been investigated by a coroner.<sup>1524</sup>

A number of witnesses, particularly medical witnesses, submitted that the coroner's role in death and injury prevention would be more effective if the level of reporting of deaths could be increased, particularly in relation to medical adverse events. For example, the Victorian Consultative Council on Anaesthetic Mortality and Morbidity submitted that this would best be achieved by clearer definitions of reportable deaths and the provision of appropriate guidelines in relation to reporting deaths. <sup>1525</sup> It

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<sup>&</sup>lt;sup>1523</sup> Ibid.

<sup>&</sup>lt;sup>1524</sup> Ian Freckelton and David Ranson, *Death Investigation and the Coroner's Inquest* (2006) 746–7.

<sup>&</sup>lt;sup>1525</sup> Victorian Consultative Council on Anaesthetic Mortality and Morbidity, Submission no. 22, 3.

considers that coronial recommendations have a high level of impact which could be improved with further reporting. 1526

The Committee has already discussed the provisions according to which deaths are to be reported to the coroner, and it has made recommendations designed to address the issue of under-reporting in chapters three and four.

# The National Coroners Information System (NCIS)

The NCIS has great potential to be the cornerstone of a new model of death investigation which is evidence-based and policy-driven. 1527

The NCIS is a national database of information from coronial investigations — the first of its kind in the world. The database is an initiative of the Australian Coroners Society and is based at and operated by VIFM in Melbourne. 1528 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. 1529

The NCIS contains information on all Australian coroners' cases in which findings were recorded since the database became operational in 2000. There were approximately 95,000 cases recorded by July 2005. 1530 The NCIS includes information such as the medical cause of death, 1531 the circumstances of the death, toxicology and autopsy reports, as well as the coronial finding (including any comments and recommendations). State Coroner Mr Johnstone told the Committee that 45 to 50 percent of these deaths are due to natural causes, as some are reported where a death certificate cannot be written or there is no medical history, but the rest are deaths from violent, unnatural or accidental causes.

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

<sup>&</sup>lt;sup>1526</sup> Ibid.

<sup>&</sup>lt;sup>1527</sup> Victorian Institute of Forensic Medicine, Submission no. 40, 20.

<sup>&</sup>lt;sup>1528</sup> Previously, the database was managed by the Monash University National Centre for Coronial Information. Changes to the governance and management of the NCIS resulted in the Victorian Institute of Forensic Medicine assuming responsibility for the management of the NCIS in 2005. See:

http://www.vifp.monash.edu.au/ncis/web pages/historical background.htm.

<sup>&</sup>lt;sup>1529</sup> National Coroners Information System brochure, *National Coroners Information* System, undated. Available at http://www.vifp.monash.edu.au/ncis/web\_pages/publications.htm.

<sup>&</sup>lt;sup>1530</sup> State Coroner's Office, Submission no. 70, 38. Cases from Queensland were added to the system in 2001.

<sup>&</sup>lt;sup>1531</sup> Toxicology refers to the examination of samples to detect and establish levels of alcohol, drugs and poisons.

investigations, thus enhancing their ability to identify systematic hazards within the community'. <sup>1532</sup> In addition, researchers and government agencies have access to the data for research and prevention purposes. <sup>1533</sup> 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. <sup>1534</sup>

The NCIS is not publicly available but is available by application only. All applications for online access to NCIS data must be approved by the Victorian Department of Justice Research Ethics Committee, prior to which they are reviewed by the NCIS Research Committee (NRC). Generally, the time frame for the entire application process is at least eight weeks. <sup>1535</sup> Authorised users of the NCIS are required to enter into an NCIS access agreement that governs the use of NCIS data, and the terms include compliance with NCIS privacy protocols.

The access rules are determined by State and Chief Coroners of participating jurisdictions and have been endorsed by the Standing Committee of Attorneys-General. These rules are contained within a license agreement between the NCIS and each jurisdiction, which is not a public document. The rules provide for two levels of access to completed cases: level 1 (all data) and level 2 (non-identifying data only). The rules allow the NCIS to provide access to government agencies and departments, academic institutions (including research centres, departments and students), and other bona fide research agencies. However, the rules do not allow the NCIS to provide access to private individuals, including next of kin or solicitors acting in a current coronial investigation, or commercial organisations, including media organisations. The standard participation is a current coronial investigation, or commercial organisations, including media organisations.

An annual online subscription to the NCIS (for between one and three users) costs \$3300.1538 The NCIS can also conduct database searches on behalf of interested parties; the hourly rate for this service is \$110.1539

http://www.justice.vic.gov.au/CA2569020010922A/page/Resources-Research+Ethics-

Justice+Agencies?OpenDocument&1=0-Resources~&2=0-Research+Ethics~&3=0-Justice+Agencies~.

<sup>1532</sup> See http://www.vifp.monash.edu.au/ncis/index.htm.

<sup>&</sup>lt;sup>1533</sup> State Coroner's Office, Submission no. 70, 38.

<sup>&</sup>lt;sup>1534</sup> National Coroners Information System brochure, *National Coroners Information System* (undated). Available at

http://www.vifp.monash.edu.au/ncis/web pages/publications.htm.

<sup>&</sup>lt;sup>1535</sup> See for example

<sup>&</sup>lt;sup>1536</sup> Victorian Department of Justice, *Department of Justice Ethics Guidelines — March 2005 Version*, 21. See:

<sup>&</sup>lt;sup>1537</sup> Ibid.

<sup>&</sup>lt;sup>1538</sup> See http://www.vifp.monash.edu.au/ncis/web\_pages/how\_to\_apply\_for\_access.htm.

Examples of searches previously conducted:

- Deaths involving all-terrain vehicles (ATVs);<sup>1540</sup> and
- The number of deaths in custody; and
- The number of fire-related deaths; and
- The number of deaths involving suicide in a certain locality; and
- Deaths involving a particular drug.<sup>1541</sup>

VIFM has commented that NCIS data has begun to make its way directly into coronial findings.<sup>1542</sup> Indirect use of the information by coroners has also been effective. For example, the full extent of the dangers concerning the use of ATVs was not fully recognised until data from the NCIS identified a disturbing pattern of deaths in late 2002, in response to a request by the State Coroner to investigate the issue.<sup>1543</sup> The NCIS has been successfully utilised in a similar way by agencies external to the coronial system to identify hazards.<sup>1544</sup>

The NCIS is currently funded through a joint Commonwealth and State initiative by the following agencies:

- The justice departments of each State and Territory; and
- The Commonwealth Department of Health and Ageing; and
- The Australian Institute of Criminology; and
- The Office of the Australian Safety and Compensation Council (previously known as the National Occupational Health and Safety Commission); and
- The Australian Competition and Consumer Commission. 1545

<sup>&</sup>lt;sup>1539</sup> This is the figure published on the National Coroners Information System website:

http://www.vifp.monash.edu.au/ncis/web pages/how to apply for access.htm.

<sup>&</sup>lt;sup>1540</sup> This term refers to four-wheel motorcycles or 'quad bikes' that are often used on farms.

<sup>&</sup>lt;sup>1541</sup> See http://www.vifm.org/in ncis research.phtml.

<sup>&</sup>lt;sup>1542</sup> Victorian Institute of Forensic Medicine, 'Practical Uses of the NCIS' (January 2004).

<sup>&</sup>lt;sup>1543</sup> National Coroners Information System: 'The Benefits of the National Coroners Information System (NCIS):

The World's First Database of Coronial Information' (October 2005), 5. Available at

http://www.vifp.monash.edu.au/ncis/web pages/Benefits%20of%20NCIS%20 update%20Oct%2005 .pdf.

<sup>&</sup>lt;sup>1544</sup> For example, a request instigated by the Commonwealth health department in response to information from a parent led to the identification of a number of child deaths involving strangulation by curtain and blind cords: *NCIS News* Issue 1 (2005), 7.

<sup>&</sup>lt;sup>1545</sup> See http://www.vifp.monash.edu.au/ncis/web\_pages/funding\_of\_the\_ncis.htm.

The NCIS has also received support from a range of agencies, including the Australian Bureau of Statistics, the Flinders University Research Centre for Injury Studies, VIFM, the Monash University Accident Research Centre and the Monash University Department of Epidemiology and Preventive Medicine. Funding of the NCIS between 2000 and 2003 by various government agencies was provided on the condition that after July 2003 a user-pays system be adopted to finance the operations of the NCIS. A user-pays system was implemented but proved insufficient to sustain the NCIS, hence further government funding was sought and approved. 1547

Despite the value of the NCIS to death and injury prevention, the database is not yet recognised in the Act. A number of further reasons that the database is not being used to its full potential will be discussed below.

### Other jurisdictions

Each of the Australian States and Territories has a licence agreement with VIFM that permits the transfer of coronial information for storage and dissemination via the NCIS. Data entry is performed at each of the coroner's offices into local case management systems by coronial clerks. The NCIS website states that data from these case management systems is uploaded to the NCIS on a regular basis, in most cases nightly.<sup>1548</sup> However, it has been suggested that there are data entry backlogs in some jurisdictions, which the Committee considers is particularly likely in relation to rural cases.<sup>1549</sup>

In Queensland the *Coroners Act 2003* makes express provision for information obtained under the legislation to be included in a 'national coronial database', subject to certain requirements, including that the information is made available only to persons with a legitimate interest and that the conditions for making the information available are reasonable.<sup>1550</sup>

The Committee notes that, while the NCIS is intended to be a comprehensive national database of coronial findings, strictly speaking this is not yet the case due to the different practices of some coronial jurisdictions in recording findings. In New South Wales, for example, a finding is not recorded following each and every coronial investigation. Coroners in New South Wales make written findings in relation to inquests but do not do so in relation to chambers findings or 'findings on the papers'.

<sup>&</sup>lt;sup>1546</sup> Ibid.

<sup>&</sup>lt;sup>1547</sup> See <a href="http://www.vifp.monash.edu.au/ncis/web">http://www.vifp.monash.edu.au/ncis/web</a> pages/funding of the ncis.htm. The Committee notes that in its 2005 submission to this inquiry VIFM states that the operational expenses of the NCIS, as funded by agencies including those referred to above, are approximately \$750,000 per annum: Victorian Institute of Forensic Medicine, Submission no. 40, Appendix B.

<sup>&</sup>lt;sup>1548</sup> See http://www.vifp.monash.edu.au/ncis/web\_pages/how\_is\_it\_collected.htm.

<sup>&</sup>lt;sup>1549</sup> See Victorian Institute of Forensic Medicine, *Submission no. 40*, Appendix B.

<sup>&</sup>lt;sup>1550</sup> Coroners Act 2003 (Qld) s 93.

# **Evidence received by the Committee**

Citing as an example the Queensland provisions which recognise a national coronial database, the State Coroner's Office submitted that it needs to have clear authority to collect and analyse the information it assembles in its investigations, including maintaining the current NCIS database and hosting research projects focussed on particular public safety or prevention issues.<sup>1551</sup>

VIFM also submitted that it would be beneficial if similar recognition were granted to the NCIS in the Victorian Act, given its potential role in death investigation and prevention. <sup>1552</sup> VIFM also considers this to be necessary in light of its recommendation that autopsy reports not be included on the public record of a coronial investigation. An exception to this would be information stored on the NCIS for access by coroners and researchers with ethics committee approval. <sup>1553</sup> VIFM also considers that the legislation needs to formally recognise the obligation of public agencies to provide relevant data to the NCIS, due to the continuing development of privacy and health information laws. <sup>1554</sup>

One of the main issues limiting the effectiveness of the NCIS is that it is simply not being used enough by Victorian coroners. Several witnesses expressed concern that the NCIS is not routinely utilised by coroners when investigating deaths. VIFM attributed this problem to a number of factors, including:

- cultural change required for coroners to consider their role as including death and injury prevention; and
- lack of expertise of coroners, coronial clerks, administrative officers and coronial police in issues of public health and in using information technologies; and
- lack of time to conduct searches; and
- lack of incorporation into existing processes (for example NCIS searches are not yet done as a matter of routine when preparing a brief for the coroner); and
- lack of awareness about the system.<sup>1555</sup>

VIFM stated in 2005 that of the five full-time coroners in Victoria, two are regular users of the NCIS system, two are occasional users and one uses the system only

<sup>&</sup>lt;sup>1551</sup> As the Committee noted earlier, the State Coroner's Office submitted that this could be achieved in section 1 of the Act: State Coroner's Office, Submission no. 70, 54-55.

<sup>&</sup>lt;sup>1552</sup> Victorian Institute of Forensic Medicine, Submission no. 40, 20.

<sup>1553</sup> Ibid

<sup>1554</sup> Ibid Appendix B.

<sup>&</sup>lt;sup>1555</sup> Ibid 20.

infrequently.<sup>1556</sup> According to VIFM, use of the NCIS by the 90 other magistrates in Victoria who act as coroners on a part-time basis is starting to increase, albeit from a low starting point. VIFM commented that these part-time coroners would probably benefit from the NCIS the most, as they are less familiar with previous fatalities or coronial recommendations.<sup>1557</sup>

Similarly, Associate Professor Ranson, the director of the NCIS, submitted that, despite the fact that the NCIS is capable of identifying similar kinds of death, the use of the system by coroners and their staff 'can best be described as minimal'.<sup>1558</sup> Attempts to address this have had some success in encouraging more coroners to use the information available on the NCIS. Initiatives have included awareness sessions, newsletters, individual training sessions and training coronial staff to perform searches for coroners.<sup>1559</sup> Those managing the NCIS are also looking at ways of making improvements to the database which facilitate its use and improve the search process.<sup>1560</sup>

However, Associate Professor Ranson considers that even without such initiatives, the existing database could be used more effectively by coroners when investigating deaths, stating that it would be 'relatively simple' for the staff of the Coroner's Office to search the database online for similar cases. This would enable, first, the significance of the death to be identified in terms of frequency and, second, the results of previous investigations of similar cases to be obtained. Such searches could increase the efficiency of death investigations and reduce their costs. <sup>1561</sup> Associate Professor Ranson submitted that, while the State Coroner is 'one of the most prolific users of the database', it is not used on a daily basis by the State Coroner's Office and its use by other Victorian coroners is extremely limited. <sup>1562</sup>

The NCIS could certainly be enhanced by the development of expert systems that could assist coroners in developing optimal death investigation standards and processes. Automatic pattern recognition could help to identify hazards in our community that lead to preventable deaths. However, the real resource issue in relation to the NCIS lies not with the database itself but with the capacity of the coroners and their staff to make use of the database for their day-to-day work. Coroner's offices are not usually staffed by specialist researchers and/or investigators with experience in the utilisation of sophisticated databases and knowledge of how they could be incorporated into coronial death investigation processes. The existence of such staff within the Victorian State Coroner's office would greatly enhance the capacity of the Victorian State

<sup>&</sup>lt;sup>1556</sup> Ibid.

<sup>&</sup>lt;sup>1557</sup> Ibid.

<sup>&</sup>lt;sup>1558</sup> David Ranson, Submission no. 19, 58.

<sup>&</sup>lt;sup>1559</sup> Victorian Institute of Forensic Medicine, Submission no. 40, 20.

<sup>&</sup>lt;sup>1560</sup> David Ranson, Submission no. 19, 58.

<sup>&</sup>lt;sup>1561</sup> Ibid.

<sup>&</sup>lt;sup>1562</sup> Ibid 59.

Coroner to routinely utilise the resources of the NCIS in each and every death investigation undertaken. 1563

Associate Professor Ranson informed the Committee that in some cases VIFM had identified patterns of deaths from the NCIS database and referred these to the relevant government department, leading to the problem in question being resolved long before an inquest was held into such a death.<sup>1564</sup>

Former coroner Ms Jacinta Heffey commented in her submission that few coroners other than those at the State Coroner's Office are even aware of or have access to the NCIS database, which has to be formally arranged. While it is a valuable resource, especially for researchers, it is largely under-utilised by coroners. Ms Heffey noted that interpreting the data is a specialised skill and that coroners in the main are not trained in these skills and do not have time to research the database. Accordingly, Ms Heffey submitted that 'the offices of a researcher are required'. Ms Heffey also observed that if the NCIS were to be utilised by coroners throughout the State as originally envisioned there would be resource issues.

The Committee noted earlier that access to the NCIS is on application only. This is problematic not only for coroners. Several witnesses expressed concern that the NCIS is currently not sufficiently widely available. Dr Freckelton told the Committee:

It is very unhelpful that at the moment lawyers and members of the public cannot get easy access to the decisions of coroners. There is a national coroners information system but it is not publicly accessible. This is truly ludicrous. It is not the fault of the state coroner's office in this state, but it is absurd that there are considerable data that are inaccessible. They are variably used by the coroners of this state. Some use them very readily and informedly; others do not use them. But at the moment lawyers representing parties cannot have access to them, cannot use them and cannot assist the coroner by reference to them. That is manifestly unsatisfactory and needs to be addressed.<sup>1567</sup>

Similarly, the Australian Nursing Federation (ANF) submitted that information for identifying similar kinds of deaths should be available on-line or disseminated on a regular basis to interested groups such as ANF.<sup>1568</sup> It submitted that the information would be useful for nurses because if they were able to identify similar kinds of deaths

<sup>1564</sup> David Ranson, Victorian Institute of Forensic Medicine, *Minutes of Evidence*, 28 November 2005, 248.

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<sup>&</sup>lt;sup>1563</sup> Ibid 58.

<sup>&</sup>lt;sup>1565</sup> These details can be obtained from the Victorian Institute of Forensic Medicine, available at www.vifm.org.

<sup>&</sup>lt;sup>1566</sup> Jacinta Heffey, Submission no. 33, 24.

<sup>&</sup>lt;sup>1567</sup> Ian Freckleton, *Minutes of Evidence*, 20 September 2005, 207.

<sup>&</sup>lt;sup>1568</sup> Australian Nursing Federation, *Submission no.* 39, 2.

through a readily accessible database then extra care could be taken in their duties while at work. <sup>1569</sup> Another medical stakeholder, Austin Health, submitted that:

Unfortunately, the current systems offer insufficient information for health care providers. Industry would benefit from the provision of timely, readily accessible de-identified data. Information, such as data examining the frequency of particular events and the associated learnings, would greatly assist organisations with the development and implementation of systems changes to improve patient safety. This would provide a platform for organisations to share their experiences and subsequent outcomes from implementing Coronial recommendations. 1570

The Committee received evidence supporting the identification by VIFM and Associate Professor Ranson of the need for ongoing improvements to the user interface and data correlation capacity of the NCIS database. For example, Acting Emergency Services Commissioner Ms Fiona Williams submitted that the emergency services, particularly Life Saving Victoria (LSV), are conscientious users of the NCIS for the purpose of identifying factors common to a pattern of deaths. However, Ms Williams submitted that the protocols on the database for identifying deaths (for example, due to drowning) need to be improved, that agencies such as LSV should be consulted for the purpose of improving the protocols, and that the NCIS search facilities should be examined and improved to enable more specific searches.

Another issue limiting the effectiveness of the NCIS is that in some other jurisdictions, as noted earlier, not all coronial investigations result in findings that are entered on the database. The State Coroner told the Committee that, despite the additional cost of recording such findings, he considers this to be important to the development of the NCIS because it would enable a more comprehensive search of death investigation cases. The State Coroner stressed the importance of coronial information being exchanged nationally and internationally, stating that 'death has no boundaries' and that improved use across the country of the NCIS has significant potential in relation to the exchange of such information. The NCIS has significant potential in relation to the exchange of such information.

A related issue is the lack of resources for entering details from coronial investigations onto the NCIS database. VIFM submitted that Victoria is the only State with a dedicated NCIS coding officer, while in other jurisdictions coronial clerks must perform NCIS coding in addition to their normal duties. This can result in a backlog of data entry. VIFM considers that an ideal solution would be for the different jurisdictions to divert resources to the employment of a NCIS coding officer on a part- or full-time

<sup>&</sup>lt;sup>1569</sup> Ibid.

<sup>&</sup>lt;sup>1570</sup> Austin Health, Submission no. 45, 6.

<sup>&</sup>lt;sup>1571</sup> Office of the Emergency Services Commissioner, Submission no. 74, 8.

<sup>&</sup>lt;sup>1572</sup> Ibid 7-8.

<sup>&</sup>lt;sup>1573</sup> Graeme Johnstone, State Coroner's Office, *Minutes of Evidence*, 19 September 2005, 78.

<sup>&</sup>lt;sup>1574</sup> Ibid 73.

basis. This would help to ensure that coroners across the country (including Victoria) to have access to accurate and timely data.<sup>1575</sup>

The establishment of the NCIS has been a significant step forward in terms of increasing the coronial system's ability to identify similar kinds of death. However, it requires specialist skills for coroners to make full use of the information contained in the database and identify preventative measures. In the next section of the chapter the Committee will review the research and investigation expertise available to coroners for this purpose.

### Research and investigation expertise available to coroners

Since the introduction of the Act there has been an increasing level of subspecialisation of death investigation in the coronial jurisdiction, which has supported the aim of prevention. Some examples of specialised research or investigation teams available to assist the Coroner include the Clinical Liaison Service (CLS), the Work-Related Liaison Service (WRLS), stranged and the Consultative Committee on Road Traffic Fatalities (CCRTF). Below, the Committee will discuss the work of these teams, the role of specialist advisory groups and collaboration between the Coroner's Office and other agencies with expertise in injury prevention, and the need for a well-resourced research unit which can review available data in a systematic way.

### Specialist investigation and research expertise within the Coronial Services Centre

The State Coroner's Office submitted that it had been assisted in the recent past by three Grade 3 Researchers. One was funded by the Department of Justice and performed suicide research; one was funded by WorkSafe; and the other, a general injury researcher, was funded by the Department of Human Services. At present the suicide researcher's position is ongoing (after a period of vacancy), the work-related death researcher's position has been subsumed into the WRLS and the general injury researcher's position has expired. Research is also a component of the operations of the CLS. The State Coroner's Office noted that a number of these research projects have been used by governments, industry and the community to inform standards, practices and procedures. However, the effectiveness of these research activities has been limited by the lack of an overall management or support structure.

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<sup>&</sup>lt;sup>1575</sup> Victorian Institute of Forensic Medicine, *Submission no. 40*, Appendix B.

<sup>&</sup>lt;sup>1576</sup> Ibid 21

<sup>&</sup>lt;sup>1577</sup> This was formerly called the Workplace Death Investigation Unit.

<sup>&</sup>lt;sup>1578</sup> State Coroner's Office, Submission no. 70, 38.

<sup>&</sup>lt;sup>1579</sup> See http://www.vifm.org/research\_cls.html; Cf State Coroner's Office, Submission no. 70, 38.

<sup>&</sup>lt;sup>1580</sup> State Coroner's Office, Submission no. 70, 38.

The research and investigation infrastructure within the Coronial Services Centre now includes the Special Investigations Unit, which comprises the CLS and the WRLS, operating as joint initiatives of VIFM and the Coroner's Office but housed within VIFM. Until recently there was also the CCRTF. The work of these services will be discussed below.

### Clinical Liaison Service (CLS)

Due to the highly complex and specialised nature of the modern health-care system, a thorough medical investigation cannot be carried out effectively without the input of clinicians. This point has been made in the Shipman Inquiry, the Luce Report and the Bristol Infirmary inquiry in the UK, and in the Queensland public hospitals inquiry.<sup>1581</sup>

The CLS is a new and unique initiative of the State Coroner's Office and VIFM aimed at improving patient safety. VIFM considers that the need to establish the service is supported by an expanding body of research evidence indicating that addressing contributing, underlying system factors may prevent a significant proportion of medical adverse events.<sup>1582</sup>

The CLS utilises coronial data on deaths in a health-care setting to address the underlying systemic factors which contribute to adverse medical treatment events. The CLS is currently staffed by two medical practitioners, two registered nurses, a research assistant and an administration officer. 1583

The tasks of the CLS include:

- assisting the Coroner to investigate adverse medical treatment events; and
- formulating a validated method for classifying and recording information that may be related to adverse events within health-care institutions;<sup>1584</sup> and
- exploring the effective use of coronial data to inform changes to the health-care system as well as to the coronial process to improve patient safety initiatives; and
- identifying the reform priorities for patient safety that reflect the interests of coroners, health departments and health-care professionals throughout Australia; and

<sup>&</sup>lt;sup>1581</sup> Geoff Davies, Queensland Public Hospitals Commission of Inquiry Report (30 November 2005), 535.

<sup>&</sup>lt;sup>1582</sup> See http://www.vifm.org/research\_cls.phtml.

<sup>&</sup>lt;sup>1583</sup> Ihid

<sup>&</sup>lt;sup>1584</sup> This information can be used for a number of purposes, including analysis of individual or clusters of adverse event cases and reporting trends that may be useful in the early recognition of underlying system issues in health-care organisations.

• improving communication between coroners, health departments and health-care professionals about adverse medical treatment events. 1585

In its submission VIFM commented on the value of the CLS:

The work of the CLS has highlighted that successful death investigation is also about getting the right approach to those who are the "subject" of the investigation. For example, using investigators with medical training (albeit independent of the hospital system) to investigate adverse events has resulted in greater communication with hospitals and health professionals. This has resulted in a higher level of reporting adverse events which creates greater opportunity for the improvement of hospital procedures to prevent future adverse events.<sup>1586</sup>

The Committee notes that in the Queensland Public Hospitals Commission of Inquiry Report Commissioner the Hon Geoff Davies AO recommended that the Queensland State Coroner have access to a 'specialised panel of trained persons' to provide advice in relation to investigations of deaths resulting from health procedures, citing as an example the CLS in Victoria:

I am informed that the Victorian State Coroner has such a system in place. Under the Victorian System all deaths are initially reviewed by a multidisciplinary team of clinicians who advise coroners whether a death warrants investigation. In the event that the advice of this clinical liaison team is that a particular death should be investigated, the team then advises what investigative steps are appropriate, and what independent experts might need to provide an opinion in the matter. This information is then used by those persons involved in the investigation, including police officers.<sup>1587</sup>

Professor Joseph Ibrahim, Director of the CLS, described the role of the CLS in relation to coronial investigations in the following way:

What CLS offers, in a sense, is a medical advice model to the coroner's investigation process. In other words, we assist the coroner by helping to evaluate the information that has come in, to help ask the relevant questions of the right people, but we are not directing the investigation. It is still the coroner's decision as to what is done in terms of the investigation. 1588

Professor Ibrahim told the Committee that the CLS does not investigate psychiatric cases, due in part to resource constraints, the complexity of the subject and the fact that staff members of the CLS do not have psychiatric expertise. In its submission the State Coroner's Office supported the recommendation made in a review of the CLS that more resources should be committed to specialist psychiatric

<sup>&</sup>lt;sup>1585</sup> Victorian Institute of Forensic Medicine, *Submission no. 40*, 21. See also:

http://www.vifm.org/research\_cls.phtml.

<sup>&</sup>lt;sup>1586</sup> Victorian Institute of Forensic Medicine, Submission no. 40, 21.

<sup>&</sup>lt;sup>1587</sup> Geoff Davies, Queensland Public Hospitals Commission of Inquiry Report (30 November 2005), 535.

<sup>&</sup>lt;sup>1588</sup> Joseph Ibrahim, Clinical Liaison Service, *Minutes of Evidence*, 28 November 2005, 255.

<sup>&</sup>lt;sup>1589</sup> Ibid 254–5, 257.

investigations.<sup>1590</sup> The Committee considers that this is an important issue. The Committee has discussed earlier in this chapter the evidence from a number of families whose relatives had died following discharge from mental health care facilities. The Committee understands that, aside from the need for improved investigative expertise, the full extent of this problem cannot be determined without proper statistical analysis. The Committee considers that weaknesses and limitations in the currently available statistics are an area of real concern. As the Committee noted earlier, the State Coroner's Office currently has the benefit of a suicide researcher, which should assist in the ongoing development of accurate data, although it appears that the focus will be on assisting coroners with particular cases rather than major reports. However, it has also been suggested to the Committee that there is scope for the involvement of the CLS in research into these types of deaths in future.

The Committee notes here the comments of Ms Storm, reported earlier in this chapter, that statistics relating to the deaths of persons involved in the mental health system are difficult to find and should be made publicly available so that the extent of the problem can be made more widely known. The Committee agrees that such statistics should be publicly available and believes that this is also the view of the Coroner's Office and the CLS.

In addition to its advisory role in relation to investigations, the CLS is actively engaged in the education of health-care professionals about the coronial system, particularly the system's focus on prevention rather than blame, and in increasing awareness about the problems which have been identified in relation to patient safety.<sup>1591</sup> The CLS arranges seminars, conferences, workshops, coroner's open days and other activities for this purpose. It also publishes a regular free newsletter called the *Coronial Communiqué*, which is distributed widely to over 1200 recipients (of whom many are in senior medical management positions and distribute the newsletter to their staff), and which summarises all of the coronial investigations related to patient safety, using terminology appropriate for its medical audience.<sup>1592</sup>

Finally, the Committee understands that a serious difficulty affecting the CLS is that it has been subject to uncertainty regarding its ongoing funding. The CLS has stated that it has been allocated funding from the Department of Justice until at least the end of the 2006–07 financial year.<sup>1593</sup>

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<sup>&</sup>lt;sup>1590</sup> State Coroner's Office, *Submission no. 70*, 144. The State Coroner's Office refers in its preliminary submission to an 'Impact Consulting Report on the Clinical Liaison Service': *Submission no. 1*, 1.

<sup>&</sup>lt;sup>1591</sup> Joseph Ibrahim, Clinical Liaison Service, *Minutes of Evidence*, 28 November 2005, 259.

<sup>&</sup>lt;sup>1592</sup> Joseph Ibrahim, Clinical Liaison Service, *Minutes of Evidence*, *28 November 2005*, 259; Ian Freckelton and David Ranson, *Death Investigation and the Coroner's Inquest* (2006) 743.

<sup>&</sup>lt;sup>1593</sup> Clinical Liaison Service (2006) 4(1) Coronial Communiqué, 1.

### Work-Related Liaison Service (WRLS)

In October 2004 the Minister for WorkCover, Attorney-General Robert Hulls, in response to community concerns about the rate of workplace death and injury, announced funding of \$2 million over four years to establish a Work-Related Death Investigation and Resource Unit within the Coroner's Office, funded by the Victorian WorkCover Authority. The unit was introduced to widen the scope and improve the quality and coordination of work-related death investigations, with a priority being the development of higher quality data about workplace deaths so that causes and trends can be identified. According to the Coroner's Office, management of the unit has been transferred to VIFM to allow appointments to be made outside those able to be made under the current court guidelines, although the State Coroner chairs a steering committee which assists in administrative management of the unit.

The unit is now called the Work-Related Liaison Service (WRLS). <sup>1594</sup> The WRLS aims to assist the Coroner and other safety agencies to investigate work-related deaths and formulate injury prevention strategies by providing historical, national and international surveillance data and prevention advice. Also, in a similar role to that played by the CLS in relation to health-care organisations, the WRLS acts as an interface between investigatory agencies, industry, unions and the community. The service has begun publishing a regular free newsletter about coroner's cases called *Workwise*, with the aims of improving the awareness of workers and employers about possible work-related fatality prevention opportunities and improving the understanding of organisations about the coronial system.

### Consultative Committee on Road Traffic Fatalities (CCRTF)

The CCRTF was established in 1992 under section 139 of the *Health Services Act* 1988 as a joint initiative of VIFM, the Royal Australasian College of Surgeons and Monash University. 1595 Until recently the CCRTF reviewed the medical management and the mechanisms of injury of individuals who die following road traffic accidents. Its three principle objectives were:

- to identify organisational and clinical errors or inadequacies; and
- to assess whether individual problems have contributed to mortality; and
- to examine the potential preventability of individual deaths.<sup>1596</sup>

VIFM submitted that the CCRTF has been successful in identifying problems in the delivery of road trauma services in Victoria, allowing improvements in trauma care

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<sup>1594</sup> See http://www.vifm.org/wrls.phtml.

<sup>&</sup>lt;sup>1595</sup> It has variously been funded by the Transport Accident Commission, the Department of Human Services and the Victoria Trauma Foundation: Victorian Institute of Forensic Medicine, *Submission no. 40*, 21.

<sup>&</sup>lt;sup>1596</sup> Ibid.

delivery.<sup>1597</sup> The CCRTF 'has established a comprehensive clinico-pathological database of road traffic fatalities providing a baseline against which the effectiveness of changes in trauma care can be measured'.<sup>1598</sup> The Committee notes that the work of the CCRTF is recognised as having resulted in an improvement in the management of patients with injuries from all causes, not just road trauma.<sup>1599</sup> The CCRTF ceased to operate in 2005 upon the expiry of its funding grant for the trauma care initiative.<sup>1600</sup>

### Specialist external advisory groups

The Committee notes that there are a large number of agencies external to the coronial system with expertise in death and injury prevention. In many cases coroners will seek the expertise of, or collaborate with, these agencies during a death investigation and as part of the process of identifying safety measures. Such liaison and collaboration is not recognised or provided for in the Act.

The State Coroner has also established specialist advisory groups in relation to transport safety, tree-felling safety and health and medical issues. These groups meet regularly at the State Coroner's Office and are active in health and safety issues in their respective areas. The Transport Industry Safety Group (TISG), for example, is a cooperative venture between many government agencies and the industry. Chris Maxwell QC (now President of the Court of Appeal) said of the TISG:

This Group was established in 1997 to develop and facilitate an industry approach to occupational health and safety, following coronial inquests into fatalities in the transport industry. The group consists of representatives of the Transport Workers Union (Victorian Branch), the Victorian Road Transport Association, the Bus Association of Victoria, VicRoads, Victoria Police and the Authority (WorkCover).

It was evident from my meeting with the Group, and from its publications, that there is a high level of commitment and co-operation between the stakeholders in relation to health and safety for all persons who are involved in - or affected by - the transport industry. 1602

The submission to this inquiry by the TISG illustrates the gains that can derive from interaction between the Coroner's Office and external agencies:

The role of the Coroner over recent years has been significant in improving the overall safety climate within the transport and storage industry. There have been a number of key

<sup>&</sup>lt;sup>1597</sup> Ibid 22.

<sup>&</sup>lt;sup>1598</sup> Ibid.

<sup>&</sup>lt;sup>1599</sup> Ibid.

<sup>&</sup>lt;sup>1600</sup> See http://www.vifm.org/inf03annrepachievement5.html.

<sup>&</sup>lt;sup>1601</sup> State Coroner's Office, Submission no. 70, 39.

<sup>&</sup>lt;sup>1602</sup> Chris Maxwell, 'Occupational Health and Safety Act Review' (March 2004) paras 1047–50.

investigations and recommendations that have, like the road toll initiatives, had a marked incremental advance in safety. 1603

Recommendations regarding the wearing of high visibility safety vests and the fitting of reversing beepers, for example, have in time become the norm in almost all industries and activities, without any legislative action required. For example there is currently no "legal requirement' to wear a safety vest.<sup>1604</sup>

The recommendation for wider industry consultation has evolved to a cooperation and collaboration between associated parties that is unique in the world. Recommendations regarding Forklift safety have pressured the transport and storage industry and the suppliers to improve dramatically. 1605

The Committee notes that other jurisdictions are also adopting a specialist approach to death investigation. For example, VIFM observed that in the State of Virginia in the US a number of investigatory or research project teams have been established:

Over the past few years, the General Assembly has expanded the medical examiner system's public-health mission by mandating fatality-review teams to analyze medical examiner data and make recommendations for interventions and prevention. The multidisciplinary Child Fatality Review Team makes recommendations to agencies and systems to prevent child deaths. The Family and Intimate Partner Surveillance Team endeavors to gain insights into and make recommendations to prevent the seemingly irreducible one-third of homicides in Virginia among persons who at one time presumably cared for one another. The newest initiative, the Maternal Mortality Review Team, is studying the deaths of women that occur within one year of delivery to learn why society is losing mothers during their most active and productive years. Reports of the teams are posted on the Office of the Chief Medical Examiner Web-site http://www.vdh.virginia.gov/ medexam.<sup>1606</sup>

In New Zealand, the coronial legislation recognises the importance of collaboration between coroners and agencies which also have expertise in death investigation. The *Coroners Act 2006* (NZ) states that, in order to achieve its purposes, the Act 'provides for an independent coronial system for investigations of deaths by coroners liaising with other authorities permitted or required by law to investigate those deaths'. Similarly, the Act includes as part of the role of coroners in relation to a death:

to determine whether the public interest would be served by the death being investigated by other investigating authorities in the performance or exercise of their functions, powers, or

<sup>&</sup>lt;sup>1603</sup> Transport Industry Safety Group, Submission no. 75, 1.

<sup>&</sup>lt;sup>1604</sup> Ibid.

<sup>&</sup>lt;sup>1605</sup> Ibid.

<sup>&</sup>lt;sup>1606</sup> See Victorian Institute of Forensic Medicine, *Submission no. 40*, 22; see also

http://www.vifsm.org/news/2004/0224medical examiner oped.htm.

<sup>&</sup>lt;sup>1607</sup> Coroners Act 2006 (NZ) s 3(2)(c).

duties, and to refer the death to them if satisfied that the public interest would be served by their investigating it in the performance or exercise of their functions, powers, or duties.<sup>1608</sup>

The Coroners Act 2006 (NZ) also sets out various functions of the Chief Coroner, including:

To help avoid unnecessary duplication and expedite investigation of deaths by liaison, and encouragement of co-ordination (for example, through development of protocols, with other investigating authorities and other official bodies or statutory officers.<sup>1609</sup>

In its submission the State Coroner's Office highlighted the importance of various external agencies in contributing to investigations and identifying prevention measures, such as:

- Worksafe Victoria
- Office of the Chief Electrical Inspector
- Office of Gas and Safety
- Metropolitan Fire Service
- Country Fire Authority
- University research departments (for example the Monash University Accident Research Centre)

Several other witnesses to this inquiry referred to the ongoing need for the coronial system to collaborate with other agencies that focus on preventing death and injury, in order to work more efficiently and avoid duplication of effort. For example, Ms Williams stressed the importance of such relationships and suggested that the Act should establish a formal mechanism for the Coroner to act in partnership with the Emergency Services Commissioner and the Ombudsman, since:

The partnership between these independent offices currently exists to strengthen a coordinated, collaborative and efficient approach to public safety and accountability, especially where public agencies may be involved. Legislative recognition to this effect may therefore further solidify the partnership between the Coroner, Commissioner and Ombudsman and also provide an opportunity to further clarify the roles of each office with respect to investigation and prevention in instances where jurisdiction may be shared.<sup>1610</sup>

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<sup>1610</sup> Office of the Emergency Services Commissioner, Submission no. 74, 3.

<sup>&</sup>lt;sup>1608</sup> Coroners Act 2006 (NZ) s 4(2)(c).

<sup>&</sup>lt;sup>1609</sup> Coroners Act 2006 (NZ) s 5(k).

<sup>353</sup> 

Ms Williams submitted that such legislative recognition would enable the Coroner to draw upon the assistance of the Commissioner and the Ombudsman. Ms Williams also submitted that the State Coroner forms a part of Victoria's emergency management framework and that deaths resulting from fires or emergencies should be the subject of a coordinated response by the Coroner's Office and the various emergency service agencies. Ms. 1612

Consumer Affairs Victoria (CAV) noted that it and the Coroner's Office have closely aligned objectives in relation to reducing the occurrence of death and injury, with CAV's particular focus being on product safety. 1613 CAV recommended the following changes to build on the existing synergies between the two offices.

First, CAV submitted that it would like to see the Coroner's Office improve the flow of information to CAV and other regulatory agencies, including improving and simplifying access to the NCIS.<sup>1614</sup> CAV considers that allowing it access to the NCIS to undertake searches and extract information would work better than the current system, whereunder CAV submits a request for information to the Coroner's Office. The request process can be time consuming and inflexible in that the request needs to be quite specific and succinct to ensure that the Coroner's Office extracts the relevant data.<sup>1615</sup>

Secondly, CAV submitted that it should be provided with information in advance of a formal coronial finding where a causal link has been established between a consumer, domestic, household or domestic product and the death of an individual. 1616 CAV submitted that it can take a number of months from the time of death to the completion of an investigation and that this time lag increases the risk of the identified product causing another death or injury. 1617

Despite the gains that can be made by collaboration between agencies, it has been observed that one of the reasons that injury prevention does not have the funding, profile or scientific tradition that other leading cause-of-death fields have is a failure by policy makers to recognise injury prevention as a single public health issue. While deaths from injuries have been found to outweigh deaths from heart disease and cancer in terms of numbers of years of life lost, for every \$1 spent on injury research \$5 is spent on heart research and \$10 on cancer research:

<sup>1612</sup> Ibid 3.

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<sup>&</sup>lt;sup>1611</sup> Ibid 6.

<sup>&</sup>lt;sup>1613</sup> Minister for Consumer Affairs, Submission no. 72, 1.

<sup>&</sup>lt;sup>1614</sup> Ibid 2.

<sup>&</sup>lt;sup>1615</sup> Ibid.

<sup>&</sup>lt;sup>1616</sup> Ibid.

<sup>&</sup>lt;sup>1617</sup> Ibid.

<sup>&</sup>lt;sup>1618</sup> Lyndal Bugeja, Accident Research Centre, Monash University, *PhD Confirmation of Candidature Report: The Role of Coroner's Recommendations in Injury Prevention and Control*, May 2006, 5-6.

Unlike heart disease and cancer, injury does not have a single foundation or society devoted to promoting its causes and prevention. Some sectors, such as road transport, have an agency responsible for injury prevention, while others do not. This results in governments having difficulty viewing injury as a single public health issue, professional fragmentation and missed opportunities to coordinate across injury causes.<sup>1619</sup>

Ms Lyndal Bugeja, of the Monash University Accident Research Centre, considers this fragmentation to be a major barrier to the implementation of injury control and prevention measures, observing that responsibility for injury issues is spread across multiple government portfolios at a state and federal level, such as, for example, health (Department of Human Services), industrial relations (WorkSafe), justice (Country Fire Authority, Office of the Emergency Services Commissioner, Life Saving Victoria), infrastructure (Marine Safety Victoria), transport (VicRoads) and university departments (Monash University Accident Research Centre, Victorian Institute of Occupational Health and Safety).<sup>1620</sup>

There is clearly a role for specialist death investigation teams and advisory groups to play in researching and analysing particular problem areas and identifying preventative measures. However, a potential shortcoming of such initiatives is that they do not review death and injury prevention in a systematic and comprehensive way. Accordingly, it appears to the Committee that there is a need for a generalist research unit within the Coronial Services Centre that can perform such a role, as will be discussed below.

#### Coronial Services Centre research unit

Making recommendations adds a complex dimension to the role of coroners. The evidence received by the Committee demonstrates clearly that coroners, particularly those working outside metropolitan Melbourne, 'need support to undertake the investigations and research required to formulate relevant and effective recommendations'. The State Coroner's Office considers that research is an important part of any effective coronial system and that it helps inform the process at multiple stages:

Properly directed and managed researchers can use the information system and incoming cases to help identify trends at an early stage, assist in providing focus for the Coroner's investigation in important areas for community benefit in health and safety, inform developing investigations

<sup>&</sup>lt;sup>1619</sup> Ibid, citing I R Johnston, 'Research, Policy Making and Intervention Programming in Injury Prevention — A Classic Case of Suboptimisation' (2003) 27(1) IATSS Research, 58–65.

<sup>&</sup>lt;sup>1620</sup> Lyndal Bugeja, Accident Research Centre, Monash University, *PhD Confirmation of Candidature Report: The Role of Coroner's Recommendations in Injury Prevention and Control*, May 2006, 6.

<sup>&</sup>lt;sup>1621</sup> See Victorian Institute of Forensic Medicine, Submission no. 40, 20.

with health, safety and preventative information and assist in educating the research and general community. 1622

The State Coroner told the Committee that, for the coronial process to identify whether deaths are preventable by system changes, there must be adequate resources for the NCIS database to be properly researched. The NCIS potentially provides an important tool for coroners aiming to investigate deaths and formulate recommendations. However, as noted earlier in the chapter, the NCIS is not routinely used by coroners, who often lack the time required to conduct database searches. The solution proposed by VIFM is that:

A new model for the coronial system should build on the multidisciplinary research-based approach of the CLS and the CCRTF by including a Research Unit with the capacity to properly utilise the NCIS and conduct research relevant to each case on behalf of coroners as well as seeking to identify trends in or clusters of deaths which should be investigated further. Such a Unit would operate independently of the coroner, without impeding the coroner's control of individual investigations, and could therefore have closer communication with agencies to ensure that coronial recommendations take account of real world constraints, resulting in greater likelihood of implementation. 1624

#### Further, VIFM submitted that:

the coronial death investigation procedures should be supported by a Research Unit with data analysis and epidemiology expertise to operate independently of the coroner to review the literature and NCIS and other data for individual cases as well as conduct more general research to identify trends in deaths or clusters of deaths to which a specialist death investigation team could be directed. A Research Unit could also improve communication with the agencies ultimately responsible for implementing systems improvements, enabling it to gather information about such implementation which could be provided to coroners prior to making their findings. 1625

The need to establish a research unit within the Coroner's Office was advocated by several other witnesses, including Dr Eric Wigglesworth AM, an honorary senior research fellow of the Monash University Accident Research Centre. Dr Wigglesworth considered that the effectiveness of the coronial system would be enhanced by 'well-funded scientific infrastructure' and suggested such a unit should comprise two to three staff members.<sup>1626</sup>

<sup>&</sup>lt;sup>1622</sup> State Coroner's Office, Submission no. 70, 38.

<sup>&</sup>lt;sup>1623</sup> Graeme Johnstone, State Coroner's Office, Minutes of Evidence, 19 September 2005, 73.

<sup>&</sup>lt;sup>1624</sup> Victorian Institute of Forensic Medicine, Submission no. 40, 22.

<sup>&</sup>lt;sup>1625</sup> Ihid

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<sup>&</sup>lt;sup>1626</sup> See for example Dr Eric Wigglesworth, Monash University Accident Research Centre, *Minutes of Evidence*, 28 *November 2005*, 223.

The Committee heard that coroners do not have the resources and in some cases may lack the necessary skills to undertake the required research. It appears that, while skilled researchers have at times been recruited to perform this type of work, the funding constraints of the Coroner's Office have meant that these positions have generally been funded by external agencies. Such arrangements require the majority of the work to be undertaken for the purposes of the agency, rather than to assist coroners with regular case work. Accordingly, coroners do not currently have the necessary support to be able to formulate feasible and effective recommendations in a systematic way. 1629

#### Discussion and conclusion

The Committee considers that one of the primary hurdles to the coronial system playing a larger preventative role, particularly in relation to medical adverse events, is the problem of under-reporting. The Committee has made recommendations in relation to this problem in chapters three and four.

Nonetheless, there is much valuable information about deaths which have been reported and investigated that is not being properly utilised. It is clear to the Committee that the NCIS is a source of empirical information about death and injury which has a large amount of untapped potential.

The Committee is concerned, first, that at present the role of the NCIS is not recognised in the Act. The Committee considers that the NCIS should be supported by the legislation, as is the case in Queensland, with a provision authorising the provision of data to and retrieval of data from the NCIS, using section 93 of the *Coroners Act 2003* (Qld) as a model.

The Committee also considers that increased funding should be made available for the NCIS to enable the user interface, search facilities and data fields of the database to be improved, and to enable further training initiatives for coroners and other agencies.

A further issue is the availability of access to the NCIS to agencies and organisations with an interest in preventing deaths and injury or in an individual coronial investigation. The Committee is concerned that the current barriers to third-party access of the database may be too high, preventing optimum use by the community of coronial information for preventative purposes. While the restrictions on level 1 access are clearly justified for privacy reasons, the policy rationale for limiting access to level 2 (de-identified) data is less obvious, particularly as the access rules are not yet included in a public document. The Committee accepts that even with level 2 data

<sup>&</sup>lt;sup>1627</sup> Jacinta Heffey, Submission no. 33, 24.

<sup>&</sup>lt;sup>1628</sup> Lyndal Bugeja, Accident Research Centre, Monash University, *PhD Confirmation of Candidature Report: The Role of Coroner's Recommendations in Injury Prevention and Control*, May 2006, 10.

<sup>&</sup>lt;sup>1629</sup> Ibid.

there is a risk that derivative use of the information could enable families to be identified by, for example, media organisations. However, the Committee received limited evidence in relation to the basis for the current restrictions. The Committee considers that that the State Coroner, in conjunction with other Australian State and Chief Coroners, should review the rules governing access to the NCIS database and consider whether access to the database can be made more widely available, in a way that is consistent with applicable privacy considerations. The Committee refers to these privacy considerations in chapter eight.

With data from over 90 000 death investigations since July 2000 available to coroners, it would be worthwhile for coroners to make use of the NCIS as part of the routine death investigation process. This would allow previously unrecognised trends and patterns in deaths to be detected early in the course of a death investigation, which could shape the direction and scope of the Coroner's inquiries and enable the identification of significant causal factors. For the coronial system to become more effective in preventing death and injury, it is essential that more coroners in Victoria are trained and encouraged to use the NCIS as a regular component of death investigations.

However, the Committee is also aware of the time and resource constraints on many coroners and considers that coroners need to be able to draw on the assistance of specialist researchers in identifying similar kinds of death. Further, many coroners will lack the skills for extracting complex information from the available data. Dr Freckelton comments that:

Coroners as legal officers are rarely strongly conversant with statistically based empirical research techniques ... Unless specialists in epidemiological analysis are employed by coroner's offices on a regular basis, it seems unlikely that the available data sets will be mined in a way that their potential would allow.<sup>1632</sup>

It has already been shown that specialist research and investigation units within the coronial jurisdiction can make a substantial contribution towards preventing death and injury. However, investigation and research initiatives to date have developed in a piecemeal fashion as funding from interested agencies has been made available. At present, database searches generally tend to occur where a coroner has already identified issues of interest on a particular type of death, and the searches are used to validate the particular concern. More sophisticated use of the data in the NCIS could enable a much more comprehensive understanding of risks to public health and safety. 1633

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<sup>&</sup>lt;sup>1630</sup> Ian Freckelton and David Ranson, Death Investigation and the Coroner's Inquest (2006) 741.

<sup>&</sup>lt;sup>1631</sup> Ibid 734, 741.

<sup>&</sup>lt;sup>1632</sup> Ibid 741.

<sup>&</sup>lt;sup>1633</sup> Ibid.

Dr Freckelton and Associate Professor Ranson have pointed out that the role of the coroner, as it begins to extend beyond that of a decision maker to a convener of multidisciplinary death investigations that comprehend a vast array of different scenarios, is extremely demanding. However, apart from the existence of a few specialised investigation units, increased community expectations in relation to coroners' work have not been planned for or budgeted for, nor adequately recognised in the legislation. Hoss

Accordingly, the Committee supports the recommendation by witnesses such as the State Coroner, VIFM and Associate Professor Ranson that a research unit be established within the Coronial Services Centre with adequate resources to properly utilise the NCIS database to conduct research relevant to individual cases both on behalf of coroners and at the unit's own instigation, to identify trends and clusters of deaths requiring further investigation and to enable the development of death and injury prevention measures based on valid epidemiological information. The goal should be to move towards a more systematic process for conducting research so that resources available for the development of prevention measures are allocated in an efficient and proportionate way.

The Committee considers that such a unit should operate independently of the Coroner's Office but that its services should be available to coroners to assist in investigations and the making of recommendations. The Committee's view is that the unit should be housed within VIFM in order to have the crucial benefit of VIFM's strong links with relevant university departments, enabling access to available research literature and academic guidance from departments such as the Monash University Accident Research Centre. The independence of the unit from the Coroner's Office would also, as suggested by VIFM, enable closer communication with agencies to ensure that coronial recommendations take account of real world constraints, resulting in greater likelihood of implementation. The Committee has already recommended the establishment of a Coronial Advisory Council to provide expert advice and policy guidance to the State Coroner's Office, and it considers that such a council could also assist in providing policy direction to the proposed full-time research unit.

It was clear to the Committee that there have been significant achievements in improving safety where there is a high level of coordination and collaboration between the Coroner's Office and external agencies. Some witnesses expressed concern that at present there is the potential for duplication of investigative and research work in relation to death investigations. The Committee considers that the inclusion of a provision similar to section 5 of the *Coroners Act 2006* (NZ) would recognise and facilitate ongoing coordination and collaboration between the State Coroner's Office and other parties with expertise in death investigation.

<sup>&</sup>lt;sup>1634</sup> Ibid 769.

<sup>&</sup>lt;sup>1635</sup> Ibid 765, 769.

Finally, the Committee was concerned by evidence of the lack of psychiatric expertise available to the Coroner's Office and in particular within the CLS. The Committee notes that the general lack of services for the mentally ill is an issue currently receiving much overdue attention by governments at all levels. This presents an ideal opportunity for input from the Coroner's Office to feed into reform and improvement of the mental health system. The Committee therefore recommends that as a high priority the CLS be funded to extend its operation to include psychiatric expertise, in order to better equip the Coroner's Office to make well-informed recommendations on system improvements.

Recommendation 71. That the *Coroners Act 1985* be amended to recognise the existence of, and authorise the provision of data to and retrieval of data from, the National Coroners Information System, using section 93 of the *Coroners Act 2003* (Qld) as a model.

Recommendation 72. That increased funding be made available for the National Coroners Information System to enable the search interface and data fields of the database to be improved, and to enable further training initiatives for coroners and other agencies.

Recommendation 73. That the State Coroner, in conjunction with other Australian State and Chief Coroners, review the rules governing access to the National Coroners Information System database and consider whether access to the database can be made more widely available, in a way that is however consistent with applicable privacy considerations.

Recommendation 74. That a research unit be established within the Coronial Services Centre with the capacity to properly utilise the National Coroners Information System database, to conduct research relevant to individual cases on behalf of coroners, and to identify trends and clusters of deaths requiring further investigation.

Recommendation 75. That the *Coroners Act 1985* be amended to provide, using section 5 of the *Coroners Act 2006* (NZ) as a model, that one of the functions of the State Coroner is to help avoid unnecessary duplication and expedite investigation of deaths by liaison and encouragement of coordination (for example, through development of protocols) with other investigating authorities, official bodies or statutory officers.

Recommendation 76. That as a high priority funds be provided to the Clinical Liaison Service to extend its operation to include psychiatric expertise.

# The power of coroners to comment and make recommendations

In Victoria section 19(2) of the Act provides, under the heading, 'Findings and Comments of a coroner', that:

A coroner may comment on any matter connected with the death including public health or safety or the administration of justice. 1636

Further, section 21(2) of the Act provides, under the separate heading 'Reports', that:

A coroner may make recommendations to any Minister or public statutory authority on any matter connected with a death which the coroner investigated, including public health or safety or the administration of justice. 1637

This provision is repeated in section 38(2) of the Act in relation to fires. 1638

At the completion of any investigation or inquest a coroner will issue written findings in relation to the death of a person, as required by section 19(1). 1639 In appropriate cases some coroners will also, using the power in section 19(2), include comments (which in practice may include recommendations) in the text about measures which have the potential to prevent similar deaths or injury. This may occur where a coroner considers that the death raises public health or safety issues that could be addressed by making appropriate comments or recommendations. However, the power to do so is discretionary. Under section 21(2) the coroner is then able to provide copies of the recommendations to the Attorney-General and any relevant Minister or public statutory authority.

The Committee notes that there is limited capacity for litigants to appeal a coroner's comments or recommendations, as opposed to findings. It has been suggested that, if the recommendations or comments are not reasonably open on the evidence before the coroner, there may be power to quash them.<sup>1640</sup> However, the issue has not been squarely resolved.<sup>1641</sup> The Committee has discussed the subject of appeals further in chapter five.

However, the power of a coroner to comment or make recommendations is limited to 'any matter connected with a death' which in general terms requires there to be a nexus between the comment or recommendation and the circumstances surrounding

<sup>&</sup>lt;sup>1636</sup> Coroners Act 1985 s 19(2).

<sup>&</sup>lt;sup>1637</sup> Coroners Act 1985 s 21(2).

<sup>&</sup>lt;sup>1638</sup> Coroners Act 1985 s 38(2).

<sup>&</sup>lt;sup>1639</sup> This is discussed in chapter 5.

<sup>&</sup>lt;sup>1640</sup> Ian Freckelton and David Ranson, *Death Investigation and the Coroner's Inquest* (2006) 662.

The question of whether the Supreme Court may quash comments and recommendations of a coroner was raised in the Northern Territory Supreme Court but was decided on the particular facts of the case. Kearney J held, 'In all the circumstances of this case, I consider that it is not open to me to quash the findings, comments and recommendations complained of': *Director of National Parks and Wildlife v Barritt* (1990) 102 FLR 392, 408 (Sup Ct NT per Kearney J). See also *The Solicitor-General of New Zealand v The Coroner of Kaitaia* (Unreported, High Court of New Zealand 13 March 2003); Victorian Bar, *Submission no. 81*, 12.

<sup>&</sup>lt;sup>1642</sup> Harmsworth v State Coroner [1989] VR 989, 996; see also Clancy v West [1996] 2 VR 647.

the death which are investigated by a coroner. The cases have taken a reasonably narrow view of the requisite connection, as will be outlined below.

## Case law limiting the power to comment and make recommendations

A comment or recommendation must arise out of the coroner's findings under section 19(1). There are significant limits on the extent to which coroners can comment on matters which they do not have authority to investigate. In New Zealand, Heron J in *Matthews v Hunter* has noted that:

[in] going about his function the coroner must recognise the damage to reputations and the aggravation of personal suffering such comments may bring. In making recommendations and comments about matters not the direct cause of death in the circumstances, care should be taken to make that clear.<sup>1644</sup>

In Victoria, in *Harmsworth v The State Coroner*, Nathan J held that the coroner's power to comment is a limited one:

The power to comment, arises as a consequence of the obligation to make findings: see s. 19(2). It is not free ranging. It must be comment "on any matter connected with the death". The powers to comment and also to make recommendations pursuant to s. 21(2) are inextricably connected with, but not independent of the power to enquire into a death or fire for the purposes of making findings. They are not separate or distinct sources of power enabling a coroner to enquire for the sole or dominant reason of making comment or recommendation. It arises as a consequence of the exercise of a coroner's prime function, that is to make "findings". 1645

Nathan J held unequivocally that the power to comment is 'incidental and subordinate' to the mandatory power to make findings related to how the deaths occurred, their causes and the identity of any contributory persons.<sup>1646</sup>

Similarly, in *Chief Commissioner of Police v Hallenstein*, Hedigan J observed that the power to comment may 'easily be attended by philosophical self-indulgence'. The case involved an appeal from an inquest into a police shooting at an armed robbery. Coroner Hallenstein's findings had comprised 164 pages, much of which involved wide-ranging comment on police strategy and tactics in dealing with criminal activity. Hedigan J noted in *obiter dicta*, 1648 citing the above quotation by Nathan J, that the

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<sup>&</sup>lt;sup>1643</sup> Ian Freckelton and David Ranson, *Death Investigation and the Coroner's Inquest* (2006) 659.

<sup>&</sup>lt;sup>1644</sup> Matthews v Hunter [1993] 2 NZLR 683, 687–8 (HC) per Heron J.

<sup>&</sup>lt;sup>1645</sup> Harmsworth v State Coroner [1989] VR 989, 996.

<sup>&</sup>lt;sup>1646</sup> Ibid. The Committee notes that the requirement in section 19(1)(e) to find the identity of persons who contributed to a death was repealed in 1999.

<sup>&</sup>lt;sup>1647</sup> Commissioner of Police v Hallenstein [1996] 2 VR 1, 7.

<sup>&</sup>lt;sup>1648</sup> 'Obiter dicta' refers to statements said 'by the way', that is remarks or observations made by a judge that, while included in the body of the court's opinion, do not form a necessary part of the court's decision.

power of the coroner is wide but not without boundaries, as the matters on which comment may be made must be 'connected with the death'.<sup>1649</sup>

Hedigan J also observed that, since the right of appeal from an inquest conferred by section 59 of the Act is limited to review of findings, difficulties arise if 'findings and comment[s], which must in many cases be closely linked, are not disentangled by a clear and separate statement of the s[ection] 19(1) findings'.<sup>1650</sup>

More recently, the approach by Nathan J in *Harmsworth* was adopted by the ACT Supreme Court in *R v Coroner Doogan*.<sup>1651</sup> However, the court stated clearly that comments may be broader in scope than findings, albeit without expanding the inquiry itself:

Comments may obviously extend beyond the scope of "findings". The latter term refers to judicial satisfaction that facts have been proven to the requisite standard or that legal principles have been established. The former refers to observations about the relevant issues, and may extend to recommendations intended to reduce the risk of similar fires, deaths or disasters occurring in the future. However, conferral of the power to make comments does not enlarge the scope of the coroner's jurisdiction to conduct an inquiry. <sup>1652</sup>

Thus the power to comment and make recommendations has been viewed by the courts as incidental and subordinate to the mandatory power to make findings relating to how a death occurred and the cause of the death. The scope of the coroner's jurisdiction to conduct an inquiry, which is determined by the obligatory findings under section 19(1), is not expanded by the power to comment under section 19(2).

The State Coroner's Office considers that decisions such as *Harmsworth* have limited the scope of Victorian coronial investigations and the capacity of coroners to perform public health and safety roles. However, there has been much discussion in the cases of the need to contain the scope of coronial inquiries within reasonable boundaries. If the power to comment or make recommendations were to be viewed as enlarging the scope of the jurisdiction to conduct an inquiry beyond the obligation to make findings about the matters defined in section 19(1), such as cause of death, it is possible that inquiries would become extremely wide-ranging without the constraint of any terms of reference.

The courts in cases such as *Harmsworth* and *R v Coroner Doogan* have stressed the importance of the principle of causation in determining the reasonable boundaries of coronial inquiries. In *Harmsworth* the coroner was investigating the deaths of prisoners in a cell block fire. Nathan J illustrated the operation of the principle of causation using the following example:

<sup>1650</sup> Ibid.

<sup>1649</sup> Ibid

<sup>&</sup>lt;sup>1651</sup> R v Coroner Doogan; ex parte Lucas-Smith (2005) 158 ACTR 1.

<sup>&</sup>lt;sup>1652</sup> Ian Freckelton and David Ranson, *Death Investigation and the Coroner's Inquest* (2006) 660.

The enquiry must be relevant, in the legal sense to the death or fire, this brings into focus the concept of "remoteness". Of course the prisoners would not have died, if they had not been in prison. The sociological factors which related to the causes of their imprisonment could not be remotely relevant. This can be tested by considering how wide, how prolix and indeterminate the inquest might be if each of the many facets of the individual personalities, of all those involved were to be considered. <sup>1653</sup>

Nathan J pointed out that such discursive investigations might never end and hence never arrive at the coherent and concise findings actually required by the Act under section 19(1).

Similarly, in *Doogan* the ACT Supreme Court noted that the ACT legislation does not authorise a wide-ranging coronial inquiry similar to a royal commission. The court discussed in detail the problems which such an inquiry would create, including the difficulty of containing such inquiries within reasonable bounds while at the same time ensuring due fairness to those who might be the subject of an adverse comment. Wide-ranging coronial inquiries could also blur the boundaries between the judicial and executive arms of government, since an inquiry into the wider issues surrounding a death or fire could expand beyond the immediate facts of a case to become, for example, an open-ended inquiry into the merits of government policies.

### Other jurisdictions

As in Victoria, coroners in all other Australian jurisdictions have the power to make comments and recommendations. However, in some jurisdictions, unlike in Victoria, the power to comment is a mandatory rather than a discretionary power.

The Tasmanian legislation imposes a positive duty on coroners to make recommendations:

A coroner must, whenever appropriate, make recommendations with respect to ways of preventing further deaths and on any other matter that the coroner considers appropriate. 1655

<sup>&</sup>lt;sup>1653</sup> Harmsworth v State Coroner [1989] VR 989, 996.

The Committee notes that there are fundamental differences between a coronial inquiry and a royal commission. Royal commissions in Australia are formally established by letters patent issued by the Governor or Governor-General on the advice of the government. They have coercive powers to collect and procure information, and to compel witnesses to attend hearings and give evidence even if self-incriminating; see Dr Scott Prasser, When should a royal commission be appointed?, paper presented to the Australasian Study of Parliament Group, 15 June 2005 at www.vic.aspg.org.au. The proceedings of a commission are not subject to the ordinary rules of evidence and judicial procedure. Their decisions are not final and this can lead to the airing of unjustified allegations as well as insufficient determination of allegations; see Dr Mark Cooray, Human Rights in Australia, at http://www.ourcivilisation.com.

<sup>&</sup>lt;sup>1655</sup> Coroners Act 1995 (Tas) s 28(2).

The Committee notes that in Tasmania the powers of a coroner to make findings, comments and recommendations are all included within one section of the legislation. In addition, the power to make recommendations to the Attorney-General is provided under a section entitled 'Reports', as is the case in Victoria.

In Western Australia a coroner is required to comment on the quality of the supervision, treatment and care of a person who died while in care. <sup>1657</sup> In relation to other kinds of deaths, a coroner in Western Australia has a discretionary power to comment. <sup>1658</sup>

Similarly, in the Northern Territory a coroner is obliged to make recommendations with respect to the prevention of future deaths in custody as the coroner considers relevant. <sup>1659</sup> In relation to other kinds of death, a coroner has a general power to comment. <sup>1660</sup>

The power of a coroner in New South Wales, Queensland and the ACT to make recommendations is similar to the discretionary power to comment in Victoria. In South Australia the power is also similar, in that a coroner may make a recommendation which might prevent or reduce the likelihood of a recurrence of a similar event. 1662

However, an important feature of the ACT legislation is that a coroner is prohibited from including in a finding or report under the Act a comment which is adverse to a person, unless the coroner has taken all reasonable steps to give the person a copy of the proposed comment and an opportunity within a specified period to make a submission or give the coroner a written comment in relation to it.<sup>1663</sup>

In New Zealand the legislation enables a coroner holding an inquiry to make recommendations or comments of a preventative nature, in a way that recognises prevention as a purpose of inquiries. Section 47 provides that the purposes of an inquiry, in addition to establishing that a death occurred, who died, when and where they died, and the cause of and circumstances surrounding a death, also include:

<sup>&</sup>lt;sup>1656</sup> Coroners Act 1995 (Tas) s 28(2).

<sup>&</sup>lt;sup>1657</sup> Coroners Act 1996 (WA) s 25(3).

<sup>&</sup>lt;sup>1658</sup> Coroners Act 1996 (WA) s 25(3).

<sup>&</sup>lt;sup>1659</sup> Coroners Act 1993 (NT) s 26(2).

<sup>&</sup>lt;sup>1660</sup> Coroners Act 1993 (NT) s 34(2).

<sup>&</sup>lt;sup>1661</sup> Coroners Act 1980 (NSW) s 22A; Coroners Act 2003 (Qld) s 46; Coroners Act 1997 (ACT) s 52(4).

<sup>&</sup>lt;sup>1662</sup> Coroners Act 2003 (SA) s 25(2).

<sup>&</sup>lt;sup>1663</sup> Coroners Act 1997 (ACT) s 55.

To make specified recommendations or comments... that, in the coroner's opinion, may, if drawn to public attention, reduce the chances of the occurrence of other deaths in circumstances similar to those in which the death occurred.<sup>1664</sup>

The New Zealand legislation also provides that the coroner may not comment adversely on a person who died without first indicating an intention to do so, adjourning the inquest for at least seven days, notifying every member of the person's immediate family who during the adjournment requests the coroner to do so and giving every such member a reasonable opportunity to be heard in relation to the proposed comment. In addition, a coroner is not permitted to comment adversely on any living person, corporation or body without taking steps to notify them of the proposed comment and giving them a reasonable opportunity to be heard in relation to it. In the been observed that It has been obs

The Committee notes that the New Zealand Law Commission considered the question of whether the legislation should also ensure individuals are notified of any proposed recommendations that may affect them, and provide a right of reply. It was concerned that the notion of private communication with only some of those represented at the hearing is incompatible with the exercise of judicial functions and the concepts of natural justice. The Commission concluded that a Chief Coroner's role should include notification of affected persons prior to public release of recommendations but not the provision of an opportunity to reply, unlike the position in relation to adverse comments.

### Evidence received by the Committee

The evidence discussed below concerns the legislative provisions which enable coroners to make comments and recommendations of a preventative nature, and it includes some discussion of the permitted findings to which the comments and recommendations are related.

The State Coroner's Office submitted that the provisions of section 19(1) and (2) of the Act unduly restrict a coroner's power to perform a public safety and prevention role and that a coroner investigating a death should be able to make a finding as to whether the death was 'preventable'. The State Coroner's Office submitted that, in

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<sup>&</sup>lt;sup>1664</sup> Coroners Act 2006 (NZ) s 47(3).

<sup>&</sup>lt;sup>1665</sup> Coroners Act 2006 (NZ) s 48(2).

<sup>&</sup>lt;sup>1666</sup> Coroners Act 2006 (NZ) s 48(3).

<sup>&</sup>lt;sup>1667</sup> See *Abbott v Coroners Court of New Plymouth* (Unreported, High Court of New Zealand, New Plymouth, Randerson J, 20 April 2005) 46; *Solicitor-General for New Zealand v The Coroner at Kaitaia* (Unreported, High Court of New Zealand, Ronald Young J, 13 March 2003) 12.

<sup>&</sup>lt;sup>1668</sup> New Zealand Law Commission, Report no. 62, Coroners, 57, para 191.

<sup>&</sup>lt;sup>1669</sup> State Coroner's Office, *Submission no. 70*, 77, 130. The Coroner's Office submitted that the Act should define 'preventable death' as meaning a death that would not have occurred but for identified system failures'.

the case of such a finding, 'the coroner should have unfettered discretion to comment and make recommendations'. Similarly, family member Ms Storm told the Committee that, while she did not want to see coroners making findings of blame, she considered that coroners should at a minimum be able to state that a death was preventable in order to identify faults in the mental health system which would potentially reduce the number of deaths in future. 1671

However, the Victoran Bar submitted that an expansion of power of the kind suggested by the State Coroner would mean that every coroner would assume the role of a far-reaching royal commissioner, without the restraint of appropriate terms of reference for the inquiry. This would have substantial cost ramifications for the State and for parties who appear before the coroner. The Victorian Bar stated:

It is essential that the logical connection between the statutory functions of a coroner to determine causation and the consequential power to make recommendations is maintained. 1672

The extent to which a new power to find that a death was 'preventable' would change the currently required nexus between causation and the power to comment or make recommendations is unclear, particularly as it is not a finding which is available in other jurisdictions. Arguably, the power to make such a finding could invite broadranging inquiries of the kind alluded to by the Victorian Bar (and cautioned against by the courts), by allowing coroners to inquire into far wider issues than factual causation when hypothesising whether a death was preventable.<sup>1673</sup>

Another significant issue, as Professor Stephen Cordner, Director of VIFM, pointed out, is that a finding of 'preventability' would have the potential to reintroduce notions of civil or criminal blame, which have long been rejected as legitimate matters for inclusion in coronial findings. The Committee has already noted that in 1999 the obligation of a coroner to make a finding about the identity of a person who contributed to a death was removed on the basis that such a finding could be misunderstood as meaning that the person was in some way legally responsible for the death. Avoiding issues of blame is important, since the coronial jurisdiction aims to make inquisitorial determinations of fact rather than judicial determinations of legal responsibility.

The State Coroner told the Committee that the vast majority of coronial cases involve human error rather than instances of criminality or negligence and thus invite a focus

<sup>1671</sup> Caroline Storm, *Minutes of Evidence*, 22 August 2005, 10.

<sup>1670</sup> Ibid.

<sup>&</sup>lt;sup>1672</sup> Victorian Bar. Submission no. 81, 21.

<sup>&</sup>lt;sup>1673</sup> Commentators such as Dr Freckelton and Associate Professor Ranson are much less averse to the prospect of coroners having a role that is 'something akin to standing Royal Commissioners into death and serious injury': see lan Freckelton and David Ranson, *Death Investigation and the Coroner's Inquest* (2006) 769.

<sup>&</sup>lt;sup>1674</sup> Stephen Cordner, Victorian Institute of Forensic Medicine, *Minutes of Evidence*, 19 September 2005, 130.

on prevention via system changes.<sup>1675</sup> As a result, Victorian coroners have emphasised in public forums that their focus is not on issues of blame but on a systems approach which aims to prevent similar deaths in the future.<sup>1676</sup> It is arguable that in many cases a comment or recommendation designed to prevent similar deaths in future cannot logically be made without a coroner concluding, explicitly or implicitly, that the death investigated was itself preventable. Indeed, the Committee notes that it is not uncommon for coroners to make comments to that effect. Such comments and recommendations may at times be interpreted as implying fault, but a formal finding that an individual death was preventable arguably encroaches on territory that properly belongs to the civil and criminal courts.

While the Committee did not receive detailed evidence discussing this issue, it notes that there may be important differences between a formal finding based on the evidence before a coroner that a death was preventable and mere comments to that effect by a coroner. Whether the public and the media can differentiate between a finding and a comment is debatable, but if coroners were to issue such findings they would potentially be more damaging and could well be the subject of numerous appeals by affected parties. The Committee notes that a proposal in 1995 by the Ontario Law Reform Commission that a stated purpose of coronial investigations in that jurisdiction be to determine whether a death was preventable has not been adopted in Ontario's coronial legislation.<sup>1677</sup>

A further issue that was raised in evidence to the Committee was that of whether coroners should be given power to initiate inquiries for the purpose of making recommendations. In New Zealand, as noted earlier, the legislation permits an inquiry to be held for the purpose of making comments or recommendations designed to reduce the chances of similar deaths occurring in future. In Victoria coroners may only make comments and recommendations on matters connected with a death which the coroner investigated, powers which the courts have interpreted as incidental to the making of findings. Witnesses such as the Victorian Bar and Dr Freckelton submitted that it is important that there should be a nexus between recommendations and findings, as decided in *Harmsworth* v *State Coroner*. Dr Freckelton also recommended that the existing list of findings available to coroners in section 19(1) should not be changed. However, he considered that coroners should be encouraged to make recommendations where feasible, that the preventative role should be

<sup>&</sup>lt;sup>1675</sup> Graeme Johnstone, State Coroner's Office, *Minutes of Evidence*, 19 September 2005, 73, 79.

<sup>&</sup>lt;sup>1676</sup> Stephen Cordner, Victorian Institute of Forensic Medicine, *Minutes of Evidence*, 19 September 2005, 129.

<sup>&</sup>lt;sup>1677</sup> Ontario Law Reform Commission, Report on the Law of Coroners (1995) 184; Coroners Act RSO 1990.

<sup>&</sup>lt;sup>1678</sup> Coroners Act 2006 (NZ) s 47. See also Ian Freckleton, Minutes of Evidence, 20 September 2005, 207; Matthews v Hunter [1993] 2 NZLR 683.

<sup>&</sup>lt;sup>1679</sup> Coroners Act 1985 ss 15, 19, 21.

<sup>&</sup>lt;sup>1680</sup> [1989] VR 989.

recognised in the Act, and that inquests should be able to be focused overtly on the assembly of information necessary to make recommendations.<sup>1681</sup>

Another important issue raised in relation to recommendations is that they need to be feasible and realistic. Former coroner Ms Heffey submitted that recommendations should only be made after consultation with professionals in the area being considered, and she suggested that an opportunity could be given to all those affected by a proposed recommendation to make submissions in reply before the recommendation is published. As the Committee noted above, the New Zealand legislation contains a similar requirement in relation to proposed adverse comments. An example of where such a provision would be useful is a medical treatment case, where there might be divergent views about the practicality of implementation. The recommendation would need to be adjusted to take this into account. Ms Heffey stated that the overall aim should be for coroners to make recommendations that have integrity and that will be recognised as such by all persons potentially affected by them. This issue will be discussed further below.

Concern was also expressed to the Committee that the existing legislative provisions which recognise the preventative role of coroners are too ambiguous. The Federation of Community Legal Centres (FCLC) told the Committee that the coroner's preventative role should be expanded and encouraged within these provisions, stating that, while sections 19(2) and 21(2) give coroners discretion to make comments and recommendations, they offer little guidance about the circumstances in which these should be made. Accordingly, the FCLC told the Committee that the Act should oblige a coroner to make recommendations where a coroner considers that to do so would prevent a recurrence of similar injury or death, particularly (as required in the Northern Territory)<sup>1684</sup> in relation to deaths in custody.<sup>1685</sup> At the very least, the FCLC considers that sections 19(2) and 21(2) should be amended to better encourage and promote the preventative role.<sup>1686</sup>

Finally, Acting Emergency Services Commissioner Ms Williams supported the introduction in Victoria of a positive duty on coroners to make recommendations whenever appropriate, as is the case in Tasmania. Ms Williams also submitted that, by having a duty which includes the flexibility not to make recommendations where it would be inappropriate to do so, the significance and influence of recommendations

<sup>1684</sup> Coroners Act 2003 (NT) s 26(2).

<sup>&</sup>lt;sup>1681</sup> Ian Freckleton, *Minutes of Evidence*, 20 September 2005, 207.

<sup>&</sup>lt;sup>1682</sup> Jacinta Heffey, Submission no. 33, 25.

<sup>&</sup>lt;sup>1683</sup> Ibid 24.

<sup>&</sup>lt;sup>1685</sup> Hugh de Kretser, Brimbank Melton Community Legal Centre, *Minutes of Evidence*, *19 September 2005*, 111; Federation of Community Legal Centres, *Submission no. 55*, 18.

<sup>&</sup>lt;sup>1686</sup> Hugh de Kretser, Brimbank Melton Community Legal Centre, *Minutes of Evidence*, 19 September 2005, 111.

would be enhanced because they would be based on a coroner's decision that there is a genuine need for them, rather than a legislative obligation.<sup>1687</sup>

Having reviewed the evidence from witnesses in relation to the legislative power to comment and make recommendations, the Committee will discuss below a range of factors which impact on the effectiveness of recommendations in preventing death and injury.

# Effectiveness of recommendations in preventing death and injury

The traditional view of the role of the coroner is that the coroner is a 'public messenger' whose task is completed on delivery of the message. What happens beyond that point has been seen to be outside the control of the coroner, as a coroner has no power to oversee or audit compliance with recommendations. Further, as discussed later in this chapter, responses to coroners' recommendations are not mandatory in Victoria. In other words, coroners' recommendations may be completely ignored. This has been the subject of considerable criticism and a source of frustration for families of people who have died in circumstances giving rise to coronial recommendations which are not acted upon. However, as noted by VIFM and many others, much has been achieved by the coronial system over the past two decades in identifying trends and hazards in preventable deaths and developing safety measures.

A good example of the effectiveness of the coronial system is the introduction of boom barriers for railway level crossings. Dr Eric Wigglesworth, a leading expert in this area, told the Committee that their introduction resulted in the rate of deaths 'per 100 crossing years' dropping from 5.7 to 0.3:

You do not get better results than that anywhere in the accident prevention field, and I make the point that that came about due to the study made possible by the present coronial system.<sup>1691</sup>

Dr Wigglesworth told the Committee that the results of Victorian research led to international changes of approach to an issue once seen as intractable (due to driver behaviour) into one that 'is amenable to scientific attack'. Further progress was

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<sup>&</sup>lt;sup>1687</sup> Office of the Emergency Services Commissioner, Submission no. 74, 3.

<sup>&</sup>lt;sup>1688</sup> Hal Hallenstein, Suicide: the Coroner as Catalyst (Paper presented at AIC Conference No. 13, July 1990) 177.

<sup>&</sup>lt;sup>1689</sup> Cf the position in the ACT and the NT. Response to reports: see *Coroners Act 1997* (ACT) s 76; Coroners Act (2004) s 46B.

<sup>&</sup>lt;sup>1690</sup> Victorian Institute of Forensic Medicine, Submission no. 40, 3–4.

<sup>&</sup>lt;sup>1691</sup> See for example Eric Wigglesworth, Monash University Accident Research Centre, *Minutes of Evidence*, 28 *November* 2005, 221.

<sup>&</sup>lt;sup>1692</sup> Ibid.

made subsequently when coronial data showed that a previously unrecognised proportion of level-crossing accidents were attributable to suicide. 1693

Other Victorian examples where coronial recommendations have contributed to changes aimed at reducing death and injury in the community include:

- the development of legislation regarding safety barriers around private swimming pools and spas as a toddler drowning prevention measure;
- fitting of heavy vehicles with audible reversing warning devices;
- the need for protective mesh and public warnings following deaths involving falls through corrugated fibreglass sheet roofing;
- the means to improve safety on a particular bridge where nine road fatalities and 83 injuries occurred over a four-year period;
- training, licensing, design, maintenance and work practices for forklift drivers following 20 forklift-related deaths;
- recall of faulty Mistral cooling fans that caused fires and contributed to the death of two children;
- rollover protection structures on tractors;
- review of a methadone maintenance program for intravenous drug users after a spate of deaths identified by VIFM;
- changes to protocols for the use of firearms and high-speed pursuits by police;
- marine safety relating to both domestic and commercial boats;
- workplace-related fatalities;
- review of building designs for prison cells to reduce or eliminate the availability of hanging points;
- major fire-safety reviews following recommendations in the Kew Residential Services and Linton fire inquests; and
- system issues in medical adverse events.<sup>1694</sup>

More generally, Victoria 'has played a leading role in shifting the thinking of coroners nationally and internationally about their responsibilities in preventing death and

<sup>&</sup>lt;sup>1693</sup> Ibid 222.

<sup>&</sup>lt;sup>1694</sup> See, eg, State Coroner's Office, *Submission no. 70*, 174-5; Victorian Institute of Forensic Medicine, *Submission no. 40*, 3-4.

injury'.<sup>1695</sup> A good example is the development of the NCIS, which has been commented on favourably by various inquiries in the UK and elsewhere.

Despite these successes, the effectiveness of the current system is limited by a number of factors, including:

- the lack of protocols to guide coroners in the forming of recommendations;
- the lack of systematic training for coroners in relation to public health, public policy and injury epidemiology and prevention;
- the power to make recommendations is discretionary and used infrequently by coroners:
- the lack of a requirement for organisations to respond to recommendations, as a result of which it is difficult to determine the degree to which coroners' recommendations are considered and implemented, and difficult for coroners to receive feedback on the effectiveness of recommendations;
- the lack of an electronic system for monitoring recommendations sent by coroners, the organisations to which the recommendations are directed, and responses received (according to Ms Bugeja, any responses received are collated in a folder, and a copy is kept with the manual investigation record);<sup>1696</sup> and
- only a limited number of organisations respond systematically to coroners' recommendations.

Other barriers to the effectiveness of recommendations may exist at an organisational level beyond the coronial system, including:

- lack of resources or unwillingness to fund the changes recommended by a coroner;
- concern about unknown adverse effects of implementation of the recommendation; and
- moral or political opposition to the recommendation (in some cases a recommendation may conflict with social norms or be in direct opposition to the government's policy on a particular issue).

Some perspective on the effectiveness of coronial recommendations can be found in one of the most recent success stories: the introduction of mandatory wearing of

<sup>&</sup>lt;sup>1695</sup> Victorian Institute of Forensic Medicine, Submission no. 40, 4.

<sup>&</sup>lt;sup>1696</sup> Lyndal Bugeja, Accident Research Centre, Monash University, *PhD Confirmation of Candidature Report: The Role of Coroner's Recommendations in Injury Prevention and Control*, May 2006, 5.

<sup>&</sup>lt;sup>1697</sup> Ibid 10. An example is the State Coroner's proposed restrictions on P-plate drivers, discussed below.

lifejackets or personal flotation devices (PFDs) on recreational or commercial vessels in Victoria. 1698 This recommendation was first made by the State Coroner on 12 May 1988 after a commercial fisherman drowned on Port Phillip Bay. Between that time and the introduction of the new laws more than 100 other people died, despite such deaths having been found to be highly preventable by the use of PFDs. Ms Bugeja and Associate Professor Ranson comment:

It is frustrating and distressing for the health and safety community to see the same deaths occurring over and over again, particularly in circumstances where coroners have formulated sensible and feasible recommendations that have been repeatedly ignored.1699

Not surprisingly, many witnesses to this inquiry expressed the view that the way coronial recommendations are dealt with in the current system is not sufficiently effective in preventing death and injury and that the potential of the system, given the coroner's unique position, is not being fully realised.

The Victorian Aboriginal Legal Service (VALS), for example, considers that the lack of effectiveness has resulted in an increase in the number of Indigenous Australians who have died in custody since the Royal Commission into Aboriginal Deaths in Custody (RCADC), as compared with the previous decade. 1700 VALS considers that the State Coroner is in a position to prevent deaths in custody, being aware of the causes of such deaths, but that, because such information is not being used effectively and because the RCADC recommendations have not been implemented, avoidable deaths are occurring. Accordingly, VALS supports the implementation of RCADC recommendations 13 to 23, which include calls for the mandatory making of recommendations by coroners in death in custody cases, mandatory responses to such recommendations by relevant parties, and the tabling in parliament of such responses. 1701

This is a view shared by the Coroner's Office, which in its submission identified the need for mandatory responses by agencies to coronial recommendations as a minimum requirement for improving effectiveness. 1702 Mandatory reporting is discussed in more detail below.

However, other witnesses considered that coronial recommendations have been effective in preventing deaths and injuries. For example, Ms Williams submitted that the Coroner has been recognised as an important component of Victoria's emergency

<sup>&</sup>lt;sup>1698</sup> See Marine (Personal Flotation Devices and Other Safety Equipment) Regulations 2005.

<sup>&</sup>lt;sup>1699</sup> Lyndal Bugeja and David Ranson, 'Coroner's Recommendations: A Lost Opportunity' (2005) 13 Journal of Law and Medicine 173, 174.

<sup>&</sup>lt;sup>1700</sup> See for example Victorian Aboriginal Legal Service, Submission no. 57, 9.

<sup>&</sup>lt;sup>1701</sup> Ibid 9–10.

<sup>&</sup>lt;sup>1702</sup> State Coroner's Office, Submission no. 70, 133.

management framework because of the preventative, mitigatory and risk-reducing capability of the coroner's recommendations. Ms Williams submitted that the value of coronial recommendations derives from the breadth and depth of inquiries and inquests held by the coroner. An observation shared by other commentators.

The Committee will discuss below some of the main factors limiting the effectiveness of coronial recommendations under the current system. The Committee notes that these factors, and others which are significant, have been discussed in detail by Dr Freckelton and Associate Professor Ranson. Additional factors which inhibit the effectiveness of recommendations once they have been made will be discussed later in this chapter under the heading 'Implementation and monitoring powers'.

### Lack of empirical studies on effectiveness of recommendations

Associate Professor Ranson submitted that the coronial system has contributed significantly to public health and safety by identifying key factors that have contributed to deaths and thereby assisting in the development of preventative strategies that have saved lives.<sup>1707</sup> However, he noted that it is difficult to be certain of the contribution of the coronial system towards reducing preventable deaths. One reason is that death and injury prevention processes for audit and review exist in many organisations and operate continuously independent of the coronial system. Another reason is the lack of research activity to date designed to evaluate the implementation rate of recommendations.<sup>1708</sup> Further, it is impossible to gauge accurately the impact of coronial recommendations in the absence of a formal reporting mechanism which records the agencies that are the subject of recommendations, their responses to the recommendations and what actions have been taken.<sup>1709</sup>

[U]ntil we have more information regarding the empirical basis for concluding that the coroner has a major part to play in preventing death and injury we can only rely upon the many anecdotal stories that certainly tend to demonstrate that the coroner indeed has been successful in this area.<sup>1710</sup>

A study by Ms Halstead of 16 coronial inquests into deaths in custody between 1990 and 1992 showed that coroners had made recommendations in relation to only six of

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<sup>&</sup>lt;sup>1703</sup> Office of the Emergency Services Commissioner, Submission no. 74, 8.

<sup>&</sup>lt;sup>1704</sup> Ibid 4.

<sup>&</sup>lt;sup>1705</sup> Ian Freckelton and David Ranson, *Death Investigation and the Coroner's Inquest* (2006) 723-5.

<sup>&</sup>lt;sup>1706</sup> Ibid Ch 20.

<sup>&</sup>lt;sup>1707</sup> David Ranson, Submission no. 19, 61.

<sup>&</sup>lt;sup>1708</sup> Ibid.

<sup>&</sup>lt;sup>1709</sup> Ibid 63.

<sup>&</sup>lt;sup>1710</sup> Ibid 61.

the inquests, leading to a total of 12 recommendations.<sup>1711</sup> In response to a written request from the Department of Justice, the agencies concerned provided responses in relation to three of the recommendations and acknowledged receipt of four of the other recommendations. There was not even a letter of acknowledgement from the agencies in relation to the other five recommendations. The Department of Justice did not follow up on the missing responses. Ms Halstead wrote:

No documentary evidence was located from the case studies which would indicate that responses to coroner's recommendations were reliably indicated to anyone. Where such communication was made, it was made only to the Department of Justice. There is no indication that any of the other parties, including the coroner, were ever informed of the responses.<sup>1712</sup>

However, as Mr Justin Malbon observes,<sup>1713</sup> Ms Halstead's study appears to be at odds with a 1991 article in *The Age* which commented on a survey by the Victorian Attorney-General's Department of 100 cases in 12 months and found that about two-thirds of recommendations made at coronial inquiries were implemented.<sup>1714</sup> This appears to be a relatively high response rate in comparison to Ms Halstead's study. However, as Mr Malbon argues, it is difficult to tell just how meaningful the positive responses were, since a government department might, for example, advise that a recommendation to remove hanging points in a cell is being implemented when implementation merely involves a ministerial directive which is ignored in practice.<sup>1715</sup>

The Committee will discuss the need for mandatory responses and greater monitoring of the implementation of coroners' recommendations later in this chapter. For present purposes it is sufficient to note that the accuracy of any commentary on the effectiveness of recommendations is limited by the current lack of a reporting and monitoring system.

### Lack of rigour in decisions and lack of guidelines

The practice of coroners in Australia is to write decisions which provide a narrative account of the circumstances and manner of death, unlike the more brief verdicts which were delivered by juries prior to their removal from the jurisdiction.<sup>1716</sup> This raises the question of whether coroners are equipped with the skills more commonly

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<sup>&</sup>lt;sup>1711</sup> Boronia Halstead, 'Coroners' Recommendations Following Deaths in Custody', in Hugh Selby (ed), *The Inquest Handbook* (1998) 186–207.

<sup>&</sup>lt;sup>1712</sup> Ibid 186, 204.

<sup>&</sup>lt;sup>1713</sup> Justin Malbon, 'Institutional Responses to Coronial Recommendations' (1998) 6 *Journal of Law and Medicine* 35, 42.

<sup>&</sup>lt;sup>1714</sup> 'Coroners Often Ignored', *The Age* (Melbourne), 24 November 1991, cited in Graeme Johnstone, 'An Avenue for Death and Injury Prevention', in Hugh Selby (ed), *The Aftermath of Death* (1992), 140, 158. Cf Hugh Cameron, 'An Investigation into the Coronial System in Victoria', *Victorian Parliamentary Internship Report* (1996).

<sup>&</sup>lt;sup>1715</sup> Justin Malbon, 'Institutional Responses to Coronial Recommendations' (1998) 6 *Journal of Law and Medicine*, 35, 42.

<sup>&</sup>lt;sup>1716</sup> Ian Freckelton and David Ranson, Death Investigation and the Coroner's Inquest (2006) 736.

required of intermediate and superior court judges, namely 'to compose lucid, legally correct and internally consistent written reasons for their findings'.<sup>1717</sup>

Various judges have suggested that coroners' analyses have lacked robustness and the hallmarks of sound legal reasoning, an example being failure in some cases to distinguish clearly between statutory findings and sub-findings of fact.<sup>1718</sup> Another example is failure to distinguish clearly between findings, comments and recommendations. While it is the practice of some coroners to clearly delineate these different aspects under separate headings, others do not do so, a fact which has been criticised in some cases and needs to be addressed.<sup>1719</sup>

Part of the problem is that there is a relative lack of legal guidance for coroners on how their enabling statutory provisions are to be interpreted. This has led to a degree of creative interpretation of the coroner's role by innovative coroners. However, such an approach has the potential to be overturned on appeal, especially by judges who interpret the role more narrowly. Appeals from coroners' findings and even from their recommendations have increased in recent times, and such appeals have not disclosed uniform approaches by the higher courts. Treat that thus far the legislation has failed fundamentally to redefine the role of the coroner in contemporary death investigation and prevention.

A related issue is whether coroners are sufficiently able to perform the difficult public policy task of synthesising large amounts of material that might be relevant to the making of recommendations in a way that is amenable to practical implementation. <sup>1725</sup> Dr Freckelton and Associate Professor Ranson observe that this task requires non-judicial skills of the kind found at high levels of specialist bureaucracies, and that it is an aspect of the coronial role that highlights the need for specialist training which until recently has not been available. <sup>1726</sup>

<sup>&</sup>lt;sup>1717</sup> Ibid.

<sup>&</sup>lt;sup>1718</sup> Ibid.

<sup>&</sup>lt;sup>1719</sup> See for example *Commissioner of Police v Hallenstein* [1996] 2 VR 1, 7.

<sup>&</sup>lt;sup>1720</sup> Ian Freckelton and David Ranson, *Death Investigation and the Coroner's Inquest* (2006) 745.

<sup>&</sup>lt;sup>1721</sup> Ibid 749. The authors have observed that the development of a focus on prevention has depended thus far on the initiative of individual coroners. The authors argue that the danger of this is that continuity of philosophy and purpose can be lost, and that the preventative role of coroners needs to be transferred away from the 'cult of personality' and into clearly defined legislation and consistent procedures.

<sup>&</sup>lt;sup>1722</sup> Ibid 745.

<sup>&</sup>lt;sup>1723</sup> Ibid.

<sup>&</sup>lt;sup>1724</sup> Ibid.

<sup>&</sup>lt;sup>1725</sup> Ibid 737.

<sup>&</sup>lt;sup>1726</sup> The Committee notes that the Australian Coroners' Society is now providing training and the opportunity for scholarly exchange; at the initiative of State Coroner Graeme Johnstone, it also publishes a journal, *In-Quest*.

It also appears that problems in these areas stem in part from a lack of any clear guidelines for coroners on how to set out their findings and formulate recommendations. The Committee understands that the State Coroner is considering the preparation of appropriate guidelines in relation to the drafting of recommendations.

### Practicality and feasibility of recommendations

A major difficulty with coroners' recommendations is that a number of them have been labelled as ill-informed or impractical.<sup>1727</sup> Indeed, this is one of the factors which led to the removal of the recommendation power from coroners in the UK.<sup>1728</sup>

This has been of particular concern to medical practitioners. Many fields of modern medicine are complex and involve groups of specialists with differing opinions as to what constitutes best practice. Problems arise where coroners formulate recommendations in relation to specialist medical practice based on the advice of a single expert. Even within a particular specialist area of medicine there are likely to be differences in what individual doctors would consider to be ideal or even acceptable practice. The result of a coroner relying on a single expert is that his or her conclusions may be treated with disdain by reasonable medical practitioners who hold an alternate view.

The issue is not confined to medicine, as there are other areas where a coroner's recommendations may not be feasible. An example of this is where coroners make scientifically valid recommendations concerning car design but there are serious economic obstacles to implementation. For instance, the State Coroner has identified the potential of electronic stability control devices in motor vehicles to prevent single-vehicle accidents; however, at present these devices are considered too expensive to be included in all vehicles.<sup>1733</sup>

Another situation where coronial recommendations may not be practical is where they are inconsistent with public policy. An example is the recent recommendation by the State Coroner that the government and road safety authorities consider restricting the number of passengers permitted to be carried by probationary drivers.<sup>1734</sup> In response,

<sup>&</sup>lt;sup>1727</sup> Ian Freckelton and David Ranson, *Death Investigation and the Coroner's Inquest* (2006) 737.

<sup>&</sup>lt;sup>1728</sup> Ibid, citing Brodrick Committee, *Report of the Committee on Death Certification and Coroners*, Cm 4810 (1971).

<sup>&</sup>lt;sup>1729</sup> Ibid.

<sup>&</sup>lt;sup>1730</sup> Ibid.

<sup>&</sup>lt;sup>1731</sup> Ibid.

<sup>&</sup>lt;sup>1732</sup> Ibid 738.

<sup>&</sup>lt;sup>1733</sup> ABC Television, 'Hit Run Kills Six', *The 7.30 Report*, 20 February 2006. Transcript available at:

http://www.abc.net.au/7.30/content/2006/s1574372.htm.

<sup>1734 &#</sup>x27;Coroner's P-Plate Recommendations', *The Age* (Melbourne, 24 May 2005). Available at

the Premier and the Minister for Transport expressed concern that the recommendation was impractical and could jeopardise the designated driver policy. While there may have been empirical evidence supporting this recommendation, there are practical difficulties in its implementation for which it attracted criticism from a range of people. The recommendation has not been implemented. 1736

### Inconsistency in recommendations

One of the problems inherent in making recommendations arising from findings in relation to a particular death is that they inevitably arise in a piecemeal way in response to the issues raised by particular cases.<sup>1737</sup> As Dr Freckelton and Associate Professor Ranson observe, in making recommendations, coroners extrapolate from deficiencies highlighted in a particular case to propose reforms applicable to many scenarios, moving from the specific to the more general.<sup>1738</sup> The challenge is to refrain from making wide-scale recommendations for change where there is insufficient information to appreciate the ramifications of the proposed measures while nonetheless being prepared to advance constructive proposals where the information in a particular case supports such action.<sup>1739</sup>

There is an obvious need to avoid making impractical, 'utopian' recommendations;<sup>1740</sup> however, this must be balanced against the fact that social policy often takes time to catch up with calls for change and that recommendations which may seem impractical at the time may be regarded as having been farsighted some years hence.

Coroners adopt different approaches to this situation. One is to avoid making any recommendations, on the basis that insufficient information is available for extrapolation to complex, broader issues.<sup>1741</sup> Another is to make very specific recommendations while acknowledging that these are less than a complete answer but are nonetheless justified on the basis of the information available.<sup>1742</sup> A compromise adopted by some coroners is to make recommendations only in general terms — for example, that an agency review its policies in relation to an issue or

http://www.theage.com.au/articles/2005/05/24/1116700689846.html.

<sup>&</sup>lt;sup>1735</sup> Nassim Khadem and Stephen Moynihan, 'Coroner Urges P-Plate Passenger Limit', *The Age* (Melbourne), 25 May 2005, 5.

<sup>&</sup>lt;sup>1736</sup> See for example Tanya Giles, 'P-Plate Plan to Curb Toll: Coroner Seeks Passenger Limit', *Herald Sun* (Melbourne), 25 May 2005, 7; Nassim Khadem and Stephen Moynihan, 'Coroner Urges P-Plate Passenger Limit', *The Age* (Melbourne), 25 May 2005, 5; and Editorial, 'P-Platers Not Alone', *Herald Sun* (Melbourne), 25 May 2005, 22.

<sup>&</sup>lt;sup>1737</sup> Ian Freckelton and David Ranson, Death Investigation and the Coroner's Inquest (2006) 738.

<sup>&</sup>lt;sup>1738</sup> Ibid.

<sup>&</sup>lt;sup>1739</sup> Ibid.

<sup>&</sup>lt;sup>1740</sup> Ibid.

<sup>&</sup>lt;sup>1741</sup> Ibid.

<sup>&</sup>lt;sup>1742</sup> Ibid.

investigate matters further.<sup>1743</sup> Dr Freckelton and Associate Professor Ranson comment that each approach is open to criticism. For example, the often favoured approach of making general recommendations can tend to result in recommendations of limited impact.<sup>1744</sup> However, the worst scenario is probably for coroners to make erroneous, impractical or ill-informed recommendations. The latter recommendations reduce the esteem in which coroners are held and encourage agencies to ignore the proposals.

A related problem is that different coroners will make recommendations in relation to the same issue in ways that are inconsistent. For example, Ms Halstead's case study of deaths in custody found that, in cases where recommendations were made, each coroner made recommendations based on different expectations as to the standard of care that custodial agencies should adopt, resulting in inconsistent recommendations.<sup>1745</sup>

### Recommendations made too infrequently

Given that recommendations are viewed as one of the most relevant and powerful aspects of a coroner's findings with respect to achieving public good, it is surprising how infrequently they are made.<sup>1746</sup> Several witnesses pointed out that the degree to which coroners choose to look at wider trends and patterns during the investigative process and to make recommendations to prevent further deaths is a subjective decision under the current system.<sup>1747</sup> While some coroners consider that their role includes the prevention of future death and injury, the majority do not.<sup>1748</sup>

A recent study by Ms Bugeja of the Monash University Accident Research Centre using the NCIS database found that, of the 19 387 coronial death investigations completed in Victoria between 1 July 2000 and 30 June 2005, 377 cases (resulting from 345 incidents) contained a formal recommendation in the coroner's finding, representing approximately 2 percent.<sup>1749</sup> In addition, in the course of searching for formal recommendations, Ms Bugeja identified 49 cases (resulting from 45 incidents)

<sup>1744</sup> For example, in her submission to this inquiry Ms Storm criticised the recommendations arising from the inquest into the death of her daughter Anne as mere 'feelgood' prescripts or 'motherhood statements' that would never be implemented: Caroline Storm, *Submission no. 28*, 6.

<sup>&</sup>lt;sup>1743</sup> Ibid.

<sup>&</sup>lt;sup>1745</sup> Boronia Halstead, 'Coroner's Recommendations Following Deaths in Custody', in Hugh Selby (ed), *The Inquest Handbook* (1998) 186.

<sup>&</sup>lt;sup>1746</sup> Ian Freckelton and David Ranson, *Death Investigation and the Coroner's Inquest* (2006) 738–9.

<sup>&</sup>lt;sup>1747</sup> Victorian Institute of Forensic Medicine, Submission no. 40, 18.

<sup>&</sup>lt;sup>1748</sup> Ibid.

Lyndal Bugeja, Accident Research Centre, Monash University, *PhD Confirmation of Candidature Report: The Role of Coroner's Recommendations in Injury Prevention and Control*, May 2006, 17. Cf Lyndal Bugeja and David Ranson, 'Coroner's Recommendations: A Lost Opportunity' (2005) 13 JLM 173, 175; and Victorian Institute of Forensic Medicine, *Submission no. 40*, 18.

where a coroner made a preventative comment other than a formal recommendation.<sup>1750</sup> An extensive search for such comments was outside the scope of the study, hence they may have been under-reported.<sup>1751</sup>

The State Coroner informed the Committee that three coroners in Victoria consistently make recommendations, a situation which could be improved significantly with increased training, for which initiatives were being developed.<sup>1752</sup> Associate Professor Ranson observed in his submission that the low recommendation rate indicated that there is a need to emphasise to coroners the importance of making recommendations.<sup>1753</sup>

The Committee notes, however, that in many cases coroners may be reluctant to make recommendations as a result of concerns about their feasibility or practicality. Thus, in addition to the need for improved training, there is also the need for mechanisms enabling improved feedback to coroners about the viability of proposed recommendations prior to their release.

### Few recommendations made by rural magistrates

The State Coroner told the Committee that an option for improving this situation is to identify approximately eight country coroners who could specialise in and conduct a significant proportion of coronial work.<sup>1754</sup> Such coroners could receive relevant support services, training, advice and assistance from the Coronial Services Centre, including, if a research office were established, the ability to discuss the prevention implications of cases with the researchers from that office. This would be enhanced by a state-wide computerised administrative system.<sup>1755</sup> The Coronial Services Centre has already conducted some training courses, which have been attended by a number of country coroners.<sup>1756</sup> Another improvement would be to have more full-time coroners from Melbourne visiting the country to investigate the more significant types of cases. However, the State Coroner stressed the importance of having local coroners, who, if committed to coronial work and improving the safety of the

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<sup>&</sup>lt;sup>1750</sup> Lyndal Bugeja, Accident Research Centre, Monash University, *PhD Confirmation of Candidature Report: The Role of Coroner's Recommendations in Injury Prevention and Control*, May 2006, 17.

<sup>&</sup>lt;sup>1751</sup> Ibid 16.

<sup>&</sup>lt;sup>1752</sup> Graeme Johnstone, State Coroner's Office, *Minutes of Evidence*, 19 September 2005, 81.

<sup>&</sup>lt;sup>1753</sup> Associate Professor Ranson, *Submission no. 19*, 62. The Committee notes that the State Coroner's Practice Manual states, 'Recommendations and comments are an important part of the modern coroner's function and careful consideration needs to be given to this aspect of the work. Investigating coroners need to be mindful of the historical fact that there are examples of cases where no recommendations have been made and preventable deaths have continued': State Coroner Victoria, *State Coroner's Practice Manual* (2005), 38.

<sup>&</sup>lt;sup>1754</sup> Graeme Johnstone, State Coroner's Office, *Minutes of Evidence*, 19 September 2005, 82.

<sup>&</sup>lt;sup>1755</sup> Ibid.

<sup>&</sup>lt;sup>1756</sup> Ibid.

community, may be able to exert more influence than someone coming from the city.<sup>1757</sup>

# Delays between a death and the making of recommendations

The problem of delay has been discussed in other parts of this report. While statistics are not yet available on the average period between a death and the subsequent release of recommendations, it is clear that inquests often occur months or years after the death. Dr Freckelton and Associate Professor Ranson comment that:

This reduces the immediacy of the coronial response, allows distress and anger to fester on the part of family and community members, and takes the sting out of recommendations by coroners for change, as these can be readily dismissed as dealing belatedly with different times and different factual scenarios than those currently obtaining.<sup>1758</sup>

The result of delay is that, by the time an inquest is held and recommendations are made, there is a risk that a coronial investigation will be perceived as having been overtaken by other events. In some cases an agency will have instituted measures long before the coroner delivers his or her findings. A far more serious problem is that in other cases there is a risk that further deaths may occur in similar circumstances prior to any recommendations being released.<sup>1759</sup>

## Recommendations arise only from death investigations

Aside from the jurisdiction to inquire into the cause and origin of fires, Victorian coroners are generally only able to inquire into certain categories of deaths. The difficulty this poses is that deaths represent only a small fraction of incidents in which people's lives are put at risk and during which serious injuries may be sustained. As a result there is a risk that coroners' findings and recommendations are skewed in the direction of deaths, whereas conduct that causes only a small number of deaths may be causing significant numbers of serious injuries. Consequently, the focus of coroners may be on an unrepresentative sample of risks that endanger public health and safety.

In its submission the Transport Workers Union (TWU) stated that the transport industry and the public would benefit from being able to make submissions to the coroner on an ad hoc basis. The TWU submitted that the Act should be amended to enable the coroner to conduct investigations into near-deaths or serious incidents where there is sufficient public interest to warrant such investigations.<sup>1760</sup>

<sup>&</sup>lt;sup>1757</sup> Ihid

<sup>&</sup>lt;sup>1758</sup> Ian Freckelton and David Ranson, *Death Investigation and the Coroner's Inquest* (2006) 749.

<sup>&</sup>lt;sup>1759</sup> See for example David Kaufmann, *Minutes of Evidence*, 22 August 2005, 61.

<sup>&</sup>lt;sup>1760</sup> Transport Workers Union, Submission no. 64.

The reason the TWU has suggested this approach is that from our experience, many deaths, particularly in the area of road safety, could have been prevented if adequate education and awareness of the dangers of particular practices had occurred. 1761

The TWU submitted that this would add an extra advisory dimension to the existing jurisdictional capacity of VicRoads, WorkSafe and Victoria Police in relation to prevention.1762

### Discussion and conclusion

The evolution of the preventative role of coroners has been attributed to the initiative of particular coroners and creative interpretation of the role. However, the discussion above suggests that this aspect of coronial work has developed in a somewhat ad hoc way due in part to insufficient recognition in the legislation. The Committee has already recommended earlier in this chapter the inclusion of a preventative purpose in the Act, but it considers that further changes are necessary to recognise and enhance the preventative role of coroners.

However, the Committee considers that care needs to be taken in the way that a preventative focus is developed in the legislation. The Committee does not consider that, as submitted by the State Coroner's Office, the legislation should enable coroners to make a formal legal finding that a death was 'preventable'. The Committee considers that such a power would expand the potential scope of a coroner's investigation beyond any reasonably definable limits, as submitted by the Victorian Bar. The current requirement that there be a nexus between recommendations and a finding of causation is important, because the question of causation is constrained by the principle of remoteness, as discussed by the courts in relation to coronial matters and also in the case law on negligence. However, the question of whether a death was preventable could raise an endless series of 'but for' questions about factors which arguably led to the death. Decisions such as Harmsworth and R v Coroner Doogan have illustrated the problems inherent in permitting coroners to embark on an infinite chain of inquiry unconstrained by the terms of reference that would apply, for example, to a royal commission.

Further, the ability to make findings of preventability could feasibly reintroduce notions of culpability into coroners' findings and result in numerous appeals in relation to coroners' procedures and findings. While this would not be a problem in every type of investigation, it is not difficult to imagine that in many cases an individual or organisation adversely affected by a finding that a particular death was preventable might wish to litigate the matter. This is particularly so given that the media, when interpreting such a finding, could fail to make the distinction between system faults and issues of blame. Thus the effect of such an amendment could be counterproductive, resulting in legal disputes around issues of blame for past events

<sup>&</sup>lt;sup>1761</sup> Ibid 8.

<sup>&</sup>lt;sup>1762</sup> Ibid 6.

instead of a focus on measures which could prevent future deaths in similar circumstances. While as a matter of logic it may not be possible for a coroner to recommend preventative measures without first concluding that a death was preventable, in order to ensure that the emphasis is forward looking the Committee's view is that such conclusions should be not be the subject of the formal findings.

Nonetheless, the Committee considers that the preventative role of coroners needs to be strengthened under the Act. It is clear that the existing powers to comment and make recommendations are used too infrequently by Victorian coroners. The Committee has recommended in chapter five that the Act should be amended to state the purposes of an inquest, which should include the making of preventative recommendations. The Committee also considers that the Act should impose a positive duty on coroners to make recommendations in appropriate cases. In Tasmania a coroner must, whenever appropriate, make recommendations with respect to ways of preventing further deaths and on any other matter that the coroner considers appropriate. The Committee recommends that a similar provision be inserted into section 19 of the Victorian Act, and that the provision refer explicitly to the preventative function of recommendations. The Committee considers that such provisions could also invite the courts to develop a less restrictive interpretation of the requisite nexus between findings and comments (and recommendations) than is expressed in *Harmsworth*.

Evidence to the Committee suggested that the potential exists for coronial recommendations to be ill-informed, impractical, inconsistent and difficult to implement. The Committee believes that it is essential for coroners to receive adequate guidance and training if they are to be able to make effective recommendations. Accordingly, the Committee recommends that the State Coroner develop guidelines for use by other coroners when formulating recommendations. Coroners should be encouraged, for example, to separate findings, comments and recommendations under separate headings where possible. In addition, the Committee recommends that the State Coroner's Office provide training for coroners, particularly rural magistrates who act as coroners, in relation to the formulation of effective recommendations. Further, to ensure a consistent and thorough approach, the Committee agrees with Ms Heffey that all recommendations made by coroners should be approved by the State Coroner and should be issued from the State Coroner's Office as a press release.

The Committee also considers that the Act should include a requirement for coroners to give all persons about whom it is proposed that an adverse comment be made an opportunity to make submissions in relation to the proposed comments, as is the case in the ACT and New Zealand.<sup>1763</sup> The Committee is aware of the potential of such a

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<sup>&</sup>lt;sup>1763</sup> Coroners Act 1997 (ACT) s 55, which provides that 'shall not include in a finding or report ... a comment adverse to a person identifiable from the finding or report unless he or she has, prior to the making of the finding or report, taken all reasonable steps to give to the person a copy of the proposed comment and a written notice

requirement to delay finalisation of coronial investigations, and it therefore recommends that careful consideration be given to the time frames in which submissions could be made and that these be included in the legislation.<sup>1764</sup>

It was suggested to the Committee that the Act should contain a similar requirement in relation to proposed recommendations, in order to provide natural justice to individuals and agencies the subject of the recommendations, and also to provide feedback to coroners about the feasibility of recommendations prior to their implementation. The Victorian Bar went even further than this in its submission by suggesting that there should be a right to appeal recommendations:

Although a coroner's recommendation is not binding or enforceable, it can adversely affect the careers and reputations of persons who are the subject of such a process. In those circumstances, a right of appeal is highly desirable. Given the current practice of independent wide circulation of recommendations by coroners, justice and fairness require that interested parties have the right to challenge comments and recommendations, and not only findings. This is required by the significant shift from the framework of the Act, where recommendations are to the relevant minister or public statutory authority, to the present practice, in which comments and recommendations are directed to private individuals and corporations under the authority of the coroner acting independently.<sup>1765</sup>

However, the Committee does not consider that a right of appeal should exist in these circumstances. Further, the Committee considers that, while there may be circumstances in which it is desirable for coroners to hear submissions in relation to proposed recommendations by affected individuals or agencies, its view is that the provision of such opportunities to respond should be at the discretion of the coroner rather than a requirement under the Act. The Committee's view is that the legislation should preserve the independence of the coroner in making recommendations to protect public health and safety.

In relation to the problem of delays between deaths and the release of recommendations, the Committee notes that it has addressed issues concerning delay in chapter eight.

advising the person that, within a specified period (being not more than 28 days and not less than 14 days after the date of the notice), the person may—

- (a) make a submission to the coroner in relation to the proposed comment; or
- (b) give to the coroner a written statement in relation to it.'

Coroners Act 2006 (NZ) s 48, which contains requirements that a coroner take all reasonable steps to notify persons affected proposed adverse comments, and give the person a reasonable opportunity to be heard in relation to the proposed comment. The Committee notes that there are different provisions in s 48 in relation to comments about dead persons and comments about living persons.

<sup>&</sup>lt;sup>1764</sup> The Committee notes that such time frames are specified in the ACT and New Zealand provisions: *Coroners Act 1997* (ACT) s 55(1); *Coroners Act 2006* (NZ) s 48(2)(b).

<sup>&</sup>lt;sup>1765</sup> Victorian Bar, Submission no. 81, 13–14.

It was suggested to the Committee that the role of coroners is unduly limited by the focus of the jurisdiction on death investigation. The Committee believes that there is potentially great public benefit, in terms of identifying hazards and improving safety measures, to be gained from the investigation of serious incidents other than deaths. However, it considers that the resources potentially available to the coronial system are insufficient for such a radical extension of its role, 1766 which would involve activities resembling those of the Transport Accident Commission but in relation to a broader range of incidents. As the jurisdiction evolves increasingly towards a greater preventative role, the ability to investigate further categories of non-fatal events may become a more realistic possibility.

Finally, the Committee has observed that it is not possible to gauge accurately the effectiveness of coronial recommendations in the absence of any requirement for agencies and organisations to provide written responses to such recommendations, and in the absence of a formal system for monitoring such responses. The need for mandatory responses and monitoring of such responses will be discussed in the next section of this chapter.

Recommendation 77. That section 19 of the *Coroners Act 1985* be amended to include a requirement that a coroner must, whenever appropriate, make recommendations with respect to ways of preventing further deaths in similar circumstances and on any matter connected with the death including public health and safety or the administration of justice.

Recommendation 78. That the State Coroner prepare detailed guidelines for coroners in relation to the formulation of recommendations.

Recommendation 79. That the State Coroner's Office provide further training for coroners in relation to the formulation of recommendations.

Recommendation 80. That the *Coroners Act 1985* be amended to include a requirement, modelled on section 55 of the *Coroners Act 1997* (ACT), that a coroner shall not include in a finding or report under the Act a comment adverse to a person identifiable from the finding or report unless the coroner has, prior to the making of the finding or report, taken all reasonable steps to give to the person a copy of the proposed comment and a written notice advising the person that, within a specified period (being not more than 28 days and not less than 14 days after the date of the notice), the person may:

- (a) make a submission to the coroner in relation to the proposed comment; or
- (b) give to the coroner a written statement in relation to it.

<sup>&</sup>lt;sup>1766</sup> As the Committee discusses in chapter six, coroners already have jurisdiction to investigate non-fatal fires, but these investigations are relatively rare.

Recommendation 81. That the *Coroners Act 1985* be amended to require that all coronial recommendations be approved by the State Coroner and be made publicly available.

# The need for implementation and monitoring powers

A key issue for the effectiveness of the coronial system in preventing deaths and injuries is the extent of the obligations government departments and other organisations have to take notice of and implement a coroner's recommendations.<sup>1767</sup>

The Committee has discussed above the potential of such recommendations to save lives and prevent injuries in the community. However, as the New Zealand Law Commission has observed in relation to coronial recommendations in that jurisdiction:

the problem that has arisen is that there is no process for ensuring recommendations are brought to the attention of relevant agencies or individuals. Further, where recommendations are brought to the attention of the appropriate agency, there is no requirement that the agency must consider the recommendations or act on them. The ability of recommendations to achieve their purpose is therefore limited.<sup>1768</sup>

At present the main imperative for compliance with recommendations probably arises from the publicity given to coronial proceedings by the media and the resulting effect on public opinion.<sup>1769</sup> However, in many cases organisations have been able to disregard coroners' recommendations with impunity, even if another death occurs as a result of ignoring them.<sup>1770</sup>

This problem was highlighted by the RCADC, which referred to numerous instances where coronial recommendations were 'ignored or paid scant regard by the relevant authorities'.<sup>1771</sup> To overcome this problem the RCADC recommended that government departments or agencies which are the subject of coronial recommendations in relation to a death in custody be required to respond in writing to the Minister responsible for the department or agency, including a report as to what action if any is to be taken.<sup>1772</sup> This approach was subsequently adopted in the ACT and Northern Territory in relation to deaths in custody.

Such measures have been described as revolutionary to the extent that they impose a positive obligation on the part of people affected by a recommendation to respond in

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<sup>&</sup>lt;sup>1767</sup> Ian Freckelton, 'The Evolving Institution of Coroner' (1999) 24 Alternative Law Journal 156, 157.

<sup>&</sup>lt;sup>1768</sup> New Zealand Law Commission, Report no. 62, *Coroners*, 54, para 180.

<sup>&</sup>lt;sup>1769</sup> Ian Freckelton, 'The Evolving Institution of Coroner' (1999) 24 Alternative Law Journal 156, 157.

<sup>&</sup>lt;sup>1770</sup> Justin Malbon, 'Institutional Responses to Coronial Recommendations' (1998) 6 *Journal of Law and Medicine*, 35, 47.

<sup>&</sup>lt;sup>1771</sup> Ibid, 41; citing Royal Commission into Aboriginal Deaths in Custody, *National Report* (1991) vol 1.

<sup>&</sup>lt;sup>1772</sup> Royal Commission into Aboriginal Deaths in Custody, *National Report* (1991) vol 1, para 4.5.98.

some way to what coroners have found to be the cause of death and measures which could potentially avoid further deaths. They may also mark the beginning of a process leading to mandatory responses to other coronial recommendations. <sup>1773</sup> Indeed, recent amendments to the *Coroners Act 1993* (NT) have introduced such obligations for non-custodial agencies, in what could be regarded as a pioneering step towards achieving greater accountability.

In Victoria a coroner's recommendation does not have the same status as a judge's order, and there is no sanction for non-compliance. Under the Act a coroner may report to the Attorney-General on a death which the coroner has investigated, and s/he may also make recommendations to any Minister or public statutory authority, as noted earlier in this chapter.<sup>1774</sup> Section 21 of the Act provides that:

#### 21. Reports

- (1) A coroner may report to the Attorney-General on a death which the coroner investigated.
- (2) A coroner may make recommendations to any Minister or public statutory authority on any matter connected with a death which the coroner investigated, including public health or safety or the administration of justice.
- (3) A coroner must report to the Director of Public Prosecutions if the coroner believes that an indictable offence has been committed in connection with a death which the coroner investigated.<sup>1775</sup>

The above provisions are repeated in section 38 of the Act in relation to fires, ie with the word 'death' in each subsection replaced by 'fire'.

In addition to advising Ministers and public statutory authorities, it is the practice of the State Coroner's Office to send copies of coronial findings to anyone who may be interested or could benefit from the information in the finding. Troe For example, in a recent asbestos-related inquiry, the State Coroner sent a copy of the recommendations to 40 groups, including James Hardie Industries, WorkSafe, the Environmental Protection Authority and the Safety Institute of Australia. In the inquiry, the State Coroner recommended that the James Hardie Group consider working with appropriate government safety agencies in a major programme to

<sup>&</sup>lt;sup>1773</sup> Ian Freckelton, 'The Evolving Institution of Coroner' (1999) 24 Alternative Law Journal 156.

<sup>&</sup>lt;sup>1774</sup> Coroners Act 1985 s 21(2).

<sup>&</sup>lt;sup>1775</sup> Coroners Act 1985 s 19(2).

<sup>&</sup>lt;sup>1776</sup> Interview conducted with the State Coroner in 'The State Coroner', *Victoria Police Association Journal*, June 2000, 19.

<sup>&</sup>lt;sup>1777</sup> Record of Investigation into a Death, Coroner's Case No. 2286/04, State Coroner's Office, Victoria, 19 November 2004. Available at www.coronerscourt.vic.gov.au.

ensure that home renovators are advised on issues such as the identification of asbestos-related products and how to minimise risks when removing these products.

# Position in other jurisdictions

## **Australian Capital Territory**

Unlike the Victorian Act, the ACT legislation requires certain groups to respond to particular coronial recommendations, using the approach recommended by the RCADC. After completing an inquest into a death in custody, a coroner must report his or her findings to:

- (a) the Attorney-General; and
- (b) the custodial agency in whose custody the death occurred and to the Minister responsible for that agency; and
- (c) the Australian Institute of Criminology; and
- (d) if the deceased was an Aboriginal person or Torres Strait Islander an appropriate local Aboriginal legal service; and
- (e) any other person whom the coroner considers appropriate. 1778

The ACT Act also requires the coroner to make available a copy of the report of his or her findings into a death in custody to:

- (a) a member of the immediate family of the deceased or a representative of that member; and
- (b) a witness who appeared at an inquest into the death. 1779

Section 76 of the ACT Act further 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 receipt of the report. In its response the agency is required to include a statement of the action (if any) which has been, is being, or will be taken with respect to any aspect of the findings contained in the report. The Minister must then forward a copy of the response to the coroner. The coroner must in turn give a copy of the response to each person or agency to which the coronial report was given.

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<sup>&</sup>lt;sup>1778</sup> Coroners Act 1997 (ACT) s 72(1).

<sup>&</sup>lt;sup>1779</sup> Coroners Act 1997 (ACT) s 72.

<sup>&</sup>lt;sup>1780</sup> Coroners Act 1997 (ACT) s 76(1).

<sup>&</sup>lt;sup>1781</sup> Coroners Act 1997 (ACT) s 76(2).

<sup>&</sup>lt;sup>1782</sup> Coroners Act 1997 (ACT) s 76(3).

<sup>&</sup>lt;sup>1783</sup> Coroners Act 1997 (ACT) s 76(4).

Following its enactment the *Coroners Act 1997* (ACT) was described as marking the beginning of a new direction for coronial legislation in Australia in terms of increasing accountability. Dr Freckelton commented:

While these provisions are limited to findings in respect of deaths in custody, they mark a significant innovation in terms of requirement for responses by government bodies to coroner's findings ... The agencies are made to account to their Minister, and so to Parliament, as well as to the coroner, for what they do in response to fatalities. They do not have to do anything, but they do have to explain why they are not responding if that is the course they choose to adopt ... the initiative is to be welcomed.<sup>1784</sup>

However, Dr Freckelton has observed that the provisions are unsatisfactorily drafted in terms of promoting accountability insofar as the custodial agencies are required to respond to 'findings'. While in practice the formal document that contains the coroner's report will include any comments and recommendations, the ACT legislation requires clarification in relation to the obligation of agencies to respond to such comments and recommendations, as well as to findings.<sup>1785</sup>

## **Northern Territory**

As a result of recent amendments, the Northern Territory legislation goes further than that of the other jurisdictions in imposing mandatory responses to coronial recommendations. The Northern Territory legislation requires a coroner who holds an inquest into a death in custody to make such recommendations as he or she considers relevant to the prevention of future deaths in similar circumstances. The coroner must send such a report or recommendation 'without delay' to the Attorney-General. The coroner may also make reports or recommendations to the Attorney-General in relation to any deaths or disasters investigated by the coroner.

If the report or recommendation contains comment relating to an 'Agency' or the police force of the Northern Territory, the Attorney-General must, without delay, give a copy of the report or recommendation to the 'Chief Executive Officer' of the 'Agency' or the Commissioner of Police, as the case requires. <sup>1789</sup> If the report or recommendation contains comment relating to a 'Commonwealth department or agency' the Attorney-General must, without delay, give a copy of the report or

<sup>&</sup>lt;sup>1784</sup> Ian Freckelton, 'Glimpses of the Coroner's Future: The Coroners Act 1997 (ACT)', (1998) 6 *Journal of Law and Medicine* 1, 26–7.

<sup>&</sup>lt;sup>1785</sup> Ibid 26, 27.

<sup>&</sup>lt;sup>1786</sup> Coroners Act 1993 (NT) s 26(2).

<sup>&</sup>lt;sup>1787</sup> Coroners Act 1993 (NT) s 27(1).

<sup>&</sup>lt;sup>1788</sup> Coroners Act 1993 (NT) s 35(1), (2).

<sup>&</sup>lt;sup>1789</sup> Coroners Act 1993 (NT) s 46A (1). The 'chief executive officer' is defined as having the same meaning as in the *Public Sector Employment and Management Act 2005* (NT). The term 'Agency' is not defined in the statute.

recommendation to the Commonwealth Minister responsible for the administration of the department or agency.<sup>1790</sup>

If a Chief Executive Officer or the Commissioner of Police receives a copy of a coroner's report or recommendation he or she must, within three months after such receipt, give to the Attorney-General a written response to the findings in the report or to the recommendation.<sup>1791</sup> The response must include a statement of the action that the Agency or the police force is taking, has taken or will take with respect to the coroner's report or recommendation.<sup>1792</sup>

On receiving the response of the Chief Executive Officer or the Commissioner of Police, the Attorney-General:

- must, without delay, report on the coroner's report or recommendation and the response to the coroner's report or recommendation;
- may give a copy of his or her report to the coroner; and
- must table a copy of his or her report before the Legislative Assembly within three sitting days after completing the report.<sup>1793</sup>

The coroner may give a copy of the Attorney-General's report to:

- the senior next of kin<sup>1794</sup> (or their representative) of the person who died;
- a witness who appeared at the inquest the subject of the report (if any); and
- any other person who the coroner considers has sufficient interest in the inquest or investigation that is the subject of the report. 1795

Thus the Northern Territory legislation now extends a mandatory response regime, which was first trialled in Australia in relation to deaths in custody, to a wide range of death investigations. Ms Helen Roberts, Deputy Coroner of the Northern Territory, has informed the Committee 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.<sup>1796</sup> These are usually considered letters of response rather than pro-forma responses.

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<sup>&</sup>lt;sup>1790</sup> Coroners Act 1993 (NT) s 46A(2).

<sup>&</sup>lt;sup>1791</sup> Coroners Act 1993 (NT) s 46B(1).

<sup>&</sup>lt;sup>1792</sup> Coroners Act 1993 (NT) s 46B(2).

<sup>&</sup>lt;sup>1793</sup> Coroners Act 1993 (NT) s 46B(3).

<sup>&</sup>lt;sup>1794</sup> The term 'senior next of kin' is discussed in chapter 8.

<sup>&</sup>lt;sup>1795</sup> Coroners Act 1993 (NT) s 46B(4).

<sup>&</sup>lt;sup>1796</sup> Email, Helen Roberts, Deputy Coroner, Northern Territory, to Committee Legal Research Officer, 1 August 2008.

Ms Roberts stated that the Northern Territory Coroner is aware of the preventative potential of this pioneering legislative regime but also of the greater scrutiny which attaches to coronial recommendations where responses are obligatory, as well as the potential cost to the government of considering the recommendations. Consequently, the Coroner generally makes recommendations only after a public inquest, at which agencies that are the subject of proposed recommendations are given an opportunity to make submissions in relation to such recommendations.

#### **South Australia**

The South Australian legislation has also taken up the RCADC recommendations in relation to deaths in custody. In South Australia the Coroner's Court may add to its findings any recommendation that might, in the opinion of the Court, prevent, or reduce the likelihood of, a recurrence of an event similar to the event that was the subject of the inquest. 1797 As soon as practicable after the inquest, the Court must forward a copy of its findings and any recommendations to the Attorney-General. 1798 In the case of an inquest into a death in custody, if the Court has made a recommendation directed to a Minister or other agency or instrumentality of the Crown, it must forward a copy to that Minister, agency or instrumentality. The Minister or the Minister responsible for the agency or instrumentality must, within eight sitting days of the expiry of six months after receipt of the findings and recommendations, cause a report to be laid before each house of parliament giving details of any action taken or proposed to be taken in consequence of those recommendations, 1800 and forward a copy of the report to the State Coroner. 1801 The Committee notes that these provisions are more clearly drafted than the ACT provisions insofar as the mandatory response requirements apply both to findings and recommendations, rather than only to findings.

#### Queensland

In Queensland the legislation only requires that a coroner who has investigated the death of a person in care or custody give a copy of the findings and comments to the Attorney-General, the appropriate chief executive and the appropriate Minister (as defined in the section). There is no requirement in the Act that these persons respond to the findings or comments, nor is there a requirement that the recommendations be tabled in parliament.

<sup>&</sup>lt;sup>1797</sup> Coroners Act 2003 (SA) s 25(2).

<sup>&</sup>lt;sup>1798</sup> Coroners Act 2003 (SA) s 25(4)(a).

<sup>1799</sup> It must also forward a copy to each person who appeared personally or by counsel at the inquest and to any other person who, in the opinion of the Court, has a sufficient interest in the matter: *Coroners Act 2003* (SA) s 25(4)(b).

<sup>&</sup>lt;sup>1800</sup> Coroners Act 2003 (SA) s 25(5)(a).

<sup>&</sup>lt;sup>1801</sup> Coroners Act 2003 (SA) s 25(5)(b).

<sup>&</sup>lt;sup>1802</sup> Coroners Act 2003 (Qld) s 47.

#### New South Wales, Tasmania and Western Australia

The legislation in these jurisdictions does not impose mandatory responses in relation to coronial recommendations. In New South Wales a coroner or a jury may make such recommendations as they consider necessary or desirable in relation to any matter connected with a death, suspected death, fire or explosion, such as public health and safety.<sup>1803</sup> Such recommendations may include that a matter be investigated or reviewed by a specified person or body.<sup>1804</sup> However, the Act requires the State Coroner to make a written annual report to the Attorney-General containing a summary of the details of deaths in custody during the year. These reports are also published on the New South Wales Coroner's Court website, and the summaries include findings and recommendations.

In Tasmania a unique feature of the legislation is that it imposes a duty to make recommendations in that a coroner must, whenever appropriate, make recommendations with respect to ways of preventing further deaths and on any other matter that the coroner thinks appropriate. The legislation also provides, as does the legislation in Western Australia and Victoria, that a coroner may comment on any matter connected with the death, including public health and safety or the administration of justice. In Tasmania, as in Victoria, the coroner is entitled to report to the Attorney-General on any death that the coroner investigates, and to make recommendations to the Attorney-General on any matter connected with a death which the coroner investigated, including public health and safety or the administration of justice.

In Western Australia, where the death investigated is of a person held in care, the legislation requires the coroner to comment on the supervision, treatment and care of the person while in that care. The Tasmanian Act imposes a similar requirement, unlike the Victorian Act. In Western Australia the State Coroner must report annually to the Attorney-General on deaths which have been investigated in each year, including a specific report on the death of each person held in care. The Attorney-General is required, within 12 days of receipt of the report, to cause such a report to be laid before each house of parliament. The State Coroner is also empowered to

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<sup>&</sup>lt;sup>1803</sup> Coroners Act 1980 (NSW) s 22A.

<sup>&</sup>lt;sup>1804</sup> Coroners Act 1980 (NSW) s 22A (2).

<sup>&</sup>lt;sup>1805</sup> Coroners Act 1995 (Tas) s 28(2).

<sup>&</sup>lt;sup>1806</sup> Coroners Act 1995 (Tas) s 28(3); Coroners Act 1996 (WA) s 25(2); Coroners Act 1985 s 19(2).

<sup>&</sup>lt;sup>1807</sup> Coroners Act 1995 (Tas) s 30(1); Coroners Act 1985 s 21(1).

<sup>&</sup>lt;sup>1808</sup> Coroners Act 1995 (Tas) s 30(2). Coroners Act 1985 s 21(2).

<sup>&</sup>lt;sup>1809</sup> Coroners Act 1996 (WA) s 25(3).

<sup>&</sup>lt;sup>1810</sup> Coroners Act 1995 (Tas) s 28(5).

make recommendations to the Attorney-General 1811 and to make written recommendations to relevant agencies in relation to a death in care. 1812

## Law reform agencies

#### **RCADC**

The provisions in the ACT legislation relating to a death in custody were introduced in 1998 in response to recommendations by the RCADC in 1991. The RCADC proposed an administrative framework for the implementation of coronial recommendations in its recommendations 14, 15, 16 and 17. Ms Halstead comments that the four recommendations together constitute a 'step-by-step accountability circuit' and that therefore only full implementation of all four recommendations can achieve a systematic framework of accountability which fully protects the public interest.

#### RCADC recommendation 14 proposed:

That copies of the findings and recommendations of the coroner be provided by the Coroner's Office to all parties who appeared at the inquest, to the Attorney-General or the Minister for Justice of the State or Territory in which the inquest was conducted, to the Minister of the Crown with responsibility for the relevant custodial agency or department and to such other persons as the coroner deems appropriate. 1814

This recommendation has been implemented in the Act following an amendment to section 21 in 1999, as the Committee has discussed earlier in this chapter, although the provision only refers to Ministers and public statutory authorities, not 'such other persons as the coroner deems appropriate'.1815

However, the remaining three recommendations (15, 16 and 17) have not been implemented. RCADC recommendation 15 proposed:

That within three calendar months of publication of the findings and recommendations of the coroner as to any death in custody, any agency or department to which a copy of the findings and recommendations has been delivered by the coroner shall provide, in writing, to the Minister of the Crown with responsibility for that agency or department, its response to the findings and

<sup>&</sup>lt;sup>1811</sup> Coroners Act 1996 (WA) s 25(3).

<sup>&</sup>lt;sup>1812</sup> Coroners Act 1996 (WA) s 25(4).

<sup>&</sup>lt;sup>1813</sup> Royal Commission into Aboriginal Deaths in Custody, *National Report* (1991), vol 1, Recommendations 14–

<sup>18.</sup> As an aid to readers, these recommendations are listed in Appendix 7 to this report.

<sup>&</sup>lt;sup>1814</sup> Ibid Recommendation 14.

<sup>&</sup>lt;sup>1815</sup> It has been suggested that the legislation should be amended to include a wider distribution power: See Department of Justice, Victorian Implementation Review of the Recommendations from the Royal Commission into Aboriginal Deaths in Custody (October 2005), vol 1, 465.

recommendations which should include a report as to whether any action has been taken or is proposed to be taken with respect to any person.<sup>1816</sup>

#### RCADC recommendation 16 proposed:

That the relevant Ministers of the Crown to whom responses are delivered by agencies or departments, as provided for in Recommendation 15, provide copies of each such response to all parties who appeared before the coroner at the inquest, to the coroner who conducted the inquest and to the State Coroner. That the State Coroner be empowered to call for such further explanations or information as he or she considers necessary, including reports as to further action taken in relation to the recommendations.<sup>1817</sup>

#### RCADC recommendation 17 proposed:

That the State Coroner be required to report annually in writing to the Attorney-General or Minister for Justice, (such report to be tabled in Parliament), as to deaths in custody generally within the jurisdiction and, in particular, as to findings and recommendations pursuant to the terms of Recommendation 13 above and as to the responses to such Findings and recommendations provided pursuant to the terms of Recommendation 16 above.<sup>1818</sup>

The Victorian Aboriginal Justice Forum (the Forum) recently conducted a review on behalf of the Victorian Koori community and the State Government regarding the implementation of recommendations by RCADC. In 2002 the Forum asked government departments to make a self-assessment of each department's progress in implementing the RCADC recommendations. The Implementation Review Team was established in 2003 as a partnership between the State Government and the Koori community to assess these government responses in a review report.

The relevant government departments reported that there had been no progress towards the implementation of recommendations 15, 16 and 17.1820 The review report noted that the State Coroner had recommended in the Port Phillip deaths in custody inquiry that the mandatory response requirements proposed in RCADC recommendation 15 be introduced. However, the government had decided that the reporting and response arrangements between correctional agencies and the coroner were working well, and therefore it did not consider that developing such legislation

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<sup>&</sup>lt;sup>1816</sup> Royal Commission into Aboriginal Deaths in Custody, *National Report* (1991), vol 1, 173.

<sup>&</sup>lt;sup>1817</sup> Ibid Recommendation 16.

<sup>&</sup>lt;sup>1818</sup> Ibid Recommendation 17.

<sup>&</sup>lt;sup>1819</sup> For the self-assessment of the implementation of recommendations in relation to coronial inquiries, see table 1, 'Royal Commission into Aboriginal Deaths in Custody Recommendations, Descriptions and Implementation Status 2003' in Attachment 1 to Department of Justice, *Victorian Implementation Review of the Recommendations from the Royal Commission into Aboriginal Deaths in Custody Discussion Paper*, March 2004. Available at www.justice.vic.gov.au, 4–6.

<sup>&</sup>lt;sup>1820</sup> See Department of Justice, *Victorian Implementation Review of the Recommendations from the Royal Commission into Aboriginal Deaths in Custody* (October 2005), vol 1, 459.

was necessary at that time. Similarly, the review report noted that the coroner also does not have power to request further explanations as proposed by recommendation 16, nor is there a regime of reporting to the Attorney-General on an annual basis of the kind envisaged by recommendation 17. Findings, comments and recommendations are sent to the Attorney-General in individual cases only.<sup>1821</sup>

As an aid to readers of this report, the full list of RCADC recommendations relating to coronial investigations are listed in Appendix 7 to this report.

#### The State Coroner, Victoria

In 2000 the 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.<sup>1822</sup>

#### **New Zealand Law Commission**

The New Zealand Law Commission stated in its report in 2000 that, given the potential for action taken in response to coronial recommendations to save lives, it favours a proactive strategy towards achieving implementation of recommendations, as occurs in some other jurisdictions. Therefore it recommended that:

[W]here a coronial recommendation concerns a government agency, a Chief Coroner must give notice of that recommendation to the agency concerned, the Minister responsible for that agency, the Attorney-General, and any other agency or individual affected by the recommendation. The government agency 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. The Chief Coroner must include particulars of the government agency's response in the annual report from the Office of the Chief Coroner. <sup>1823</sup>

The Commission took the view that, while the Attorney-General should be notified of recommendations affecting government agencies, a Chief Coroner should be responsible for monitoring the implementation of recommendations, or reasons why implementation has been postponed or rejected, and should include this information in an annual report to the Attorney-General.

However, the Commission was concerned that enabling a Chief Coroner to report to parliament would interfere with the separation of powers, and so it was opposed to the tabling in parliament of an annual report. Instead it recommended that a Chief Coroner should produce an annual report from the Office of the Chief Coroner, a

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<sup>&</sup>lt;sup>1821</sup> Ibid 465.

<sup>&</sup>lt;sup>1822</sup> Deaths in Custody at Port Phillip Prison (State Coroner's Office, Victoria), Part 1, 208.

<sup>&</sup>lt;sup>1823</sup> New Zealand Law Commission, Coroners, Report no. 62, (2000) 60.

synopsis of which would be included in the annual Report of the New Zealand Judiciary.<sup>1824</sup>

In contrast to the recommendations of the Law Commission, the *Coroners Act 2006* (NZ) does not include a mandatory response regime for government agencies. The Act requires a coroner, after completing an inquiry, to send a certificate of findings to the 'Secretary', namely the chief executive of the responsible department of state, together with other information including all depositions of evidence admitted for the purpose of the inquiry and any specified recommendations or comments.<sup>1825</sup> The Act does not require a coroner to send a copy of the certificate to the Solicitor-General.

Interestingly, the Act provides for increased publication of coronial recommendations, the intended purpose being to improve their implementation. In its review of the Coroners Bill 2004, the New Zealand Justice and Electoral Committee stated:

We recommend the insertion of a provision to establish a register of coronial recommendations or summaries of such recommendations, and require that it be maintained as a part of the chief coroner's duties. This register should be available for public inspection. A register of coronial recommendations will help relevant organisations and the public to access findings readily, and facilitate the analysis of, and implementation of, such findings. We believe that this will enhance the ability of coroners to prevent similar deaths. 1826

Accordingly, the *Coroners Act 2006* provides that one of a Chief Coroner's functions is to set up and maintain a register, open for public inspection at all reasonable times, of summaries of coroners' specified recommendations or comments.<sup>1827</sup>

# Evidence received by the Committee

# The need for mandatory responses to coronial recommendations

Almost all of the witnesses to this inquiry who gave evidence on this issue supported the view that there should be mandatory responses to coronial recommendations. Many submitted that the RCADC recommendations regarding mandatory responses to recommendations, as adopted in different forms in the ACT and Northern Territory legislation, should be included in the Victorian Act. The view that there should be mandatory responses was shared by witnesses from within the coronial system, stakeholders representing the medical profession and various health-care organisations, witnesses from the legal profession including community legal

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<sup>&</sup>lt;sup>1824</sup> Ibid 58

<sup>&</sup>lt;sup>1825</sup> Coroners Act 2006 (NZ) s 84(4).

<sup>&</sup>lt;sup>1826</sup> New Zealand Justice and Electoral Committee, preface to Coroners Bill 2004 (NZ), 2.

<sup>&</sup>lt;sup>1827</sup> Coroners Act 2006 (NZ) s 5(ha).

<sup>&</sup>lt;sup>1828</sup> Victorian Institute of Forensic Medicine, *Submission no. 40*, 18–19.

<sup>&</sup>lt;sup>1829</sup> See for example Victorian Surgical Consultative Council, *Submission no. 21*, 3; Australian Medical Association Victoria, *Submission no. 38*, 3; General Practice Divisions Victoria, *Submission no. 44*, 5; Royal Children's

centres, <sup>1831</sup> family witnesses, <sup>1832</sup> and other witnesses with an interest in death and injury prevention. <sup>1833</sup> These witnesses generally did not make submissions as to which particular categories of cases such provisions should apply to, but many were clearly of the view that such provisions should extend well beyond deaths in custody. <sup>1834</sup>

Given the number of witnesses who made submissions in relation to mandatory responses, the Committee will only refer to parts of this evidence in detail. The Coroner's Office stated:

Although under the current Act a coroner has jurisdiction to report his or her findings and recommendations are public documents open to general distribution, there is no obligation to implement or respond to them. The only incentive or sanction to ensure that recommendations are considered and acted upon is the potential adverse publicity brought about by the coroner's increasingly prominent community role, substantial media/public interest and the pressure these bring to bear.<sup>1835</sup>

The Office went on to specify what they considered an appropriate reporting regime:

At a minimum, Government agencies should be required to respond to recommendations made by coroners within six months of delivery of the finding, recommendations or comments. These responses should indicate reception of the recommendations, changes and planned changes made in response to the recommendations and, where the recommendations have been

Hospital, *Submission no. 47*, 2; Australian Council for Safety and Quality in Health Care, *Submission no. 51*, 7; Medical Practitioners Board of Victoria, *Submission no. 56*, 4; Royal College of Nursing, *Submission no. 63*, 7.

1830 Victorian Bar, *Submission no. 81*, 19 — this submission observes that '[t]he tabling in Parliament of coronial recommendations, requiring a response from the Government, and that the response be tabled would certainly add to transparency and accountability on the part of the Executive'; Victoria Legal Aid, *Submission no. 34*, 5; Maurice Blackburn Cashman, *Submission no. 42*, 8.

<sup>1831</sup> See for example Federation of Community Legal Centres, *Submission no. 55*, 18–19; Hugh de Kretser, Brimbank Melton Community Legal Centre, *Minutes of Evidence*, *19 September 2005*, 110; Disability Discrimination Legal Service, *Submission no. 29*, 13; Vivienne Topp, Mental Health Legal Centre, *Minutes of Evidence*, *5 December 2005*, 303; Pauline Giliberto, Springvale Monash Legal Centre, *Minutes of Evidence*, *20 September 2005*, 138.

<sup>1832</sup> See for example Graeme Bond, *Submission no. 48*, 12; Caroline Storm, *Minutes of Evidence*, *22 August 2005*, 14; Lynette King, *Minutes of Evidence*, *22 August 2005*, 43, 45; Anne Anderson, *Submission no 43*, 5; David and Margrit Kaufmann, *Submission no. 71*, 8; David and Margrit Kaufmann, *Minutes of Evidence*, *22 August 2005*, 64.

<sup>1833</sup> See for example Transport Safety Industry Group, *Submission no. 75*, 2; Ian Hunter, Metropolitan Fire Brigade, *Minutes of Evidence*, *5 December 2005*; Life Saving Victoria, *Submission no. 53*, 3; Office of the Emergency Services Commissioner, *Submission no. 74*, 4; Association for the Prevention of Medical Errors, *Submission no. 79*, 23–4.

<sup>&</sup>lt;sup>1834</sup> See for example Ian Freckelton, *Minutes of Evidence*, 20 September 2005, 208.

<sup>&</sup>lt;sup>1835</sup> Coroner's Office, Submission no. 77, 132–3.

rejected, the reasons for their rejection. ... The State Coroner should then be required to include these responses in his annual report to Parliament. 1836

The submission by VIFM contains a useful summary of the arguments in favour of mandatory responses:

Although recommendations are presently made by some coroners, responses to these recommendations are not mandatory and there is no system for evaluating the implementation of recommendations. Coroners' recommendations can be completely ignored. This cannot be right. The community should at least be assured that the coroner's recommendations have been considered by the relevant agencies, organisations and individuals. The lack of response to their recommendations also means that there is little feedback to coroners regarding the practicality of their recommendations. This may result in the subsequent release of coronial recommendations which are not informed by real world constraints.

The coronial system is one in which a large amount of time and effort is spent investigating the causes of fatalities, and in some cases considering possible remedies for these tragedies. However, at present the system does not sufficiently ensure that the community benefits from that information by helping to prevent the preventable.<sup>1837</sup>

An issue that requires consideration in relation to proposals for mandatory responses is whether there should be a specified time frame for such responses and, if so, what length of time should be specified. The Committee has already noted that section 76 of the ACT *Coroners Act* and section 46B of the Northern Territory *Coroners Act* both provide a time frame of three months for responses to coronial recommendations. VIFM submitted that responses should be required within a specified time frame so that the issues raised by the coroner are addressed in a timely manner, and so that proper monitoring of responses is possible. 1838 VIFM and the State Coroner submitted that the Act should require organisations to respond to coroners' recommendations within six months, 1839 while other witnesses expressed a preference for the RCADC's recommended time frame of three months. 1840

A further issue is whether the State Coroner should have the power to comment on the adequacy of responses to coronial recommendations. VIFM submitted that the State Coroner should be empowered to comment on the adequacy of an agency's response to a coronial recommendation in an annual report tabled in Parliament. The State Coroner expressed support for the introduction of annual reports to Parliament

<sup>&</sup>lt;sup>1836</sup> Ibid 133.

<sup>&</sup>lt;sup>1837</sup> Victorian Institute of Forensic Medicine, Submission no. 40, 18–19.

<sup>&</sup>lt;sup>1838</sup> Ibid 23.

<sup>&</sup>lt;sup>1839</sup> Victorian Institute of Forensic Medicine, *Submission no. 40*, 37; State Coroner's Office, Submission no. 70, Recommendation 5.2, 20.

<sup>&</sup>lt;sup>1840</sup> See for example Federation of Community Legal Centres, *Submission no. 55*, 18; cf Hugh de Kretser, Brimbank Melton Community Legal Centre, *Minutes of Evidence*, *19 September 2005*, 111.

each year, suggesting that this could potentially enable the drawing together and synthesis of recommendations by the various coroners throughout the State. Such reports could also include comments on the responses by the State Coroner and statistics on the implementation of all the recommendations made in the previous year. A useful example of such an approach appears in the annual Ontario Report on Inquests. In Ontario agencies asked to respond to recommendations are given the opportunity to evaluate their own responses based on a list of codes representing different degrees of implementation or reasons for non-implementation, failing which staff at the Chief Coroner's Office will assign appropriate response codes. The reports contain detailed statistical analysis of responses to recommendations made in all of the inquests which took place in a particular year. 1842

Another significant issue raised by the proposal that there be mandatory responses to coronial obligations is whether such obligations should be confined to the public sector or should apply to organisations in the private sector as well. State Coroner Mr Johnstone told the Committee that mandatory responses should be required initially of public sector organisations, followed by private sector organisations once they have been further educated about the preventative role of the coronial system.<sup>1843</sup> In contrast, VIFM submitted that mandatory response provisions should also apply to private sector organisations, since deaths do not only occur within the sphere of public regulations, and private organisations may not have as many entities to which they are accountable.<sup>1844</sup>

However, the FCLC expressed concern with the State Coroner's suggestion that only government departments should be required to respond to recommendations, citing as an example the operation by private companies of two prisons in Victoria as well as various immigration detention centres around the country. Mr Hugh de Kretser, principal community lawyer of Brimbank Community Legal Centre, told the committee that it is important that such private agencies are not excluded, but suggested that the Act should require that an organisation's resources and ability to respond be taken into account in relation to mandatory response obligations.<sup>1845</sup>

The FCLC strongly supports mandatory responses to coronial recommendations and it supports RCADC recommendation 15 in this area. The FCLC referred to an inquest into the shooting death of a prisoner where the coroner's recommendations were successfully implemented as 'an excellent example of the way the coronial process can achieve significant policy reform'. <sup>1846</sup> In that case, shortly after the inquest Corrections Victoria released an amended firearms policy. However, other

<sup>&</sup>lt;sup>1841</sup> Graeme Johnstone, State Coroner's Office, Minutes of Evidence, 19 September 2005, 81.

<sup>&</sup>lt;sup>1842</sup> Office of the Chief Coroner, Toronto, Ontario, 2002 Report on Inquests (October 2004).

<sup>&</sup>lt;sup>1843</sup> State Coroner Graeme Johnstone, *Minutes of Evidence*, 19 September 2005, 79.

<sup>&</sup>lt;sup>1844</sup> Victorian Institute of Forensic Medicine, Submission no. 40, 23.

<sup>&</sup>lt;sup>1845</sup> Hugh de Kretser, Brimbank Melton Community Legal Centre, *Minutes of Evidence*, 19 September 2005, 111.

<sup>&</sup>lt;sup>1846</sup> Ibid, 110.

recommendations were not implemented, and the FCLC had difficulty tracking the progress of these because of the lack of mandatory reporting.

However, one problem the FCLC anticipates if such provisions are introduced is that large organisations and government bodies will appeal the findings of inquests to the Supreme Court if the recommendations affect their operations, which will occur at the expense of families who lack the funds to contest such appeals.<sup>1847</sup>

The FCLC also told the Committee that families should be involved in the reporting process, as they are interested in knowing what happens with recommendations, and that they should receive letters on a regular basis (for example, at six-monthly intervals) to update them on the implementation of any recommendations.<sup>1848</sup>

It is very important for them to feel that the life lost of their loved one is not a waste. 1849

#### The FCLC submitted that:

By making coronial recommendations optional when in fact it's the recommendations themselves that are central to death prevention we are concerned that the Victorian system is putting the focus on blame rather than prevention.<sup>1850</sup>

The Committee found that a strong theme emerging from the evidence of family members was the need for coronial recommendations to be taken seriously by the agencies to which they are directed. Some of these witnesses agreed with the proposal that coronial recommendations should be the subject of mandatory responses required to be tabled in Parliament.<sup>1851</sup> Several expressed their considerable frustration at the lack of any enforceable requirement for coroners' recommendations to be implemented. Mrs Kaufmann told the Committee:

Enforceability of recommendations: had recommendations in previous inquests been heeded by the organisations involved — that is, the police — Mark might still be alive. Therefore we feel that recommendations should be enforceable, in particular those recommendations pertaining to government bodies. There is no point inquiring into a problem, discovering areas in need of fixing and then working out recommendations to address the problem if the pertinent parties are at liberty to ignore or dilute the recommendations. 1852

<sup>&</sup>lt;sup>1847</sup> Federation of Community Legal Centres, Submission no. 55, 19.

<sup>&</sup>lt;sup>1848</sup> Pauline Spencer, Federation of Community Legal Centres, *Minutes of Evidence*, 19 September 2005, 114.

<sup>&</sup>lt;sup>1849</sup> Ibid.

<sup>&</sup>lt;sup>1850</sup> Federation of Community Legal Centres, Submission no. 55, 17.

<sup>&</sup>lt;sup>1851</sup> Lynette King, *Minutes of Evidence*, 22 August 2005, 49.

<sup>&</sup>lt;sup>1852</sup> Margrit Kaufmann, *Minutes of Evidence*, *22 August 2005*, 64. See also David and Margrit Kaufmann, *Submission no. 71*, 8.

Similarly, Ms Lynette King told the Committee of her disappointment on discovering that the recommendations which arose from the inquest into the death of her mother in an aged care facility had not been implemented:

It was certainly our intention, and we understood it to be the coroner's, to prevent similar things happening to other people, so those recommendations we saw as a big plus, as most important and certainly needing to be and able to be implemented. To find that the places they were to be sent to were not expected to respond blew my mind ... <sup>1853</sup>

This is why the coroner's process was so important for us. It was to highlight the failures within a number of areas across a number of facilities. So when those recommendations came down, even though they only dealt with the medication because that was all that could be dealt with, to find that they need not be responded to or enacted in any way was a huge failure in the overall system.<sup>1854</sup>

Family witnesses such as the Kaufmanns also expressed concern that there is no mechanism in place for informing families about the progress, or lack of progress, in the implementation of recommendations.<sup>1855</sup>

We and the public will not be advised as to the accountability of those persons and organisations involved in Mark's death. We believe that we and the public should be informed. There is no mechanism to inform us of any progress or lack thereof in the implementation of any recommendations. There is no public accountability for any non-enforcement. Nothing has frustrated or enraged us more than the fact that there is no enforceability. 1856

When asked by the Committee during the public hearings about the difficulties posed by coroners making inconsistent recommendations in relation to individual cases, Mr Kaufmann commented that, if coroners know that a recommendation and responses to it are going to be put before Parliament, 'they are going to be very careful how they would frame that recommendation'. The Committee considers that this argument is supported by the approach taken by the Northern Territory Coroner when making recommendations, as referred to above.

The Committee notes that much has been written over the years about preventable deaths which have occurred as a result of there being no requirement for government departments and agencies to respond to coronial recommendations. A number of examples of deaths considered to have been avoidable were referred to in evidence to the Committee. For instance, the submission by the TISG submitted:

<sup>1855</sup> David and Margrit Kaufmann, Submission no. 71, 8.

<sup>&</sup>lt;sup>1853</sup> Lynette King, Minutes of Evidence, 22 August 2005, 43.

<sup>&</sup>lt;sup>1854</sup> Ibid 45.

<sup>&</sup>lt;sup>1856</sup> Margrit Kaufmann, *Minutes of Evidence*, *22 August 2005*, 64. See also David and Margrit Kaufmann, *Submission no. 71*, 8.

<sup>&</sup>lt;sup>1857</sup> David Kaufmann, *Minutes of Evidence*, 22 August 2005, 67.

Yes there should be responses required to specific recommendations. Case in point regards the planning of housing estates to properly allow service vehicles access without risk to the inhabitants. Despite recent deaths and specific recommendations to the appropriate authorities nothing has happened and the planning guidelines have not even noted these recommendations. Where a Council for example, attempts to uphold the intent of a recommendation it is overturned at a higher authority. 1858

While many witnesses were in favour of mandatory responses, the Committee notes that several expressed the view that coroners should have enforcement powers in relation to recommendations, rather than relying on mere responses. Those who were sceptical about the propensity of bureaucracies to respond in a meaningful way tended to consider that coroners should have 'teeth'. For example, criminologist Dr Maartje Van-der-Vlies told the Committee:

The coroners need the power not to make recommendations but make directions. 1860

However, a number of witnesses observed that the introduction of such powers would be highly problematic. One reason is that two coroners looking at the same issue may in some cases make different recommendations. Another reason is that in some cases coroners' recommendations are impracticable and therefore cannot be implemented. There are many other reasons that such a proposal would not be practical, and the evidence was strongly weighted against the idea of coroners having powers of sanction to enforce the implementation of recommendations.

Finally, a notable exception to the view that there should be mandatory responses to coronial recommendations was the submission by former coroner Ms Heffey. Ms Heffey submitted that she is opposed to the idea of mandatory responses, suggesting that the State Coroner may lack sufficient information to assess such responses and could be embarrassed in the event of a further death in similar circumstances which was not foreseen by a specific recommendation. Ms Heffey's view is that:

<sup>&</sup>lt;sup>1858</sup> Transport Industry Safety Group, Submission no. 75, 2.

<sup>&</sup>lt;sup>1859</sup> See for example Mike Zaccaro, Victorian Aboriginal Legal Service, *Minutes of Evidence*, *5 December 2005*, 294.

<sup>&</sup>lt;sup>1860</sup> Maartje Van-der-Vlies, Minutes of Evidence, 22 August 2005, 37.

<sup>&</sup>lt;sup>1861</sup> See for example Eric Wigglesworth, Monash University Accident Research Centre, *Minutes of Evidence*, *28 November 2005*, 222.

<sup>&</sup>lt;sup>1862</sup> Mark Cannon, Springvale Monash Legal Service, *Minutes of Evidence*, 20 September 2005, 138.

<sup>&</sup>lt;sup>1863</sup> See for example Ian Freckelton, *Minutes of Evidence, 20 September 2005*, 208; Eric Wigglesworth, *Minutes of Evidence, 28 November 2005*, 222. See also Justin Malbon, 'Institutional Responses to Coronial Recommendations' (1998) 6 *Journal of Law and Medicine*, 35, 43.

<sup>&</sup>lt;sup>1864</sup> Jacinta Heffey, Submission no. 33, 25.

The greatest incentive to comply with a coronial recommendation should be the public odium in the event of non-compliance leading to a further death. 1865

However, Ms Heffey observed that the persons involved in any such death would have the opportunity to explain publicly why the recommendation could not be implemented.<sup>1866</sup>

## Monitoring responses to recommendations

Evidence to the Committee suggests that there are two main advantages to improved monitoring of recommendations. The first is that such monitoring would provide an opportunity for critical evaluation of responses to specific recommendations. The second is that it would provide valuable information allowing the effectiveness of coronial recommendations to be measured more accurately.

In relation to critical evaluation, VIFM submitted that 'at the very least' the State Coroner should be empowered to comment on the adequacy of an agency's response to a coronial recommendation in an annual report tabled in Parliament. VIFM suggested that further monitoring may need to be undertaken by government agencies such as the Victorian WorkCover Authority, which has an enforcement role in ensuring that health and safety improvements are implemented in the workplace. VIFM submitted that consideration should be given to allocating the monitoring of implementation of coronial recommendations to a centralised body within government. For example, the UK Home Office position paper *Reforming the Coroner and Death Certification Service* recommends that all coroners' reports be sent to the Health and Safety Executive. 1869

In relation to the effectiveness of coronial recommendations, a large number of witnesses submitted that it is difficult to measure whether coronial recommendations are being implemented because there is no formal process by which this is assessed. There is currently a lack of monitoring of the implementation of coronial recommendations. The task of monitoring such implementation is by nature complex and potentially onerous, separately given the absence of mandatory responses. Mr Johnstone told the Committee that mandatory responses are 'essential' for coroners

<sup>&</sup>lt;sup>1865</sup> Ibid.

<sup>&</sup>lt;sup>1866</sup> Ibid.

<sup>&</sup>lt;sup>1867</sup> Victorian Institute of Forensic Medicine, Submission no. 40, 23.

<sup>&</sup>lt;sup>1868</sup> Ibid.

<sup>&</sup>lt;sup>1869</sup> Ibid.

<sup>&</sup>lt;sup>1870</sup> See for example, Victorian Institute of Forensic Medicine, *Submission no. 40*, 18-19, David Ranson, *Submission no. 19*, 62. Federation of Community Legal Centres, *Submission no. 55*, 19.

<sup>&</sup>lt;sup>1871</sup> Victorian Institute of Forensic Medicine, Submission no. 40, 23.

to learn about how effective their recommendations are and where they have not been effective. 1872

Dr Freckelton observed that it would be very helpful to know the implementation rate of coroners' recommendations and that no such information is available at present. He observed that some recommendations are not amenable to implementation because they are ill-informed and unrealistic, but that if that was the case to a significant extent then it would be useful for coroners to have better feedback regarding unsatisfactory recommendations. On the other hand, to the extent that coroners are making good recommendations which are advanced but ignored, the community needs to know more about that as well. Mandatory responses would 'start to enable data-informed decision making about how to adjust and evolve the coroner's jurisdiction in this state'.<sup>1873</sup>

The discussion paper asked who should be responsible for monitoring responses to coronial recommendations. Some witnesses suggested that this should be the responsibility of the Attorney-General, while others were of the view that this should be done by the Coroner's Office.<sup>1874</sup> For example, Mr Bond submitted:

The State Coroner should be responsible [for monitoring implementation] and should have the necessary staff to follow up on responses.<sup>1875</sup>

The FCLC commented that an advantage of coroners being responsible for implementation of their own recommendations is that a coroner will already have been involved in the investigation and will be familiar with the facts of the case.<sup>1876</sup>

Ms Helen Rowan, Family Services Manager at the Royal Children's Hospital, also submitted that the coroner should be responsible for overseeing the implementation of coroners' recommendations. Ms Rowan proposed an implementation model which would involve the establishment of a consultative group to coordinate the implementation process. This group would identify relevant stakeholders and invite participation in a working party, which would plan and implement the interventions and provide an interim and final report to the coroner in relation to the implementation.

Finally, the MPBV, while reserving its opinion, commented in its submission that giving the coroner an ongoing role in monitoring the implementation of recommendations would constitute a fundamental change in the traditional role of the

<sup>&</sup>lt;sup>1872</sup> Graeme Johnstone, State Coroner's Office, *Minutes of Evidence*, 19 September 2005, 81.

<sup>&</sup>lt;sup>1873</sup> Ian Freckleton, *Minutes of Evidence*, 20 September 2005, 208.

<sup>&</sup>lt;sup>1874</sup> See for example Victorian Aboriginal Legal Service, *Submission no. 57*, 10.

<sup>&</sup>lt;sup>1875</sup> Graeme Bond, Submission no. 48, 12.

<sup>&</sup>lt;sup>1876</sup> Federation of Community Legal Centres, Submission no. 55, 19.

coroner. 1877 The Committee also has concerns about the extent of monitoring which is possible and desirable for the coroner to undertake.

Requiring mandatory responses to recommendations is identified by most witnesses as the minimum level of monitoring which should be imposed. The next stage would be the assessment of the appropriateness and adequacy of responses, which could also be undertaken by the Coroner's Office and its conclusions included in its annual report.

However, as noted above by VIFM, to go beyond this level of monitoring is potentially an onerous task, and a careful cost/benefit analysis would need to be undertaken before its value could be properly assessed. It is likely that the only realistic monitoring which could be done beyond the receipt and assessment of a mandatory response would be dependent on the voluntary reporting by relevant agencies of their implementation progress. Such a process is very resource intensive, requiring periodic requests for updates, inevitable follow-up where responses are not provided or are inadequate, and subsequent assessment of responses. It is also susceptible to non-compliance if there is no obligation by agencies to report beyond the initial mandatory response. Further, self-assessment can be subject to a lack of rigour and a tendency to portray performance in the best possible light. Responses can also lack clarity in terms of time frames, as for example when a recommendation may be supported subject to budgetary constraints. The Committee notes that the very nature of a recommendation is non-mandatory, and hence continued compliance monitoring can only serve as a continuing public airing of non-compliance or lack of progress. Where agencies choose to respond this will often be with a view to inhibiting rather than enhancing transparency, if they perceive the former to be in their best interests.

# The need for increased publication of coronial recommendations

#### Media releases

Ms Heffey submitted that all recommendations should be issued from the State Coroner's Office in the form of a press release, as occurs in Ontario. Recommendations should not come from individual coroners, but any which they wish to see made should be reviewed by the State Coroner through a process of consultation with the individual coroner. This would prevent the devaluing of recommendations by impractical or otherwise uninformed features that might be dismissed by parties the subject of such recommendations. The State Coroner should have available a panel of experts to provide independent advice before a recommendation is publicly issued. The recommendations should not identify any person or institution but be in general terms as much as possible. In addition to the press release, the recommendations should be forwarded to all interested parties and

<sup>&</sup>lt;sup>1877</sup> Medical Practitioners Board of Victoria, Submission no. 56, 5.

<sup>&</sup>lt;sup>1878</sup> Jacinta Heffey, Submission no. 33, 24.

<sup>&</sup>lt;sup>1879</sup> Ibid 25.

all agencies that might be affected by the recommendations. Ms Heffey suggested that the State Coroner should have the power to issue press releases in relation to potential, as distinct from actual, deaths where evidence has been brought to his or her notice of life-threatening injuries and there is a risk that deaths may occur in similar circumstances in future. An example is where the coroner is informed of a design fault in a commonly used product and no warnings have been issued in relation to the problem. 1881

## Internet publication of recommendations

Mr Mark Cannon of Springvale Monash Legal Service (SMLS) told the Committee that the State Coroner's Office website needs to be improved, particularly in relation to the publication of recommendations. At present the website contains a limited number of 'findings of public interest'. Mr Cannon suggested that the NCIS contains information that is in the public interest and that the current limited availability of the information (to researchers and government agencies) tends to create a perception of secrecy about the coronial process and findings. SMLS recommended that the Coroner's Office website contain a well-indexed database of coronial findings and recommendations, suggesting that the recommendations could be published in an annual report both online and in hard copy. 1882 This would assist with the implementation of recommendations and would be relevant to the public in general, to public interest groups and to parties with an interest in coronial proceedings. SMLS cited as an example the State Coroner's provision, on request, to Ford Motor Company of 60 case findings which enabled the company to identify safety improvements for its vehicles. 1883 SMLS considers that the website is a powerful tool that could provide the public with a large amount of information that could help protect the safety of Victorians. 1884

#### Discussion and conclusion

The Committee is greatly concerned that, while considerable resources are expended in the process of investigating deaths and formulating recommendations arising from such investigations — particularly inquests — this may be a wasteful exercise if the recommendations can be ignored by those to whom they are directed.<sup>1885</sup>

The Committee agrees with the conclusion of Dr Freckelton and Associate Professor Ranson that:

<sup>1881</sup> Ihid

<sup>&</sup>lt;sup>1880</sup> Ibid.

<sup>&</sup>lt;sup>1882</sup> Mark Cannon, Springvale Monash Legal Service, *Minutes of Evidence*, 20 September 2005, 136,138.

<sup>&</sup>lt;sup>1883</sup> Ibid 136.

<sup>&</sup>lt;sup>1884</sup> Ibid.

<sup>&</sup>lt;sup>1885</sup> See for example Victorian Institute of Forensic Medicine, Submission no. 40, 23.

There is much to be said for bodies being compelled to report to a legal authority such as the Attorney-General regarding what response, if any, they propose to make in respect of recommendations made as a result of a death. Such an obligation does not compel compliance with recommendations but does mandate responsiveness in the public interest and on the public record. If the community expends considerable sums of money on public inquests, this would seem to be a modest and proportionate provision for monitoring assessment of considered proposals arising from deaths that may have been avoidable.<sup>1886</sup>

The Committee's view is that the ability of the coronial system to prevent death and injury would be substantially improved by the implementation of the accountability framework recommended by the RCADC, particularly the mandatory response regime which has been adopted in different forms in the ACT, the Northern Territory and South Australia. The Committee considers that limiting such an approach to cases involving deaths in custody would be too tentative and difficult to justify on a public policy basis, given the number of deaths which occur in circumstances involving non-custodial agencies. The Northern Territory legislation provides a working example of a mandatory response system that applies to non-custodial matters.

The potential benefits that would arise from a system of mandatory responses are numerous. The Committee considers that such a system would ensure greater levels of accountability by placing responses on the public record, and it would increase the likelihood that coronial recommendations will be brought to the attention of department heads. Such a system would also place coroners' findings, comments and recommendations in the spotlight, ensuring a trend towards greater professionalism within the jurisdiction, while providing coroners with the tools required to develop more effective recommendations. In addition, the responses would provide the data required for proper assessments of implementation rates and therefore of the effectiveness of the role of coroners. Finally, and importantly, increasing levels of accountability would provide relief to grieving families who rightly demand systemic changes designed to avoid further deaths.

Accordingly, the Committee considers that the Act should be amended to incorporate the proposals in RCADC recommendations 15, 16 and 17, and that the application of the accountability framework should not be restricted to deaths in custody. The Committee does not consider that the application of these provisions should be restricted to recommendations directed towards government departments and agencies, as is the case in the Northern Territory. The Committee considers that responses should also be mandated from incorporated companies and other private agencies, and from community organisations, peak organisations and individuals where appropriate. Those covered by the obligation should be specified in the Act.

Further, in contrast to the time frame envisaged by RCADC recommendation 15, the Committee considers that a time frame of six months for responses to coronial

<sup>&</sup>lt;sup>1886</sup> Ian Freckelton and David Ranson, *Death Investigation and the Coroner's Inquest* (2006) 679.

recommendations would allow adequately for consideration of recommendations directed towards complex systemic problems.<sup>1887</sup>

The Committee considers that a summary of all cases in which recommendations have been made should be included in an annual report by the State Coroner's Office to be tabled in Parliament and published on the State Coroner's website. The Committee notes that in the ACT such a report is included in the annual report of the combined Magistrates Courts<sup>1888</sup> and considers that a similar approach could be adopted in Victoria.

In relation to the question of what level of monitoring of compliance with coronial recommendations should be required, the Committee considers that mandatory responses should be subject to an assessment process undertaken by the Coroner's Office, the report of which should also be included in the Coroner's annual report and on the website.

This task could be performed by an adequately resourced research unit within the Coronial Services Centre. The establishment of such a research unit has been recommended earlier in this chapter. The Committee considers that coroners should have ready access to such information, given their knowledge of the subject matter of investigations, but that coroners should be able to focus on the task of investigating cases rather than monitoring compliance.

The Committee agrees with VIFM that any further monitoring should normally be undertaken by specialist agencies such as the Victorian WorkCover Authority. The Committee believes, however, that the Coroner's Office could play a role in following up recommendations which it considers have particular public importance and where another relevant body does not exist which could take on this role. The Committee therefore recommends that the coroner be given the power under the Act to call for additional information in relation to the implementation of recommendations and that guidelines be developed to determine the parameters within which this power will be exercised.

The Committee considers that greater implementation of recommendations would be facilitated by improving their publication and dissemination to relevant agencies and organisations, and by increasing their availability to those who wish to conduct online searches for information. Earlier in this chapter the Committee discussed the level 1 and level 2 access restrictions which apply to the detailed information contained on the NCIS database, which are necessary for privacy considerations. The Committee considers that a third level of easily accessible information needs to be developed for general public access, in order to increase the community's awareness of the injury

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<sup>&</sup>lt;sup>1887</sup> The Committee notes that the specified time frame for responses in the ACT and Northern Territory is three months and in South Australia six months.

<sup>&</sup>lt;sup>1888</sup> See www.courts.act.gov.au/magistrates/.

prevention measures identified in coroners' recommendations and to improve implementation rates as a result.

The Committee notes that the existing list of 'findings of public interest' available on the State Coroner's Office website is limited to a relatively small number of cases. Further, while the NCIS has a useful webpage containing links to the published findings of other Australian coronial jurisdictions, the Committee considers that in future it will be important for the combined recommendations of coronial investigations around the country to be available online in a form that can be searched effectively by any interested person or organisation. Therefore, the Committee recommends that the NCIS, in conjunction with the State Coroner, consider the development of a comprehensive, categorised and readily searchable online database of all recommendations by State and Territory coroners.

#### Recommendation 82. That the *Coroners Act 1985* be amended to:

- a) empower a coroner to refer findings and/or recommendations to any individual or agency and require that individual or agency to provide, within six calendar months, a written response including a report as to whether any action has been taken or is proposed to be taken in response to the recommendation.
- b) identify those agencies and individuals to which this section applies, which at a minimum will include government departments or agencies and incorporated companies.

Recommendation 83. That the *Coroners Act 1985* be amended to require the coroner to provide a copy of the response referred to in recommendation # above to:

- a) the senior next of kin of the person whose death is mentioned in the coroner's findings or their representative;
- b) a witness who appeared at an inquest into the death the subject of the findings; and
- c) any other person who the coroner considers has sufficient interest in the inquest or investigation the subject of the findings.

Recommendation 84. That the *Coroners Act 1985* be amended to empower the State Coroner to call for such further explanations or information as he or she considers necessary, in relation to the implementation of recommendations.

Recommendation 85. That the *Coroners Act 1985* be amended to require:

- a) the State Coroner to include in the Coroner's annual report to Parliament:
  - i) a summary of all coronial investigations in which recommendations have been made; and

- ii) a summary of responses to the recommendations made in the previous year, including a list of those recommendations which are still awaiting implementation or responses.
- b) that the State Coroner's annual report be tabled in Parliament.
- c) that the State Coroner's annual report be published on the website of the State Coroner's Office.

Recommendation 86. That the National Coroners Information System, in conjunction with the State Coroner, consider the development a comprehensive, categorised and readily searchable online database of all recommendations by State and Territory coroners.

# **Alternative systems**

The Committee examined relevant jurisdictions to consider existing or proposed alternative systems for implementing coronial recommendations. The system in Ontario and a model proposed in the review of Queensland coronial law that is based on the Ontario system were identified by the Committee as alternative systems to consider in this report.

# The Ontario regional coroner review system

In this system coroners hold informal meetings with organisations to discuss the circumstances surrounding particular deaths, usually in the presence of independent experts, and discuss recommendations which would prevent similar deaths. The organisations may then enter into agreements with the coroner which stipulate the measures required to be taken to avoid future deaths. These agreements may be monitored by coroners and affected families for compliance, although there is no actual penalty for non-compliance. However, if at a later stage another similar death occurs the Ontario Coroner will often hold a public inquest at which the organisation is required to account for why the person died.

Regional coroners' reviews were introduced in Ontario as a result of an initiative by then Chief Coroner Dr James Young, who was concerned that coronial procedures were cumbersome and did not deliver optimum benefits to the community.<sup>1893</sup> As an

<sup>1893</sup> Ibid 35, 46.

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<sup>&</sup>lt;sup>1889</sup> Office of the Chief Coroner, Ontario, Guidelines for Regional Coroner Reviews (January 2002).

<sup>&</sup>lt;sup>1890</sup> W Jarred, *The Coroners Bill 2002: Highlighting the Important Role of Coroners in Accident Prevention*, Queensland Parliamentary Library, 2003, 4–5.

<sup>&</sup>lt;sup>1891</sup> Justin Malbon, 'Institutional Responses to Coronial Recommendations' (1998) 6 *Journal of Law and Medicine*, 35, 47.

<sup>&</sup>lt;sup>1892</sup> Ibid.

experiment he began holding informal meetings with the families of people who had died and institutions, with a view to finding effective ways of preventing future deaths.<sup>1894</sup> In the early stages of this experiment families and institutions would sometimes both attend a meeting; however, experience proved that it was more productive for the coroner to meet with the two groups separately.<sup>1895</sup>

In 1995 the Ontario Law Reform Commission provided the following description of the regional coroner review system:

This function can best be described as a combination of fact-finding and mediation, which is used either in lieu of, or as a preliminary to, an inquest. After extensive investigation, the investigating coroner and the regional coroner will approach the relevant parties, including the family of the [person who died], with a view to conducting an informal meeting or series of meetings in which facts from the investigation and expert data and opinions are placed before the interested parties. The objective of the regional coroner's review is both to inform the interested parties and to begin processes of rectifying problems that have been discovered. 1896

The process involves an informal meeting conducted by a regional supervising coroner to clarify issues identified in the circumstances surrounding the death of a person in an institution, and usually to discuss the opinion of an expert (from one of the expert committees of the Chief Coroner's Office or a single expert) regarding possible recommendations for changes by the institution. Often an expert investigator attends the meeting. At these meetings no families or lawyers (for either the family or the institution) are present, attendance is not compulsory, and discussions are not recorded, although a list of those present is recorded. The meetings are not open to the public, and generally recommendations which arise from them are not made public, although in some cases where the recommendations apply to systemic issues across many institutions they will be issued in press releases.

The coroner will begin by summarising the details of the case as understood from review of the medical record and the coroner's investigation, which is followed by discussion of the expert opinion, after which a number of recommendations may be

<sup>&</sup>lt;sup>1894</sup> The Committee notes that this initiative was not a result of legislative amendment. Ontario coroners view the power to hold regional coroners' reviews as deriving from section 15(4) of the *Coroners Act 1990* (Ontario), which authorises coroners to obtain assistance or the use of experts during any part of an investigation or inquest.

<sup>&</sup>lt;sup>1895</sup> J Malbon, G Airo-Farulla and C Banks, *Review of Queensland Coronial Law — Final Report* (Queensland Department of Families, Youth and Community Care, Brisbane, 1997) 27.

<sup>&</sup>lt;sup>1896</sup> Ontario Law Reform Commission, Report on the Law of Coroners (1995) 139–40.

<sup>&</sup>lt;sup>1897</sup> Office of the Chief Coroner, Ontario, Guidelines for Regional Coroner Reviews (January 2002).

<sup>&</sup>lt;sup>1898</sup> J Malbon, G Airo-Farulla and C Banks, *Review of Queensland Coronial Law — Final Report* (Queensland Department of Families, Youth and Community Care, Brisbane, 1997) 28.

<sup>&</sup>lt;sup>1899</sup> Office of the Chief Coroner, Ontario, Guidelines for Regional Coroner Reviews (January 2002).

<sup>&</sup>lt;sup>1900</sup> Email, Dr Barry McClellan, Chief Coroner for Ontario, to Committee Executive Officer, 8 May 2006.

suggested.<sup>1901</sup> The institution may indicate a preliminary response to the recommendations. Dr Young informed the Queensland review authors that:

When a meeting goes well, there is a frank discussion about the cause of death; the institution outlines where they consider things went wrong and their recommendations to prevent the same thing from happening again; and the institution and the coroner agree on the measures to be taken to prevent a similar death occurring.<sup>1902</sup>

The coroner records the recommendations arising from the meeting and will subsequently write to the institution requesting a formal response to recommendations. The coroner subsequently provides a copy of this letter and a copy of the institution's response to the family. The coroner will also meet with families frequently to explain the results of the reviews and to make sure that their concerns are heard. The coroner will also meet with families frequently to explain the results of the reviews and to make sure that their concerns are heard.

Both institutions and families were initially suspicious of the informal meeting approach; however, Chief Coroner for Ontario Dr Barry McClellan told the Committee that the process is now well received by both sides. Institutions were initially reluctant to attend the reviews without their lawyers present, but now hospitals (where the reviews are most often used) often request a regional review in lieu of an inquest. Similarly, to begin with families preferred formal inquests, but with time more families became involved in informal meetings with coroners. After such meetings, families typically do not seek to have a matter dealt with by an inquest:

Once the family feels assured that they have been told everything the coroner knows about the death, and that he or she will pursue the matter with the institution, there is a sense that some positive outcome will result from their family member's death. Thus, often families that are initially determined to pursue a matter through an inquest and perhaps a negligence claim will, after a meeting, prefer that the coroner meet with the institution and agree on a process that will prevent similar deaths in future. 1908

Where an agreement has been made, while coroners and the families themselves may monitor compliance, there is no penalty or other explicit sanction for non-

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<sup>&</sup>lt;sup>1901</sup> Office of the Chief Coroner, Ontario, Guidelines for Regional Coroner Reviews (January 2002).

<sup>&</sup>lt;sup>1902</sup> See Justin Malbon, 'Institutional Responses to Coronial Recommendations' (1998) 6 *Journal of Law and Medicine*, 35, 46; J Malbon, G Airo-Farulla and C Banks, *Review of Queensland Coronial Law — Final Report* (Queensland Department of Families, Youth and Community Care, Brisbane, 1997) 28.

<sup>&</sup>lt;sup>1903</sup> Office of the Chief Coroner, Ontario, Guidelines for Regional Coroner Reviews (January 2002).

<sup>&</sup>lt;sup>1904</sup> Committee meeting with Dr Barry McClellan, Chief Coroner for Ontario, 21 June 2005.

<sup>&</sup>lt;sup>1905</sup> Committee meeting with Dr Barry McClellan, Chief Coroner for Ontario, 21 June 2005.

<sup>&</sup>lt;sup>1906</sup> Email, Dr Barry McClellan, Chief Coroner for Ontario, to Committee Executive Officer, 8 May 2006.

<sup>&</sup>lt;sup>1907</sup> J Malbon, G Airo-Farulla and C Banks, *Review of Queensland Coronial Law — Final Report* (Queensland Department of Families, Youth and Community Care, Brisbane, 1997) 28.

<sup>&</sup>lt;sup>1908</sup> Ibid.

compliance. 1909 However, if the family is not satisfied with the results of a regional coroner's review it is still possible to request an inquest. Likewise, if an institution refuses to consider the recommendations made for no apparently valid reason the coroner can still call an inquest. 1910 Indeed, if a similar death occurs after an agreement has been made, the Ontario Coroner will often hold a public inquest, at which the institution will be required to explain why the agreement did not prevent the death. 1911 Because inquests are held less frequently, they tend to attract a greater amount of public interest and media attention, and so they are something to be feared by an organisation that failed to comply with its agreement with a coroner. 1912

The Ontario Law Reform Commission suggested that such informal reviews are not appropriate for all matters investigated by coroners:

This informal process has proven effective in situations in which the preventable aspect of the death is both clear and apparently rectifiable. For example, cooperative programs for change have resulted from reviews with respect to some deaths in institutions, like hospitals or residential centres. Of course, these reviews can succeed only where the interested parties are content to cooperate. Moreover, they require substantial fact finding by the coroner and regional coroner to ensure that adequate material about the death, and the means of prevention, can be placed before the parties. Factual disputes will not encourage resolution. The more determinative an investigation, the greater the likelihood that the parties will accept its conclusion. 1913

These observations have been confirmed to the Committee by Dr McClellan, who commented that it is not often in regional reviews that the cause of death has not already been established. He also commented that the reviews are particularly effective, compared to an inquest, in cases where the recommendations apply to only one institution. Such institutions tend to be hospitals, and one of the benefits of the reviews is that they avoid the need to present complex evidence to the coronial jury, which is not an issue in Victoria. It was suggested to the Committee that the reviews were initiated partly in response to cost constraints on holding inquests; however, it seems that Ontario's informal conferencing strategy has also proven to be

<sup>&</sup>lt;sup>1909</sup> See Justin Malbon, 'Institutional Responses to Coronial Recommendations' (1998) 6 *Journal of Law and Medicine*, 35, 46.

<sup>&</sup>lt;sup>1910</sup> Email, Dr Barry McClellan, Chief Coroner for Ontario, to Committee Executive Officer, 8 May 2006.

<sup>&</sup>lt;sup>1911</sup> See Justin Malbon, 'Institutional Responses to Coronial Recommendations' (1998) 6 *Journal of Law and Medicine*, 35, 47.

<sup>&</sup>lt;sup>1912</sup> Ibid.

<sup>&</sup>lt;sup>1913</sup> Ontario Law Reform Commission, Report on the Law of Coroners (1995), 140.

<sup>&</sup>lt;sup>1914</sup> Email, Dr Barry McClellan, Chief Coroner for Ontario, to Committee Executive Officer, 8 May 2006.

<sup>&</sup>lt;sup>1915</sup> Ibid.

an effective way of securing implementation of recommendations in appropriate cases. 1916

## The system proposed in the Queensland review

In 1998 a review prepared for the Queensland Department of Families, Youth and Community Care proposed the introduction of a similar system of informal conferencing. In this system, cases involving 'institutions' which may in some way have been responsible for a person's death would initially proceed by way of private conference with the Registrar at the Coroner's Office. The institution would be given the opportunity to propose measures which it would then implement to avoid similar deaths in the future. Where the institution later decided that it was impossible to implement a measure, it would be required to explain why.

It was proposed that any admissions as to liability made by the institution at the conference could not be used in any civil or criminal trial. If the Registrar and the institution could not agree on the proposed preventative measures to be implemented by the institution, the Registrar would then refer the case to the State Coroner for an inquest. The review anticipated that such conferencing would reduce the number of inquests, and assist the coronial system to develop 'a sense of purpose and efficiency' and reduce the waste of resources caused by the existing system's 'excessive formality and inflexibility'. 1918

# Evidence received by the Committee

Evidence to the Committee as to whether the Ontario conferencing system would work in Victoria was varied, several witnesses expressing qualified support for the proposal. For example, VIFM submitted that the advantage of the type of system proposed in the Queensland review is that coroners may be able to develop recommendations that are already endorsed by the relevant parties and are therefore more likely to be implemented. Preducing the need for inquests would also save time and resources. However, VIFM expressed concern about the effects of not holding inquests, which occur in a public forum and during which a coroner can conduct further investigations by obtaining statements and testimony from witnesses. VIFM submitted that any 'closed door' system would have to ensure that the issues identified by the coroner and the agreed recommendations are on the public record. This would provide a historical account of the circumstances of the death and the recommended solutions, should further deaths occur in similar

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<sup>&</sup>lt;sup>1916</sup> Committee meeting with Dr Barry McClellan, Chief Coroner for Ontario, 21 June 2005.

<sup>&</sup>lt;sup>1917</sup> J Malbon, G Airo-Farulla and C Banks, *Review of Queensland Coronial Law — Final Report* (Queensland Department of Families, Youth and Community Care, Brisbane, 1997) 9–11.

<sup>&</sup>lt;sup>1918</sup> Ibid 29.

<sup>&</sup>lt;sup>1919</sup> Victorian Institute of Forensic Medicine, *Submission no. 40*, 23.

<sup>&</sup>lt;sup>1920</sup> Ibid 23-4.

circumstances.<sup>1921</sup> VIFM also submitted that the question which needs to be considered is whether a consultation process between the coroner and the parties before making recommendations would reduce the strength or impartiality of recommendations.<sup>1922</sup>

State Coroner Mr Johnstone, who has advocated a system requiring mandatory responses to recommendations, noted in relation to the idea of informal conferences held in camera in the absence of lawyers that they are undoubtedly an alternative that could work in some cases. However, Mr Johnstone stressed the need for coroners to have available the necessary expertise to run such inquiries effectively. He also expressed concern that it would not be a public process and that, if a further death occurred following the signing of recommendations, the coronial system could be criticised for not investigating the death satisfactorily. Mr Johnstone considered that the Ontario review system could be managed in specific cases but that this would have some real risks. He suggested that a halfway house between inquests and roundtable discussions might be a better method to start with, where lawyers were present but in an informal atmosphere that would assist in breaking down barriers in the thought process of the parties involved in relation to a death.

Associate Professor Ranson observed in his submission that the Ontario system provides a highly collaborative process that engages organisations which are the subject of a recommendation in 'a death prevention partnership' with the coroner. However, Associate Professor Ranson expressed doubt that such a system could be as successful in Australia, stating that in Ontario the coroner is a medical practitioner rather than a lawyer and that his or her involvement in an agreement outside an inquest is 'founded on a public health principle rather than a legal principle'. Hence, in his view the possibility of introducing such a system into Australia, where coroners are lawyers and judicial officials without public-health expertise or experience, seems remote. While he accepted that the introduction of such a system could have major public health benefits, he suggested that this would require the appointment of medical coroners or assistant coroners.

Nonetheless, the Committee heard evidence that supported the potential of informal conferencing for future coronial inquiries in Victoria. For example, Mr Bob MacDonald, executive officer, Volunteer Fire Brigades Victoria (VFBV), told the Committee that VFBV considered that the Esplin inquiry into fires in the northeast of Victoria elicited

<sup>&</sup>lt;sup>1921</sup> Ibid 24.

<sup>&</sup>lt;sup>1922</sup> Ibid.

<sup>&</sup>lt;sup>1923</sup> Graeme Johnstone, State Coroner's Office, *Minutes of Evidence*, 19 September 2005, 79.

<sup>&</sup>lt;sup>1924</sup> Ibid.

<sup>&</sup>lt;sup>1925</sup> Ibid 80.

<sup>&</sup>lt;sup>1926</sup> David Ranson, Submission no. 19, 63.

<sup>&</sup>lt;sup>1927</sup> Ibid.

<sup>&</sup>lt;sup>1928</sup> Ibid 63-4.

facts and information from a wide range of sources and produced a number of recommendations that were widely accepted by the community. VFBV considered that this had been possible because the investigation involved virtually no legal representation of interested parties, unlike the Linton fires inquest, which involved 90 days of hearings and in which much of the information was conveyed through legal representatives. However, the Committee notes that Commander Ian Hunter of the Metropolitan Fire Brigade (MFB) expressed a more sanguine view of the efficacy of the Linton inquest, stating that the MFB had learnt a great deal from the inquest and that the Coroner had provided the impetus for the introduction of water tank level warning devices on fire trucks in Victoria. 1930

Other witnesses also expressed support for the Ontario approach. For example, the FCLC supported the introduction of the type of coronial agreements used in Ontario to ensure that recommendations are implemented effectively. Family witness Mr Bond submitted that the Ontario system 'seems to be a step in the right direction' and that 'anything would be an improvement on what we have now'.

Lawyers representing the Medical Negligence Malpractice Group of Maurice Blackburn Cashman (MBC) submitted that the Ontario system appeared to be sensible but suggested that a properly operating coronial system should produce a public inquiry at which an organisation involved in a death has to account for the circumstances in which the death occurred. MBC also stated that it was not clear who would monitor compliance with an agreement, and it expressed concern that this system would possibly limit the application of a recommendation to a particular organisation instead of achieving wider publication of identified risks. 1934

The strongest concerns put forward by witnesses in relation the Ontario conferencing system relate to the potential impact on the principle of open justice. For example, Health Services Commissioner Ms Beth Wilson submitted that it would be inappropriate and unacceptable to the Victorian public for coroners to be investigating deaths in secret. Ms Wilson's main reservation was that informal hearings would not be open to the public, stating, '[i]t is confidential, so how do you learn from it?' Ms Wilson is a strong advocate of conciliation meetings in the coronial context, having been actively involved in a large number of conciliations between families, medical practitioners and hospitals over many years. Ms Wilson noted that it is possible for conciliation to take place through her office after an inquest is complete and that her office plays a role in dealing with the grief and other problems facing families affected by a coronial inquest. However, Ms Wilson observed that a fundamental objective of

<sup>&</sup>lt;sup>1929</sup> Bob MacDonald, Volunteer Fire Brigades Victoria, *Minutes of Evidence*, *5 December 2005*, 272.

<sup>&</sup>lt;sup>1930</sup> Ian Hunter, Metropolitan Fire Brigade, *Minutes of Evidence*, 5 December 2005, 277.

<sup>&</sup>lt;sup>1931</sup> Federation of Community Legal Centres, *Submission no. 55*, 19.

<sup>&</sup>lt;sup>1932</sup> Graeme Bond, Submission no. 48, 12.

<sup>&</sup>lt;sup>1933</sup> Maurice Blackburn Cashman, Submission no. 42, 8.

<sup>&</sup>lt;sup>1934</sup> Ibid.

coronial investigations is to satisfy the public need for the circumstances surrounding an unexpected or unnatural death to be aired. While inquests do not necessarily have to be conducted in an adversarial way, conciliation and mediation should be kept separate from the coronial jurisdiction.

Indeed, evidence to the Committee from Mr Aron Gingis highlights the risk of informal hearings (in this instance, a conciliation meeting) proving to be unsatisfactory substitutes for a public inquest. Mr Gingis had sought an inquest into the death of his father-in-law, who died while being treated in a hospital, but the coroner had decided not to hold one. Mr Gingis described his experience of conciliation with hospital staff provided by the Health Services Commission as being completely unsatisfactory. 1935 Mr Gingis felt that the conciliation had done little in terms of arriving at any kind of resolution of his allegations of medical negligence by the hospital. Mr Gingis told the Committee:

I want my day in the coroner's court at a proper inquest. 1936

While the meeting attended by Mr Gingis would have been very different from an Ontario-style coroner's review, similar frustration might be experienced by families in cases where such a review was substituted for an inquest.

An important example of the concerns about closed hearings impinging on the principle of open justice is that there would be scope for institutions involved with a death to engage in 'plea bargaining' — agreeing to implement recommendations in exchange for concessions in findings of fact recorded by the coroner. The Mental Health Legal Centre (MHLC) submitted that it is already deeply concerned about the practice of plea bargaining, where, for example, a hospital or department will agree to certain actions in exchange for concessions. The MHLC cited the inquiry into the fire at Kew Cottages as an example of this. 1937 However, it appears that regional coroners' reviews in Ontario are usually undertaken in cases where the cause of death has been established. Asked whether the reviews are ever criticised as enabling plea bargaining, Dr McClellan responded:

That's not a criticism we've heard. Most parties find it very helpful and the families feel that something positive has resulted. 1938

In contrast to the view that in-camera hearings would interfere with the principle of open justice, some would argue that one of their main advantages as an alternative to inquests is that they provide scope for an abrogation of the privilege against selfincrimination, provided that nothing which was said could be used in subsequent proceedings. Indeed, Dr McClellan informed the Committee that, since neither the

<sup>&</sup>lt;sup>1935</sup> Aron Gingis, *Minutes of Evidence*, 20 September 2005, 146.

<sup>&</sup>lt;sup>1936</sup> Ibid 148.

<sup>&</sup>lt;sup>1937</sup> Mental Health Legal Centre, Submission no. 41, 2.

<sup>&</sup>lt;sup>1938</sup> Email, Dr Barry McClellan, Chief Coroner for Ontario, to Committee Executive Officer, 8 May 2006.

families nor lawyers for any of the parties are present, an institution may be more willing to disclose information about the circumstances surrounding a death. This advantage could potentially result in a more successful search for truth by the investigating coroner, thus facilitating the identification of preventative measures. However, if a family is not satisfied with the results of a review and suspects that some form of compromise or bias has taken place, the family can request an inquest as noted above.

#### Discussion and conclusion

Would an Ontario-style informal conferencing system as described above work in Victoria? The Committee considers that there are important differences between the coronial jurisdictions in Ontario and Victoria. For example, in Ontario such hearings enable coroners to consider medical adverse events without having to put complex medical evidence before a jury, a jury being a requirement in Ontario at an inquest. However, in Victoria inquests do not involve juries, and unlike their Ontario counterparts coroners here are legally rather than medically trained.

Aside from jurisdictional differences, the Committee is concerned that conferences held in camera would interfere with the principle of open justice and diminish public confidence in the integrity of coronial inquiries. Yet there is also an argument that incamera hearings could facilitate a more informed search for truth due to the absence of the need for the privilege against self-incrimination. However, the Committee has already recommended a qualified abrogation of the privilege in coronial inquests in chapter four, subject to the issuing of certificates preventing the use of such evidence in subsequent proceedings (as occurs in New South Wales). This recommendation would enable a more informed search for truth at inquests without compromising the need for coronial inquiries to be open to public scrutiny.

The Committee notes that the majority (approximately 80 percent) of cases do not go to inquest and so do not receive a 'public airing' in any event, other than when the findings are placed on the public record upon completion of the investigation. In contrast, of the cases which do go to inquest, some are the subject of mandatory inquests and so would not be suitable for informal hearings away from the public gaze. Thus the debate about open justice is most relevant to the type of case where a coroner has the discretion under section 17(2) to hold an inquest on the basis that to do so would be 'desirable' but might choose to hear it informally using the Ontario approach. The Committee's view is that public accountability is an essential feature of the coronial jurisdiction and that any trial of in-camera hearings should be performed with caution.

Nonetheless, the Committee's view is that, in appropriate cases of the kind identified by the Ontario Law Reform Commission, less formal proceedings potentially offer a number of advantages. These include formulating feasible recommendations which in some cases will be agreed to by an organisation, thereby increasing the likelihood of implementation, saving time and expense by avoiding the need for an inquest (unless a similar death occurs after the measures are agreed), and creating a more flexible,

efficient and effective coronial system. Another advantage of more informal hearings is that they would avoid the problem of families feeling alienated or intimidated by the legalistic nature of inquests, thus making the coronial process an easier experience for them and increasing the potential for a therapeutic outcome. However, the risk is that for some families such hearings would fail to satisfy their desire for public accountability. It is clearly an option that could only be applied in appropriate cases and that would require the involvement of experts, as is the case in Ontario. It seems unlikely that Victorian coroners would be able to consider medical adverse events as effectively as their medically trained Ontario counterparts without significant expert assistance.

In conclusion, on the evidence available the Committee cannot assess definitively whether gains could be achieved from the use of informal conferencing by Victorian coroners. However, the approach has been successful in Ontario, a coronial jurisdiction which has long been recognised as a leader in the field of prevention. As Dr Justin Malbon, one of the authors of the report of the Department of Families, Youth and Community Care review discussed above, comments:

Initial concerns about how a new coronial system would work is natural, and arose in Ontario. If Ontario's experience is anything to go by, these concerns will change, once the system is established, from scepticism to active support by the community, and by families of the deceased in particular. An adaptation and improvement of Ontario's system offers far greater and more effective organisational response to deaths than is the case in most jurisdictions.<sup>1940</sup>

The Committee recommends that the State Coroner's Office undertake a trial of informal conferencing, modelled on the Ontario regional coroners' review system, in appropriate cases which the State Coroner considers could appropriately be dealt with in this manner. The Committee does not consider that legislative amendment is required to encourage such a process at this stage. Rather, informal conferencing should be introduced and tested as a way of formulating feasible recommendations and securing agreements for their implementation in a small number of selected cases. Any agreement reached would not be legally binding but should be published (with the consent of the organisation and the family) on the State Coroner's Office website and in the State Coroner's annual report. Where consensus on the recommendations is not forthcoming but the coroner considers that his or her recommendations are still viable, the coroner should submit his or her draft recommendations to the State Coroner for review prior to their release to the organisation. Finally, the Committee considers that the trials should be formally

<sup>&</sup>lt;sup>1939</sup> Ian Freckelton and David Ranson, *Death Investigation and the Coroner's Inquest* (2006) 533-4. The authors observe that therapeutic jurisprudence considerations suggest that the potential for inquests to cause psychological harm and distress should be minimised where possible, citing, for example, B J Winnick and D B Wexler, *Judging in a Therapeutic Key* (2003).

<sup>&</sup>lt;sup>1940</sup> Justin Malbon, 'Institutional Responses to Coronial Recommendations' (1998) 6 *Journal of Law and Medicine*, 35, 48.

evaluated and that this evaluation should be included in the State Coroner's annual report.

Recommendation 87. That the State Coroner's Office undertake a trial of informal conferencing modelled on the Ontario regional coroners' review system for cases which the State Coroner considers could appropriately be dealt with in this way.

Recommendation 88. That the features of the informal conferencing model to be trialled include the following:

- a) any agreement reached in relation to implementing recommendations should be published (with the consent of the organisation and the family) on the State Coroner's Office website and in the State Coroner's annual report.
- b) where consensus is not forthcoming but the coroner considers his or her recommendations to be feasible, the coroner is to submit draft recommendations to the State Coroner for review prior to their release to the organisation.

Recommendation 89. That the trial of informal conferencing be formally evaluated and that this evaluation be reported in the State Coroner's annual report.

# CHAPTER EIGHT — THE NEEDS, RIGHTS AND SUPPORT OF FAMILIES AND OTHERS IN THE CORONIAL SYSTEM

There are times when bereaved people can feel their rights have been disregarded. The legal system for instance may appear to be so preoccupied with the processes of law in regard to the case that the survivors feel overlooked.<sup>1941</sup>

The terms of reference for this inquiry required the Committee 'to recommend any areas where the Act should be amended or modernised to better meet the needs of the community' and to consider whether the Act 'provides an appropriate framework for the provision of support for the families, friends and others associated with a deceased person who is the subject of a coronial inquiry'.

These requirements are consistent with the Attorney-General's commitment to review the *Coroners Act 1985* and improve the capacity of the Office of the State Coroner to contribute to accident prevention and safety measures and ensure that the needs of families are appropriately met:

The Coroner's role must be tempered with appropriate and sensitive consideration of the needs of families and others affected by the necessary investigation of sudden and, unexpected and tragic events by the Coroner.

The *Coroner's Act 1985* established, for the first time, the Office of the State Coroner. A new facility for the State Coroner's Office and the Victorian Institute of Forensic Medicine was built in 1988. Since then, coronial practice has evolved to include greater recognition of the needs of the deceased's family and the development of appropriates service for them.

The Government believes that a review of the Coroner's Act is timely. It will undertake such a review to improve the Court's capacity to contribute to accident prevention and safety strategies, and meet the needs of families of deceased persons and others who may be affected by a sudden, unexpected and tragic accident.<sup>1942</sup>

Given the terms of reference, chapter six of the discussion paper examined what rights the Act currently provides to the family of a person whose death is the subject of a coronial investigation and asked stakeholders a series of questions regarding

<sup>&</sup>lt;sup>1941</sup> G Glassock, 'Coping with Grief', in Hugh Selby (ed), *The Aftermath of Death*, 192.

<sup>&</sup>lt;sup>1942</sup> Attorney-General's Justice Statement, 'New Directions for the Victorian Justice System 2004–2014', May 2004, 46.

what rights families should be given under the Act in order to meet their needs. The Committee also invited submissions on other needs which may not have been identified in the discussion paper.

In this chapter, the Committee discusses the needs of families and others associated with a person whose death is the subject of a coronial investigation or inquest, before considering in detail the legal rights and support services that are available or should be available to families and others affected by the coronial system.

## The needs of families, friends and witnesses in the coronial system

The Committee sought evidence about the experiences of family, friends and witnesses who have been involved in a coronial process. This inquiry would have been incomplete if it did not take these experiences into account. It is important to note however that the scope of the inquiry was limited by the terms of reference, which directed the Committee to consider an appropriate legislative framework. The Committee could not investigate individual cases or make findings about the conduct of cases. The purpose of gathering evidence from witnesses to the inquiry was to gain information which could inform the Committee's general recommendations for reform of the Act.

#### Existing research

The experience of the family of a person whose death is the subject of a coronial inquiry has scarcely been considered in academic research. While most of the relevant research has been conducted in the UK, the findings of that research are relevant to the Victorian context, given the similarities between the two coronial systems. Research on the impact on families of a coronial inquest, which appears to be limited to a small series of papers from the 1970s, is focused solely on suicide cases and is mainly quantitative; that is, it seeks to quantify distress rather than understand its nature. Until some recent UK studies, there was a lack of research conducting the necessary qualitative investigation of the experiences of those associated with a person whose death forms the subject of an inquiry. It is arguable that this limited consideration is also evident in the coronial system, in terms

<sup>&</sup>lt;sup>1943</sup> Myndscape Consulting, Review of the Coroner's Act 1985: Final Report, March 2006, 16.

<sup>&</sup>lt;sup>1944</sup> Ibid. See also B Barraclough and D Shepherd, 'The Immediate and Enduring Effects of the Inquest on Relatives of Suicide' (1977) 131 *British Journal of Psychiatry*, 400–4; B Barraclough and D Shepherd, 'Public Interest: Private Grief' (1976) 129 *British Journal of Psychiatry*, 109–13; D Shepherd and B Barraclough, 'The Aftermath of Suicide' (1974) 2(919) *British Medical Journal*, 600–3, D Shepherd and B Barraclough, 'Suicide Reporting: Information or Entertainment' (1978) 132 *British Journal of Psychiatry*, 283–7.

<sup>&</sup>lt;sup>1945</sup> See Lucy Biddle, 'Public Hazards or Private Tragedies? An Exploratory Study of the Effect of Coroner's Procedures on Those Bereaved by Suicide' (2003) *Social Science & Medicine* 56, 1033–45. See also Gwynn Davis et al, *Experiencing Inquests*, Home Office Research Study 241 (2002). Available at <a href="http://www.homeoffice.gov.uk/rds/pdfs2/hors241.pdf">http://www.homeoffice.gov.uk/rds/pdfs2/hors241.pdf</a>.

of lack of attention to, and assessment of, procedures and protocols designed to govern dealings with grieving families, friends and others.<sup>1946</sup>

Aside from the initial 1970s reports, a study by Ms Lucy Biddle in 2003 is the most relevant and therefore the most influential in this area of research. To a lesser extent, the findings by Dr Harwood et al also offer some insight. Ms Biddle examined how suicide inquests can affect the relatives of the person who died and impact upon their grief. Unlike the earlier studies, which were largely quantitative, Ms Biddle conducted a qualitative investigation into the effect of coronial procedures on those bereaved by suicide. In the study, in-depth qualitative interviews were conducted with a sample of 16 individuals bereaved by suicide in order to explore their experiences of the inquest. Thematic analysis was used to identify recurrent problems and their effects.

Ms Biddle found that several interviewees had been significantly traumatised by the inquest process. The research found that coronial inquests adversely affected resolution of grief in two main ways: by exacerbating common grief reactions associated with the suicide of a family member such as, shame, guilt and anger, and by interfering with necessary grief work — in particular, the task of arriving at a meaningful and acceptable account of the death. 1949

Participants felt that the formality of the court setting criminalised the death of the person who died and their relatives, thereby increasing feelings of shame and stigma (Ms Biddle suggested that coronial practices have not reflected the decriminalisation of suicide). The interviewees also objected to the way the coroner handled private information, allowing its public disclosure. Many participants had not even been informed that the press may attend the inquest. Further, the majority of participants stated that they were distressed by the evidence they heard during the inquest. The interviewees also expressed anger over the way the inquest was conducted, such as the lack of confidentiality and sympathy, and the lack of information and preparation prior to the event, that were offered to them. Several interviewees also expressed anger over their personal treatment, feeling that they were regarded merely as witnesses rather than as grieving persons. They felt that the system failed to acknowledge their personal tragedy. Relatives who had been left a suicide note were angered and distressed by confiscation of the letter.

The majority of respondents also struggled to cope with the delayed inquest. Almost all of the respondents were distressed by the delay, which many described as

<sup>&</sup>lt;sup>1946</sup> Myndscape Consulting, Review of the Coroner's Act 1985: Final Report, March 2006.

<sup>&</sup>lt;sup>1947</sup> D Harwood et al, 'The Grief Experiences and Needs of Bereaved Relatives and Friends of Older People Dying through Suicide: A Descriptive and Case-Control Study' (2002) 72 *Journal of Affective Disorders*, 185.

Lucy Biddle, 'Public Hazards or Private Tragedies? An Exploratory Study of the Effect of Coroner's Procedures
 On Those Bereaved by Suicide' (2003) Social Science & Medicine 56, 1033.
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<sup>&</sup>lt;sup>1950</sup> Ibid 1043.

prolonging their grief and preventing them from 'moving on'. In some cases delay gave rise to fearful speculation as they tried to rationalise it:

It's been months now. I keep thinking they must be keeping something awful from me. The coroner hasn't been contacting me at all. Even when I ring he doesn't get back to me. I can't find out what's going on. They must be keeping things from me. 1951

When the inquest arrived it did not always bring the closure that many expected. In fact, many respondents found that the delayed inquest reversed their path through grief by resurrecting painful emotions.<sup>1952</sup>

Indeed, one of the main difficulties for families was the lack of resolution from the inquest findings. A major task for families is constructing a 'last chapter' for the person who died. <sup>1953</sup> This involves arriving at an account of the death that makes sense of what happened and which they can come to terms with. The interviewees expressed a strong sense of pointlessness in relation to the inquests. Ms Biddle commented that the crux of such problems is the differing agendas of families and the coroner. While the coroner's brief is merely to establish 'how' or 'by what means' a person died, families seek to understand 'why' as they attempt to comprehend the death.

The few participants who relayed positive coronial experiences described the coroner as sympathetic, as holding the bereaved person's best interests in mind (for example, minimising the discussion of unnecessary details) and as advising families of their rights at each stage of the process. The one respondent who attended an inquest in an informal setting (as opposed to a court room) described a much easier and less intimidating experience.

Thus overall the respondents had negative experiences, which evidently could have been improved if coroners had conducted inquests with sympathy, and if there was better communication from coroner's offices, better preparation for the inquest and possibly the use of alternative settings. The few positive accounts appeared to have resulted from the sense and discretion of individual coroners in balancing legal requirements with the needs of families. Thus Ms Biddle advocated for

<sup>1952</sup> However, it has been suggested that the distress and grief experienced by families affected by a death would be likely to reduce their tolerance for minor errors and delays: D Harwood et al, 'The Grief Experiences and Needs of Bereaved Relatives and Friends of Older People Dying through Suicide: A Descriptive and Case-Control Study' (2002) 72 *Journal of Affective Disorders*, 185.

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<sup>&</sup>lt;sup>1951</sup> Ibid 1033, 1039.

<sup>&</sup>lt;sup>1953</sup>Lucy Biddle, 'Public Hazards or Private Tragedies? An Exploratory Study of the Effect of Coroner's Procedures on Those Bereaved by Suicide' (2003) *Social Science & Medicine* 56, 1033, 1038. See also T Walter, 'A New Model of Grief: Bereavement and Biography' (1996) 1(1) *Mortality* 7.

<sup>&</sup>lt;sup>1954</sup> Ibid 1043–5: Biddle concluded that coroners should have the discretion to process some suicides without a public inquest, since many such cases were evidently straightforward and were private tragedies rather than cases requiring the broadcast of public hazards.

standardisation of practice and specific formal guidelines or protocols for dealing with grieving families that are made public and reviewed.

The research by Dr Harwood et al found slightly more favourable results for coronial inquiries, compared to the findings of the research by Ms Biddle. Less than half of the respondents (42.4 percent) reported problems in their dealings with the coroner's Office, and 20 percent described difficulty in dealing with the delay of the inquest. Over 30 percent of respondents were further distressed by the media's reporting of the case, which was described as graphic and inaccurate.

Neither Ms Biddle's research, nor the study conducted by Dr Harwood considered the impacts of autopsy on the bereaved. Research by Oppewal and Meyboom-de-Jong investigated bereaved family members' experiences of autopsy. 1955 They found that relatives were surprised by the request for an autopsy because they assumed that autopsies were only performed in suspicious circumstances. The research also found that the range of terms used to refer to autopsy (for example post-mortem, obduction, and necropsy) was confusing for family members. Clear and careful explanation of the procedures and purpose of the autopsy allayed these concerns. Finally, family members who did not have the autopsy report discussed with them or provided to them felt that they were left to speculate and worry unnecessarily. On the other hand, those relatives who were provided with a copy of the report were unfamiliar with the scientific language and terminology. Oppewal and Meyboom-de-Jong recommended that a suitable person discuss the autopsy results with the bereaved family once the report has been compiled. 1956 In addition to the concerns held by respondents in that research, Brown identified further concerns of lay people with regard to autopsies. Some of these are that the deceased and the family have suffered enough, delayed funeral arrangements, and distress at the impending mutilation of the body. 1957

Many of the themes identified in the UK studies discussed above are consistent with those that emerged in evidence heard by the Committee in relation to the Victorian coronial system. One would expect many of the findings from the UK studies to be relevant to the Victorian context and that many of the emotional and practical difficulties for families would be the same. However, caution needs to be exercised when comparing experiences in different countries with different coronial laws and practices. Accordingly, in addition to receiving evidence from a large number of witnesses affected by the death of a family member, the Committee commissioned a study of the impact of coronial investigations on Victorian families and sought their views on ways in which these investigations could be improved. The study targeted family members who had not made submissions, appeared at public hearings or

<sup>&</sup>lt;sup>1955</sup> F Oppewal and B Meyboom-de-Jong, 'Family Members' Experiences of Autopsy' (2001) 18(3) *Family Practice* 304. The Committee discusses autopsies and the needs of families in the Victorian context later in this chapter.

<sup>&</sup>lt;sup>1957</sup> H G Brown, 'Perceptions of Autopsy: Views from the Lay Public and Program Proposals' 21 *Human Pathology* 154.

otherwise made contact with the Committee, with a view to gaining a broader representation of people who have experienced the coronial system. This study is discussed below.

#### Consultants' research

The Committee commissioned an external research study by a consulting group with expertise in forensic psychology, with the aim of collecting evidence regarding the experiences of Victorian families affected by the coronial system, in order to address more specifically the questions raised by the terms of reference. A summary of the research design and findings, taken largely from the consultants' report, is presented below.

#### Study design

The study aimed to: (1) investigate interviewees' perceptions and experiences of a coronial death investigation or inquest in order to investigate areas where the Coroner's Office responded well to interviewees' needs, (2) identify areas that could be improved and (3) formulate recommendations for enhancing the support and services offered to families and friends of the person who has died.

The participants were recruited using data held by the Coroner's Office from a pool of 200 family members deemed suitable for the study, 1960 based on random selection according to particular inclusion criteria. The Committee reviewed a final list of 18 interested parties and selected 12 family members with a view to providing as broad a cross-section of participants as possible. The selected research participants consisted of 12 people who were the next of kin of a person whose death was the subject of a coronial inquiry. There was equal gender representation in the study — six men and six women — and they ranged in age from 25 to 70 years. Three of the participants had attended an inquest, and the remainder had not. The research was restricted to coronial cases completed within the two years before the study. Two of the participants' investigations or inquests took place in metropolitan areas, and the remaining 10 were in rural locations. 1961 The largest proportion of the deaths analysed in the study resulted from car accidents, followed by deaths from suicide, and then from medical disease. One death was caused by a drug overdose and one occurred shortly after birth. The majority of the participants were partners or adult children of the person who died. The remainder comprised mothers, fathers and a sister.

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<sup>&</sup>lt;sup>1958</sup> Myndscape Consulting, Review of the Coroner's Act 1985: Final Report, March 2006.

<sup>&</sup>lt;sup>1959</sup> Namely, whether the Act provides an appropriate framework for the provision of support to families and friends of the person whose death is investigated by the Coroner, and in this regard which areas should be amended or modernised to better meet the needs of the community.

<sup>&</sup>lt;sup>1960</sup> Initially, 100 family members were approached; due to the low initial response rate, a further 100 family members were approached.

<sup>&</sup>lt;sup>1961</sup> Myndscape Consulting, Review of the Coroner's Act 1985: Final Report, March 2006, 24.

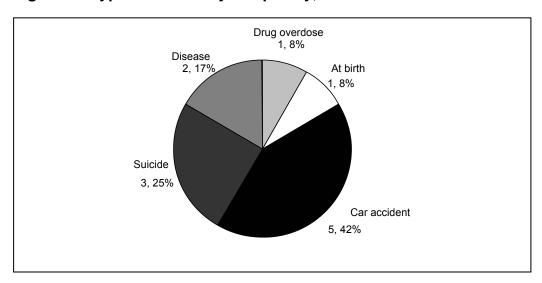


Figure 2 - Types of Death by Frequency,

Source: Myndscape Consulting, Review of the Coroners Act 1985: Final Report, March 2006, 22.

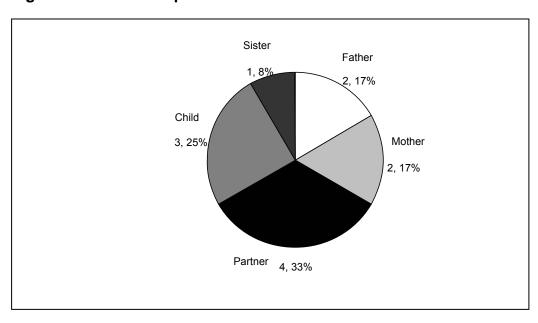


Figure 3 - Relationship to deceased

Source: Myndscape Consulting, Review of the Coroners Act 1985: Final Report, March 2006, 22.

This study fulfilled a number of ethical considerations which are referred to in the report. The Committee commissioned an ethics review of the proposed study from an external ethics consultant. Participants were approached via the Coroner's Office using a method designed to prevent the researchers from identifying the people approached unless the people agreed to be interviewed. Consent, confidentiality and the need for counselling were also addressed.

The researchers constructed a questionnaire by reviewing existing research on the bereavement process and by conducting interview discussions with the Committee and the Coroner's Office. The questionnaire contained 30 questions. Interviews of between one and two hours were conducted with one family representative, rather than the entire family, to encourage more open communication. The participants provided detailed descriptions of their experiences before, during and after the coronial process.

#### Limitations of the study

The main limitations of this study are its restricted sample size and potential sampling biases, which have obvious implications for the extent to which accurate generalisations can be drawn. The sample size was dictated by resource considerations as well as low initial response rates.

The study was cross-sectional rather than longitudinal. A longitudinal study would be necessary to draw strong conclusions regarding causal associations among variables and changes over time. There is a possibility of bias, in that the participants who volunteered to take part in the research may have differed in their personal experiences from those who declined to participate. Furthermore, the findings are based on self-reports, which are vulnerable to social desirability biases whereby participants may be influenced by what they perceive the interviewers want to hear. In addition, some interviewees may have been unable to recall some of the specific information sought by the questions, particularly given the nature of the subject matter and the grief they were undoubtedly experiencing at the time.

In spite of the above methodological limitations, the Committee believes that the study produced useful findings and recommendations concerning the needs of families in the coronial process. The results contain many similarities to those found in two recent UK studies in this area<sup>1962</sup> as well as to the evidence heard by the Committee from approximately 20 witnesses who had dealt with the coronial system.

#### Summary of consultants' research findings

The study revealed that families were unclear on the roles, functions and processes of the coroner as well as others associated with an investigation or inquest, such as the police. Family members were also unaware as to whether they were able to engage in specific processes throughout the coronial investigation, including, at the Coroner's Office, viewing or touching the person who died; being consulted about, and giving permission for, an autopsy; or viewing documentation considered by the coroner, including police briefs.

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<sup>&</sup>lt;sup>1962</sup> Lucy Biddle, 'Public Hazards or Private Tragedies? An Exploratory Study of the Effect of Coroner's Procedures on Those Bereaved by Suicide' (2003) *Social Science & Medicine* 56, 1033; Gwynn Davis et al, *Experiencing Inquests*, Home Office Research Study 241 (2002). Available at

<sup>&</sup>lt;a href="http://www.homeoffice.gov.uk/rds/pdfs2/hors241.pdf">http://www.homeoffice.gov.uk/rds/pdfs2/hors241.pdf</a>.

This report also revealed the need for improvements in the frequency of communication from the Coroner's Office regarding the progress of the investigation, the reasons for any delays and the time frames for completion of the investigation. In short, families wanted more frequent updates. Several participants commented that they would have been able to cope with delays far better had they been given reasons for those delays (in some cases that simply meant an explanation of the coronial process) and an expected time frame for the completion of an investigation. Families also suggested that the manner of communication was often too formal and matter-of-fact, with most wanting more sensitive personal contact in addition to formal approaches such as letters. Several participants thought that they should have been met in person by coronial staff for this purpose.

The need for families to be better informed about the availability of counselling and support services was another key finding of this research. The timing of this support was also raised, with participants suggesting that it should be offered throughout the process, not just at the beginning. When asked about the timing and quality of support services, more than half of the participants indicated that they were not satisfied, either because the timing was not appropriate or because they were not offered any support at all.

Finally, ways to improve the experiences of families attending an inquest hearing also emerged. One was better preparation for families through the provision of information on the inquest proceedings and what to expect. Another was increasing families' awareness of their right to obtain legal representation to help translate legal terminology and answer questions throughout the proceedings.

The findings of the study will be discussed further under relevant headings later in this chapter.

#### Evidence received by the Committee

In the early stages of the inquiry, the Committee identified the following key needs:

- the need to access information about the coronial process, including the need for a family involved in the process to be informed about their rights and key events, where possible; and
- the need for coronial law to accommodate, where possible, spiritual, cultural and other considerations.

These needs were confirmed during the Inquiry, in which the Committee received evidence from more than 20 family members who had been involved in the coronial system as a result of the death of a relative. In addition to the need for information about rights and key events, the evidence demonstrated a need for families to have certain specific rights under the Act which they do not currently have.

The evidence from witnesses raised similar issues to those which emerged in the consultants' research described above, as well as a range of additional concerns. The

evidence will be discussed in relation to specific topics later in the chapter, but some general observations should be made first.

The Committee found that the one of the most significant problems for families was simply lack of information. When a person dies, the family of that person needs any information that is relevant to their relative and the death. Such information assists families initially in making decisions and regaining a sense of control during difficult times, and ultimately in gaining a sense of resolution or closure. The evidence of these witnesses is consistent with existing psychological research which shows that clear information is important during times of grief. <sup>1963</sup> Information is also critical for families to be able to exercise their rights, such as the right to object to a coroner's direction that an autopsy be performed.

Apart from the need to be provided with sufficient information concerning the coronial process, the evidence of witnesses from families affected by the death of a relative included concerns in relation to:

- the length of the period between a death and the handing down of a coroner's finding, which in some cases was several years, and the lack of updates on the progress of the investigation;
- the carrying out of unnecessary autopsies in cases where there were no suspicious circumstances surrounding the death and the cause of death could be established in other ways;
- their inability to view and touch the body of the person who died while the body was in the coroner's jurisdiction;
- inadequate case investigations caused by a lack of thoroughness in collecting witness statements or by inexperienced coroner's assistants, particularly in the context of medical investigations;
- their inability in some cases to have a case investigated adequately or at all by the coroner, in circumstances where families had unanswered questions about the cause of death or felt that certain parties should be made accountable for the death:
- the adversarial nature of the inquest proceedings and the disparity of the legal representation available to families compared to that available to well-funded hospitals, government departments and large corporations;

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<sup>&</sup>lt;sup>1963</sup> See, eg, A L Beautrais, 'Suicide Postvention – Support for Families, Whānau and Signficant Others after a Suicide – A Literature Review and Synthesis of Evidence', *Report for the New Zealand Ministry of Youth Development* (2004), 14, 15, 38, 39. See also Elizabeth Kennedy, Royal Children's Hospital, *Submission no.* 17, 7.

- disappointment with regard to the failure of a coronial investigation to address systemic issues in areas such as mental health and aged care, particularly as a result of coronial recommendations being unenforceable;
- insensitive remarks or other mistreatment by unsympathetic coronial staff.

In addition to the evidence of family members, the Committee also received a large amount of evidence from other stakeholders in the coronial system about the needs of families and others affected by a death and the ways in which the Act could meet those needs. The Committee will discuss this evidence in the section of this chapter that examines the specific rights that family members have or should have under the Act.

However, one important issue should be raised at this stage. The Committee heard the view of some stakeholders that professionals working in coronial matters are faced with complex tasks in circumstances that can vary widely. Accordingly, there was a degree of resistance to the idea of prescribing various rights for families in the Act, on the basis that to do so would impede the investigation process in some cases 1964 and place unreasonable demands on professionals working in the system. In its submission the Coroner's Office suggested that there are some limits to the capacity of the Coroner's Office to meet all the needs of families; for example, when the death is a homicide and touching the body may involve contamination of the evidence. As a result, the Coroner's Office is of the view that the provision of information and appropriate services to families and others should not be prescribed as rights in the Act but should be included in the State Coroner's Office charter and remain open to interpretation on a case-by-case basis. 1965

#### Discussion and conclusion

Existing research, the findings of the Committee's external consultants and the evidence of a large number of witnesses all show that the needs of families are not being adequately met under the current legislation. The Committee acknowledges that many improvements to existing practices and procedures in the coronial system have already been made by dedicated staff. However, it is the Committee's view that such developments are not sufficient by themselves and that the problems highlighted in evidence to the inquiry can only be addressed adequately by changes to the legislation.

Therefore, the remaining sections of this chapter will consider the ways in which the Act might be improved to better meet the needs of families. The Committee examines, first, whether meeting the needs of families should be one of the express purposes of the Act before considering, second, the nature of specific rights that are or should be provided for in the Act.

<sup>&</sup>lt;sup>1964</sup> State Coroner's Office, Submission no. 70, 109. See also Shelley Robertson, Submission no 35, 8.

<sup>&</sup>lt;sup>1965</sup> State Coroner's Office, Submission no. 70, 109.

#### The needs of family members as a purpose of the Act

The primary purpose of the current Act is to provide a legislative framework for the reporting and investigation of notifiable deaths and fires. Section 1 of the Act provides that:

#### 1. Purpose

The purpose of this Act is to -

- (a) establish the office of the State Coroner;
- (b) require the reporting of certain deaths;
- (c) set out the procedures for investigations and inquests by coroners into deaths and fires;
- (d) establish the Victorian Institute of Forensic Medicine.

A question the Committee has considered is whether accommodating the needs of families should be an additional purpose of the Act. Answering this question requires consideration of both the historical and the presently evolving role of the coroner. The historical development of the role has already been discussed in chapter two of this report; however, a few observations should be made here.

The Committee has noted that office of Coroner or 'Crowner' has a long history which began with investigating deaths and acting as a tax collector for the Crown. The role of the coroner evolved over time to include making recommendations about public safety. However, historically, coronial investigations were not for the benefit of grieving families, but for the Crown, with the effect that traditionally the needs of families received little recognition by the system.

In recent years the needs of families have been recognised more clearly in the coronial jurisdictions around the world. In Victoria, since 1995 a Counselling and Support Service has operated within the Coroner's Office, and since 2004 that service has been integrated with the family liaison coordinators from the Donor Tissue Bank of Victoria (run by VIFM).<sup>1969</sup> This partnership is called the Family Liaison Service,

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<sup>&</sup>lt;sup>1966</sup> Some historians have found references to the office dating to the time of Alfred the Great, who ruled from AD 871. See for example Department of Justice, Equality and Law Reform (Ireland), '*Review of the Coroner Service - Report of the Working Group*' (2004) 2; New South Wales, *Parliamentary Debates*, Legislative Assembly, 29 October 2003, 16 (Graham West, Parliamentary Secretary).

<sup>&</sup>lt;sup>1967</sup> See for example State Coroner's Office, *Submission no. 70*, 43–55. See also Ian Freckelton and David Ranson, *Death Investigation and the Coroner's Inquest* (2006) 1–67.

<sup>&</sup>lt;sup>1968</sup> Lucy Biddle, 'Public Hazards or Private Tragedies? An Exploratory Study of the Effect of Coroner's Procedures on Those Bereaved by Suicide' (2003) *Social Science & Medicine* 56, 1033, 1043.

<sup>&</sup>lt;sup>1969</sup> See for example Victorian Institute of Forensic Medicine, Submission no. 40, 27.

which is responsible for coordinating contact with and providing information to families. These services, which are discussed in more detail later in this chapter, have greatly improved the experience of families who come into contact with the coronial process.<sup>1970</sup>

However, the evidence reviewed in this chapter demonstrates that there are many areas in which the legislation does not adequately recognise the needs of families, friends and others affected by the death of a person whose death is the subject of a coronial investigation.

#### Other jurisdictions

The coronial legislation in the ACT, Western Australia and Queensland has been substantially amended in recent years to better accommodate the needs of families. However, this purpose has not been recognised explicitly in the relevant statutes of any other Australian jurisdictions.

In New Zealand, the *Coroners Act 2006* includes as one its purposes recognition of 'the cultural and spiritual needs of family of, and of others who were in a close relationship to, a person who has died'.<sup>1971</sup> Further, the legislation describes the role of a coroner, which includes a requirement 'to give members and representatives of the immediate family notice of significant matters' in the carrying out of prescribed duties and processes in relation to a death.<sup>1972</sup>

#### Evidence received by the Committee

Witnesses were asked whether accommodating the needs of families should be a specific function of the Act. 1973 As discussed earlier, several witnesses, including the Coroner's Office, suggested that there are limits to the capacity of the Coroner's Office staff to meet all of the specific needs of families. However, the Coroner's Office is of the view that it has a duty to minimise the effect of an investigation on the grieving process and on everyone who is involved in a coronial investigation. Accordingly, the Coroner's Office recommended that section 1 of the Act should be amended so that one of the stated purposes of the legislation is to 'provide support for families, friends and others associated with a death which is the subject of a coronial investigation'. 1974

However, 'to provide support for families' could be read in a restricted sense as referring to counselling or similar services and would be a narrower purpose for the Act than to 'accommodate' or 'meet the needs of families' (as envisaged in the

<sup>&</sup>lt;sup>1970</sup> Ihid

<sup>&</sup>lt;sup>1971</sup> Coroners Act 2006 (NZ) s 3(2)(b)(i).

<sup>&</sup>lt;sup>1972</sup> Coroners Act 2006 (NZ) s 4(1)(f).

<sup>&</sup>lt;sup>1973</sup> Discussion paper, question 45.

<sup>1974</sup> State Coroner's Office, Submission no. 70, 58.

Attorney-General's Justice Statement). Thus, while the Coroner's Office is in favour of including support for families in the purposes of the Act, this should not be read as support for the broader proposition. The Coroner's Office noted that:

There will always be a tension between the coronial process required for proper investigations to be performed and its intrusion on grief and mourning for loved ones who have died.<sup>1976</sup>

This tension is certainly an issue for pathologists and other professionals working in the coronial system. For example, forensic pathologist Dr Shelley Robertson submitted that the needs of families should not form part of the legislation, as this may result in the loss of coronial ability to investigate a matter in a scientific and impartial manner in the interests of the community as a whole. However, most witnesses were in favour of the proposition that accommodating the needs of families should be a specific function of the Act, particularly those witnesses who had experienced the coronial system after the death of a family member.

#### Discussion and conclusion

The Committee agrees with the submission of the Coroner's Office that the Act should include as one of its purposes the provision of support for families, friends and others associated with a death which is the subject of a coronial investigation. However, the evidence received by the Committee has highlighted many problems experienced by families who feel totally excluded from the coronial system in ways that could not be addressed by improved support services alone. The terms of reference seek recommendations as to where the Act 'should be amended or modernised to better meet the needs of the community', and the Attorney-General's Justice Statement refers to improvements in the capacity of the coronial process to 'meet the needs of families'. 1978 Accordingly, the Committee considers that one of the purposes of the Act should be to accommodate the needs of, and provide support for, families, friends and others associated with a death which is the subject of a coronial investigation.

Recommendation 90. That section 1 of the *Coroners Act 1985* be amended to include, as a purpose of the Act: to accommodate the needs of and provide support for families, friends and others associated with a death which is the subject of a coronial investigation.

<sup>&</sup>lt;sup>1975</sup> Attorney-General's Justice Statement, 'New Directions for the Victorian Justice System 2004–2014', May 2004, 46.

<sup>&</sup>lt;sup>1976</sup> State Coroner's Office, Submission no. 70, 55.

<sup>&</sup>lt;sup>1977</sup> Shelley Robertson, Submission no. 35, 7.

<sup>&</sup>lt;sup>1978</sup> Attorney-General's Justice Statement, 'New Directions for the Victorian Justice System 2004–2014', May 2004, 46.

#### Definition of 'family' and 'senior next of kin'

Before the Committee considers what rights are, or should be, available to the family of a person who died, it is necessary to examine the question of which persons should be entitled to such rights.

At present the Act does not define the term 'family' and the term is barely used. 1979 However, the Act gives certain rights to persons considered to be the 'senior next of kin'. 1980

#### Senior next of kin

The concept of senior next of kin is important because, under section 29 of the Act, only the senior next of kin may object to an autopsy being performed. The definition of senior next of kin in section 29 establishes a hierarchy of people who may object to an autopsy.

Where the person who died had a spouse or domestic partner, this spouse or domestic partner is considered the senior next of kin. The term 'domestic partner' is defined broadly in section 3, which refers to circumstances where, among other things, two people live together and provide each other with personal or financial support of a domestic nature. The spouse or domestic partner, this spouse or domestic partner, the spouse or domestic partner is domestic partner, the spouse or domestic partner is domestic partner, the spouse or domestic partner is domestic partner.

If the person who died did not have a spouse or partner (or if the spouse or partner is not available), the senior next of kin is an adult child of the person who died. 1984

If the person who died did not have any adult children (or if none of the children is available), then the senior next of kin is a parent of the person who died. 1985

If a parent is not available, then the senior next of kin is an adult sibling. Where no such person is available, the senior next of kin is the person named as the executor in the will of the person who died, or their personal representative. 1986

<sup>&</sup>lt;sup>1979</sup> It is only used in Pt 9: *Coroners Act 1985* ss 66A(4)(c), (d). The word 'family' is also contained in the example provided in s 66A.

<sup>&</sup>lt;sup>1980</sup> Coroners Act 1985 s 29(5).

<sup>&</sup>lt;sup>1981</sup> Coroners Act 1985 s 29(1), (3).

<sup>&</sup>lt;sup>1982</sup> Coroners Act 1985 s 29(5)(a).

<sup>&</sup>lt;sup>1983</sup> Coroners Act 1985 s 3.

<sup>&</sup>lt;sup>1984</sup> Coroners Act 1985 s 29(5)(b).

<sup>&</sup>lt;sup>1985</sup> Coroners Act 1985 s 29(5)(c).

<sup>&</sup>lt;sup>1986</sup> Coroners Act 1985 s 29(5)(d).

#### Other jurisdictions

The definition of 'senior next of kin' in most jurisdictions is similar to the Victorian definition. The New South Wales, Western Australia, Tasmanian and Northern Territory legislation all contain a definition of 'senior next of kin'.

However, Tasmania, and the Northern Territory also recognise Indigenous familial relationships within their definitions. The definition of senior next of kin used in Tasmania includes:

(f) if the person is an Aborigine, a person who, according to the customs and tradition of the community or group to which the person belongs, is an appropriate person.<sup>1988</sup>

The ACT and Queensland legislation also recognises such relationships, but does so within definitions of 'immediate family' and 'family member' respectively, rather than 'senior next of kin'.

In Western Australia, the definition of 'senior next of kin' does not include a 'domestic partner' as in Victoria but instead refers to a 'marriage-like relationship'. The definition also gives priority (in relation to autopsy objections) to partners who lived with the person who died immediately before the death:

- s. 37 Objections to Post Mortem Examinations
- (5) In this section, unless otherwise prescribed, "senior next of kin" in relation to the deceased person means the first person who is available from the following persons in the order of priority listed —
- (a) a person who, immediately before the death, was living with the person and was either
  - (i) legally married to the person; or
  - (ii) of or over the age of 18 years and in a marriage-like relationship (whether the persons are different sexes or the same sex) with the person;
- (b) a person who, immediately before death, was legally married to the person;
- (c) a son or daughter...

<sup>&</sup>lt;sup>1987</sup> Coroners Act 1995 (Tas) s 3: Definition of senior next of kin; Coroners Act 1997 (ACT) s 3: Definition of 'immediate family member'; Coroners Act 1993 (NT) s 3: Definition of 'senior next of kin'; Coroners Act 2003 (Qld), Schedule 2: Definition of 'ATSI family member'.

<sup>&</sup>lt;sup>1988</sup> Coroners Act 1995 (Tas). This paragraph is mirrored in the Northern Territory: Coroners Act 1993 (NT) s 3. Cf the definition of 'ATSI family member' used in the Coroners Act 2003 (Qld), Schedule 2.

<sup>&</sup>lt;sup>1989</sup> Coroners Act 1996 (WA) s 37.

Similarly, in New South Wales, where more than one person is considered to be a spouse, then the latest spouse is determined to be the senior next of kin. 1990

#### **Family**

As noted earlier, the Act at present does not contain a definition of family. It could be said that there is no need for such a definition in the Act at present, as it does not provide rights to family members other than the senior next of kin.

However, in this chapter the Committee has recommended the creation of a number of rights which would apply to people other than the senior next of kin. Accordingly, the issue arises as to how such other people are to be defined in the Act.

#### Other jurisdictions

In Western Australia, only the senior next of kin may object to an autopsy, as noted above. However, the Act gives a number of rights to other family members, such as the right to be informed of certain matters. The legislation defines such family members as the 'next of kin under section 37(5)', the effect of which is to include all of the categories of people referred to in the definition of senior next of kin.

In the ACT, the legislation gives certain rights to the 'immediate family', which is defined as:

- (a) a person who was the domestic partner of the deceased, or a parent, grandparent, child, brother or sister, or guardian or ward, of the deceased; and
- (b) if the deceased was an Aboriginal person or Torres Strait Islander—a person who, in accordance with the traditions and customs of the Aboriginal or Torres Strait Island community of which the deceased was a member, had the responsibility for, or an interest in, the welfare of the deceased. 1991

For example, a member of the immediate family of the person who died may request that a coroner dispense with the conduct of a post-mortem examination of the body. Thus the ACT does not designate one person as the senior next of kin, as is the case in all other Australian jurisdictions.

The Queensland legislation contains the term 'family member' and provides, for example, that a coroner must, before ordering an internal examination of a body, consider any concerns raised by a family member. The definition in the Queensland Act of the term 'family member' is almost identical to the definitions of 'senior next of kin' used in other jurisdictions, in that it sets out a similar hierarchy of persons

<sup>&</sup>lt;sup>1990</sup> Coroners Act 1980 (NSW) s 4: Definition of 'spouse'.

<sup>&</sup>lt;sup>1991</sup> Coroners Act 1997 (ACT) s 3.

<sup>&</sup>lt;sup>1992</sup> Coroners Act 1997 (ACT) s 20(2).

considered to be a 'family member'. In this case, as in the other states, one person is designated as having the right to object to an autopsy etc.

#### Law reform agencies

In New Zealand, the *Coroners Act 2006* contains a broad definition of immediate family that includes:

- (a) members of the dead person's family, whānau, or other culturally recognised family group, who:
  - (i) were in a close relationship with the person; or
- (ii) had, in accordance with customs or traditions of the community of which the person was part, responsibility for, or an interest in, the person's welfare or best interests.
- (b) to avoid doubt, includes persons whose relationship to the dead person is, or is through one or more relationships that are, that or those of: --
  - (i) spouse, civil union partner, or de facto partner of the dead person;
  - (ii) child, parent, guardian, grandparent, brother, or sister of the dead person;
  - (iii) stepchild, stepparent, stepbrother, or stepsister of the dead person. 1993

The New Zealand Law Commission's recommendations in this area, prior to the drafting of the new legislation, were influenced by the approach adopted in the ACT legislation. <sup>1994</sup> Interestingly, the *Coroners Act 2006 (NZ)* provides explicitly that every family member may object to an autopsy. <sup>1995</sup> The issue of who should be able to object to an autopsy is discussed later in this chapter.

#### Evidence received by the Committee

Witnesses highlighted two main areas where the current definition of 'senior next of kin' is problematic. The first is in relation to family disputes as to who is the senior next of kin, and the second is in relation to Indigenous and other cultural concepts of family and senior next of kin. The Committee will discuss those two areas below.

#### Family disputes as to who is the senior next of kin

A few witnesses stated that the current definition of 'senior next of kin' is satisfactory, while others found it inadequate and potentially discriminatory. Associate Professor

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<sup>&</sup>lt;sup>1993</sup> Coroners Act 2006 (NZ) s 7. The Committee notes that in Victoria the Act defines 'parent' to include stepparents, adoptive parents, foster parents, guardians etc, whereas the terms 'son' and 'daughter' used in s 29 are not similarly defined: Coroners Act 1985 s 3.

<sup>&</sup>lt;sup>1994</sup> New Zealand Law Commission, *Coroners*, Report no. 62 (2000), 101.

<sup>&</sup>lt;sup>1995</sup> Coroners Act 2006 (NZ) s 31(2).

David Ranson and others commented that the notion of the senior next of kin is simply not representative of the reality of family relationships:

The definition of certain family members has been covered a number of times in legislation and the Coroners Act defines some of these for the purposes of reviewable death. In practice however the question as to which members of a family a coroner should communicate with in respect of the death investigation is far more complex. On a legal basis it is far easier to define a single individual such as the senior next of kin as the conduit for all information to and from the family. This however does not take into account the reality of family dynamics. Problems emerge when the senior next of kin is a very elderly or frail individual or one whose mental status is uncertain. In some situations the senior next of kin will be completely estranged from the remainder of the family (including the deceased) and may specifically exclude other family members who were closer to the deceased from all decisions or involvement with the coroner's process. Particular problems have occurred when the senior next of kin is a new live-in boyfriend or girlfriend who must be considered the de facto of a young deceased person and where this individual then specifically excludes the parents of the deceased from all aspects of the decisions that must be made in relation to the coroner's investigation and subsequent disposal of the body. 1996

These comments were reflected in the submission by the Coroner's Office, which noted that family structures have changed substantially since 1985. The experience of the Coroner's Office is that the person who meets the current criteria of senior next of kin is often not the most appropriate person to be making decisions about the body of the deceased.<sup>1997</sup>

For example, in circumstances where the person who died had been separated from his or her spouse for a long time but has not divorced, the senior next of kin under the current definition remains the spouse, even when there are adult children or a new partner who have a closer relationship with the person who died. At the other end of the scale is the example provided by Associate Professor Ranson, where a person could claim the status of senior next of kin after living in a domestic relationship for only a short time with the person who died, potentially excluding close family members from the decision making process.

Accordingly, the Coroner's Office recommended that Victoria adopt the definition of 'senior next of kin' used in the Western Australia Act, which applies a stricter test in relation to unmarried partners, referring to a 'marriage-like' (including same-gender) relationship instead of a 'domestic partnership'. However, the Western Australia Act gives clear priority to a partner who, immediately before the death, was living with the person who died over a spouse with whom the person was no longer living.

<sup>&</sup>lt;sup>1996</sup> David Ranson, Submission no. 19, 69-70.

<sup>&</sup>lt;sup>1997</sup> State Coroner's Office, Submission no. 70, 83-4.

<sup>&</sup>lt;sup>1998</sup> Coroners Act 1985 s 29(5); Coroners Act 1996 (WA) s 37(5). Both definitions include same-gender partnerships.

The Federation of Community Legal Centres (Vic) Inc (FCLC) submitted that the Act should have a very broad definition of 'family member' that includes carers and other interested parties. FCLC stated that this is particularly important where the person who died had a psychiatric disability, as often there will have been tensions and unresolved conflicts between that person and their carers or family. In such circumstances, it may be beneficial for the coroner concerned to have access to third parties such as friends who have independent experience and knowledge and who can provide insight into the life of the person who has died.

Constituents of East Yarra Province suggested that the term 'family member' can be interpreted in a broader sense nowadays, especially where the deceased did not have any living blood relatives. Their observation is consistent with the suggestion by the State Coroner that there have been changes in the structures of modern families and the way the community perceives the concept of family. The Royal Women's Hospital also submitted that, if defined in the Act, the term 'family member' should be defined as broadly as possible.

Finally, witnesses such as Dr Patrick van der Hoeven, of Gippsland Pathology Service, submitted that a definition of family should be given but that there should be scope for reasonable extension of family privileges by the coroner in appropriate circumstances.<sup>2002</sup>

### Indigenous and other cultural concepts of 'family' and 'senior next of kin'

Problems may arise where the relevant definitions do not take into account cultural differences regarding the structure of the family and its relationship to the community, or family structures that do not fit within the prescribed definition.

In addition to the question of whether the definition of senior next of kin is problematic, witnesses were also asked whether the term 'family member' should be defined in the Act (and whether anyone other than the 'senior next of kin' should be able to object to an autopsy). In general, witnesses considered that the term 'family member' or 'family' should be defined broadly in future legislation.

The Victorian Aboriginal Legal Service Co-operative Ltd (VALS) argued in its submission that the definitions in the Act should reflect an understanding of the relevance of Aboriginal culture and history. VALS submitted that the Act should define the term 'family member', and that Indigenous Australian familial relationships should be included in the definition. It argued that the exclusion in section 29 of the Act of persons other than the 'senior next of kin' is discriminatory, as it results in a failure to

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<sup>&</sup>lt;sup>1999</sup> Constituents of East Yarra Province, Submission no. 20, 7.

<sup>&</sup>lt;sup>2000</sup> State Coroner's Office, *Submission no. 70*, 68-69.

<sup>&</sup>lt;sup>2001</sup> Royal Women's Hospital, *Submission no. 18*.

<sup>&</sup>lt;sup>2002</sup> Patrick van der Hoeven, Submission no. 6, 3.

consider the needs of the Aboriginal community by excluding Aboriginal elders and respected persons. Similarly, the term 'family member' needs to take into account the differing nature and constitution of Indigenous Australian families and family relationships, which involve extended family or kinship networks.

VALS reiterated the views put forward in its submission to the Implementation Review Team of the Royal Commission into Aboriginal Deaths in Custody (RCADC) as at July 2004. In that submission, VALS noted that the RCADC made 179 recommendations concerning the criminal justice and coronial systems and that these recommendations have not been adequately legislated for in relation to coronial systems. Recommendation 8 proposed:

[t]hat the State Coroner be responsible for the development of a protocol for the conduct of coronial inquiries into deaths in custody and provide such guidance as is appropriate to Coroners appointed to conduct inquiries and inquests.<sup>2005</sup>

#### Recommendation 38 states:

[t]he Commission notes that whilst the conduct of a thorough autopsy is generally a prerequisite for an adequate coronial inquiry some Aboriginal people object, on cultural grounds, to the conduct of an autopsy. The Commission recognises that there are occasions where as a matter of urgency and in the public interest the Coroner may feel obligated to order that an autopsy be conducted notwithstanding the fact that there may be objections to that course *from members of the family or community of the deceased*.

The Commission recommends that in order to minimise and to resolve difficulties in this area the State Coroner or the representative of the State Coroner should consult generally with Aboriginal Legal Services and Aboriginal Health Services to develop a protocol for the resolution of questions involving the conduct of inquiries and autopsies, the removal and burial of organs and the removal and return of the body of the deceased. It is highly desirable that as far as possible no obstacle be placed in the way of carrying out of traditional rites and that relatives of a deceased Aboriginal person be spared further grief. The Commission further recommends that the Coroner conducting an inquiry into a death in custody should be guided by such protocol and should make all reasonable efforts to obtain advice from the family and community of the deceased in consultation with relevant Aboriginal organisations.<sup>2006</sup>

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<sup>&</sup>lt;sup>2003</sup> Victorian Aboriginal Legal Service Co-Operative Limited, 'Submission to the Implementation Review Team of The Royal Commision into Aboriginal Deaths in Custody as at July 2004', (2004). Available at:

http://www.vals.org.au/news/submissions/7%20 VALS%20 submission%20 RCIADIC%20%20 Implementation%2019-7-04.pdf.

<sup>&</sup>lt;sup>2004</sup> See also Amnesty International, 'Deaths in custody: how many more?' (1997) 2(4) *Aboriginal Indigenous Law Reporter* 551. Available at

http://web.amnesty.org/library/pdf/ASA120041997ENGLISH/\$File/ASA1200497.pdf.

<sup>&</sup>lt;sup>2005</sup> Royal Commission into Aboriginal Deaths in Custody, *National Report* (1991) vol 1, Recommendation 8.

<sup>&</sup>lt;sup>2006</sup> Ibid Recommendation 38 (emphasis added).

VALS considered that the current definition of 'senior next of kin' is inadequate as it does not make provision for the above recommendations. VALS considers that the Act is discriminatory towards members of the Aboriginal community, Aboriginal elders and respected persons. This is particularly so in its exclusion under section 29 of people other than senior next of kin from objecting to autopsies, as these people may have cultural interests in whether or not an autopsy is performed.<sup>2007</sup> As a result, VALS considers that the Act does not reflect an understanding of how Aboriginal culture and community relate to coronial investigations.

VALS submitted that the Act should be amended to reflect the following comments by Commissioner Elliott Johnson QC of the RCADC, which were supported by Beach J in *Green v Johnstone*:<sup>2008</sup>

[N]o autopsy should be performed until the coroner has made every reasonable effort to contact the deceased's family and other interested persons to give them an opportunity to make representations in relation to the conduct of an autopsy.<sup>2009</sup>

VALS notes that Commissioner Johnson did not limit standing to next of kin but referred to 'other interested persons', which could incorporate Indigenous community members, Aboriginal elders and respected persons.

VALS referred to the case of *Green v Johnstone*,<sup>2010</sup> in which the most senior Aboriginal man in the Gippsland region did not have standing to initiate an objection to an autopsy. The senior Aboriginal man could only write an affidavit supporting the objections of the senior next of kin to an autopsy. The facts of this case are discussed later in this chapter in relation to the right to object to autopsies. For present purposes, the relevant aspect of the case is that a respected elder did not have the requisite standing to object, having fallen outside the definition of senior next of kin, despite the fact that such persons play an important part in the decision making of Indigenous Australians.

Accordingly, VALS suggested that the Act should be amended to reflect the *Coroners Act 1993* (NT), which as noted above includes the following in the definition of next of kin: 'where a person is an Aborigine – a person who, according to the customs and tradition of the community or group to which the person belongs, is an appropriate person'.<sup>2011</sup> VALS also considers that a protocol needs to be established about cultural issues in relation to objections to an autopsy.

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<sup>&</sup>lt;sup>2007</sup> See discussion below of the effect of autopsies on Aboriginal culture under the heading, 'Right to Object to Autopsies' (emphasis added).

<sup>&</sup>lt;sup>2008</sup> *Green v Johnstone* [1995] 2 VR 176. This case is discussed further below under the heading 'Right to object to autopsy'.

<sup>&</sup>lt;sup>2009</sup> Victorian Aboriginal Legal Service (VALS), Submission no. 57.

<sup>&</sup>lt;sup>2010</sup> Green v Johnstone [1995] 2 VR 176.

<sup>&</sup>lt;sup>2011</sup> Coroners Act 1993 (NT) s 3(e).

The Committee invited a broad cross-section of community groups to participate in this inquiry, and it acknowledges that there is a range of cultural concepts of what constitutes family and senior next of kin. However, the Committee received limited evidence in relation to cultures other than those of Indigenous Australians and Pacific Islanders. The Committee appreciated the helpful submission by the South Pacific Foundation of Victoria Inc (SPFV) in relation to the definitions of family and senior next of kin in this community. Once again, the definitions currently in the Act appear unsatisfactory when considered from the view of a different culture. SPFV submitted that it is vital that definitions of 'family' and 'senior next of kin' be drafted so as to allow collective decision making processes, which are integral to the cultural communities it represents, to take precedence over individual decision making. 2012 SPFV also stated that there needs to be scope for persons other than the senior next of kin as currently defined to object to the carrying out of an autopsy. 2013 The Committee notes, however, that this view of the primacy of collective rights is not easily accommodated in a legal system which commonly deals with individual rights. Consideration for collective rights could likely only be encouraged by providing the coroner with the discretion to allow a case-by-case assessment.

Finally, the Committee notes that the Coroner's Office submitted that it is sensitive to the collective decision making processes adopted by some cultures in determining appropriate responses to the death of family members.<sup>2014</sup> It appears that, while the legislative definition of senior next of kin has shortcomings in this area, significant efforts are made to accommodate different cultural needs.<sup>2015</sup>

#### Discussion and conclusion

The Committee found that there are situations in which the existing definition of senior next of kin is unsatisfactory or inadequate. The Committee's view is that the legislation needs in particular to overcome the problems identified by witnesses in relation to disputes between families and spouses and to accommodate Indigenous and other cultural concepts of family and senior next of kin.

Given the problems identified by the Coroner's Office and Associate Professor Ranson, the Committee considered whether the reference in section 29 of the Act to a 'domestic partner' should be replaced with a more stringent test, such as that used in Western Australia, where the definition of senior next of kin includes a person in 'a marriage-like relationship'.<sup>2016</sup> The Committee notes that the Victorian Government

<sup>&</sup>lt;sup>2012</sup> SPFV submitted, for example, that this would also prevent 'non-cultural' spouses from making decisions which are inappropriate in terms of cultural protocols and therefore erode the cultural rights of both the person who died and the family. An example is where the community wishes to return the body of the person who died to his or her native country.

<sup>&</sup>lt;sup>2013</sup> South Pacific Islander Association of Victoria Inc, *Submission no. 54*, 14, 19.

<sup>&</sup>lt;sup>2014</sup> State Coroner's Office, Submission no. 70, 84.

<sup>&</sup>lt;sup>2015</sup> State Coroner's Office, Submission no. 70, 109.

<sup>&</sup>lt;sup>2016</sup> Coroners Act 1996 (WA) s 37.

conducted a thorough review of Victorian legislation in 2001 for the purpose of identifying and amending any discriminatory provisions, leading to the enactment of the *Statute Law Amendment (Relationships) Act 2001*. This legislation introduced the term 'domestic partner' into various Victorian Acts, including the *Coroners Act 1985*, to recognise the rights and liabilities of partners in domestic relationships.<sup>2017</sup> Thus the Committee's view is that the reference in section 29 of the Act to a 'domestic partner' should not be changed.

However, the *Statute Law Amendment (Relationships) Act 2001* adopted two definitions of the term 'domestic partner'. The broader of these two definitions was introduced to certain statutes, including the *Coroners Act 1985*. In light of the evidence it received, the Committee considers that this approach should be revisited, and that the definition of the term 'domestic partner' in section 3 of the Act should be amended to the narrower, principal definition of domestic partner, which defines such a person as: 'a person to whom the person is not married but with whom the person is living as a couple on a genuine domestic basis (irrespective of gender)'. The Committee considers that the use of the term 'genuine domestic basis' achieves the same outcome as the suggested use of the term 'marriage-like relationship' as a descriptive tool in assessing the merit of a domestic partner's claim to be the senior next of kin, but is consistent with other Victorian legislation and equal opportunity principles.

Further, to address the problem of separated spouses exercising rights when adult children or a new partner have a closer relationship with the person who died, the Committee also considers that the definition of senior next of kin should be amended to reflect the structure of the definition in Western Australia. This would give priority to a domestic partner who, immediately before the death, was living with the person who died, over another person who was legally married to the person who died, provided that the new relationship was established as a genuine domestic relationship.

In relation to the needs of Indigenous Australians, the Committee considered the submission by VALS that the definition of family member and senior next of kin should include a special provision relating to Indigenous Australians, as used in the definition of senior next of kin in the *Coroners Act 1993* (NT). While the Committee agrees with this in principle, it also considers that the Act should accommodate other cultural concepts of family and senior next of kin.

Thus the Committee considers that the definition of such terms should be drafted broadly, as is the case in the Coroners Act 2006 (NZ), to include members of

<sup>&</sup>lt;sup>2017</sup> See also Scrutiny of Acts and Regulations Committee, 'Discrimination in the Law: Inquiry Under Section 207 of the Equal Opportunity Act 1995', September 2005; and Victorian Government, *Response to Report on Discrimination in the Law: Inquiry under Section 207 of the Equal Opportunity Act 1995*, March 2006;

<sup>&</sup>lt;sup>2018</sup> See for example *State Superannuation Act 1988* s 3, definition of 'domestic partner'.

'culturally recognised group[s]' who 'had, in accordance with the customs or traditions of the community of which the person was part, responsibility for, or an interest in, the welfare of the deceased'.<sup>2019</sup>

The Committee has also considered whether the coroner ought to have a discretion to depart from the definition of senior next of kin where this is necessary in the interests of justice in order to accommodate the reality of family dynamics in a particular case. The addition of such flexibility might assist coroners in taking into account particular cultural needs or close relationships not covered by the definitions. However, the Committee considers that the Act needs to retain as far as possible the guidance provided to coroners by clear definitions, particularly in relation to autopsy objections, given the potential for disputes to arise between family members. 2021

The Committee notes that the definition of 'senior next of kin' used in the Northern Territory provides a degree of discretion to a coroner, albeit limited to circumstances where none of the persons in the defined categories (spouse, children, parent etc) are available, in which case the senior next of kin is someone who had a relationship with the person who died that, in the opinion of the coroner, is sufficient for the purpose of being the senior next of kin.<sup>2022</sup> The Committee recommends that a similar provision be included in the Victorian Act.

Later in this chapter the Committee has recommended the provision of certain rights to family members other than the senior next of kin, and for this reason this group also needs to be defined. The Committee notes that the approach in Western Australia is to define 'next of kin' (who have certain rights, for example, to information) by reference to all of the persons listed in the definition of 'senior next of kin'. The Committee considers that a similar approach should be adopted in Victoria, although it considers that the term 'immediate family' rather than 'next of kin' would be more appropriate to accommodate the recommendations in this report.

Recommendation 91. That the *Coroners Act 1985* be amended to define 'senior next of kin' as the first person who is available from the following persons in the order of priority listed:

- a) a person who, immediately before the death, was living with the person and was either
  - (i) legally married to the person;

<sup>&</sup>lt;sup>2019</sup> Coroners Bill 2006 (NZ) s 7.

<sup>&</sup>lt;sup>2020</sup> See for example the concerns expressed by Aron Gingis in relation to his father-in-law: Aron Gingis, *Minutes of Evidence*, *20 September 2005*, 145–6, 149–50.

<sup>&</sup>lt;sup>2021</sup> Coroners Act 1993 (NT) s 3.

<sup>&</sup>lt;sup>2022</sup> Coroners Act 1993 (NT) s 3.

<sup>&</sup>lt;sup>2023</sup> Coroners Act 1996 (WA) ss 20, 37(5).

- (ii) a domestic partner of the person;
- b) a person, who, immediately before the death, was legally married to the person;
- c) a son or daughter, who is of or over the age of 18 years, of the person;
- d) a parent of the person;
- e) a brother or sister, who is of or over the age of 18 years, of the person;
- f) a person who had, in accordance with the customs or traditions of the community of which the person was part, responsibility for, or an interest in, the welfare of the person who has died.
- g) an executor named in the will of the person or a person who, immediately before the death, was a personal representative of the person; or
- h) any person nominated by the person to be contacted in an emergency;
- i) where paragraphs (a) to (h) do not apply or a person who would be the senior next of kin under those paragraphs is not available a person who immediately before the death had a relationship with the person who died that, in the opinion of the coroner, is sufficient for the purpose of being the senior next of kin.

Recommendation 92. That the definition of 'domestic partner' in the Act be amended to 'a person to whom the person is not married but with whom the person is living as a couple on a genuine domestic basis (irrespective of gender)'.

Recommendation 93. That the *Coroners Act 1985* be amended to include a definition of 'immediate family' that includes all of the categories of people referred to in the definition of senior next of kin.

#### Rights of family members under the Act

At the beginning of this chapter the Committee discussed the needs of families affected by the coronial system and considered whether those needs are currently being met. The Committee concluded that there were deficiencies in many areas that could be addressed by amendments to the Act giving families important and specific rights, including rights to information, which they do not currently have. This part of the chapter will discuss a range of such rights and whether they should be included in the amended legislation.

The Committee recognises that members of staff at the Coroner's Office and VIFM currently perform an important role in communicating information to family members and engaging with them on issues such as autopsies. They have been increasingly proactive in this regard, particularly as a result of the Family Contact Program, which is discussed later in this chapter. They have also published, in conjunction with

Victoria Legal Aid (VLA), an information booklet for family and friends on the coronial process.<sup>2024</sup>

However, there are a number of areas where the needs of families are not being met by the current system and in respect of which the Committee believes families are too dependent on the non-mandatory initiatives of staff members and other professionals in the coronial jurisdiction.

#### Right to view or touch the body while in the coroner's jurisdiction

A coroner has control over the body of a person who has died if the death was reportable,<sup>2025</sup> and under the Act family members do not have the right to view or touch the body until the coroner releases the body for burial or cremation.

Yet many families feel a need to view their relative's body in its natural state prior to cosmetic changes by a funeral home. The last opportunity to do so may be while it is under the coroner's jurisdiction. For some communities, such as Pacific Islanders, it is particularly important for relatives to be able to touch the body of the person who has died.<sup>2026</sup> When a person dies in custody, it may also be especially important for some members of the family to view the body or have their own doctor or representative view the body before an autopsy is performed.

However, there may be practical and legal obstacles to such viewing and, in particular, touching; for example, where there is a risk of contaminating evidence relevant to a criminal investigation or where there are health and safety issues.

Viewing the body of the person who died, which may include time spent in the presence of the body, should be distinguished from identification of a body for police purposes, which is likely to be a much more limited process.

#### Other jurisdictions

In the ACT, Western Australia and Queensland, family members are given legal rights of access to the body of the person who has died.

In the ACT, immediate family members or representatives involved in an inquest may make a request to the coroner to view the body.<sup>2027</sup> If the coroner refuses the request

<sup>&</sup>lt;sup>2024</sup> State Coroner's Office and Victorian Institute of Forensic Medicine, *The Coroner's Process: Information for Family and Friends* (2005). This booklet, a revised edition of an earlier version, was published in conjunction with the Victoria Law Foundation. It is discussed further in this chapter under the heading, 'Counselling and support services'.

<sup>&</sup>lt;sup>2025</sup> Coroners Act 1985 s 24: Control is subject to the directions of the State Coroner and ends when the Coroner issues a certificate permitting burial or cremation.

<sup>&</sup>lt;sup>2026</sup> Prue Vines, 'Objections to Post-Mortem Examination: Multiculturalism, Psychology and Legal Decision Making' *Journal of Law and Medicine*, vol 7, May 2000, 42.

<sup>&</sup>lt;sup>2027</sup> Coroners Act (ACT) (1997) s 23(1)(a).

on the basis that it would not be in the public interest or the interests of justice to do so, the coroner must give the person who made the request written notice of the refusal and an explanation for the refusal.<sup>2028</sup> In Western Australia, the next of kin may view the body while it is under the control of the coroner.<sup>2029</sup> They may also touch the body, unless the coroner determines that it is undesirable or dangerous to do so.<sup>2030</sup>

The Queensland guidelines advise coroners that the family should be provided with an opportunity to view the body if possible, although the relevant guideline appears to be particularly directed to viewing the body at the death scene.<sup>2031</sup>

#### Law reform agencies

In 2000 the Law Commission of New Zealand recommended that the New Zealand *Coroners Act* be amended to give the family, with the consent of the coroner, the option of viewing and touching the body before an autopsy is performed.<sup>2032</sup>

The Commission noted that none of the submissions to its inquiry had raised any objection to this option in principle.<sup>2033</sup> However, certain practical reservations were expressed by pathologists.<sup>2034</sup> The main reservation was that bodies should be protected from contamination in cases of suspicious death. Pathologists from Health Waikato Hospital noted that visitors cannot be left unattended in the mortuary area, in the interests of ensuring that the premises, specimens and bodies are secure, and that the proposed option would tie up available staff members. A further problem with touching prior to an autopsy is that occasionally it is only discovered afterwards that a death is a homicide. Finally, the pathologists were concerned about the time factor and that prayers and similar practices create delay. The Commission heard that, while there are no general medical reasons that touching should not be allowed, there are categories where such an option would not be straightforward, such as homicides where the body is badly deteriorated or incinerated, or where infectious diseases are present. The Commission recognised that some upgrading of mortuary facilities would be required to facilitate its proposal and that protocols would need to be developed

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<sup>&</sup>lt;sup>2028</sup> Coroners Act (ACT) (1997) s 23(2). Cf Coroners Act (ACT) (1997) s 70(1)(a) in relation to deaths in custody.

<sup>&</sup>lt;sup>2029</sup> Coroners Act 1996 (WA) s 20(1)(f).

<sup>&</sup>lt;sup>2030</sup> Coroners Act 1996 (WA) s 20(1)(c).

<sup>&</sup>lt;sup>2031</sup> State Coroner's Guidelines — Version 0 December 2003, para 3.4.1. Available at

http://www.justice.qld.gov.au/courts/coroner/pdfs/guidelines.pdf.

<sup>&</sup>lt;sup>2032</sup> Law Commission of New Zealand, *Coroners*, Report no. 62 (2000), 89. The Committee notes that section 23 of the *Coroners Act 2006* (NZ) now permits immediate family members, their representatives, or people chosen by the family to perform religious or similar functions, to view, touch and remain near the body when authorised by the coroner.

<sup>&</sup>lt;sup>2033</sup> Ibid 88.

<sup>&</sup>lt;sup>2034</sup> Ibid 89.

with input from sectors such as police, pathologists and hospitals to ensure the security of the body and the integrity of the autopsy.<sup>2035</sup>

The RCADC in its final report recommended that, when a death in custody occurs, the family of the person who has died should have the right to view the body unless the coroner directs otherwise.<sup>2036</sup>

#### **Evidence received by the Committee**

Witnesses to the inquiry who had experienced the death of a family member generally felt that there should be an almost unrestricted right to view and touch the body of the person who died. An exception to this right would be where there were suspicions that a family member might interfere with the body in some way.

The following statement by a witness, Ms Caroline Storm, indicates how important the ability to view or touch is to family members:

Holding my dead daughter six days after her death, when she was returned to me at the funeral home, is a memory so painful, so precious, I wish I could have done it earlier. I was too shocked to ask....there should be no limit to that strange gift of grace.<sup>2037</sup>

The Committee was concerned that in some cases there had been substantial suffering as a result of the lack of an opportunity to view and touch the body. Witness to this inquiry Ms Carol Smith described the difficulties she and her family had experienced after the death of her son in a motorcycle accident. Ms Smith stated that when she first went to see her son, in a rural hospital pathology department, he was presented in a physical state that only added to their trauma, while they had to view him from behind a glass screen. She said:

We could not touch him, we could not be with him, we could not do anything. 2038

Ms Hazel Watt, the grandmother of the victim, commented in her submission to the Committee that this viewing provided 'very little comfort'.<sup>2039</sup> The situation apparently resulted from a decision by the coroner that the body could not be touched until an autopsy was performed.<sup>2040</sup> Ms Smith told the Committee:

<sup>2036</sup> Royal Commission into Aboriginal Deaths in Custody, *National Report* (1991) vol 1, Recommendation 25. As an aid to readers, the recommendations relating to coroners' inquests are listed in Appendix 7 to this report. A review of all the recommendations has been conducted on behalf of the Victorian Aboriginal Justice Forum by the Victorian Implementation Review at the Department of Justice.

<sup>&</sup>lt;sup>2035</sup> Ibid.

<sup>&</sup>lt;sup>2037</sup> Caroline Storm, Submission no. 28.

<sup>&</sup>lt;sup>2038</sup> Carol Smith, *Minutes of Evidence*, 22 August 2005, 21.

<sup>&</sup>lt;sup>2039</sup> Hazel Watt, Submission no. 26.

<sup>&</sup>lt;sup>2040</sup> Carol Smith, *Minutes of Evidence*, 22 August 2005, 23.

I believe our family went through very significant additional trauma for no reason. We were not able to get a dignified viewing except by arranging for that in the hour before the funeral commenced. That was for a pregnant wife, me, his father, his youngest brother and his stepbrother, who happened to be his best friend. Yet at the viewing we had arranged the night before, his wife, Sarah, had arranged for a number of his mates to come, my mother was there, and it was exceptionally traumatic and very unnecessary additional pain. Then we had an hour for all those close people who wanted to have some time with him by themselves. It was impossible to do.<sup>2041</sup>

In his submission to the Committee, Associate Professor Ranson made the following comments in relation to viewing or touching a body in the coroner's jurisdiction:

From time to time families in Victoria have been permitted to touch the body of a deceased person in the care and control of the coroner in circumstances which provide a controlled and safe environment. There will be situations where such physical contact constitutes a health hazard or creates a potential interference with a civil or criminal justice process. These factors need to be considered in any legislative amendment. Where a family is permitted to touch the body of the deceased person a far greater degree of supervision is required by death investigation staff than when the family simply views the body from the other side of a glass window as may occur during the formal process of identification of the deceased. There are therefore significant human and physical resource implications for amending the legislation to grant this right to families.<sup>2042</sup>

However, VIFM stated in its submission that it has no objection in principle to family members viewing and touching the body whilst the body is held at the Institute in Melbourne, provided there are no clinical reasons that there should not be such contact.<sup>2043</sup> VIFM noted that this has certainly been facilitated in the past. VIFM observed that currently the clerical staff members of the Coroner's Office are responsible for facilitating viewings and family contact with the body. However, VIFM submitted that, as viewings occur in a clinical context, infection and other issues need to be determined by medical staff at VIFM.

VIFM also noted that there are resource issues in regional areas such that there might not be immediate access to bodies. For example, there may be no staff on the premises after hours or over a weekend, or staff may not be available to prepare the body for viewing at the time the family prefers. This is because coronial autopsies in regional areas are performed in the pathology departments of public hospitals. By contrast, in Melbourne autopsies are performed by VIFM at the Coronial Services Centre. VIFM also submitted that there are resource implications if family members

<sup>2042</sup> David Ranson, Submission no. 19, 71.

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<sup>&</sup>lt;sup>2041</sup> Ibid 22.

<sup>&</sup>lt;sup>2043</sup> Victorian Institute of Forensic Medicine, Submission no. 40, 31.

wish to spend extended time with the deceased and that this type of viewing should be handled by funeral homes.<sup>2044</sup>

The situations where touching a body would constitute a health hazard would include cases where an infectious disease or dangerous toxins are present. An example of a safety concern was raised in the submission by the Radiation Advisory Committee of the Department of Human Services (DHS), which pointed out that if a person who died has been treated with radiopharmaceuticals then the body may still be radioactive. In most cases, touching or spending short periods of time near the body should not transmit any significant dose. However, in the unlikely case of a person dying of the maladministration of a radiopharmaceutical, the radioactivity in the body may be unexpectedly high and caution needs to be exercised to ensure that those viewing or touching the body are not exposed to a significant dose.<sup>2045</sup>

A further occupational health and safety concern in relation to viewing and touching a body was referred to by former coroner Jacinta Heffey. She observed that coronial staff are frequently reduced in number — for example, in the 24-hour office — and that the situation can be very emotional and there may be conflict between family members. Ms Heffey suggested that a funeral home can always be asked to allow a viewing of the body and family members could touch the body in this environment.<sup>2046</sup>

A similarly restrictive approach was recommended by Dr Robertson, who suggested that the family should view the body as part of the identification requirement only, that no direct interference should occur until the body has been released from the coroner's jurisdiction and that viewing should be restricted to the senior next of kin or nominated representative. Dr Robertson stated that the appropriate place for contact with the deceased is at the funeral home and that the current system of allowing multiple family members access to view bodies in coronial custody at any time is costly and time consuming.<sup>2047</sup>

On the other hand, Dr Mark Garwood, Chief Medical Officer of the Austin Hospital, submitted that the family should have the right to touch and view the body, except in circumstances where the coroner judges that such access may impede an investigation or place health and safety at risk. Particular effort should be made to inform families of this right where the person who died was in state custody or care at the time of death.<sup>2048</sup>

Similarly, Dr van der Hoeven submitted that the Act should allow families reasonable contact with those who have died, including touching or spiritual practices, but that the

<sup>&</sup>lt;sup>2044</sup> Victorian Institute of Forensic Medicine, Submission no. 16, 1.

<sup>&</sup>lt;sup>2045</sup> Radiation Advisory Committee, *Submission no. 16*, 1.

<sup>&</sup>lt;sup>2046</sup> Jacinta Heffey, Submission no. 33, 26.

<sup>&</sup>lt;sup>2047</sup> Shelley Robertson, Submission no. 35.

<sup>&</sup>lt;sup>2048</sup> Austin Hospital, Submission no. 45, 8.

coroner should be able to limit such contact if it could be detrimental to the coronial function.

An example of the special cultural considerations that may need to be borne in mind in relation to viewing and touching is contained in the submission of the South Pacific Islander Association of Victoria. The association said that the Act should be amended to include the recommendations regarding cultural needs in this context made by the New Zealand Law Commission,<sup>2049</sup> observing that Pacific Islanders generally have common values regarding the handling of the dead. In particular, their tradition requires that the body should be kept 'warm' (in a spiritual sense) by the presence of a guardian and should not be allowed to lie alone between death and burial. To meet this requirement, a guardian (*kaitiaki*) should be allowed to remain in the vicinity of the Coroner's premises while the body is there.<sup>2050</sup>

#### Consultants' research findings

The research of consultants engaged by the Committee found that most participants felt that viewing or touching was an important process, either for themselves or for their family members, and should be allowed shortly after the death. One of the family members stated:

I was not allowed to touch, and I needed to desperately. I was only allowed to view the body. No-one would tell me why I couldn't touch... $^{2051}$ 

Waiting until the body was released to the funeral home was considered by most to be unsatisfactory, since family members wanted to see the person who died in their natural state, without the cosmetic alterations used at the funeral home. Participants were mostly unaware that there is no right to view or touch the body. As no explanation was offered for this, they were quite frustrated and annoyed that they could not pay their respects at this time.<sup>2052</sup>

#### **Discussion and conclusion**

The Committee heard conflicting opinions on the proposed right of families to view and touch their relative's body. Some witnesses argued that it is more appropriate for such contact to take place in funeral homes. Clearly, it is not a right that could be given to families without creating some administrative problems. However, the evidence reviewed by the Committee suggests that providing the option of viewing and touching a body is realistic, provided that coroners have the power to refuse this where it would be impractical or against the public interest.

<sup>&</sup>lt;sup>2049</sup> Law Commission of New Zealand, *Coroners*, Report no. 62 (2000).

<sup>&</sup>lt;sup>2050</sup> South Pacific Islander Association of Victoria, *Submission no. 54*, 16, 17.

<sup>&</sup>lt;sup>2051</sup> Myndscape Consulting, Review of the Coroner's Act 1985, March 2006, 38.

<sup>&</sup>lt;sup>2052</sup> Ibid 38, 66.

The Committee considers that, while the practical disadvantages of giving families a right to view and touch the body that were raised by some witnesses to this inquiry are not insignificant, trauma caused to families who are not able to view and touch the body needs to be avoided whenever possible.

Accordingly, the Committee's view is that the coroner should be required to permit the immediate family of the person who has died to view and touch the body while the body is under the coroner's control wherever practicable.<sup>2053</sup> If the request is refused, the person who made the request should be given written reasons for the refusal.

The Committee notes that in chapter three it has recommended that the initial reception of bodies and the decision as to whether an autopsy should be carried out become the delegated responsibility of VIFM. This responsibility has until recently been delegated to a coroner's clerk.<sup>2054</sup> In line with this earlier recommendation, the Committee believes that as part of this process it is appropriate that VIFM staff also decide whether there are any reasons that the viewing or touching of the body is not practicable or desirable. Where a request is not granted, the matter would be referred to the coroner, who must determine the course of action and provide written reasons if the request is to be refused.

As with the conclusions of the New Zealand Law Commission, the Committee considers that coroners are in the best position to weigh competing considerations such as the cultural and religious needs of families. The recommended procedure also ensures that the coroner retains control of the investigation process.

Finally, the Committee has noted in the foreword to this report that on 21 July 2006 the Attorney-General announced a number of changes at the State Coroner's Office, following an investigation into events that led to the release of the wrong bodies to two grieving families in July 2005. The investigation's recommendations, which aim to ensure that families are treated with proper care and sensitivity, include several initiatives designed to improve the body identification area and processes at the Coronial Services Centre. These include:

The public spaces at the Coronial Services Centre have been repainted and new furniture has been ordered to create a more welcoming environment for families.

The Department is developing plans for the longer term refurbishment of the Coronial Services Centre, subject to funding...The plans include further work on the identification area to make it

<sup>&</sup>lt;sup>2053</sup> Cf *Coroners Act* (ACT) (1997) s 23(1)(a), where the language used is, 'unless the coroner determines that it is not in the public interest or in the interests of justice to do so', and *Coroners Act 1996* (WA) s20(1)(c), which refers to circumstances that are 'undesirable or dangerous'.

<sup>&</sup>lt;sup>2054</sup> However, on 14 July 2006 the State Coroner issued a direction that all autopsies were to be ordered and signed off by coroners: Department of Justice, *State Coroner's Office Improvement Project – Briefing for Victorian Parliament Law Reform Committee*, August 2006. The Committee discusses this issue again later in the chapter under the heading 'Autopsies'.

consistent with contemporary understandings of the needs of grieving families. For example, families may want physical contact with deceased relatives rather than viewing bodies through a glass partition. Family support officers should also be located nearby so that they are available for immediate support.

In July 2006 the Department engaged...an independent review of identification processes in Victoria. The review is examining identification processes from the very beginning of the process at the scene of death, through to the involvement of hospitals, undertakers and the SCO, and the eventual release of deceased persons for burial or cremation.

The interim recommendations [of the independent review] address issues such as the need for clearer documentation of processes, secure management of case documents and the use of counsellors to assist families during identifications. 2055

The Department informed the Committee that it expects the final report of the independent review in September 2006 and that it will be considering the recommendations closely. 2056

Recommendation 94. That the Coroners Act 1985 be amended to include a requirement that, wherever practicable, the coroner permit the immediate family of the person who has died to view and touch the body while the body is under the coroner's control. If the coroner determines not to grant the requested authorisation, the person who made the request should be given written reasons for the refusal.

# Right to inspect the scene of death

In Victoria, families do not have the right under the Act to inspect the scene of a death. In practice, however, usually the only time that family members would be restricted from attending the scene of a death would be if it were a suspected or actual crime scene.

In order to ensure that the evidence collected from a crime scene can be used in court it is necessary to show that the evidence is reliable, and there should be no possibility that the evidence could have been interfered with or altered in any way. Thus it is essential that the death scene is effectively secured and controlled.2057 However, the Act does not give a coroner the specific power to restrict access to the

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<sup>&</sup>lt;sup>2055</sup> Department of Justice, State Coroner's Office Improvement Project – Briefing for Victorian Parliament Law Reform Committee, August 2006.

<sup>&</sup>lt;sup>2056</sup> Ibid.

<sup>&</sup>lt;sup>2057</sup> Ian Freckelton and David Ranson, *Death Investigation and the Coroner's Inquest* (2006) 201.

place where a death occurred. The Act does give the coroner the power, when investigating a fire, to restrict access to the place where the fire occurred.<sup>2058</sup>

# Other jurisdictions

By contrast to the situation in Victoria, in the ACT and Queensland, where a coroner has the power to restrict access to a place where a death has occurred, the coroner also has the power to authorise the immediate family, in certain circumstances, to inspect the scene of the death.<sup>2059</sup>

In the ACT a coroner may, if requested to do so by a member of the immediate family of the deceased, or a representative of that person, authorise an inspection of a death scene. If the coroner refuses such authorisation on the grounds that it would not be in the public interest or in the interests of justice to do so, the person who made the request must be given written notice of the refusal and an explanation for the refusal.<sup>2060</sup>

In Queensland a coroner has the power to direct a police officer to restrict entry to a death scene that is not a crime scene and the power to give permission to persons to be at the place.<sup>2061</sup> Forensic examination of suspected crime scenes must be given priority.<sup>2062</sup> However, the Queensland State Coroner's guidelines state that the power of restriction should be used sparingly.

# **Evidence received by the Committee**

The discussion paper asked witnesses whether the Act should give a coroner the specific power to restrict access to the place where a death occurred. It also asked whether the Act should give the immediate family of the person who died the right to inspect the place where a death occurred, and whether this right should have any limits.

Submissions to the Committee contained limited discussion regarding access to a scene of death. Former coroner Ms Heffey observed in her submission that in practice the only time attendance by family members at the scene of a death would be restricted would be if it were a crime scene. She said that, if this were considered to require clarification, the Act could be amended to give specific power to the coroner to restrict access.<sup>2063</sup> Similarly, Ms Elizabeth Kennedy, corporate counsel for both the

<sup>&</sup>lt;sup>2058</sup> Coroners Act 1985 s 40(1).

<sup>&</sup>lt;sup>2059</sup> Coroners Act 1997 (ACT) s 23(1)(b), 70(1)(a) (death in custody: a coroner may authorise access unless the Coroner believes on reasonable grounds that it would not be in the interests of justice).

<sup>&</sup>lt;sup>2060</sup> Coroners Act 1997 (ACT) s 23(1)(b).

<sup>&</sup>lt;sup>2061</sup> Police Powers and Responsibilities Act 2000 (Qld) s 371AC.

<sup>&</sup>lt;sup>2062</sup> State Coroner's Guidelines — Version 0 December 2003, para 3.4.2. Available at

http://www.justice.qld.gov.au/courts/coroner/pdfs/guidelines.pdf.

<sup>&</sup>lt;sup>2063</sup> Jacinta Heffey, Submission no. 33, 26.

Royal Women's and Royal Children's Hospitals, submitted that the coroner should be able to restrict access to a death scene, but that families should have the right to inspect the scene, subject to approval by the police and the coroner.<sup>2064</sup>

Ms Smith submitted that the coroner should be given the specific power to restrict access to the scene of death, but that the power should be used sparingly, only where evidence needed to be gathered and for a limited time. Ms Smith considered that everything possible should be done to assist the family with their need for information and that the need to visit 'the last place of life' should be accommodated as early as possible.<sup>2065</sup>

Dr Robertson submitted that the coroner should have the right to limit access to the scene of death, but only under specific guidelines for the investigation of categories of death.<sup>2066</sup>

The Committee did not hear evidence relating to any special cultural requirements concerning access to the scene of death. However, while this question was not addressed directly by VALS, the Committee notes RCADC recommendation 25, which proposes that the family of the deceased or their representative should have a right to view the body and to view the scene of death. The South Pacific Foundation of Victoria submitted that South Pacific Islander families would be content to wait for the scene of death to be vacated before visiting the scene for prayers.<sup>2067</sup>

### Discussion and conclusion

The Committee considers that Victoria should follow the model used in section 23 of the *Coroners Act 1997* (ACT) and amend the Victorian Act so that a coroner may, if requested by a member of the immediate family of the person who died, or a representative of that family member, authorise an inspection of the scene of the death by the family member or representative. If the coroner refuses the request on the ground that such an inspection would be impracticable, <sup>2068</sup> the person who made the request should be given written reasons for the refusal.

The main reason for restricting access to the scene of a death would be if it were a crime scene requiring the gathering of evidence; otherwise, the power to restrict access should be exercised sparingly, so that family needs to visit the place of death are not unnecessarily restricted.

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<sup>&</sup>lt;sup>2064</sup> Royal Women's Hospital, *Submission no. 18*, 7, 8.

<sup>&</sup>lt;sup>2065</sup> Carol Smith, Submission no. 25, 6, 7.

<sup>&</sup>lt;sup>2066</sup> Shelley Robertson, Submission no. 35, 5.

<sup>&</sup>lt;sup>2067</sup> South Pacific Foundation of Victoria, Submission no. 54, 18.

<sup>&</sup>lt;sup>2068</sup> Cf *Coroners Act 1997* (ACT) s 23(2), which uses the language, 'unless the Coroner determines that it is not in the public interest or in the interests of justice to do so'.

Recommendation 95. That the *Coroners Act 1985* be amended to include a provision that, wherever practicable, the coroner must authorise a member of the immediate family of the person who has died, or a representative of that family member, to access the place where the death has occurred and that, if the coroner refuses the request, the person making the request should be given written reasons for the refusal.

# Right to access information considered by the Coroner

As discussed at the beginning of this chapter, the ability of families to access information that the coroner intends to consider at an inquest is essential for a number of reasons. It provides them with information concerning the death of their relative, allows them to prepare for the inquest and provides an opportunity for families to bring additional information to the attention of the coroner.

Under the Act, a coroner may make available any statements that the coroner intends to consider at an inquest to 'any person with a sufficient interest'.<sup>2069</sup> The Act does not specify when a coroner is required to make this information available.

As part of the investigation process, the police collect all the information for the coroner in what is called the 'brief'.<sup>2070</sup> This contains copies of witness statements, police reports, medical files, the autopsy report (if an autopsy has been performed), photographs and other forensic material.<sup>2071</sup>

According to the Coroner's Office, a coroner may allow access to information in the police brief to any family member or other person who is an interested party.<sup>2072</sup>

There are a number of uncertainties in the Act and the Regulations with regard to the coroner releasing information.<sup>2073</sup> In summary, the current legislation is unclear as to:

- which people should be able to access the information:
- when they should be able to do so;
- what avenues there are to appeal a coroner's decision to refuse access to the coroner's file; and
- exactly what type of information the coroner may release.

<sup>&</sup>lt;sup>2069</sup> Coroners Act 1985 s 45(1).

<sup>&</sup>lt;sup>2070</sup> State Coroner's Office and Victorian Institute of Forensic Medicine, *The Coroner's Process: Information for Family and Friends* (2005) 19.

<sup>&</sup>lt;sup>2071</sup> Ibid.

<sup>&</sup>lt;sup>2072</sup> Ibid.

<sup>&</sup>lt;sup>2073</sup> See Transport Accident Commission, *Submission no. 50*, 18-20; Royal Women's Hospital, *Submission no. 18*, 11; Royal Children's Hospital, *Submission no. 17*, 47.

## Section 45 of the Act provides:

- 45. Rights of interested persons:
- (1) A coroner may make available any statements that the coroner intends to consider to any person with a sufficient interest.<sup>2074</sup>

However, section 45 of the Act does not define what is meant by a person with 'a sufficient interest'. As pointed out by the TAC,<sup>2075</sup> one might assume that this includes family members, but who else might have a sufficient interest? Witnesses such as the TAC suggested that the legislation should provide guidance as to what needs to be shown to demonstrate sufficient interest.<sup>2076</sup>

Case law in relation to section 45 is scarce. However, the decision of Beach J in *Barci & Asling v Heffey* provides some assistance.<sup>2077</sup> His Honour found that there are many relationships that would give rise to 'sufficient interest' in the inquest, and that this is a question of fact to be answered after considering the circumstances of the death.

While the coroner clearly has the discretion under section 45 to release statements to a person with a sufficient interest<sup>2078</sup> or not, regulation 24(1) provides:

- 24. Access to records:
- (1) Before the completion of-
  - (a) an investigation or inquest into a death; or
  - (b) an investigation or inquest into a fire—

a coroner's file or any part of it must be made available to such people or class of people as the coroner directs.<sup>2079</sup>

It is unclear whether 'such people as the coroner directs' in regulation 24 has the same scope as 'persons with a sufficient interest'. The Committee considers that the inconsistencies between the two provisions need to be addressed.

Section 45 and regulation 24 are also problematic in that neither states when a coroner is to release the statements in cases where the coroner decides to release them. The wording of section 45 — 'statements that the coroner intends to consider'

<sup>&</sup>lt;sup>2074</sup> Coroners Act 1985 s 45 (1).

<sup>&</sup>lt;sup>2075</sup> Transport Accident Commission, Submission no. 50, 18.

<sup>&</sup>lt;sup>2076</sup> Transport Accident Commission, Submission no. 50, 19.

<sup>&</sup>lt;sup>2077</sup> (Unreported, Supreme Court of Victoria, Beach J, 1 February 1995). The Committee discusses the concept of 'sufficient interest' further in chapter 5 in relation to standing at inquests.

<sup>&</sup>lt;sup>2078</sup> Coroners Act 1985 s 45.

<sup>&</sup>lt;sup>2079</sup> Coroners Regulations 1996 reg 24(1) (emphasis added).

— implies that the coroner would release the statement before, or at least during, the inquest. However, there is no clear obligation for the coroner to release the statements at any particular stage of the investigation or any time limit within which the coroner must decide whether to release them.

It is also unclear what a person should do if the coroner refuses to release some or all of the statements, or refuses to respond at all, under the above provisions. Coroners are probably excluded at present from the provisions of the *Freedom of Information Act 1982*, the *Information Privacy Act 2000*, and the *Health Records Act 2001*. These Victorian statutes are discussed below under the heading 'Privacy'. Thus the only avenues for reconsideration of a coroner's decision on this issue are an appeal to the Supreme Court, based on procedural fairness grounds,<sup>2080</sup> or a direct application under section 45.<sup>2081</sup>

Finally, section 45 appears to limit the documents that may be released to 'statements' only. This raises the question of whether the coroner can release other material which the coroner intends to consider at the inquest. In contrast, regulation 24(1) states that 'the coroner's file or any part of it' must be made available to such people or class of people as the coroner directs. The file might include, for example, photographs, interview transcripts and autopsy reports. Again, this inconsistency needs to be addressed.

## Other jurisdictions

As in Victoria, interested persons in the ACT, Western Australia, Tasmania and the Northern Territory may request statements which the coroner intends to consider at the inquest.<sup>2082</sup> The legislation in all of those states refers to the same concept that currently exists in Victoria: 'any person with a sufficient interest'.

However, the Tasmanian and Northern Territory legislation provides expressly that the question of sufficient interest is one for the coroner to decide. The Committee considers that the Tasmanian approach, which refers to 'any person who the coroner considers [italics added] has a sufficient interest' would establish more clearly the discretion of the coroner to decide who may have access to statements or information.

In terms of the kind of information that may be accessed, as in Victoria the Western Australia Act refers to 'statements', the Tasmanian Act to 'statements or affidavits', and the Northern Territory Act to 'a statement'. On the other hand, section 51 the ACT Act is much broader:

<sup>&</sup>lt;sup>2080</sup> Boyce v Munro & West (Unreported, Supreme Court of Victoria, Beach J, 2 December 1997).

<sup>&</sup>lt;sup>2081</sup> The applicant took this approach in *Barci v Heffey* (Unreported, Supreme Court of Victoria, Beach J, 1 February 1995).

<sup>&</sup>lt;sup>2082</sup> Coroners Act 1997 (ACT) s 51; Coroners Act 1997 (WA) s 42; Coroners Act 1995 (Tas) s 52; Coroners Act 1993 (NT) s 40(2).

#### 51 Access to documents etc

A coroner may make available to any person with a sufficient interest in an inquest or inquiry -

- (a) Any document or thing that is produced at, or the coroner intends to consider in relation to, an inquest or inquiry; and
- (b) Any evidence relevant to inquest or inquiry to which the coroner intends to have regard. 2083

The state legislation referred to above that provides expressly for access to information does not indicate when such access should be granted. However, in Queensland the State Coroner's guidelines indicate that, in general, family members should be able to access the information as soon as it becomes available. The guidelines provide that:

Families of deceased persons should not be denied information about the death just because it has been reported to a Coroner. The general principle is that families are entitled to any and all information concerning the death as soon as it is available unless there is a basis for suspecting that to release the information may compromise a criminal investigation.<sup>2084</sup>

The Queensland guidelines also state that families should not be required to wait until an inquest is convened to be told the results of an autopsy and any inquiries that the police may be undertaking. However, the guidelines also state that care needs to be taken when requests are made for investigation reports, and that in many cases it may be better for the investigator to discuss the evidence with the family member rather than simply hand over copies of reports.

## **Evidence received by the Committee**

The Coroner's Office described, in chapter 3 of its submission, the tasks of the coroner's clerks during the coronial process. In Melbourne the main office coroner's clerks are responsible for managing the investigation, determination and finalisation phases of the coronial system. In regional offices, the coroner's clerk attached to the regional magistrate performs this role. The submission states that, during the investigation phase, the main office coroner's clerks' tasks include providing the interested parties with a copy of the autopsy report or the coroner's brief of evidence or both. These documents are usually accompanied by a letter alerting the recipient to the contents of the documents and advising them to seek professional support when reading them.<sup>2085</sup>

<sup>&</sup>lt;sup>2083</sup> Coroners Act 1997 (ACT) s 51.

<sup>&</sup>lt;sup>2084</sup> State Coroner's Guidelines — Version 0 December 2003, para 3.2.3. Available at

http://www.justice.qld.gov.au/courts/coroner/pdfs/guidelines.pdf.

<sup>&</sup>lt;sup>2085</sup> State Coroner's Office, Submission no. 70, 113.

The view of families who have been involved in the coronial process was that family members should be able to access information as it becomes available. They indicated that, as well as keeping families informed, such access helps them with their grief and helps them to find acceptance of what has happened. It also provides opportunities for the family to comment on information that might be inaccurate, which could assist the coroner with the investigation.<sup>2086</sup>

Indeed, many witnesses commented that access to information benefits not only the family but also the coronial investigation itself. For example, Mr Graeme Bond considered that the Act should allow immediate access to statements and information. Mr Bond stated that he regarded the standard of investigations conducted by coroner's assistants<sup>2087</sup> to be generally 'of such a low standard' that he would encourage family members to take a 'most active interest in the investigation', to make suggestions and even to try to insist that important matters be followed up.<sup>2088</sup>

The ability of family members to contribute to the coroner's investigation of a matter was referred to by several other witnesses, including Ms Heffey. Ms Heffey submitted that any person who wishes to access statements in a coronial brief relating to a current investigation should be required to apply and, on application, should be allowed access if they are deemed to be a 'person with a sufficient interest'. Ms Heffey considered that there should be no automatic right to access but that any person who can demonstrate a sufficient interest should be allowed to participate fully in the investigation, including the inquest hearing if there is one. Ms Heffey stated that a person with a sufficient interest will be a person who can assist the investigation, either by giving evidence of the circumstances surrounding the death or by providing expert evidence. Family members will usually be considered to have a sufficient interest, on the basis that they have a right to be informed of the progress of the investigation. However, Ms Heffey considered that families should always have the right to inspect the file in order to be able to make representations to the coroner about the extent and direction of the investigation. Ms Heffey expressed the view that families should have the right to seek a review of the investigation in the Supreme Court if the State Coroner refuses to conduct the investigation to their satisfaction.<sup>2089</sup>

A problem with the current system is that families and their representatives often do not know when new information is available. Lawyers Maurice Blackburn Cashman (MBC) submitted on behalf of the firm's Medical Negligence Practice Group that MBC and its clients have experienced difficulties from time to time in accessing statements and other information as the brief is updated.<sup>2090</sup> It is not always clear that new information has been obtained unless a direct request for information is made to the

<sup>&</sup>lt;sup>2086</sup> Dawn Staley, Submission no. 8, 5, 6.

<sup>&</sup>lt;sup>2087</sup> The Committee discusses the role of coroner's assistants in chapter 5 of this report.

<sup>&</sup>lt;sup>2088</sup> Graeme Bond, Submission no. 48, 14.

<sup>&</sup>lt;sup>2089</sup> Jacinta Heffey, Submission no. 33, 26-7.

<sup>&</sup>lt;sup>2090</sup> Maurice Blackburn Cashman, Submission no. 42, 9.

Coroner's Office. MBC submitted that the situation would be improved if the family members or their representatives were advised as new material became available, although this might be impractical for each item that becomes available.<sup>2091</sup>

Thus MBC suggested that it might be better to identify certain stages in the process of gathering information when families should be updated; for example, when hospital records have become available, when statements from witnesses have become available or when the independent expert's opinion has become available. MBC also stated that it had received inconsistent advice from the Coroner's Office as to when access to the brief was allowed. On some occasions access was permitted upon completion of the brief, while on others access was permitted after the coroner had reviewed the brief and decided whether an inquest would be held.<sup>2092</sup>

Since families are nearly always considered persons with a sufficient interest in the death, the provision of information to them is almost guaranteed. However, Associate Professor Ranson observed that there are situations where the senior next of kin attempts to restrict the access of other family members to such information.<sup>2093</sup> The other family members would almost always be persons with a sufficient interest and so should be able to have access to the information. In view of this, Associate Professor Ranson considered that there may be some merit in prescribing access to information by family members except where a coroner feels that the information would be put to a frivolous use or would be used in a way contrary to the interests of justice. He stated that an example of the latter would be where the information might be used to identify and facilitate the intimidation of a prospective witness.<sup>2094</sup>

Similarly, Associate Professor Ranson submitted that vicarious use of information on the coroner's file involving criminal activities or commercial exploitation needs to be resisted. Not only are there moral and ethical reasons for this resistance, but also abuse of the use of coroner's records in this way could bring the jurisdiction into disrepute in the eyes of the public and so reduce its effectiveness as a vehicle for enhancing public health and safety.<sup>2095</sup> Associate Professor Ranson also commented on the important issue of privacy in the context of accessing the coronial file. This issue is discussed later in this chapter.

Many witnesses pointed out that the family of the deceased can often provide probative information about the circumstances that may have contributed to the death, which may shape the course of the investigation or the findings.<sup>2096</sup> For this reason, witnesses such as Victoria Legal Aid submitted that the Act should specify

<sup>2092</sup> Ibid.

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<sup>&</sup>lt;sup>2091</sup> Ibid.

<sup>&</sup>lt;sup>2093</sup> David Ranson, Submission no. 19, 73.

<sup>&</sup>lt;sup>2094</sup> Ibid.

<sup>&</sup>lt;sup>2095</sup> Ibid 74.

<sup>&</sup>lt;sup>2096</sup> See for example Victoria Legal Aid, *Submission no. 34*, 5.

that family members are entitled to access all statements and relevant information as soon as they are available. VLA stated that the same considerations may apply to any other person with a sufficient interest. It is particularly important that relevant information is provided to such a person when the coroner is considering making a finding that is adverse to the interests of that person because the coroner has a duty to comply with the principles of natural justice.<sup>2097</sup> VLA provided a case study illustrating the prejudicial consequences that can arise when the timing and extent of disclosure is discretionary.<sup>2098</sup>

The Federation of Community Legal Centres submitted that parties should have sufficient time to consider the information prior to the formal inquest and for that purpose supported the implementation of the relevant RCADC recommendations, 24 and 25.<sup>2099</sup> Recommendation 24 is particularly relevant in this context:

That unless the State Coroner or a Coroner appointed to conduct the inquiry otherwise directs, investigators conducting inquiries on behalf of the Coroner and the staff of the Coroner's Office should at all times endeavour to provide such information as is sought by the family of the deceased, the Aboriginal Legal Service and/or lawyers representing the family as to the progress of their investigation and the preparation of the brief of the inquest. All efforts should be made to provide frank and helpful advice and to do so in a polite and considerate manner. If requested, all efforts should be made to allow family members or their representatives the opportunity to inspect the scene of death.<sup>2100</sup>

In its submission to the Committee, SIDS and Kids Victoria stated that the needs of others such as estranged family members or parents of the child who died must be considered 'so that they are not cut out of the process'.<sup>2101</sup>

Constituents of East Yarra Province submitted that it should be at the discretion of the investigating coroner to determine who is 'a person with a sufficient interest'. However, they suggested that access to medical and legal documents containing sensitive information about living family members should be restricted, perhaps to family members only.

### Access to information in relation to deaths from medical treatment

The Committee considers that deaths resulting from medical errors require a particular focus when looking at the issue of access to information. This is because evidence from several witnesses, including the Association for Prevention of Medical Errors (APME), suggested that health providers often use a number of strategies to

<sup>&</sup>lt;sup>2097</sup> Ibid 6.

<sup>&</sup>lt;sup>2098</sup> Ibid.

<sup>&</sup>lt;sup>2099</sup> Federation of Community Legal Centres (Vic) Inc, Submission no. 55, 22.

<sup>&</sup>lt;sup>2100</sup> Royal Commission into Aboriginal Deaths in Custody, *National Report* (1991) vol 1, Recommendation 24.

<sup>&</sup>lt;sup>2101</sup> SIDS and Kids Victoria, Submission no. 10, 5.

prevent a full account of events from reaching families in the coronial process.<sup>2102</sup> The resulting 'drying up' of the flow of information about the circumstances surrounding the death can be very traumatic for the family of the person who died. APME submitted that the strategies employed by health providers include:

- careful filtering by lawyers of the witness statements of doctors and nurses to remove testimony that may ultimately support a finding of liability;<sup>2103</sup>
- selective use of independent<sup>2104</sup> clinical witnesses such that a report will only be submitted to the Coroner's Office if it favours the hospital's position;<sup>2105</sup> and
- refusal to submit the findings of internal investigations known as 'root cause analysis', on the often legally questionable basis that the *Health Services Act 1988* creates a public interest immunity for such quality assurance investigations.<sup>2106</sup>

However, APME observed that it is firmly in the public interest to dispel any secrecy surrounding the death of a patient in a health care facility and that the patient's family should be given a full account of all the circumstances of the patient's death. APME observed that psychologists consider that inability by family members to access the full details surrounding an unanticipated death magnifies their grief. They often feel 'victimised not once but twice' and that there is 'injustice piled on injustice' when the complexities of the legal system hinder their search for truth. While APME commented that in various countries the lobby for open disclosure of medical errors is gathering momentum, the Committee also heard evidence that a policy of open disclosure has been adopted in some Victorian hospitals.<sup>2108</sup>

APME stated that greater disclosure not only appeases the desire of aggrieved families to be fully informed but also encourages the shared learning needed to

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<sup>&</sup>lt;sup>2102</sup> Association for Prevention of Medical Errors, Submission no. 79, 25–6.

<sup>&</sup>lt;sup>2103</sup> See for example Coroners Case no. 1835/94 Findings at Inquest (20–23 March and 16 August 1996); Association for Prevention of Medical Errors, *Submission no. 79*, 26.

<sup>&</sup>lt;sup>2104</sup> Cf Graeme Bond, *Minutes of Evidence*, *22 August 2005*, 3. Mr Bond submitted that the independent witness called in his son's case was a close professional colleague of several senior doctors with an interest in the case.

<sup>&</sup>lt;sup>2105</sup> APME observed that unfavourable reports are withheld on the basis that they were obtained to prepare for reasonably anticipated litigation. This is known as third party privilege and is a variant of legal professional privilege: *Guiness v Peat Properties Ltd v Fitzroy Robinson Partnership* [1987] 2 All ER 716; Association for Prevention of Medical Errors, *Submission no. 79*, 26.

<sup>&</sup>lt;sup>2106</sup> Health Services Act 1988 s 139(2)(d); Association for Prevention of Medical Errors, Submission no. 79, 26. APME considers that the argument is unsustainable since the section only applies to quality assurance committees appointed by the Human Services Minister and published in the Government Gazette, which does not ordinarily occur for such reports.

<sup>&</sup>lt;sup>2107</sup> Association for Prevention of Medical Errors, *Submission no.* 79, 26.

<sup>&</sup>lt;sup>2108</sup> See for example Elizabeth Kennedy, Royal Women's Hospital, *Minutes of Evidence*, 19 September 2005, 104; Bill O'Shea, *Bayside Health, Minutes of Evidence*, 28 November 2005, 216.

improve systems and thereby reduce medical errors. As a result, APME's view is that the coronial system should facilitate prompt disclosure of information to family members of the deceased. APME suggested that a potential argument to the contrary might be that health providers would simply refuse to submit information to the coroner if they knew it would be conveyed to the grieving family. However, the Act empowers a coroner to take possession of any documents relevant to the investigation of the death and to summon a person to produce any document at an inquest. APME noted that the Act gives a coroner the discretion to make statements available to any person with a sufficient interest, and this section is supplemented by allowing the coroner's file or any part of it to be made available to such persons as a coroner directs. APME submitted, however, that in the interests of certainty the Act should go further and require a coroner to ensure that the family of the person who died has unfettered access to all relevant information that a coroner intends to consider at an inquest.

Similar concerns were raised by SANE Australia,<sup>2110</sup> a national mental health charity, in relation to suicides and mental health services. It highlighted the association between suicide and mental health problems, commenting that, for people with conditions such as depression, bipolar disorder and schizophrenia, lack of treatment or suboptimal treatment play a large part in contributing to the deterioration of mental health and, in a tragically high number of cases, suicide. Health records and statements by health professionals regarding treatment in the period preceding a suicide are important documents that allow a coroner to draw conclusions regarding the circumstances leading to a death and make recommendations to prevent such circumstances arising in the future. SANE Australia noted that such information is naturally of extreme interest to family members and other relevant persons, and recommended that such persons be given access to such material as soon as it becomes available.<sup>2111</sup>

The Committee heard evidence from Mr Bond of many of the problems described above in relation to accessing information from health care providers, in the context of the death of his son from a mental illness. Mr Bond observed that usually the solicitor and doctors will approach the policeman conducting the investigation, who is often junior, and offer witness statements. The policeman, by accepting the offer, places the decision of who the witness will be and what their statement will be in the hands of the legal representatives of the hospital and doctors, thus corrupting the investigation. Mr Bond also considered that there was evidence of tampering with the medical history of his son after he died. He therefore submitted that coroners need to use their

<sup>&</sup>lt;sup>2109</sup> Coroners Act 1985, ss 26, 46.

<sup>&</sup>lt;sup>2110</sup> SANE Australia is a business name of the Schizophrenia Australia Foundation.

<sup>&</sup>lt;sup>2111</sup> SANE Australia, Submission no.27, 2.

investigation powers more adequately by immediately seizing the medical records of a patient whose death is reportable.<sup>2112</sup>

## Consultants' research findings

The research found that most participants felt that it was important that the information the coroner intends to consider at an inquest be available to families, to avoid the element of surprise at the inquest and to enable families to be as informed as possible. However, most families were not aware that they could access this documentation, with most suggesting that this information should be conveyed to them. It was suggested that, once families are made aware that they can access these documents, the documents should only be made available on request and when the family is ready to view them, rather than as a matter of course.

A significant proportion of participants (four out of 10) indicated that they were not informed as to the time and place of the inquest. Most participants indicated they would like to have been informed of these details and given the opportunity to attend the hearing. Some participants indicated that attendance would assist them in the process of gathering information that would help with the grieving process and with gaining a sense of closure.

Further comments were made in relation to accessing police briefs. While the Coroner's Office states that a coroner may allow access to information in the police brief to any family member or other person who is an interested party,<sup>2113</sup> the research by consultants engaged by the committee found that most participants were not offered this information and that, had they been aware of its availability, they would definitely have requested it.<sup>2114</sup>

### Discussion and conclusion

The Committee considers that the Act should be amended to give family members the right to access witness statements, reports and other evidence and information concerning the death investigation as soon as they become available, unless the coroner considers that this would potentially compromise a criminal investigation.

The Committee also considers that the legislation needs to be amended in a number of areas to resolve the uncertainties referred to above concerning the scope of the term 'sufficient interest', the timing of when the coroner should release information, the avenue for appealing any decision not to release information and the type of information that should be released.

<sup>&</sup>lt;sup>2112</sup> Graeme Bond, Submission no. 48, 6-7.

<sup>&</sup>lt;sup>2113</sup> State Coroner's Office and Victorian Institute of Forensic Medicine, *The Coroner's Process: Information for Family and Friends* (2005) 19.

<sup>&</sup>lt;sup>2114</sup> Myndscape Consulting, Review of the Coroner's Act 1985, March 2006, 67.

The Committee was concerned that many witnesses expressed the view that the term 'sufficient interest' is too broad and needs to be changed. However, there is currently no alternative concept in use in Australia. The Committee considers that rather than revisiting the basic notion of 'sufficient interest', the legislation should indicate more clearly the scope of that term and in particular should include privacy principles to prevent inappropriate access to information, as discussed later in this chapter. The Committee also considers that the Act should state clearly that the question of who is sufficiently interested is one for the coroner to decide, as is the case in the Northern Territory and Tasmania.<sup>2115</sup>

The Committee also considers that the Act should include a broad definition, similar to that used in section 51 of the *Coroners Act 1997* (ACT), of the kind of information that may be accessed.

#### Recommendation 96. That the Coroners Act 1985 be amended to:

- a) give family members the right to access witness statements, reports and other evidence and information concerning the death investigation as soon as they become available unless the coroner considers that releasing the material has the potential to compromise a criminal investigation.
- b) require coroners to inform family members of their right to access such information and, if a request for such information is refused, to provide written reasons for the refusal.
- c) clarify the scope of 'persons with sufficient interest' in an inquest and the coroner's discretion to determine that question, following the model used in section 40(2) of the *Coroners Act 1993* (NT) and section 52 of the *Coroners Act 1995* (Tas);
- d) state the timing for release of the statements or other information, if the discretion to release them is exercised;
- e) establish an avenue for appealing a decision made by the coroner in relation to releasing statements; and
- f) clarify the extent and nature of the information that can be accessed, following the approach used in section 51 of the *Coroners Act 1997* (ACT); in this regard the *Coroners Act 1985* and the *Coroners Regulations 1996* should be consistent.

# Right to be kept informed

In the previous section of this chapter the Committee discussed the need for families to be able to access witness statements, reports and other evidence and information stored on the coronial file. In this section the Committee discusses the need for

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<sup>&</sup>lt;sup>2115</sup> Coroners Act 1995 (Tas) s 52; Coroners Act 1993 (NT) s 40(2).

families to be kept informed by the Coroner's Office. The Committee will discuss, first, the need for families to be kept informed of the general progress of an investigation and, second, the need for families to be notified of specific matters, particularly their rights in relation to the coronial process.

# Right to updates on the progress of an investigation

At present there is no requirement under the Act that families should be kept informed of the progress of an investigation.

# Other jurisdictions

In Western Australia the coroner must provide various kinds of information to the next of kin in relation to the coronial process. The relevant provision is discussed later in this chapter under the heading 'Notification'. However, there is no requirement in the Western Australia legislation or that of other States and Territories requiring coroners to keep families informed of the progress of investigations.

In contrast, the Queensland State Coroner's guidelines refer to 'Keeping the family apprised of developments' and state:

The family is entitled to be given as much information as possible about the cause of death and the various steps in the coronial system. They should not be required to wait until an inquest is convened to be told the results of an autopsy and the other inquiries that police may be undertaking.<sup>2116</sup>

# Law reform agencies

The New Zealand Law Commission report on coroners recommended that a coroner be required to ensure that the family receives accurate information and ongoing advice concerning the coronial process.<sup>2117</sup> Further, the *Coroners Act 2006 (NZ)* contains the following provision which is relevant to the progress of investigations:

4A Coroners must perform their duties without delay

Every coroner must, so far as it is consistent with justice and practicable to do so, perform or exercise his or her functions, powers and duties without delay.<sup>2118</sup>

The inclusion of this provision was recommended by the New Zealand Justice and Electoral Committee, which commented that it believed that an obligation to avoid delay on the part of the coroner would 'encourage the timely resolution of coronial

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<sup>&</sup>lt;sup>2116</sup> State Coroner's Guidelines — Version 0 December 2003, para 3.4.3. Available at

http://www.justice.qld.gov.au/courts/coroner/pdfs/guidelines.pdf.

<sup>&</sup>lt;sup>2117</sup> Law Commission of New Zealand, *Coroners*, Report no. 62 (2000) 76.

<sup>&</sup>lt;sup>2118</sup> Coroners Act 2006 (NZ) s 4A.

inquests, enhance public confidence in the coronial process, and minimise suffering for grieving families'.2119

## Evidence received by the Committee

As discussed earlier in this chapter, the problem of delay emerged in this inquiry as one of the most significant causes of families' dissatisfaction with the coronial process.

In relation to delay, the Committee received a submission from the Springvale Monash Legal Service Inc (SMLS) containing a recent research study by the SMLS entitled, *The Coronial Process: Delays from Death to Inquest.*<sup>2120</sup> The study examined the procedural and other causes for delays in the coronial process in Victoria, as well as the length of those delays in a large number of cases. The study found that the length of time between a death and the inquest varies significantly but is on average two years. The minimum period, according to the SMLS research, is eight months. The SMLS identified the following as the two main causes of delay: the time taken to complete an investigation, particularly collecting witness statements and expert reports; and adjournments granted at the request of interested parties, which result in matters being relisted. The Committee also had informal discussions with various individuals working within the coronial system concerning delay. In the Committee's view, a significant issue here is the lack of a proper state-wide case flow management system.

The Committee was concerned at the length of the delays described by witnesses from families involved in the coronial process. For example, Mr and Mrs Kaufmann had to wait more than three and a half years from the time of their son's death from a police shooting until the coroner's findings were handed down. This included a wait of seven and a half months between the inquest hearing and the findings being handed down. The Kaufmanns were concerned about the long waiting time and the 'total agony' of revisiting minute details about their son's death at a time so far removed from the event, when otherwise they may have been able to put some of those painful memories out of their daily life. The Kaufmanns also made the point that the passage of long periods of time could lead to a dimming of witnesses' recollections, and in some cases to witnesses being unavailable or even dead.<sup>2121</sup> The Kaufmanns also highlighted the fact that a number of further police shootings of mentally ill people occurred in the time between their son's death and the handing down of the coroner's findings.<sup>2122</sup> The Kaufmanns believe that these shootings could have been prevented with timely implementation of coronial recommendations. Among other issues, the

<sup>&</sup>lt;sup>2119</sup> New Zealand Justice and Electoral Committee, preface to Coroners Bill 2004 (NZ), 2.

<sup>&</sup>lt;sup>2120</sup> Springvale Monash Legal Service, *Submission no. 13*.

<sup>&</sup>lt;sup>2121</sup> David and Margrit Kaufmann, Submission no. 71, 1.

<sup>&</sup>lt;sup>2122</sup> David Kaufmann, *Minutes of Evidence*, 22 August 2005, 61.

Kaufmanns submitted that the coronial process 'is not administered and operated efficiently' and that families 'appear to be the least considered in the proceedings'.<sup>2123</sup>

An even longer delay was experienced by another witness, Ms Marion Stevens. Her son died at work on 1 February 2001, and the coroner handed down a finding on 1 April 2005. A significant cause of this delay was that criminal charges had been laid by the Department of Primary Industry against certain individuals in relation to the death. Therefore, the inquest was postponed so that the criminal matter could be heard first, to avoid the problem of witnesses refusing to answer questions on the grounds that they might incriminate themselves. The Committee has already discussed the relationship between criminal trials and coronial investigation in chapter 5 of this report. Ms Stevens submitted that such matters should be heard concurrently in order to relieve families of 'these excruciating four and five year waits'.<sup>2124</sup>

Ms Kathleen Hurley submitted to the Committee that she and her family had to wait nearly a year after the death of her son before they received the coronial findings. Ms Hurley submitted that 'To expect families to endure such a delay in addition to the trauma and grief they experience as a result of an unexpected death is unacceptable'.<sup>2125</sup>

# Consultants' research findings

The research found that the extent and type of information provided to families as a matter of practice is varied. This was attributed predominately to families having limited rights under the Act in this regard. Interviewees indicated that they would have appreciated this information and any other information relating to the death of their relative.

In most cases the participants had not been given any explanation about what would happen in the investigation and the expected time frame for each process. These findings are consistent with those found in similar research in the UK.<sup>2126</sup> In cases where there was no outcome for some time, families became extremely anxious and upset, and did not know when they should expect contact from the Coroner's Office. Most participants described the delays as having a significant impact on the grieving process and their sense of closure.<sup>2127</sup>

The majority of participants commented that they would have been able to accept the delays if they had been better informed about what the coronial process involves, and the reason for the delays. The majority of responses also indicated that the Coroner's

<sup>&</sup>lt;sup>2123</sup> David and Margrit Kaufmann, Submission no. 71, 1.

<sup>&</sup>lt;sup>2124</sup> Marion Stevens, *Submission no. 49*, 4.

<sup>&</sup>lt;sup>2125</sup> Kathleen Hurley, Submission no. 68, 2.

<sup>&</sup>lt;sup>2126</sup> E Goddard, 'A report on research carried out for the Review of Coroner Services by the Office for National Statistics' (2003) *UK Office for National Statistics*.

<sup>&</sup>lt;sup>2127</sup> Myndscape Consulting, Review of the Coroner's Act 1985: Final Report, March 2006, 64.

Office 'could speed up the process' and that, if there were going to be significant delays, the Coroner's Office should provide families with clear time frames and an estimate of how long it would take to complete the investigation.

### Discussion and conclusion

The Committee was concerned that at present it is common for there to be delays of two years between a person's death and the completion of the case. Delays of this length can adversely affect the next of kin's grieving process. However, evidence received by the Committee suggested that family members would be better able to cope with delays if they were given an explanation for them and a time frame for the completion of an investigation. The Committee considers this to be highly significant and that families should have a right to be given regular updates in relation to the progress of an investigation. Further, coroners should conduct six-monthly reviews of cases and provide written reasons for any delay after 12 months.

The Committee believes that many of the delays may be avoidable. The Committee is concerned that there is currently no state-wide case flow management system to aid in monitoring the progress of investigations. This would be an essential step towards reducing the time taken to complete certain investigations and would enable the provision of more accurate information to families concerning progress.

The Committee notes that in some cases delays are caused by the suspension of coronial investigations pending the completion of criminal prosecutions. The primary rationale for this is to avoid the problems caused by the exercise of the privilege against self-incrimination. The Committee considers that the removal of this privilege, subject to the issue of certificates as recommended in chapter 5, would remove the rationale for this type of delay.

Finally, in light of the distress caused to families by delays, the Committee considers that the Act should be amended to include a requirement, as has been included in the *Coroners Act 2006* (NZ), that every coroner must, so far as it is consistent with justice and practicable to do so, perform or exercise his or her functions, powers and duties without delay.

Recommendation 97. That the State Coroner's Office investigate the applicability of case management systems used in other jurisdictions and implement an appropriate state-wide case management system.

Recommendation 98. That the *Coroners Act 1985* be amended to include requirements that:

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<sup>&</sup>lt;sup>2128</sup> Lucy Biddle, 'Public Hazards or Private Tragedies? An Exploratory Study of the Effect of Coroner's Procedures on Those Bereaved by Suicide' (2003) 56 *Social Science & Medicine* 1039; Myndscape Consulting, *Review of the Coroner's Act 1985: Final Report*, March 2006, 46, 47.

- a) coroners provide regular updates to family members on the progress of investigations;
- b) coroners review the progress of each case every six months, commencing from the date that the case is referred to the coroner:
- c) where an investigation has not been concluded after 12 months have elapsed since the case was referred to a coroner, the investigating coroner give written reasons for the delays to the family of the person who died, along with an estimate of the time required to complete the investigation;
- d) the State Coroner supervise and monitor the progress of cases under consideration by other coroners in Victoria; and
- e) every coroner must, so far as it is consistent with justice and practicable to do so, perform or exercise his or her functions, powers and duties without delay.

#### **Notification**

Under the Act the family of the person who died has limited rights to be informed or to be kept informed of certain events in relation to the inquiry. For example, in certain circumstances a 'senior next of kin' may ask a coroner not to direct that an autopsy be performed, yet the Act does not require that the coroner inform this person of their right to object to the autopsy.<sup>2129</sup>

The Committee has recommended in this chapter that the family of a person who has died should be given various rights in the coronial process. However, if such rights are to be meaningful, the question arises as to how the family should be notified about those rights. Therefore, the Committee considered how families should be informed of their rights to:

- view and touch the body
- object to autopsy
- have a chosen doctor attend the autopsy
- make decisions regarding organ and tissue retention and disposal
- be informed as to whether an investigation or inquest will take place or not
- request that an inquest be held
- access information being considered by the coroner

<sup>&</sup>lt;sup>2129</sup> 'Senior next of kin' is defined in s 29(5). The Committee discusses the issue of autopsy later in the chapter.

- obtain legal advice or representation
- be informed by the coroner of progress in the investigation, reasons for any delays, the nature of the coroner's findings and progress made in the implementation of recommendations.

While the Act does not, in general, require a coroner to provide information to families about the coronial process, the practice of the Coroner's Office is somewhat different. As the Committee discusses later in this chapter, under the heading 'Counselling and support services', the Coronial Services Centre has developed a program called the Family Contact Program. Under this program counsellors from the Coroner's Office and VIFM contact families affected by reportable deaths that occur in Melbourne, and provide information about the coronial process, their rights in relation to autopsies and tissue donation, the availability of counselling and support services, and other matters. Inquest preparation seminars are also offered every three months for interested parties.

The coroner's clerks at the Coroner's Office also provide oral and written information to family members and others seeking information about the coronial process. This may include, for example, information on the likelihood of an autopsy, the right to object to an autopsy, the progress of an investigation, and the date and time of an inquest. The information provided may also include a copy of the autopsy report and the coroner's brief, along with a letter warning the recipient about the contents of the documents and the potential need to seek professional support. The role of coroner's clerks is described further in the submission of the Coroner's Office.<sup>2130</sup>

Further, an information booklet, *The Coroner's Process: Information for Family and Friends,* has been developed collaboratively by the Coroner's Office, VIFM and the Victoria Law Foundation (VLF), in consultation with a reference group of experts and focus groups of recently bereaved family and friends.<sup>2131</sup> Approximately 4000 copies are distributed annually to friends and family of persons who have died, as well as to hospitals and funeral directors. An outdated edition of the booklet is also available on the Coroner's Office website however it is not readily accessible from the main menu.<sup>2132</sup>

The Coroner's Office website contains information about the coronial process, counselling and support services (including links to services outside the Coroner's Office), information about the grieving process, links to publications (such as the information booklet) and other information that may be useful to families. The Committee received little evidence on the accessibility and user-friendliness of the website, but considers that it requires improvement, a matter which is under review by the Department of Justice and the State Coroner's Office.

<sup>&</sup>lt;sup>2130</sup> State Coroner's Office, Submission no. 70, 103-116.

<sup>&</sup>lt;sup>2131</sup> Victoria Law Foundation, Submission no. 69, 1.

<sup>&</sup>lt;sup>2132</sup> See http://www.coronerscourt.vic.gov.au.

# Other jurisdictions

In Western Australia the legislation sets out a detailed list of information that must be provided to the next of kin of the person who died:

20 Information to be provided to next of kin

- (1) A coroner who has jurisdiction to investigate a death must, as soon as practicable after assuming that jurisdiction, provide to any of the deceased person's next of kin under section 37(5) the following information
  - (a) that the body is under the control of the coroner investigating the death;
  - (b) that a post mortem examination is likely to be performed on the body under section 34;
  - (c) that while the body is under the control of the coroner investigating the death, any of the deceased person's next of kin under section 37(5) may touch the body, unless the coroner determines that it is undesirable or dangerous to do so;
  - (d) that there is a right under section 35 to request that a doctor chosen by the senior next of kin be present at the post mortem examination;
  - (e) that if tissue is to be removed from the body under section 34(3)(b), then there is a right to view the written permission of the deceased;
  - (f) that while the body is under the control of the coroner investigating the death, it may be viewed by any of the deceased person's next of kin under section 37(5);
  - (g) that there is a right under section 37 to object to the post mortem examination, and a right under section 36 to request that a post mortem examination be performed;
  - (h) that there is a possibility that tissue may be retained after the completion of the post mortem examination, where it is necessary to do so in order to investigate the death, in accordance with section 34:
    - (i) a brief summary stating the manner in which objection under section 37 may be made: and
    - (j) that a counselling service is available.
- (2) The information provided under subsection (1) must be in writing, where practicable, and in a language and form likely to be understood by the person to whom it is provided.<sup>2133</sup>

The ACT is the only Australian jurisdiction where the legislation requires the coroner to consider whether the family has been informed as to the time and place of the inquest. The relevant section from the legislation is set out below.

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<sup>&</sup>lt;sup>2133</sup> Coroners Act 1996 (WA) s 20.

- 37 Notification of immediate family
- (1) Before conducting a hearing for the purposes of an inquest into a death (other than a death in custody), the coroner shall have regard to
  - a) whether a member of the immediate family of the deceased has been notified of the time and place of the hearing; or
  - (b) if a member of the immediate family of the deceased has not been notified of the time and place of the hearing—whether reasonable efforts have been made to do so.
- (2) Nothing in subsection (1) prevents a coroner from conducting a hearing if the coroner believes, on reasonable grounds, that it would be in the public interest or the interests of justice to do so.<sup>2134</sup>

In relation to a death in custody in the ACT, the legislation prohibits a coroner from conducting an inquest unless s/he is satisfied that:

- (a) a member of the immediate family of the deceased has been notified of the time and place of the hearing; or
- (b) reasonable efforts to notify a member of the immediate family of the deceased have been made but were unsuccessful:
- and, if the deceased was an Aboriginal person or Torres Strait Islander, the appropriate local Aboriginal legal service has been notified.
- (2) Nothing in subsection (1) prevents a coroner from conducting a hearing if the coroner believes, on reasonable grounds, that it would be in the public interest or the interests of justice to do so.<sup>2135</sup>

### Law reform agencies

In relation to deaths in custody, the RCADC recommended that the family or another nominated person should be advised as soon as possible, and in adequate time, as to the date and time of the coronial inquest.<sup>2136</sup>

The Commission also recommended that no inquest should proceed in the absence of the family unless the coroner is satisfied that the family has been notified of the hearing in good time and that the family does not wish to appear in person or send a representative.<sup>2137</sup>

<sup>&</sup>lt;sup>2134</sup> Coroners Act 1997 (ACT) s 37.

<sup>&</sup>lt;sup>2135</sup> Coroners Act 1997 (ACT) s 69.

<sup>&</sup>lt;sup>2136</sup> Royal Commission into Aboriginal Deaths in Custody, *National Report* (1991) vol 1, Recommendation 21.

<sup>&</sup>lt;sup>2137</sup> Ibid Recommendation 22.

If no clear advice is available to the coroner as to the family's intention, the Commission recommended that no inquest should proceed, unless the coroner is satisfied that all reasonable efforts have been made to obtain such advice from the family, the Aboriginal Legal Service or from lawyers representing the family.<sup>2138</sup>

# Evidence received by the Committee

The Coroner's Office submitted that families and others who have an interest in a recent death should be provided with as much information as possible about the way the coronial process will affect them in a responsive, timely and culturally appropriate manner. However, the Coroner's Office is of the view that families and other interested parties are already informed of the progress of investigations and have access to information when they need it. It submitted that the information provided to families and interested parties by virtue of the Family Contact Program is already similar to that required to be provided to the next of kin under section 20 of the Coroners Act 1996 (WA).2139 It observed that families and others affected by the coronial process can also be provided with information by a range of other methods; for example, the State Coroner's Office website, the Coroner's Process publication, and pamphlets on suicide, and counselling and support. The Coroner's Office noted that some of these areas need further and ongoing development.

However, several family witnesses reported a lack of information in relation to many aspects of coronial investigations.2140 Evidence in this regard was not confined to cases in regional Victoria; in a number of cases in metropolitan Melbourne there was evidence that the information provided to families was inadequate. Further, certain family witnesses submitted that when they requested information, coronial clerical staff displayed poor sensitivity to their grief and concerns.2141 However, others had positive experiences with clerical staff. 2142

The discussion paper asked witnesses 'whether the Act should give family members the right to be informed or kept informed of certain events in relation to the inquiry'. Family witnesses were strongly in favour this proposal.<sup>2143</sup> Many witnesses considered that the Act should require, for example, the coroner to notify the senior next of kin or relevant family member of the following: that the coroner proposes to direct that an autopsy be performed; that the senior next of kin has a right to object to the direction; how to lodge an objection; if the objection is overruled, that the senior next of kin has a right to appeal the objection in the Supreme Court; the process for such an appeal;

<sup>&</sup>lt;sup>2139</sup> State Coroner's Office, Submission no. 70, 115.

<sup>&</sup>lt;sup>2140</sup> See for example Marion Stevens, Submission no. 49, 6.

<sup>&</sup>lt;sup>2141</sup> See for example Carol Smith, Submission no. 25, 3.

<sup>&</sup>lt;sup>2142</sup> Caroline Storm, *Minutes of Evidence*, 22 August 2005, 16.

<sup>&</sup>lt;sup>2143</sup> See for example Carol Smith, Submission no. 25, 4, 5, 9; Graeme Bond, Submission no. 48, 14,

and the time frame involved.<sup>2144</sup> Further, it was submitted that the senior next of kin needs to be told how to promptly withdraw an objection, as in some circumstances this can also be important.<sup>2145</sup>

Indeed, a theme emerging from evidence to this inquiry was that rights for family members in relation to the coronial process are meaningless unless families are made aware of them. For example, many of the witnesses were not made aware of their right to object to an autopsy, and some of those witnesses stated that they would have objected had they known it was possible to do so. In some cases this lack of information was a source of considerable frustration.

It was clear to the Committee that in many cases the problem of families not receiving information about their rights could be avoided if the information booklet *The Coroner's Process: Information for Family and Friends* was distributed more widely. Ms Carol Smith told the Committee that she did not receive the booklet until she complained to the State Coroner after the investigation of the death of her second son.<sup>2146</sup> She suggested, as did her sons' grandmother, Hazel Watt,<sup>2147</sup> that the booklet should be made available in a timely manner and should be available from a number of places, such as funeral homes, hospitals, police stations and courts.

If hospitals, police and undertakers had a simple leaflet letting families know what format to follow, what to expect, and what they were entitled to, it would save a lot of heartache at these terrible times.<sup>2148</sup>

It was also clear to the Committee that families require information following the completion of an investigation. It appeared to the Committee that some families have a need to have coronial findings explained to them, as some witnesses were confused or upset by the content of coronial findings. Further, many witnesses to the inquiry were highly concerned about the implementation of recommendations so that the circumstances leading to the death of their relative would not affect others in future. Some expressed the view that the families of a person who has died ought to be provided with information about what progress has been made towards the implementation of recommendations made by the coroner.

### Discussion and conclusion

The Committee considers that, in order for any rights provided to families by the legislation to be meaningful, they need to be accompanied by corresponding notification requirements. The Committee's view is that the Act should be amended to

<sup>&</sup>lt;sup>2144</sup> See for example Victorian Aboriginal Legal Service, *Submission no.* 57, 11; Royal Women's Hospital, *Submission no.* 18, 9; Royal Children's Hospital, *Submission no.* 17, 10.

<sup>&</sup>lt;sup>2145</sup> See for example Carol Smith, Submission 25, 3. See also Leon Hain, Submission no. 66, 2 and addendum 1.

<sup>&</sup>lt;sup>2146</sup> Carol Smith, Submission no. 25, 4.

<sup>&</sup>lt;sup>2147</sup> Hazel Watt, Submission no. 26, 1.

<sup>&</sup>lt;sup>2148</sup> Ibid.

include a provision similar to section 20 of the *Coroners Act 1996* (WA), which sets out a list of information that must be provided to a next of kin of the person who died.

In addition to the information that must be provided under the legislation in Western Australia, the Victorian Act should require the coroner to notify the immediate family of the time and place that an inquest will be held, as is the case in the ACT.<sup>2149</sup> The Act should also require the coroner to inform the immediate family whether an investigation or inquest will take place and that there is a right to request that an inquest be held.

The Committee considers that the Act should also require the coroner to notify the immediate family that there is a right to access information such as new evidence, witness statements and expert reports before an inquest or finding, as this material becomes available. Further, the Act should require the coroner to notify family members that they are entitled to obtain independent legal representation or advice.

The provisions should also require the coroner to provide updates on the progress of an investigation, an explanation of findings in the case, and information on the progress of implementation of recommendations arising from the case.

The Committee notes that a requirement to notify the immediate family rather than the senior next of kin could potentially place an unreasonable burden on the Coroner's Office if a large number of people make up the immediate family. In the Western Australia legislation this issue is addressed by the provisions placing an obligation to notify 'a' next of kin (this term is used rather than 'immediate family'), rather than 'the' next of kin. It is not clear what happens in practice if more than one member of the immediate family wishes to be notified. The Committee considers that the Coroners Act 2006 (NZ) includes provisions which provide a practical resolution of this potential problem with the Western Australian legislation. The New Zealand legislation sets up a mechanism to establish a representative or a number of representatives of a family, with whom the coroner will liaise. At the request or on behalf of the immediate family the coroner may recognise representatives of the immediate family and is restricted to recognising 'only the smallest number of representatives necessary to represent fairly the interests of all the different members of the immediate family'. 2150 The Committee notes that this issue will need to be addressed if provisions are introduced to give immediate family members greater access to information.

The Department of Justice has recently informed the Committee that in conjunction with the State Coroner's Office, the Department of Justice will be implementing the following initiatives to improve the level of information provided to families and others:

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<sup>&</sup>lt;sup>2149</sup> Coroner's Act 1997 (ACT) s 37.

<sup>&</sup>lt;sup>2150</sup> Coroners Act 2006 (NZ) s 20.

#### Information and communication

The Department and the SCO [State Coroner's Office] have reviewed communication and information practices at the SCO and are implementing the following initiatives:

- a dedicated 1300 telephone number for families and members of the public. The telephone line will be staffed by trained officers and provide links to counselling and interpreter services;
- a revised website that focuses on the needs of families with information about their rights and who to contact at the SCO;
- republication of the Victoria Law Foundation's The Coroner's Process: Information for Family and Friends booklet with updated information about counselling services and who to contact at the SCO;
- translation of information into community languages;
- a review of correspondence regularly sent to families to ensure that it is sensitive, supportive and culturally appropriate.

The Department has also engaged two expert clinicians to provide advice on these initiatives and to review the existing Family Contact Program ad the SCO.

#### Statement of rights for families

The SCO is working with the Department to prepare a statement of rights for families. Initiatives in other jurisdictions are being examined and work is under way to ensure that the needs of the Koori community and culturally and linguistically diverse families are addressed. The statement will be reviewed by the expert clinicians engaged by the Department and is expected to be finalised by the end of August 2006.<sup>2151</sup>

The Committee considers that these practical measures will complement its proposals for notification requirements in the Act.

Recommendation 99. That the *Coroners Act 1985* be amended to include a provision modelled on section 20 of the *Coroners Act 1996* (WA), which requires:

- (1) A coroner who has jurisdiction to investigate a death, as soon as practicable after a death, to provide to any of the immediate family of the person who died the following information:
- a) that the body is under the control of the coroner investigating the death;

<sup>&</sup>lt;sup>2151</sup> Department of Justice, *State Coroner's Office Improvement Project – Briefing for Victorian Parliament Law Reform Committee*, August 2006.

- b) that an autopsy is likely to be performed;
- c) that any of the dead person's immediate family may touch the body, where practicable;
- d) that there is a right to have a representative chosen by the senior next of kin attend the autopsy;
- e) that if tissue is to be removed from the body in accordance with the written permission of the person who died, there is a right to view such written permission;
- f) that there is a right to view the body;
- g) that there is a right to object to the autopsy, and a right to request that an autopsy be performed;
- h) that tissue may be retained after the completion of the autopsy where it is necessary to do so in order to investigate the death;
- i) a brief summary stating the manner in which an objection to autopsy may be made; and
- j) that a free counselling and support service is available.
- (2) The information provided to be in writing, where practicable, and in a language and form likely to be understood by the person to whom it is provided.

The Committee also recommends that, in addition to the matters covered in the WA legislation, provisions be included which require that the following information must also be provided to the immediate family:

- a) whether an investigation or inquest will take place, and that there is a right to request that an inquest be held;
- b) before conducting an inquest, the time and place of the hearing, where practicable;
- c) that there is a right to access or request information such as new evidence, witness statements and expert reports in advance of an inquest or finding, as this material becomes available:
- d) that they are entitled to obtain independent legal advice or representation in relation to the investigation and, if one exists, that there is a free telephone service that provides advice about objections to autopsies;
- e) reasons for delays in the investigation or inquest;
- f) findings made by the coroner and explanations of those findings where requested; and

g) details of responses to recommendations received from agencies.

# **Autopsies**

If a coroner reasonably believes that an autopsy is necessary for the investigation of a death, the coroner may direct that an autopsy be performed.<sup>2152</sup> The authority to direct that an autopsy be performed is fundamental to a coroner's death investigation function, which includes determining the medical cause of death and the factors which led to the medical cause of death.

An autopsy is a detailed physical examination of a person's body after death.<sup>2153</sup> It may include blood tests, x-rays, and an internal and external examination of the body. The internal examination may involve an examination of each of the body's main cavities and the organs within them, including removing and weighing such organs.<sup>2154</sup>

In Melbourne, external inspections and autopsies are performed by forensic pathologists who are employed by VIFM, or in hospitals. In regional Victoria, forensic autopsies may be performed by pathologists with appropriate credentials at local hospitals or on a fee-for-service basis under informal arrangements with VIFM.<sup>2155</sup> Serious or unusual cases are usually taken to Melbourne.

It is important to distinguish between medical autopsies and coronial or forensic autopsies because there is some confusion in the community about this distinction. For a medical autopsy to take place, consent is required from the next of kin.<sup>2156</sup> Medical autopsies are generally performed by the hospital where a person died and the aim is to increase medical knowledge regarding the person's condition. There is also the opportunity to collect material for medical teaching and research. In contrast, a forensic autopsy can be performed without the consent of the next of kin. However, under the Act, the family can object to a coroner ordering an autopsy.

## Right to object to autopsy

The duty of a coroner to investigate the cause of a death can sometimes come into conflict with the wishes of family members and their cultural and religious practices, particularly in relation to the conducting of autopsies.

<sup>&</sup>lt;sup>2152</sup> Coroners Act 1985 s 27(1).

<sup>&</sup>lt;sup>2153</sup> State Coroner's Office and Victorian Institute of Forensic Medicine, *The Coroner's Process: Information for Family and Friends* (2005) 15. An autopsy is sometimes referred to as a post-mortem examination or necropsy.

<sup>&</sup>lt;sup>2154</sup> D Ranson, 'The Autopsy', in H Selby (ed), *The Inquest Handbook* (1998) 108. This chapter also provides detailed information on the medical procedures involved in the internal examination.

<sup>&</sup>lt;sup>2155</sup> Except for St John of God Hospital in Ballarat and Mildura Base Hospital, which have specific agreements with the Department of Human Services: State Coroner's Office, *Submission no. 70*, 152.

<sup>&</sup>lt;sup>2156</sup> Human Tissue Act 1982 (Vic) s 30(3).

In Victoria a 'senior next of kin'2157 may ask a coroner not to direct that an autopsy be performed. But, in order to be able to object, this person would need to be informed that, first, an autopsy will take place and, second, s/he has a right to object to the autopsy. However, the Act does not require a coroner to give this information to the senior next of kin.

Where the senior next of kin does make an objection to the coroner, and the coroner nevertheless decides that an autopsy is necessary, the coroner must immediately give notice in writing to that person.<sup>2158</sup>

If a coroner believes that an autopsy needs to be performed immediately, the autopsy may take place. Otherwise, the autopsy cannot take place until 48 hours after the senior next of kin has been given notice that the autopsy will take place, unless the Supreme Court orders otherwise.<sup>2159</sup>

Within this tight time frame, the senior next of kin may appeal to the Supreme Court for an order that no autopsy be performed. The Supreme Court may make the order 'if it is satisfied that it is desirable in the circumstances'.<sup>2160</sup> However, such appeals are expensive. The filing fee alone currently costs around \$900, quite apart from the cost of hiring legal representatives.

Some families withdraw objections to autopsies under section 29, generally because of advice that the coroner intends to refuse the request or because of the potential for the funeral to be delayed while the application remains on foot. However, those objections which proceed to the Supreme Court for review are, according the Coroner's Office, usually successful.<sup>2161</sup> The following table from the submission of the State Coroner shows the number of applications under section 29 each year and how many of those applications were granted or refused.<sup>2162</sup>

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<sup>&</sup>lt;sup>2157</sup> This is discussed in the first section of this chapter.

<sup>&</sup>lt;sup>2158</sup> Coroners Act 1985 s 29(1).

<sup>&</sup>lt;sup>2159</sup> Coroners Act 1985 s 29(3).

<sup>&</sup>lt;sup>2160</sup> Coroners Act 1985 s 29(4).

<sup>&</sup>lt;sup>2161</sup> State Coroner's Office, Submission no. 70, 155.

<sup>&</sup>lt;sup>2162</sup> Ibid. The number of applications includes applications which were made and subsequently withdrawn. Also, the number refers to the total number of applications made rather than appeals to the Supreme Court.

5004003002001001996 1998 2000 2002 2004

Year

Figure 4 - Section 29 Application Outcomes in Melbourne

Source: State Coroner's Office, Submission no. 70, 154.

VIFM submitted that in 2004 the number of successful objections was approximately 12 percent of all cases dealt with, and in the first half of 2005 the figure was 14 percent.<sup>2163</sup> The increase in the number of objections to autopsies between 2003 and 2004, as shown by the above graph, is a direct result of initiatives undertaken by VIFM and the Coroner's Office to ensure that families are aware of their right to object.<sup>2164</sup>

### Cultural, religious and other reasons for opposing autopsies

In a multicultural society great weight should be given to the cultural and spiritual laws and practices of the various cultural groups forming our society, and that great care should be taken to ensure that their laws and practices, assuming they are otherwise lawful, are not disregarded or abused.<sup>2165</sup>

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<sup>&</sup>lt;sup>2163</sup> Victorian Institute of Forensic Medicine, *Submission no. 19*, 29. The Committee was informed that the number of 'cases dealt with' is similar to, but may not be identical to, the number of coronial investigations, since in come cases an autopsy will take place prior to a death proving to be unreportable. Conversation, Associate Professor David Ranson, deputy director, *Victorian Institute of Forensic Medicine*, and Committee Legal Research Officer, 17 July 2006.

<sup>&</sup>lt;sup>2164</sup> Ian Freckelton and David Ranson, *Death Investigation and the Coroner's Inquest* (2006) 167; State Coroner's Office, *Submission no. 70*, 154; Victorian Institute of Forensic Medicine, *Submission no. 40*, 29.

<sup>&</sup>lt;sup>2165</sup> Green v Johnstone (1995) 2 VR 176, 179.

Some members of the community have particular cultural or religious prohibitions on autopsies. <sup>2166</sup> For example, Aboriginal customary law may prohibit the mutilation of the body so as not to harm the spirit of the deceased. <sup>2167</sup> Jewish, Islamic, Taoist-Buddhist, Hmong and certain Indigenous beliefs entail the need for speedy burial of the person who died. <sup>2168</sup> Jewish religion views surgical autopsy as a violation of the sanctity of the body. <sup>2169</sup> Jewish customary law also requires a specially appointed guardian to attend the deceased until burial. <sup>2170</sup> Under Islamic precepts the body of the person who died must be handled with the utmost respect and should only be handled by a person of the same sex. <sup>2171</sup> Fijians traditionally view post-mortems as unthinkable and believe the dead should not be tampered with. <sup>2172</sup> Samoans and Tongans regard autopsies as an indignity to the person who died. <sup>2173</sup> Buddhists believe in reincarnation and therefore many will want the body to be kept 'whole' so that it will be reborn complete. <sup>2174</sup> These are examples of some of the cultural issues that may arise in relation to autopsies. Many other ethnic groups also have strong feelings about the intrusion on a community member's body that an autopsy represents. <sup>2175</sup>

The Committee notes that many members of the general community who do not have particular religious or cultural issues concerning delay of burial and integrity of bodies nonetheless are passionately opposed to the conduct of an autopsy. There are a number of possible reasons for this opposition. Brown<sup>2176</sup> identified the following reasons for objecting to an autopsy:

- the person who died has suffered enough;
- autopsies constitute a form of mutilation;

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<sup>&</sup>lt;sup>2166</sup> See for example Prue Vines, 'Objections to Post-Mortem Examination: Multiculturalism, Psychology and Legal Decision Making' (2000) 7 *Journal of Law of Law and Medicine* 424; John Brennan, 'Accommodating Law to Culture', in Hugh Selby (ed), *The Aftermath of Death* (1992) 212.

<sup>&</sup>lt;sup>2167</sup> See for example *Green v Johnstone* (1995) 2 VR 176, 177; *Re Death of Unchango (Jr)* (1997) 95 A Crim R 65, 68.

<sup>&</sup>lt;sup>2168</sup> Ian Freckelton and David Ranson, *Death Investigation and the Coroner's Inquest* (2006) 372. The authors cite several journal articles and other references on the conflict between autopsy decisions and cultural and religious practices.

<sup>&</sup>lt;sup>2169</sup> See for example *Deitz v Abernethy* (Unreported, Supreme Court of NSW, Abadee J, 8 May 1996).

<sup>&</sup>lt;sup>2170</sup> New Zealand Law Commission, *Coroners*, Report No 62 (2000), para 198, 62.

<sup>&</sup>lt;sup>2171</sup> John Brennan, 'Accommodating Law to Culture', in Hugh Selby (ed), *The Aftermath of Death* (1992) 212.

<sup>&</sup>lt;sup>2172</sup> New Zealand Law Commission, *Coroners*, Report No 62 (2000), para 198, 62.

<sup>&</sup>lt;sup>2173</sup> New Zealand Law Commission, *Coroners*, Report No 62 (2000), para 198, 62; see also The South Pacific Foundation of Victoria Inc., *Submission no. 54*.

<sup>&</sup>lt;sup>2174</sup> John Brennan, 'Accommodating Law to Culture', in Hugh Selby (ed), *The Aftermath of Death* (1992) 212, 213.

<sup>&</sup>lt;sup>2175</sup> See Ian Freckelton and David Ranson, *Death Investigation and the Coroner's Inquest* (2006) 373.

<sup>&</sup>lt;sup>2176</sup> H G Brown, 'Lay Perceptions of Autopsy' (1984) 108 Archives of Pathology and Laboratory Medicine 446.

- diagnosis is excellent and diagnostic machines are almost infallible;
- autopsies deny a complete body and so life in the hereafter cannot take place;
- autopsy results are not well communicated;
- autopsies take a long time and delay funeral arrangements; and
- if the medical profession could not save the person who died, it has no business seeking clues for its own failures.

Brown's study reviewed hospital autopsies. A study by Lambeth<sup>2177</sup> of objections to forensic autopsies found additional objections, such as:

- where the person who died had expressed a desire not to be subject to autopsy, and
- where there was an absence of suspicious circumstances surrounding the death.

## Case law in relation to applications to prevent autopsies

Two Supreme Court of Victoria decisions provide examples of situations in which the Court has determined that no autopsy should be performed. In these cases, the Court considered the interests of the family against the interests of the public before deciding if the autopsy should take place.

### Green v Johnstone<sup>2178</sup>

The senior next of kin was an Aboriginal man whose 10-day-old baby had died. The police determined that there were no suspicious circumstances involved with the baby's death. One possibility was that the baby died from SIDS.<sup>2179</sup> In the circumstances, the coroner ordered that an autopsy be performed, and the father of the baby, as the senior next of kin, objected and appealed to the Supreme Court.

The Court held that, in exercising its discretion, it must balance the interests of the child's parents in being permitted to follow and maintain their Aboriginal culture and law against the interests of the community to ascertain the cause of an otherwise unexplained death. In the circumstances, the Court ordered that no autopsy be performed.

<sup>&</sup>lt;sup>2177</sup> J C Lambeth, *Study of Objections to Autopsy under s 29 Coroners Act 1985 (Vic)*, (Honours Thesis, Department of Criminology, University of Melbourne, 1997). [As cited in Ian Freckelton and David Ranson, *Death Investigation and the Coroner's Inquest* (2006) 373].

<sup>&</sup>lt;sup>2178</sup> Green v Johnstone [1995] 2 VR 176.

<sup>&</sup>lt;sup>2179</sup> Sudden Infant Death Syndrome.

### Horvath v State Coroner of Victoria<sup>2180</sup>

The death of Mr and Mrs Horvath's seven-day-old boy was reported to the coroner. The police were satisfied that the death was not suspicious, and a doctor who examined the baby determined that the most likely cause of death was SIDS. To confirm his opinion, the doctor indicated that he would like to see an autopsy performed.

The coroner then decided to order an autopsy, as the medical cause of death could not be established without one. The parents of the baby objected to the autopsy, explaining that they were devout Catholics and that it was their desire to provide their baby with a funeral in an open coffin, as soon as possible.

In the Supreme Court, Morris J considered that the parents had a legitimate interest in not having an autopsy performed. He then considered the public interest. On the evidence before him, he considered that there was a prospect that an autopsy would not produce any evidence to confirm the cause of the baby's death. Also, he considered that if an autopsy did establish that there was a congenital problem with the baby's system then it was difficult to see how his death would inform the community in a way that would make deaths of that type less common.

It was for these reasons that the Court ordered that no autopsy take place. The Court also ordered that the Coroner's Office pay Mr and Mrs Horvath's legal costs and the \$900 court filing fee.<sup>2181</sup>

The decisions of Australian superior courts in cases such as *Green v Johnstone*<sup>2182</sup> and *Horvath v State Coroner*<sup>2183</sup> exhibit a consistent approach towards resolving 'the conflict between personal and public rights in relation to the state-enforced performance of autopsies'. <sup>2184</sup> Dr Freckelton and Associate Professor Ranson identify the following basic principles for such resolution, which have emerged from cases involving applications to prevent autopsies:

 when there is no clear evidence that the circumstances surrounding a death were in some way suspicious or untoward, and where there are strongly held religious

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<sup>&</sup>lt;sup>2180</sup> Horvath v State Coroner of Victoria (Unreported, Supreme Court of Victoria, Morris J, 11 October 2004).

<sup>&</sup>lt;sup>2181</sup> It should be noted that, by making the costs order, the Court did not consider that the Coroner was wrong in concluding that there should be an autopsy.

<sup>&</sup>lt;sup>2182</sup> Green v Johnstone [1995] 2 VR 176.

<sup>&</sup>lt;sup>2183</sup> Horvath v State Coroner of Victoria (Unreported, Supreme Court of Victoria, Morris J, 11 October 2004).

<sup>&</sup>lt;sup>2184</sup> Ian Freckelton and David Ranson, *Death Investigation and the Coroner's Inquest* (2006) 382.

or cultural views opposed to an autopsy taking place, the balance of interests favours an autopsy not taking place.<sup>2185</sup>

- however, where the sensibilities of the next of kin are not based on religious or cultural factors but simply 'instinctive repugnance', it is more likely, although not certain, that the autopsy will proceed.
- finally, where there is significant evidence that the death occurred unnaturally or in suspicious circumstances which may be clarified by an autopsy, a coroner's decision to order an autopsy, in spite of the views and wishes of the family of the person who died, is likely to be upheld.<sup>2186</sup>

## Other jurisdictions

In most jurisdictions, coronial legislation permits a senior next of kin to object to the direction that an autopsy take place.<sup>2187</sup> However, as in Victoria, a coroner is not required to inform this person of the right to object to the direction.

The position in Queensland is different. In that jurisdiction, a police officer is required to obtain the family member's views regarding an autopsy.<sup>2188</sup> Under the Queensland legislation, a coroner must take account of family distress or concerns regarding an order for an internal examination, wherever practicable. The relevant section is set out below.

19 Order for autopsy

. . .

(4) Before ordering an internal examination of the body, the coroner must, whenever practicable, consider at least the following—

<sup>&</sup>lt;sup>2185</sup> For examples of superior court decisions refusing an autopsy, see *Saunders v State Coroner* [2005] VSC 460; *Jones v Coroner, Albany* [2005] WASC 134; *Horvath v State Coroner*, (Unreported, Supreme Court of Victoria, Morris J, 11 October 2004); *Re the Death of Simon Unchango (Jnr)*; *Ronan v State Coroner* [2000] WASC 260; *Krantz v Hand* [1999] NSWSC 432; *Price v Johnstone* (Unreported, Supreme Court of Victoria, Mandie J, 17 June 1998); *Ex parte Simon Unchango (Snr)* (1997) 95 A Crim R 65; *Deitz v Abernethy* (Unreported, Supreme Court of NSW, Abadee J, 8 May 1996); *Green v Johnstone* [1995] 2 VR 176; *Bendet v State Coroner* (Unreported, Supreme Court of Victoria, Cummins J, 22 August 1989).

<sup>&</sup>lt;sup>2186</sup> For examples of superior court decisions ordering an autopsy over objection, see *Wuridjal v The NT Coroner* [2001] NTSC 99; *Gollop v Hand* (Unreported, Supreme Court of NSW, Grove J, 13 August 1998); *Pope v State Coroner* (1998) 70 SASR 387; *Magdiarz v Heffey* (Unreported, Supreme Court of Victoria, McDonald J, 3 October 1995).

<sup>&</sup>lt;sup>2187</sup> Coroners Act 1980 (NSW) ss 48A(1), 48(2); Coroners Act 1993 (NT) s 23(1); Coroners Act 1995 (Tas) s 38(1); Coroners Act 1996 (WA) s 37(1).

<sup>&</sup>lt;sup>2188</sup> State Coroner's Guidelines — Version 0 December 2003, para 5.3.1. Available at <a href="http://www.justice.qld.gov.au/courts/coroner/pdfs/guidelines.pdf">http://www.justice.qld.gov.au/courts/coroner/pdfs/guidelines.pdf</a>.

- (a) that in some cases a deceased person's family may be distressed by the making of this type of order, for example, because of cultural traditions or spiritual beliefs;
- (b) any concerns raised by a family member, or another person with a sufficient interest, in relation to the type of examination to be conducted during the autopsy.
- (5) If, after considering any concern mentioned in subsection (4)(b), the coroner decides it is still necessary to order the internal examination, the coroner must give a copy of the order to the person who raised the concern.<sup>2189</sup>

If a coroner has decided to direct an autopsy despite family concerns, the family member may seek review of the direction under the *Judicial Review Act 1990* (Qld).

In the ACT the legislation also requires the coroner to take into account cultural and religious beliefs before ordering an exhumation or an autopsy. A coroner contemplating making such orders must have regard to 'the desirability of minimising the causing of distress or offence to persons who, because of their cultural attitudes or spiritual beliefs, could reasonably be expected to be distressed or offended by the making of that decision'.<sup>2190</sup> This provision appears to implement the common law as it has developed in other Australian jurisdictions.<sup>2191</sup>

Dr Freckelton and Associate Professor Ranson comment that, given the coroner's obligation to investigate suspicious deaths, it is unclear how such matters can legitimately be taken into account, other than to bring about the result that, in cases where there are no indications of foul play (for example, in what would otherwise be classified as a SIDS case), an autopsy will not be ordered if cultural or religious sensibilities would be offended.

In New South Wales, unlike Victoria, persons other than the senior next of kin may also object to the performance of an autopsy.<sup>2192</sup> If the objection is made to an assistant coroner, the matter must be referred to a coroner before any further decision about the autopsy is made.<sup>2193</sup> However, the provisions which set out the rights of the senior next of kin in relation to objections to autopsies,<sup>2194</sup> including the ability to appeal to the Supreme Court for a review of the coroner's decision, do not apply to objections by persons other than the senior next of kin.<sup>2195</sup>

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<sup>&</sup>lt;sup>2189</sup> Coroners Act 2003 (Qld) s 19(4).

<sup>&</sup>lt;sup>2190</sup> Coroners Act 1997 (ACT) s 28.

<sup>&</sup>lt;sup>2191</sup> Ian Freckelton and David Ranson, *Death Investigation and the Coroner's Inquest* (2006) 362, 372–82; see further Ian Freckelton, 'Autopsy Law: Multiculturalism Working Successfully' (1998) 6(1) *Journal of Law and Medicine* 5.

<sup>&</sup>lt;sup>2192</sup> Coroners Act 1980 (NSW) s 48B.

<sup>&</sup>lt;sup>2193</sup> Coroners Act 1980 (NSW) s 48B(2).

<sup>&</sup>lt;sup>2194</sup> Coroners Act 1980 (NSW) s 48A.

<sup>&</sup>lt;sup>2195</sup> Coroners Act 1980 (NSW) s 48B(3).

In New Zealand, in deciding whether or not to authorise an autopsy, a coroner is obliged to have regard to the following issues:

- (a) The extent to which matters required by this Act to be established by an inquiry-
- (i) are not already disclosed in respect of the death concerned by information available directly to the coroner or from information arising from inquiries or examinations the coroner has made or caused to be made; but
- (ii) are likely to be disclosed by a post-mortem examination; and
- (b) Whether or not the death appears to have been unnatural; and
- (c) If the death appears to have been unnatural or violent, whether or not it appears to have been due to the actions or inaction of other persons; and
- (d) The existence and extent of any allegations, rumours, suspicions, or public concern about the cause of death; and
- (e) The desirability of minimising distress to persons who, by reason of their ethnic origins, social attitudes or customs, or spiritual beliefs, customarily require bodies to be available as soon as possible after death; and
- (f) The desirability of minimising distress to persons who, by reason of their ethnic origins, social attitudes or customs, or spiritual beliefs, find the post-mortem examination of bodies offensive; and
- (g) The desire of any member of the immediate family of the person concerned that a post-mortem examination should be performed; and
- (h) Any other matters the coroner thinks relevant. 2196

Dr Freckelton and Associate Professor Ranson comment that such factors in principle constitute a useful checklist of relevant considerations for a coroner determining whether it is 'necessary' for the investigation of a death to direct that an autopsy be performed.<sup>2197</sup>

The New Zealand legislation also allows the coroner to order prompt performance of an autopsy if the ethnic origins, social attitudes or customs, or spiritual beliefs of the person who died or their family customarily require the body to be available to the family as soon as possible after the death.<sup>2198</sup>

<sup>&</sup>lt;sup>2196</sup> Coroners Act 2006 (NZ) s 30. See also New Zealand Law Commission, Coroners, Report No 62 (2000), para 136, 42.

<sup>&</sup>lt;sup>2197</sup> Ian Freckelton and David Ranson, Death Investigation and the Coroner's Inquest (2006) 364–5.

<sup>&</sup>lt;sup>2198</sup> Coroners Act 2006 (NZ) s 35(2)(c).

It is worth comparing the reference to 'cultural traditions or spiritual beliefs' in the Queensland legislation to the words 'ethnic origins, social attitudes or customs, or spiritual beliefs' in the New Zealand legislation. The New Zealand Law Commission referred in its report to the need for relatives to have their cultural, religious or personal values respected, but the latter phrase has not been included in the *Coroners Act 2006 (NZ)*.<sup>2199</sup>

## Law reform agencies

The RCADC stated in its 1991 report that:

The right to request or refuse an autopsy may have particular significance for Aboriginal communities with strong traditional cultural practices. The conduct of an autopsy may interfere with traditional funeral rites. Consideration for Aboriginal cultural values must be balanced against the need for coronial investigations to be thorough and prompt. Integral to any right held by the family of the deceased in relation to the conduct of an autopsy is a right to be notified promptly of any intention to perform or not to perform a post-mortem examination.<sup>2200</sup>

The RCADC said in recommendation 8 that, to resolve difficulties, the State Coroner should consult generally with Aboriginal legal services to develop a protocol for the resolution of questions involving the conduct of inquiries and autopsies, the removal and burial of organs, and the removal and return of the body of the deceased.<sup>2201</sup> In 2005 the RCADC Implementation Review Team noted that this protocol has yet to be developed and recommended that the State Coroner commence immediate discussions with VALS and the Victorian Aboriginal Community Controlled Health Organisation on the development and implementation of cultural protocols.<sup>2202</sup>

The Luce Report contains the following observations about autopsies and when they should be performed:

84. Any medical investigation ordered by the coroner or Statutory Medical Assessor, whether autopsy or other test, should be to clarify a defined uncertainty or range of uncertainties about the death and should be at the lowest level of invasiveness likely to resolve the uncertainty. Referrals for autopsy or other technical investigations should never be routine or automatic. This may apply equally after traumatic deaths though when forensic autopsies are required for criminal investigations they should be carried out.

85. Where possible before any significant technical investigation is ordered, the medical records should have been scrutinised, the doctors and others who had attended the patient should be contacted as well as the family.

<sup>&</sup>lt;sup>2199</sup> New Zealand Law Commission, *Coroners*, Report No 62, (2000) para 140, 42–3.

<sup>&</sup>lt;sup>2200</sup> Royal Commission into Aboriginal Deaths in Custody, *National Report* (1991) vol 1. Para 4.6.21.

<sup>&</sup>lt;sup>2201</sup> Ibid para 4.6.24.

<sup>&</sup>lt;sup>2202</sup> Ibid Recommendation 99.

86. In cases where the family object to an autopsy it should not be proceeded with unless there is positive indication of the need to investigate a possible crime or lack of medical or other care, or a public health risk that requires the cause of the individual death to be established, in order to prevent similar fatalities.<sup>2203</sup>

## Evidence received by the Committee

The Coroner's Office and VIFM informed the Committee that the number of autopsy objections has risen dramatically as a result of improved communication with families through the Family Contact Program about their rights to object. Professor Stephen Cordner, Director of VIFM, also told the Committee that, because of this communication, most families will not make an objection under section 29 when it is unlikely that the objection will be upheld. Professor Cordner stated that, as a result, 90 percent of the objections that are made are accepted.<sup>2204</sup> Professor Cordner expects that in future more families will understand that there are some public benefits to autopsies, which will ameliorate the rise in objections.

There is considerable discussion of cultural opposition to autopsies in reports by law reform agencies and in the applicable case law. However, as noted earlier in this chapter, the Committee sought submissions from a range of community groups in response to the discussion paper, but the response was limited. Nonetheless, both VALS and SPFV provided important evidence, some of which is relevant to communities other than their own. The Committee has discussed some of this evidence in relation to the definition of family and senior next of kin, but some additional issues should be raised here.

VALS told the Committee that there has been no formal consultation between the Coroner's Office and VALS regarding the implementation of a protocol regarding the conduct of coronial investigations, including autopsies, in spite of RCADC recommendation 8 and the Implementation Review Team's recommendation 99.

SPFV recommended to the Committee that the Act should be amended to include a general cultural sensitivity requirement that would provide a basis for negotiating with the Coroner's Office in relation to cultural needs.<sup>2205</sup> Further, SPFV suggested that coroners would be assisted by training in relation to cultural requirements, that key liaison people within community groups should be identified to facilitate effective

<sup>&</sup>lt;sup>2203</sup> United Kingdom, *Death Certification and Investigation in England, Wales and Northern Ireland: The Report of a Fundamental Review*, Cm 5831 (2003). Available at

www.official-documents.co.uk.

<sup>&</sup>lt;sup>2204</sup> Stephen Cordner, *Minutes of Evidence*, 19 September 2005, 132.

<sup>&</sup>lt;sup>2205</sup> R Smith and G Hallet, South Pacific Foundation of Victoria, *Minutes of Evidence*, 20 September 2005, 162.

communication with the Coroner's Office, and that a cultural liaison officer should be appointed at the Coroner's Office.<sup>2206</sup>

One of the issues considered by the Committee is whether the Act should require a coroner to notify the senior next of kin that the coroner proposes to order an autopsy and that the senior next of kin has a right to object to the direction that an autopsy be performed.<sup>2207</sup> The Committee has discussed this issue earlier in this chapter under the heading 'Notification' and has recommended that the Act be amended to include such a requirement.

Witnesses were also asked whether there should be any circumstances in which a coroner may order an autopsy without first contacting the senior next of kin to see whether that person has any objections to the autopsy. Many witnesses submitted that only in exceptional circumstances should the coroner be able to order an autopsy without first contacting the senior next of kin to see if that person has any objections. Such circumstances would include those where:

- a reasonable period of time has elapsed; or
- significant efforts have been made to contact the family; or
- there is a compelling need to proceed with an autopsy or investigation.<sup>2208</sup>

However, witnesses such as Ms Heffey submitted that the coroner should also have this authority where there are circumstances surrounding a death that suggest that the death may have been unlawful (especially where family members are suspects) or the result of neglect. This view was supported by Associate Professor Ranson, who also referred to situations where a death has major health implications; for example, where environmental toxins or infectious agents are involved. Thus a coroner should be able to authorise an autopsy rapidly when necessary to ensure the safety of the community and the effective operation of the justice system. 2210

Yet some witnesses, such as SPFV, submitted that there should be absolutely no circumstance in which a coroner can carry out an autopsy without first advising the family of the intention to do so and of their right to object.<sup>2211</sup> It is not clear whether these witnesses had considered the types of situations raised by Ms Heffey and Associate Professor Ranson. By contrast, some witnesses submitted that, while

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<sup>&</sup>lt;sup>2206</sup> R Smith and G Hallet, South Pacific Foundation of Victoria, *Minutes of Evidence*, *20 September 2005*, 159–66; State Coroner's Office, *Submission no. 70*, 109.

<sup>&</sup>lt;sup>2207</sup> See discussion paper 93, question 37(a).

<sup>&</sup>lt;sup>2208</sup> See for example Austin Health, *Submission no. 45*, 10.

<sup>&</sup>lt;sup>2209</sup> Jacinta Heffey, Submission no. 33, 28.

<sup>&</sup>lt;sup>2210</sup> David Ranson, Submission no. 19, 76.

<sup>&</sup>lt;sup>2211</sup> South Pacific Foundation Victoria (Inc), *Submission no. 24*, 19. Cf Royal Children's Hospital, *Submission no.* 17, 10.

preferable, it should not be mandatory for the coroner to contact the senior next of kin to determine whether there are any objections. Thus these witnesses believe that the present system is sufficient.<sup>2212</sup>

Another issue considered by the Committee is whether the Act should permit anyone besides the senior next of kin to object to the coroner directing that an autopsy be performed. The Committee has already discussed this issue in this chapter under the heading "Definition of 'family' and 'senior next of kin'", at least in relation to the question of whether the definition of senior next of kin should be expanded.

A separate question is whether the Act should allow persons other than the senior next of kin, ie family members, to object to an autopsy. A number of witnesses including Associate Professor Ranson submitted that other family members should be able to object to the coroner directing that an autopsy be performed,<sup>2213</sup> as they might have legitimate concerns not conveyed by the senior next of kin, and that the coroner should take such objections seriously.<sup>2214</sup> However, VIFM submitted that only the senior next of kin should be able to object to autopsies.<sup>2215</sup>

Witnesses were also asked whether the Supreme Court is the most appropriate appeal avenue for autopsy objections. The Coroner's Office expressed concern in its submission that the Supreme Court is not the appropriate avenue of appeal. The Coroner's Office noted that the applications are almost always granted by the Supreme Court. In these cases the coroner's only recourse is to determine the cause of death as unascertained, and the opportunity to obtain vital prevention information may be lost. The Coroner's Office also considered that applications are unnecessarily expensive, challenging and time consuming for families in a traumatic period in their lives. 2217

Accordingly the Coroner's Office made two alternative recommendations. The first alternative was that section 29 of the Act be amended to exclude appeals to the Supreme Court, such that the amended section would provide:

(3) Within 48 hours after receiving notice of the decision, the senior next of kin may apply to the State Coroner for an order that no autopsy be performed.

<sup>&</sup>lt;sup>2212</sup> See for example Bayside Health, Submission no. 46, 6.

<sup>&</sup>lt;sup>2213</sup> David Ranson, Submission no. 19, 76.

<sup>&</sup>lt;sup>2214</sup> See for example Royal Women's Hospital, *Submission no. 18*, 8. See also Austin Health, *Submission no. 45*,

<sup>&</sup>lt;sup>2215</sup> Victorian Institute of Forensic Medicine, Submission no. 40, 32.

<sup>&</sup>lt;sup>2216</sup> Discussion paper 93, question 37(e).

<sup>&</sup>lt;sup>2217</sup> State Coroner's Office, Submission no. 70, 155.

(4) The State Coroner may make an order that no autopsy be performed if he or she is satisfied that the cause of death is able to be determined without an autopsy or it is otherwise desirable in all the circumstances.<sup>2218</sup>

A variation of this was proposed by Ms Heffey, who also submitted that the first appeal should be to the State Coroner if another coroner has made the decision, and that the next appeal should be to the Supreme Court.<sup>2219</sup> Associate Professor Ranson considered that it might be appropriate for decisions by coroners with respect to autopsies to be subject to administrative review.<sup>2220</sup>

The second alternative put forward by the Coroner's Office is that the Act should require the Supreme Court to hear certain evidence from the forensic pathologist who advised the coroner determining the application. The required evidence would relate to the forensic pathologist's capacity to accurately diagnose the medical cause of death without an autopsy and the public safety and prevention implications of this failure to accurately diagnose the medical cause of death. Under this proposal, the Coroner's Office recommended that section 29 provide that:

(4) After hearing evidence from the forensic pathologist who performed the physical examination of the body and advised the coroner, the Supreme Court may make an order that no autopsy be performed if it is satisfied that the cause of death is able to be determined without an autopsy or if it is otherwise desirable in all the circumstances.<sup>2221</sup>

Similarly, VIFM submitted that, when an appeal in relation to an autopsy is heard in the Supreme Court, the Coroner or VIFM should be present to put forward the public interest arguments in favour of an autopsy in the particular case. It would be possible for VIFM to make a written submission to the Court about the public benefits of the particular autopsy, or a pathologist could be called as a witness. VIFM noted that it would need to be informed of the appeal for this to happen. VIFM considers that there should be a means of ensuring that the Court has access to relevant medical information, and that the Court should be required to take into account the public benefits of an autopsy.

In relation to such public benefits, Professor Cordner made a useful point in relation to any strengthening of the preventative role of coroners proposed by the Committee:

<sup>&</sup>lt;sup>2218</sup> Ibid 155–6.

<sup>&</sup>lt;sup>2219</sup> Jacinta Heffey, Submission no. 33, 28.

David Ranson, *Submission no. 19*, 76. For example, in Queensland coroners' decisions with respect to autopsies can be reviewed administratively under the *Judicial Review Act 1991* (Qld): *State Coroner's Guidelines*— *Version 0 December 2003*, guideline 5.3.1. Available at

http://www.justice.qld.gov.au/courts/coroner/pdfs/guidelines.pdf.

<sup>&</sup>lt;sup>2221</sup> State Coroner's Office, Submission no. 70, 156.

<sup>&</sup>lt;sup>2222</sup> Victorian Institute of Forensic Medicine, Submission no. 40, 32.

If it is to come to pass that an aim of the coroner's system is to be prevention – and this is a really interesting question for you – it seems to me that part of its real meaning would be that that value, prevention, would have to be weighed into the balance when deciding whether there will be an autopsy.<sup>2223</sup>

He suggested that this would possibly result in private rights giving way to public benefit in some cases, which 'would be a serious shift in the way things are at the moment'. 2224 Professor Cordner was discussing this issue in relation to the rise in objections to autopsies in TAC cases. He commented that, while it may appear that the cause of death is obvious in a TAC case, a future coroner in a similar case might point out that there have been emergency medical procedures prior to the death and argue that without an autopsy important prevention opportunities could be lost. 2225

Several witnesses expressed concern, particularly in relation to deaths from procedures, that currently not enough autopsies are being performed in Victoria. For instance, the Victorian Surgical Consultative Council (VSCC) observed that it is difficult for a coroner to overrule an objection to an autopsy where it is clear that a death occurred due to natural causes, even if it was a result of an operation. VSCC submitted that, where autopsy findings could give a more precise cause of death which could lead to changes in the surgical management of future patients, the community as a whole would benefit from the autopsy.<sup>2226</sup>

While this is an important objective, the Committee also notes Associate Professor Ranson's comment in his submission that there is 'a common misconception amongst medical practitioners and the police that referring a death to the coroner is really about having an autopsy performed' — increasingly, coronial investigations of deaths do not necessarily involve an autopsy. Associate Professor Ranson submitted that there have been situations where a family has refused consent to conduct a hospital autopsy, so a medical practitioner has referred the death to the coroner in order to ensure that an autopsy is performed.<sup>2227</sup>

Evidence received by the Committee has also shown that many families consider that there are too many coronial autopsies or that the procedures are excessive. One of

<sup>&</sup>lt;sup>2223</sup> Stephen Cordner, Victorian Institute of Forensic Medicine, *Minutes of Evidence*, *19 September 2005*, 128.

Stephen Cordner, Victorian Institute of Forensic Medicine, *Minutes of Evidence*, *19 September 2005*, 133. Other reasons for conducting autopsies in TAC cases include the need to examine issues concerning vehicle design: H McKelvie, Victorian Institute of Forensic Medicine, *Minutes of Evidence*, *19 September 2005*, 133; and the need to examine medical causes of accidents involving ageing drivers: David Wells, Victorian Institute of Forensic Medicine, *Minutes of Evidence*, *19 September 2005*, 134.

<sup>&</sup>lt;sup>2226</sup> Victorian Surgical Consultative Council, *Submission no. 21*, 3; Australian Medical Association of Victoria, *Submission no. 38*, 3, which calls for the establishment of a benchmark requirement for the number of coronial autopsies to be performed annually.

<sup>&</sup>lt;sup>2227</sup> David Ranson, Submission no. 19, 11.

the main areas of concern for families is that autopsies are being conducted unnecessarily in cases where there were no suspicious circumstances surrounding the death. This is particularly so in the case of road accident deaths.<sup>2228</sup> For example, Ms Smith, whose two sons died in separate road accidents, said:

The medical process breaks everything down. His brain weighed so many grams and it was remarkable; his lungs weighed this and they were unremarkable...What does that prove? It is just a medical dialogue of a whole lot of stuff that does not give any information that will be useful for anybody...<sup>2229</sup>

Similarly, Mr Graeme Bond told the Committee that he considered that the cause of his son's death, ingestion of prescribed medication and subsequent asphyxiation by inhaling vomit, could have been verified 'by a blood sample and not much more'.<sup>2230</sup>

The Committee heard that currently rural pathology services are seriously under-resourced, with the result that increasingly bodies are being transferred to Melbourne for autopsies. This is a problem for rural families, who would naturally prefer the body of their relative to stay within their locality. Professor Cordner told the Committee that VIFM would prefer to see coronial autopsies continue in rural and regional Victoria. Professor Cordner suggested that one solution may be to consolidate regional pathology services into a smaller number of locations that are better resourced and managed than the existing services.<sup>2231</sup>

Finally, the Committee is concerned that the decision to order an autopsy was until recently often made by coroner's clerks acting under delegated authority from the State Coroner in relation to autopsies in both Melbourne and regional Victoria.<sup>2232</sup> Such delegation is authorised under section 10 of the Act, which states that:

A coroner may, by instrument, delegate to a coroner's clerk any power or duty of a coroner other than a power under section 17, a prescribed power or duty or this power of delegation.<sup>2233</sup>

A delegation was made by the Coroner in an instrument dated 15 March 2005, which delegates all powers and duties of the coroner, other than those excepted in section 10. The Committee considers that this broad delegation of powers needs to be reconsidered. The Coroner's Office also submitted that this system needs review.<sup>2234</sup> During the inquiry the State Coroner suggested that it would be feasible to end the

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<sup>&</sup>lt;sup>2228</sup> See also Cecil Watt, Submission no. 11.

<sup>&</sup>lt;sup>2229</sup> Carol Smith, *Minutes of Evidence*, 22 August 2005, 23. See also Cecil Watt, Submission no. 11.

<sup>&</sup>lt;sup>2230</sup> Graeme Bond, Minutes of Evidence, 22 August 2005, 8.

<sup>&</sup>lt;sup>2231</sup> Stephen Cordner, *Minutes of Evidence*, 19 September 2005, 125–6.

<sup>&</sup>lt;sup>2232</sup> State Coroner's Office, *Submission no. 70*, 153, and Appendix C, 'State Coroner's Delegation to Coroner's Clerks', x1viii.

<sup>&</sup>lt;sup>2233</sup> Coroners Act 1985 s 10.

<sup>&</sup>lt;sup>2234</sup> State Coroner's Office, Submission no. 70, 153.

practice of the delegation of the authority to direct that an autopsy be performed, given the number of coroners now available at the Coroner's Office.<sup>2235</sup> The Committee has recently received the following advice from the Department of Justice:

On 14 July 2006 the State Coroner issued a direction that all autopsies were to be ordered and signed off by coroners. Delegations to staff under the Coroners Act 1985 are also being reviewed to confirm their consistency with legal requirements.<sup>2236</sup>

# Consultants' research findings

The research indicated that most participants were not consulted about whether an autopsy was to be performed and were not aware of their right to object. Most indicated that, where an autopsy was considered necessary, their permission should be sought in the first instance and that they should have the right to object to an autopsy.<sup>2237</sup>

#### Discussion and conclusion

The Committee considers that, in order to be meaningful to families, the right to object to a direction that an autopsy be performed must be accompanied by a requirement that families be notified of such a right. The Committee has already recommended such a requirement earlier in this chapter.

The statutory provisions in New Zealand, Queensland and the Australian Capital Territory regarding cultural traditions, religious beliefs, family concerns and other factors that coroners should take into account in determining whether an autopsy should be performed are consistent with the common law as it is developing in other parts of Australia. The legislation in those jurisdictions simply prescribes that the factors identified by the courts should be taken into account in the balancing of considerations as to when an autopsy should be held. The Committee considers that Victoria should follow the approach in those jurisdictions and provide for the consideration of such factors in the legislation, in order for the Act to better meet the needs of Victoria's diverse community. The New Zealand legislation provides the most comprehensive list of factors to be taken into account when considering objections to autopsies, and therefore it should be used as a model.

In addition, the Committee considers that the State Coroner should, as recommended by the RCADC Implementation Review Team and VALS, initiate a formal consultation

<sup>&</sup>lt;sup>2235</sup> Graeme Johnstone, State Coroner's Office, *Minutes of Evidence*, 19 September 2005, 85.

<sup>&</sup>lt;sup>2236</sup> Department of Justice, *State Coroner's Office Improvement Project - Briefing for Victorian Parliament Law Reform Committee*, August 2006.

<sup>&</sup>lt;sup>2237</sup> Myndscape Consulting, Review of the Coroners Act 1985 — Final Report, March 2006, 68.

<sup>&</sup>lt;sup>2238</sup> Ian Freckelton and David Ranson, *Death Investigation and the Coroner's Inquest* (2006) 382.

<sup>&</sup>lt;sup>2239</sup> Ibid.

<sup>&</sup>lt;sup>2240</sup> Coroners Act 2006 (NZ) s 30.

process with Aboriginal legal services to develop a protocol for the resolution of questions involving the conduct of inquiries and autopsies, the removal and burial of organs, and the removal and return of the body of the deceased.

The Committee also recommends that a staff member of the Coroner's Office be designated to act as a cultural liaison officer for the purpose of developing knowledge of the cultural requirements of different groups in the community and facilitating effective communication with such groups.

The Committee considers that the right to request of a coroner that an autopsy not be performed should be extended to immediate family members other than the senior next of kin, following the approach in New South Wales.<sup>2241</sup> However, as is the case in New South Wales, in order to avoid disputes family members other than the senior next of kin should not be given the right to appeal the coroner's decision to the Supreme Court.<sup>2242</sup>

In relation to appeals by the senior next of kin, the Committee's view is that the current avenue of appeal to the Supreme Court should be retained. While Supreme Court appeals are costly for families, creating a right of appeal to a lower jurisdiction would add an additional layer of appellate jurisdiction, and would potentially undermine the status of the State Coroner's role. Given that objections to autopsies are usually made in urgent circumstances, the Committee does not believe that creating an interim appeal to the State Coroner is appropriate. The Committee considers that removing Supreme Court appeals altogether, by giving the State Coroner the final authority, would leave some families without an adequate right of review.

The Committee is however concerned with the high legal costs incurred by families who are required to lodge an objection to an autopsy in the Supreme Court. Apart from the cost of obtaining legal advice and representation at the Supreme Court application to hear the objection, family members are also required to pay Supreme Court filing fees, which are sometimes in excess of \$1000.<sup>2243</sup> The Committee notes that Morris J in *Horvath v State Coroner of Victoria* also expressed concern about the costs incurred by families. In that case Morris J made the following observation:

I was informed that the cost of bringing this proceeding was some \$900 in filing fees and no doubt thousands of dollars in legal fees and it does seem to me unjust that the amount of costs

<sup>&</sup>lt;sup>2241</sup> Coroners Act 1980 (NSW) s48B.

<sup>&</sup>lt;sup>2242</sup> Coroners Act 1980 (NSW) s48A(6).

<sup>&</sup>lt;sup>2243</sup> Supreme Court–Prothonotary's Office Fees. Available at www.supremecourt.vic.gov.au. The fee for filing the originating motion in the Supreme Court is currently \$658.80. If the Registry is required to operate outside the hours of 9.00am to 4.30pm, the family member making the objection is also required to pay a late filing fee of \$540.20.

faces parents, especially at a time like this, in order to have this issue resolved at the highest level. 2244

While the Committee accepts that the Supreme Court is the most appropriate avenue of appeal, the Committee is of the view that consideration should be given to exempting families from the requirement to pay these fees. The Committee notes that no filing fees are currently payable in relation to a number of other Supreme Court proceedings and it considers that families appealing autopsy decisions should be similarly exempted.<sup>2245</sup>

Finally, the Committee considers that while the delegation to coroners' clerks of a coroner's authority to direct that an autopsy be performed has been withdrawn, the appropriateness of the general delegation of powers to clerks should be reconsidered by the State Coroner. The Committee has noted the advice of the Department of Justice that a review of delegations to coronial staff under the Act is already underway. The Committee however believes that the autopsy decision making authority should be delegated to VIFM, consistent with its approach to requests to view or touch the body, discussed earlier in this chapter. This approach is also consistent with recommendations made in chapter three that the initial reception of bodies and related decisions be carried out by VIFM. Where a family does not agree with the decision made by VIFM, the matter should be referred to the coroner for determination. Appeal rights as discussed above would apply if the senior next of kin did not agree with a coroner's decision.

The Committee further recommends that the delegation of other powers and duties to coroners' clerks be assessed for appropriateness by considering the degree of skill and expertise required to exercise the power or duty as against the level of expertise expected of coroners' clerks as indicated by their public service grading.

Recommendation 100. That the *Coroners Act 1985* be amended to require that, before ordering an internal examination of the body, coroners have regard to a list of factors modelled on section 30 of the *Coroners Act 2006* (NZ), including:

a) the extent to which matters required by the Act to be established by an investigation are not already disclosed in respect of the death concerned, by information available directly to the coroner or from information arising from investigations or examinations the coroner has made or caused to be made but are likely to be disclosed by an autopsy;

<sup>&</sup>lt;sup>2244</sup> Horvath v State Coroner of Victoria, (Unreported, Supreme Court of Victoria, Morris J, 11 October 2004) 4.

<sup>&</sup>lt;sup>2245</sup> Supreme Court–Prothonotary's Office Fees, 4: No fee is payable to file an Originating Motion pursuant to the following rules: Rule 75.05 of Chapter 1 – Contempt of Court, Rule 80.03(4) of Chapter 1- A proceeding for an Order for substituted service of foreign process made by the Attorney-General, Rule 81.01 of Chapter 1 - A proceeding for an Order for the examination of a witness in Victoria in relation to a matter pending in a place outside Victoria.

- b) whether the death appears to have been unnatural or violent;
- c) if the death appears to have been unnatural or violent, whether it appears to have been due to the action or inaction of other persons;
- d) the existence and extent of any allegations, rumours, suspicions or public concern about the cause of death;
- e) the desirability of minimising distress to persons who, by reason of their ethnic origins, social attitudes or customs, or spiritual beliefs, customarily require bodies to be available to family members as soon as possible after death;
- f) the desirability of minimising distress to persons who, by reason of their ethnic origins, social attitudes or customs, or spiritual beliefs, find the post-mortem examination of bodies offensive;
- g) the desire of any member of the immediate family of the person concerned that a post-mortem examination should be performed; and
- h) any other matters the coroner thinks relevant.

Recommendation 101. That the *Coroners Act 1985* be amended to give immediate family members other than the senior next of kin the right to object to autopsies but not the right to appeal the coroner's decision, as is the case under the *Coroners Act 1980* (NSW).

Recommendation 102. That the Coroner's Office initiate a formal consultation process with the Victorian Aboriginal Legal Service to develop a protocol for the resolution of questions involving the conduct of inquiries and autopsies, the removal and burial of organs, and the removal and return of the body of the deceased.

Recommendation 103. That a staff member of the Coroner's Office be designated to act as a cultural liaison officer for the purpose of developing knowledge of the cultural requirements of different groups in the community regarding coronial procedures and facilitating effective communication with such groups.

Recommendation 104. That consideration be given to exempting the senior next of kin from the requirement to pay Supreme Court filing fees when lodging an objection to the decision of a coroner ordering that an autopsy be performed.

Recommendation 105. That the current delegation of powers and duties under section 10 of the *Coroners Act 1985* to coroner's clerks be reconsidered by the State Coroner.

# Alternatives to autopsy

The Act does not require a coroner to consider what kind of autopsy should be directed to be performed in each case. In a limited number of cases, where the next of kin has objected to an autopsy it may be possible to accommodate that objection if a coroner directs that a less invasive form of autopsy be performed.

The term autopsy is not defined in the Act. To many people in the community an autopsy means an internal examination of the body. However, to a forensic pathologist the term autopsy encompasses a medical investigation that includes analysis of documents such as medical records and results of medical tests, a detailed external and internal investigation of the body including imaging, and the collection of samples for various types of testing.<sup>2246</sup> Arguably, all that a coroner may do under the current Act is direct that an autopsy be performed,<sup>2247</sup> rather than control the elements that constitute the autopsy.<sup>2248</sup> However, Associate Professor Ranson observed in his submission that:

It is interesting to note that when an objection to autopsy is received by a coroner in practice they request the pathologist to carry out an investigation of the medical records together with a detailed external inspection of the body including the collection of samples of blood and other body fluids for toxicological examination. Following this procedure which a pathologist would consider at least a substantial part of an autopsy, the coroner makes a decision as to whether an "autopsy" is required by which is generally meant an internal examination of the body.<sup>2249</sup>

In addition to such recognition in coronial practice, partial autopsies have begun to receive statutory recognition in Australia. In NSW, where there is an objection to a post-mortem examination, the Supreme Court can order a partial post-mortem examination. In one example the Supreme Court ordered that an autopsy be limited to an external examination, the taking of blood samples and a radiological examination where the next of kin objected to an autopsy on religious grounds.

In Queensland, unlike in other Australian jurisdictions, a coroner may direct that a limited autopsy be performed. The autopsy may consist of:

- (i) an external examination of the body; or
- (ii) an external and partial internal examination of the body; or

<sup>&</sup>lt;sup>2246</sup> David Ranson, Submission no. 19, 76.

<sup>&</sup>lt;sup>2247</sup> Coroners Act 1985 s 27.

<sup>&</sup>lt;sup>2248</sup> David Ranson, Submission no. 19, 77.

<sup>&</sup>lt;sup>2249</sup> Ibid.

<sup>&</sup>lt;sup>2250</sup> Coroners Act 1980 (NSW) s 48A. This section was inserted in the NSW Act following the decision in *Deitz v Abernethy* (Unreported, Supreme Court of NSW, Abadee J, 8 May 1996), that the Coroner's power to direct a post-mortem examination was subject to review by the Supreme Court.

<sup>&</sup>lt;sup>2251</sup> Krantz v Hand, (Unreported, Supreme Court of NSW, Wood CJ, 23 April 1999).

(iii) an external and full internal examination of the body. 2252

The legislation provides the following example of a partial internal examination:

If the only apparent injuries to a deceased person's body are to the person's head, the coroner may consider it appropriate that only the person's head be examined internally.<sup>2253</sup>

The legislation further requires that, when ordering an autopsy, a coroner must state the type of examination that should be performed.<sup>2254</sup>

## Evidence received by the Committee

The Committee asked witnesses whether the Act should require a coroner to consider the appropriateness of less invasive forms of autopsy where the senior next of kin objects to a full internal surgical autopsy.<sup>2255</sup>

While coroners may see partial autopsies as a useful way of reconciling the wishes of a family with the need for information regarding the death, there is understandable reluctance on the part of many forensic pathologists to rely on limited or partial autopsies. The main reason for this is that, if limits are set on the process of autopsy, the result in some cases may be that the medical investigation process is unable to arrive at an unequivocal medical cause of death.

A partial autopsy may well reveal 'a' cause of death which is not 'the' cause of death. For example, a person may suffer a heart attack resulting in a fatal stroke. An autopsy limited to the chest would reveal the heart attack that caused the stroke but not the stroke itself, which in order to be identified would require examination of the brain. While some may argue that this does not matter since the causes are both natural, that will not be true if allegations are made concerning the standard of medical care provided. An incorrectly identified cause of death may have serious ramifications for the treating medical staff involved in the patient's care. <sup>2258</sup>

Associate Professor Ranson referred in his submission to the experience of a former State Coroner who would often request a pathologist to carry out a partial autopsy in consideration of a family's concerns about the full procedure. On occasions this would result in a series of partial autopsies which would eventually amount to a complete autopsy. The reason is that the coroner would order an initial partial autopsy, which

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<sup>&</sup>lt;sup>2252</sup> Coroners Act 2003 (Qld) s 19(2)(b).

<sup>&</sup>lt;sup>2253</sup> Coroners Act 2003 (Qld) s 19(2)(b).

<sup>&</sup>lt;sup>2254</sup> Coroners Act 2003 (QLD) s 19(1), (3).

<sup>&</sup>lt;sup>2255</sup> Discussion paper, 93, question 37(d).

<sup>&</sup>lt;sup>2256</sup> See for example David Ranson, *Submission no. 19*, 76–7.

<sup>&</sup>lt;sup>2257</sup> Ihid

<sup>&</sup>lt;sup>2258</sup> Ian Freckelton and David Ranson, *Death Investigation and the Coroner's Inquest* (2006) 371. See also David Ranson, *Submission no. 19*, 77.

would not show the cause of death. The pathologist would return to the coroner and explain this, and the coroner would order a further partial autopsy, and so on.<sup>2259</sup>

Dr Shelley Robertson told the Committee that the way in which autopsies are conducted at VIFM 'is very much culturally driven these days to the point where it is impinging on our scientific accuracy'.<sup>2260</sup> Dr Robertson stated that the best example of this was that VIFM is no longer able to retain brains in a routine manner. This is problematic, because, in order for pathologists to obtain proper pathological and medical information, brains need to be preserved or 'fixed' in formalin, as they are otherwise too soft to properly dissect. Resistance to such procedures by families who want the body of their relative returned 'in one piece' has, in Dr Robertson's view, compromised the way in which VIFM conducts autopsies.

However, there may be situations where a limited autopsy — such as external examination and taking bodily fluids for toxicological examination, or a partial internal examination — is a practical alternative to a full internal examination. Therefore, several witnesses, such as Ms Heffey, the Royal Children's Hospital and the Royal Women's Hospital, submitted that the Act should require coroners to consider the appropriateness of less invasive forms of autopsy, but only in circumstances where this is likely to yield the necessary information.<sup>2261</sup> Ms Heffey and others submitted that the coroner's consideration should be based on advice from the forensic pathologist.<sup>2262</sup>

Due to increasing recognition of partial autopsies as viable methods for dealing with family objections to autopsies, one of the issues considered by the Committee is whether the Act should contain provisions similar to those contained in section 19 of the *Coroners Act 2003* (Qld), which require a coroner to state, in an order that an autopsy be performed, the type of autopsy that should be performed.

The Coroner's Office submitted that the Queensland provisions are unnecessarily complicated, do not allow for the need to perform an initial external examination in order to decide what sort of autopsy to perform, and do not provide for the taking of blood samples for toxicological analysis if no autopsy is ordered.<sup>2263</sup> Therefore, the Coroner's Office considers that a simpler approach would be to amend section 3 of the Act by inserting a definition of 'autopsy' that does not include external inspection of the body or taking body fluids for toxicological analysis.<sup>2264</sup> It appears that the effect

<sup>&</sup>lt;sup>2259</sup> David Ranson, Submission no. 19, 77.

<sup>&</sup>lt;sup>2260</sup> Shelley Robertson, *Minutes of Evidence*, 5 December 2005, 311.

<sup>&</sup>lt;sup>2261</sup> Jacinta Heffey, *Submission no.* 33, 37; Royal Women's Hospital, *Submission no.* 18, 8; Royal Children's Hospital, *Submission no.* 17, 10.

<sup>&</sup>lt;sup>2262</sup> Jacinta Heffey, Submission no. 33, 37.

<sup>&</sup>lt;sup>2263</sup> Coroners Act 2003 Qld (2003) s 23.

<sup>&</sup>lt;sup>2264</sup> State Coroner's Office, Submission no. 70, 64.

of this would be to enable a coroner to determine whether an invasive autopsy was necessary after such initial inspection and testing had been performed.

However, the Committee notes that such an approach would fall short of requiring coroners to actively consider the type of autopsy that is necessary and to take into account potential distress to, and concerns of, family members, as required by section 19 of the Queensland Act. Also, VIFM submitted that it is opposed to the inclusion of a definition of 'autopsy' in the Act, since this would become the subject of extensive debate and would have implications beyond the coronial system.

SPFV submitted that the Act should encourage less invasive forms of autopsy to be undertaken unless it is shown that it is absolutely necessary that a full surgical internal autopsy be carried out.<sup>2265</sup> A number of family witnesses also submitted that the Act should require a coroner to consider whether less invasive forms of autopsy are appropriate.<sup>2266</sup> One of the issues that can cause distress to families is where autopsies involve technical procedures such as removing and weighing organs where the need to do so is not obvious. When asked about the value of such procedures, Associate Professor Ranson explained to the Committee:

The issue for a pathologist when carrying out an autopsy is you are being asked to carry out an investigation, the extent and end of which you do not know until you have come to a point where you are satisfied that you have collected all the relevant information.

Many times in a lot of investigations you collect things in the early stages which turn out to have no value, but if you failed to collect them and it turned out that they were very important, you would not survive long in the witness box, which is arguably where we are tested at the end of the day.<sup>2267</sup>

However, it is equally clear to the Committee that the scientific and evidentiary imperatives of forensic pathology may be lost on families in cases where procedures such as removing and weighing organs appear, from a lay person's perspective, to have little or no relationship to determining the cause of death.

A recent example of this problem occurred following a hit-run accident in Mildura which killed six teenagers. Relatives of Josephine Calvi, who was injured and later died at Royal Adelaide Hospital soon after the accident, were informed by the South Australian Coroner's Office that Coroner Mark Johns had ordered that her brain be removed to determine how she died. They were told that the brain would not be returned for two weeks. The Coroner's decision was based on the advice of the forensic pathologist that organ retention was necessary to determine the cause of death. A relative told *The Age*:

<sup>&</sup>lt;sup>2265</sup> South Pacific Foundation Victoria (Inc), Submission no. 24, 19.

<sup>&</sup>lt;sup>2266</sup> See for example Carol Smith, Submission no. 25, 8.

<sup>&</sup>lt;sup>2267</sup> David Ranson, Victorian Institute of Forensic Medicine, *Minutes of Evidence*, 28 November 2005.

They are saying they want to test how she died. We know how she died. A car ran into her. So its either burying a body without her brain or burying her in two weeks.<sup>2268</sup>

The relative said that as a result Josephine's mother, Carmel, was 'absolutely distraught, worse than the day the accident happened', adding, 'As if what happened isn't enough, as if we need to suffer through this'. It is not surprising that the family had difficulty accepting the rationale for the Coroner's decision. Subsequently, the Coroner announced that the case had been expedited.

It is also important to note that opposition to autopsies does not only come from families. Differences of opinion regarding the need for autopsies may also exist between other groups and individuals in the community, including pathologists themselves:

It is far too simplistic to assert that doctors are in favour of autopsies and family members are against them. Indeed, a full spectrum of views may be seen in any group within the community.<sup>2269</sup>

The Committee notes that in some cases modern technology now enables alternative examinations to be performed that do not involve dissection of the body. For example, in Manchester, England, the local coroner orders magnetic resonance imaging (MRI) as part of the autopsy process in appropriate cases.<sup>2270</sup> This practice was established in 1997 to alleviate the concerns of members the Jewish community who view surgical autopsy as a violation of the sanctity of the body. The Committee discussed the effectiveness of this practice with the Manchester Coroner, who stated that it was working well.<sup>2271</sup> A review of the MRI service over a four-year period that was published in the *British Medical Journal* states that a confident diagnosis of the cause of death was made in 87 percent of cases (47 of the 53 bodies examined).<sup>2272</sup> There has been increasing interest here and overseas, particularly in England and Switzerland, in whether scanning may obviate the need for autopsies in certain cases.<sup>2273</sup> The term 'virtopsy' has even emerged.

<sup>&</sup>lt;sup>2268</sup> Selma Milovanovich, 'Coroner's order delays girl's funeral', *The Age* (Melbourne), 22 February 2006, 4.

<sup>&</sup>lt;sup>2269</sup> David Ranson, 'The Value of an Autopsy', (2005) 13 *Journal of Law and Medicine* 19, 21. This phrase was used by a medical professional appearing as a witness in South Australia Inquest no. 8/2005.

<sup>&</sup>lt;sup>2270</sup> R Biset et al, 'Post-Mortem Examinations Using MRI Imaging: Four Year Review of a Working Service', *BMJ* vol 324, 2002, 1423.

<sup>&</sup>lt;sup>2271</sup> Committee meeting with Leonard Gorodkin, Manchester Coroner, 27 June 2005.

lbid. In a UK study commissioned by the Department of Health that compared MRI with conventional autopsy in relation to 40 adult bodies, good results were seen in 26 cases of trauma. The study found that further research is required to determine whether MRI will augment or replace the convention autopsy: Alistair Parker, 'Less Invasive Autopsy: The Place of Magnetic Resonance Imaging' (February 2004).

<sup>&</sup>lt;sup>2273</sup> Noel Woodford, Victorian Institute of Forensic Medicine, *Minutes of Evidence*, 28 November 2005, 242.

In Victoria, the State Government has recently funded the purchase of a computer tomography (CT) scanner at a cost of approximately \$2 million for use by VIFM. It has been described as the most advanced scanner in use by any mortuary in the world. <sup>2274</sup> By passing the body through a one minute scan, the scanner provides investigators with a picture of the inner landscape of the body, including bullet trajectories, knife wounds, injury patterns, bone fractures, a large number of diseases, dental histories and other information. <sup>2275</sup> CT scans are a specialised form of x-ray that are particularly good, for example, at imaging bone structures, whereas MRI scans, which use magnets and radio waves to create images, are able to provide more detail in relation to soft tissue. In some areas of medicine the results of CT and MRI scans are combined in order to provide better information.

The Committee heard evidence from forensic pathologist Dr Noel Woodford that VIFM is in the process of determining where CT scanning fits within its diagnostic system for establishing a reasonable cause of death. VIFM has been incorporating the scans as part of its admissions process, but it sees CT scanning as a powerful additional tool rather than something which will eventually replace autopsies. Dr Woodford told the Committee that VIFM has been using CT scanning in circumstances where families raise objections to autopsy under section 29:

We are using the CT scanning in a way, if you like, to validate cause of death as given on a death certificate although that is a work in progress. We are also using it in circumstances where the families or next of kin raise objections to autopsy under section 29. There is one example that comes to mind, of a baby with a presumed diagnosis of sudden infant death syndrome where the CT scanner revealed unexpected blood within the head. It would not have been seen any other way, and that changed the complexion of the case entirely.<sup>2278</sup>

Professor Cordner has also stated that in some circumstances the scanner will provide enough information on the cause of death to avoid a full internal examination, but that the decision will always rest with the coroner.<sup>2279</sup> However, Dr Woodford told the Committee:

The CT scan is not going to provide all the answers. It does not diagnose common natural disease such as ischaemic heart disease or pulmonary embolism. It does not diagnose

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<sup>&</sup>lt;sup>2274</sup> Jo Chandler, 'Forensic Medicine Cuts Out the Scalpel', *The Age*, (Melbourne), 9 September 2005.

<sup>&</sup>lt;sup>2275</sup> Ibid.

<sup>&</sup>lt;sup>2276</sup> Noel Woodford, Victorian Institute of Forensic Medicine, *Minutes of Evidence*, 28 November 2005, 242.

<sup>&</sup>lt;sup>2277</sup> Noel Woodford, Victorian Institute of Forensic Medicine, *Minutes of Evidence*, *28 November 2005*, 243; Jo Chandler, 'Forensic Medicine Cuts Out the Scalpel', *The Age*, (Melbourne), 9 September 2005.

<sup>&</sup>lt;sup>2278</sup> Noel Woodford, Victorian Institute of Forensic Medicine, *Minutes of Evidence*, 28 November 2005, 242.

<sup>&</sup>lt;sup>2279</sup> See Jo Chandler, 'Forensic Medicine Cuts Out the Scalpel', *The Age*, (Melbourne), 9 September 2005. The article also states that the CT scanner's most useful application is in mass disaster identification, and that the scanner was funded by the State Government as part of its counterterrorism operations ahead of the Commonwealth Games.

toxicologic causes of death or microbiologic ones. And perhaps most importantly it may not provide information of significance to next of kin in terms of heritable disease such as malignancy and metabolic disease processes. It also does not provide a histologic cause of death, which is often what we rely on to come to a diagnosis when the macroscopic or naked eye appearance does not help. So it [is] an exciting time ahead. It is going to provide lots of information, but the bottom line is we are not exactly sure how it fits into the diagnostic algorithm yet.<sup>2280</sup>

Pathologists interviewed by the Committee in Finland, where autopsy rates are high, commented that there had possibly been some small reduction in autopsies due to new technologies such as MRI scans but that the major effect of these new technologies had been an improvement in the accuracy of determining the cause of death. The comment was made that MRI scans could not provide an adequate substitute for autopsies. It was noted that an MRI scan was also a much more expensive and time consuming procedure than an autopsy.<sup>2281</sup> These comments should be seen in their proper context, which is that of a medical examiner system with a long established practice of undertaking a proportionally high number of autopsies, in a society which appears to have a much wider acceptance of the practice.

#### Discussion and conclusion

The Committee agrees with the Law Commission of New Zealand's view that partial autopsies are appropriate in some circumstances and may assist the coroner to balance the needs of families to have the body of their relative treated with respect and minimum intervention by the state, with the public interest in determining the cause of death.<sup>2282</sup>

The availability of sophisticated imaging equipment, while not considered to be a substitute for surgical autopsies, appears to have significant potential to minimise the distress caused to some families by an internal examination because of cultural traditions, religious beliefs or other concerns. As technology such as the CT scanner is now in use by VIFM in Melbourne, it appears that in an increasing number of cases sufficient information about a death will be obtainable without an internal examination.

The Committee considers that, in the coronial system, care should be taken to avoid unnecessary autopsy procedures and any resulting perception in the community that some autopsy procedures amount to a type of 'intellectual voyeurism'.<sup>2283</sup> As observed

<sup>&</sup>lt;sup>2280</sup> Noel Woodford, Victorian Institute of Forensic Medicine, *Minutes of Evidence*, 28 November 2005, 242.

<sup>&</sup>lt;sup>2281</sup> See also *Minutes of Evidence*, meeting with Helsinki Department of Forensic Medicine, 4 July 2005, 30–1.

<sup>&</sup>lt;sup>2282</sup> Law Commission of New Zealand, *Coroners*, Report no. 62, (2000), para 145, 44.

<sup>&</sup>lt;sup>2283</sup> This is not the view of the Committee. The phrase was used by a medical practitioner appearing as a witness at an inquest in South Australia, whose comments attracted strong criticism from the Coroner: South Australia Inquest no. 8/2005. See David Ranson, 'The Value of an Autopsy', (2005) 13 *Journal of Law and Medicine* 19, 21.

in the Luce Report, any medical investigation ordered by a coroner, whether it is an autopsy or other testing, should be to clarify a defined uncertainty or range of uncertainties about the death and should be conducted at the lowest level of invasiveness likely to achieve that aim. Given that a direction for a full internal autopsy may cause considerable distress to a family, particularly where there are cultural objections, the Committee's view is that the Act should be amended so that a coroner is required to consider whether alternatives to full internal examination may be appropriate in a particular case.

Recommendation 106. That the Act be amended to require a coroner, when determining whether an autopsy is necessary, to consider whether alternatives to internal examination, or whether partial rather than full internal examination, may be appropriate in a particular case.

# Right to request that an autopsy be performed

In some circumstances a family member of a person who died or another interested person will seek to have the cause of death determined accurately by requesting that an autopsy be performed. For example, a family member or relative who has concerns about the medical treatment of the person who died may consider that only an autopsy will identify the true cause of death. Hospitals, on the other hand, may also seek a coronial autopsy for the purpose of ascertaining the cause of death where this is unclear. In some cases a person accused of causing or contributing to a death might consider that an autopsy would establish their innocence.

The Act provides that, if a coroner has jurisdiction to investigate the death, any person may request that the coroner direct that an autopsy be performed.<sup>2284</sup> If the coroner refuses the request, the coroner must give written reasons for the refusal,<sup>2285</sup> and the person who made the request has the right to appeal within 48 hours to the Supreme Court.<sup>2286</sup> The Supreme Court may, if satisfied that it is desirable in the circumstances, make an order directing the State Coroner to require an autopsy to be performed and prohibiting prior disposal of the body.<sup>2287</sup> However, it appears that in practice it is possible that the person may instead arrange an autopsy by an independent pathologist, given the cost of an appeal to the Supreme Court on this issue.<sup>2288</sup>

<sup>&</sup>lt;sup>2284</sup> Coroners Act 1985 s 28(1).

<sup>&</sup>lt;sup>2285</sup> Coroners Act 1985 s 28(2).

<sup>&</sup>lt;sup>2286</sup> Coroners Act 1985 s 28(3).

<sup>&</sup>lt;sup>2287</sup> Coroners Act 1985 s 28(3).

<sup>&</sup>lt;sup>2288</sup> See for example Aron Gingis, *Minutes of Evidence*, *20 September 2005*, 146. Mr Gingis told the Committee of the difficulties he had experienced in relation to the death of his father-in-law. After a coroner decided that no autopsy was required, Mr Gingis spent a considerable amount of money to have an independent pathologist conduct an autopsy.

Witnesses such as Mr William O'Shea and Professor Catriona McLean of Bayside Health expressed concern that the resources of the Coroner's Office are currently insufficient to meet the number of cases that are referred to it, resulting in a low level of autopsies being performed.<sup>2289</sup> Similarly, Ms Lorraine Long, founder of the Medical Error Action Group, told the Committee that many families have been frustrated at the lack of resources available for autopsies in cases where the family wishes to know the truth about the cause of death.<sup>2290</sup>

Where an autopsy is carried out by the Coroner's Office, in some cases a family member or other interested person, such as an accused person, will have concerns about the results of an autopsy and may consider that a second autopsy is necessary.

At present the Act does not give the senior next of kin or an interested person the right to request that a second, independent autopsy be performed, nor do they have the right to have a representative attend an autopsy. The legislation in other Australian jurisdictions also does not provide the senior next of kin with the right to request that a second, independent autopsy be performed.

# Right to have an independent pathologist or religious representative present

In rare cases a family member or an accused person may have concerns about the proper performance of an autopsy, and therefore might seek to have an independent medical practitioner present. In other cases where a family has religious or cultural concerns about the dignified treatment of the body, they might seek to have a religious observer present during the autopsy.

It is possible for concerns about the integrity of autopsies to arise in a variety of circumstances. The issue not only is raised by families who doubt that a death will be properly investigated by the coronial system but also can be important for those who may become defendants in civil or criminal proceedings related to the death. The legislation in the UK, for example, provides that, where a person states on oath to a coroner that they believe that the death being investigated was caused by improper or negligent treatment by a medical practitioner or other person, that medical practitioner or other person 'shall have the right, if he so desires, to be represented at any such post-mortem examination'.<sup>2291</sup> In some criminal cases the defence may also seek to be represented by an independent pathologist.

William O'Shea and Catriona McClean, Bayside Health, *Minutes of Evidence*, 28 November 2005, 210–19. Mr O'Shea and Professor McClean also told the Committee that the categories of reportable death in the Act should be clarified in relation to medical procedures, following the model used in section 8(3) of the *Coroners Act 2003* (Qld). They suggested that the Coroner's Office might be more persuasive to families regarding the need for autopsies than inexperienced junior doctors in hospitals.

<sup>&</sup>lt;sup>2290</sup> Lorraine Long, Medical Error Action Group, *Minutes of Evidence*, 19 September 2005, 92.

<sup>&</sup>lt;sup>2291</sup> Coroners Act 1988 (UK) s 20(3)(b).

Serious concerns about autopsies have arisen in relation to Aboriginal deaths in custody. In some cases allegations of misconduct have been made against the police, which, if not seen to have been properly investigated, may lead to widespread community concern. In such cases there are often few witnesses, and an autopsy may, from the perspective of the dead person's family or community, constitute the only source of evidence with the potential to reveal scientifically the actual cause of death.

An example of such concerns occurred following the death of Mulrunji Domadgee in police custody on Palm Island in November 2004:

A week after Doomadgee's death, the findings of the first autopsy were read to a crowd of locals. When told that the report said his injuries – four broken ribs, which ruptured his liver and spleen – could have been consistent with him falling on a shallow concrete step at the Palm Island watchhouse, a riot ensued.<sup>2292</sup>

Subsequently, following requests from Mr Doomadgee's family and consistent with the coroner's own view that a second autopsy would be valuable, the coroner agreed to a second autopsy, which was observed by a pathologist on behalf of the family.<sup>2293</sup> While the results have yet to be released, the case illustrates the sensitivity that can occur around perceptions of bias in autopsy findings.

Another example of concern about the integrity of autopsy procedures occurred in relation to Eddie Murray's death in custody in the 1980s, which was one of the catalysts for the RCADC. The Eddie Murray inquest resulted in an open finding. However, in 1997, Eddie's parents had his body exhumed and another autopsy carried out.<sup>2294</sup> The second autopsy revealed a fractured sternum, which did not appear in the first autopsy report, 'the most likely cause being one or more blows to the chest'.<sup>2295</sup> As a result the case was referred to the Police Integrity Commission of New South Wales (PIC). The matter also has been raised on a number of occasions in the Legislative Council of New South Wales.<sup>2296</sup>

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<sup>&</sup>lt;sup>2292</sup> Tony Koch, 'Doomadgee Had Reading of 0.29', *The Australian* (Sydney), 07 February 2005. Available at http://www.kooriweb.org/foley/news/aust7feb05.html.

<sup>&</sup>lt;sup>2293</sup> See United Nations Commission on Human Rights, Report of the Special Rapporteur, 'Extrajudicial, Summary or Arbitrary Executions', Summary of cases transmitted to Governments and replies received, 28–30. Available at www.extrajudicialexecutions.org.

<sup>&</sup>lt;sup>2294</sup> Ian Freckelton and David Ranson, *Death Investigation and the Coroner's Inquest* (2006) 665–6.

<sup>&</sup>lt;sup>2295</sup> Report findings by Dr Johan Duflou, NSW Institute of Forensic Medicine, as reported on Friday 28 January at 6 pm on Message Stick TV, ABC Television: see <a href="http://www.abc.net.au/message/tv/ms/s1276750.htm">http://www.abc.net.au/message/tv/ms/s1276750.htm</a>.

<sup>&</sup>lt;sup>2296</sup> New South Wales, *Parliamentary Debates*, Legislative Council, Questions and Answers No. 60, 22 June 2004, 1464–5. See also New South Wales, *Parliamentary Debates*, Legislative Council, 1 March 2005 (Article No.10), 14266.

There will no doubt be circumstances that are less politically contentious than death in custody cases where the presence of an independent pathologist may also be desirable. However, the Act does not give the family of the person who died the right to be present at an autopsy, nor does it give them the right to have an independent observer such as a medical practitioner attend the autopsy.

## Other jurisdictions

In Western Australia, the legislation provides the senior next of kin with the right to have an independent doctor present at an autopsy:

#### 35. Independent doctor at post mortem examination

If the senior next of kin of the deceased asks a coroner to allow a doctor chosen by the senior next of kin to be present at a post mortem examination, the coroner is to allow that doctor to be present and is to ensure that the doctor is informed as to the time and place that the examination is to take place.<sup>2297</sup>

In contrast, the NSW Supreme Court has held that it does not have the power to direct a coroner to permit an agent of the family (a medical practitioner) to be present at an autopsy.<sup>2298</sup>

In Queensland, a coroner may allow a person or their representative to observe an autopsy if the coroner considers that the person has a sufficient interest in the autopsy.<sup>2299</sup> However, the coroner must, wherever practicable, consult with and consider the views of a family member of the person who died and the doctor who is to conduct the autopsy.<sup>2300</sup> The legislation envisages the attendance of people for training purposes, but also enables family members of the person who died or suspects in homicide cases who have concerns about the validity of processes used during an autopsy to have a representative attend and observe the autopsy.<sup>2301</sup>

In New Zealand the *Coroners Act 2006* contains a detailed section defining who may attend an autopsy.<sup>2302</sup> This includes a doctor, nurse or funeral director attending as a representative of the family of the person who died, and a doctor attending as the representative of a person who has been or may be charged with a criminal offence

<sup>&</sup>lt;sup>2297</sup> Coroners Act 1996 (WA) s 35. Cf Coroners Act 1997 (ACT) s 25, which provides that '[a] medical practitioner who attended a person professionally at or immediately before the person's death or during the person's last illness is entitled, on request, to be present as an observer at a post-mortem examination of the body of the deceased'.

<sup>&</sup>lt;sup>2298</sup> Ian Freckelton and David Ranson, *Death Investigation and the Coroner's Inquest* (2006) 364.

<sup>&</sup>lt;sup>2299</sup> Coroners Act 2003 (Qld) s 21(1).

<sup>&</sup>lt;sup>2300</sup> Coroners Act 2003 (Qld) s 21(2).

<sup>&</sup>lt;sup>2301</sup> State Coroner's Guidelines — Version 0 December 2003, guideline 5.5. Available at http://www.justice.qld.gov.au/courts/coroner/pdfs/guidelines.pdf.

<sup>&</sup>lt;sup>2302</sup> Coroners Act 2006 (NZ) s 36.

related to the death.<sup>2303</sup> Such representatives may only attend if authorised by the coroner on an application for that purpose, and are only entitled to observe the autopsy.<sup>2304</sup>

# Law reform agencies

The RCADC recommended that, in relation to deaths in custody, the family should have the right to have an independent observer attend an autopsy and to engage an independent medical practitioner to be present at an autopsy or to conduct a second autopsy.<sup>2305</sup> Commissioner Johnston made the following observations in the report:

Right to an Independent Pathologist

- 4.6.25 In some cases the family may wish to have a representative present at the autopsy. That representative may be a specialist forensic pathologist, a medical practitioner or a lay observer to view the state of the body and to see what is discovered on post-mortem examination.
- 4.6.26 The right of a third party (be it the family or some other interested person) to have an observer present during the autopsy or to conduct a second autopsy, are issues which arose in approximately twenty of the deaths investigated by the Commission. In the majority a second autopsy was performed on behalf of the relatives by a forensic pathologist of their choosing. In some of these cases efforts had been made to arrange for an observer pathologist to be present at the first autopsy without success.
- 4.6.27 It is preferable for any observer to be present at the first autopsy because the conduct and value of a second autopsy is considerably compromised by the first examination. Further, the concerns and suspicions of the family may be allayed more swiftly if the person of their choice is present at the first examination.
- 4.6.28 Coroners and forensic pathologists consulted by the Commission had no objection to the presence of an observer pathologist or other representative at the autopsy. However, most would not consider any substantial delay in conducting the autopsy in order to accommodate the attendance of such an observer. Questions of delay and other circumstances which may affect the thorough pursuit of post-mortem investigations are substantial considerations. The coroner should be granted an express discretionary power in relation to these matters.
- 4.6.29 Accordingly, I am of the opinion that unless the State Coroner, or a coroner appointed to conduct the inquiry, directs otherwise, the family of the deceased or their representative should not only have a fight [sic] to view the body and the death scene but also have an independent observer or medical practitioner present at the post-mortem or have a further postmortem conducted. In addition, the family should have a fight [sic] to receive a copy of the

<sup>&</sup>lt;sup>2303</sup> Coroners Act 2006 (NZ), ss 36(d), (e).

<sup>&</sup>lt;sup>2304</sup> Coroners Act 2006 (NZ), s 36(2).

<sup>&</sup>lt;sup>2305</sup> Royal Commission into Aboriginal Deaths in Custody, *National Report* (1991) vol 1, Recommendation 25.

post-mortem report. If a coroner exercises his or her discretion, and directs otherwise, a copy of this direction should be sent to the family and to the Aboriginal Legal Service. <sup>2306</sup>

# Evidence received by the Committee

Witnesses were asked in the discussion paper whether the Act should allow a family member or their representative to attend the autopsy, and whether the Act should permit the family to request that a second autopsy be carried out.

Several witnesses submitted that the family of the person who died should have the right to request that a medically qualified doctor or a religious elder attend the autopsy on their behalf as an independent observer.<sup>2307</sup> VIFM submitted that if the concern relates to the proper conduct of an autopsy then the observer would need to be medically qualified, preferably a pathologist. VIFM also submitted that, while it would be acceptable to have a religious observer attend an autopsy, this must be balanced with the potential risk to the observer who, if not accustomed to autopsies or surgical procedures, may be distressed or traumatised.<sup>2308</sup>

Some witnesses submitted that family members themselves should be given the right to attend the autopsy if they so desired.<sup>2309</sup> However, the evidence received by the Committee appears to be weighted against such a proposal.<sup>2310</sup>

In relation to second autopsies, VIFM submitted that families and other interested parties such as accused persons should be able to request a second autopsy. However, this should be at their own cost if staff external to VIFM, such as pathologists, are required.<sup>2311</sup> VIFM submitted that it would be able to make its facilities and technical support available at no cost to families.<sup>2312</sup>

Associate Professor Ranson commented in his submission that, while it is always possible for a family to arrange a second autopsy, conducting the second autopsy is problematic from a pathological perspective and also expensive for the family.<sup>2313</sup> Therefore, he suggested that having an extra pathologist present at an autopsy is generally preferable, although one advantage of a second autopsy is that it provides

 $<sup>^{2306}</sup>$  Ibid paras 4.6.25 - 4.6.29.

<sup>&</sup>lt;sup>2307</sup> See for example Jacinta Heffey, *Submission no.* 33, 28; Victorian Institute of Forensic Medicine, *Submission no.* 40, 32; Elaine Harrington, *Submission no.* 83, 6.

<sup>&</sup>lt;sup>2308</sup> Victorian Institute of Forensic Medicine, Submission no. 40, 32.

<sup>&</sup>lt;sup>2309</sup> For example, Mrs Anne Anderson indicated that she might well have taken the opportunity be present at her mother's autopsy: *Submission no. 43*, 6.

<sup>&</sup>lt;sup>2310</sup> See for example David Ranson, *Submission no. 19*, 80; Royal Children's Hospital, *Submission no. 17*, 11; Patrick van der Hoeven, *Submission no. 6*, 3.

<sup>&</sup>lt;sup>2311</sup> Victorian Institute of Forensic Medicine, Submission no. 40, 32.

<sup>&</sup>lt;sup>2312</sup> Ibid.

<sup>&</sup>lt;sup>2313</sup> David Ranson, Submission no. 19, 80.

the coroner with an additional pathologist's opinion. He also commented that it would be advantageous in situations where families wish to have a second autopsy performed to be able to request that the coroner arrange and pay for a second autopsy. The coroner's decision in response to such requests could be made subject to Supreme Court appeal.

Ms Elaine Harrington submitted that the family should have the right to request that a second autopsy be carried out, citing as an example her concerns about the integrity of the forensic autopsy performed on her son's body by the hospital in which he died. She submitted that autopsies should not be performed in the hospital where the death occurred. However, where the autopsy is undertaken in the same hospital, family members should be able to request a second autopsy.<sup>2314</sup>

#### Discussion and Conclusion

The Committee considers that the Act should be amended to provide that, if the senior next of kin asks a coroner to allow a doctor chosen by the senior next of kin to be present at a post-mortem examination, the coroner is to allow that doctor to be present and is to ensure that the doctor is informed as to the time and place of the examination, as is the case in Western Australia. Such a requirement would be an important safeguard against potential individual or community concerns regarding the integrity of the autopsy process in future cases.

Given the concerns raised by VIFM, the Committee does not consider that such a right should be extended to include non-medical representatives such as religious elders. Rather, whether such representatives may attend should be determined by the coroner and/or VIFM depending upon the particular circumstances of a case and preferably in accordance with guidelines developed for this purpose. The Committee is aware that it is the current practice of the coroner to facilitate such requests where possible.

Finally, the Committee considered whether the Act should be amended to give the family of a person who died or other persons with a sufficient interest in the investigation of the death the right to request a coroner to direct that a second, independent autopsy be performed. The Committee does not consider this to be a necessary amendment, as there is nothing in the Act which prevents a coroner from authorising a second autopsy and the evidence suggests that it is generally preferable to have an independent pathologist present at the initial autopsy. Further, where the latter is not possible it appears that forensic pathologists are usually comfortable with a second autopsy taking place. Again, this is a matter which could be dealt with by the development of appropriate guidelines.

<sup>&</sup>lt;sup>2314</sup> Elaine Harrington, *Submission no. 83*, 6. The Committee notes the existence of a comparable feature of coronial legislation in certain other states which bars the treating doctor of a person who died from conducting an autopsy. See for example *Coroners Act 2003* (Qld) s 19(8)(b).

<sup>&</sup>lt;sup>2315</sup> Coroners Act 1996 (WA) s 35.

Recommendation 107. That the *Coroners Act 1985* be amended to contain the following provision: If the senior next of kin asks a coroner to allow a doctor chosen by the senior next of kin to be present at a post-mortem examination, the coroner is to allow that doctor to be present and is to ensure that the doctor is informed as to the time and place of the examination.

# Organ and tissue retention and disposal, and the right to be notified about retained body organs and tissues

The rebellion against the past paternalistic behaviour of the medical profession has, in recent years, heavily influenced the development of modern medical ethics and, indeed, the way in which the law has assessed standards of appropriate medical practice.<sup>2316</sup>

The subject of inappropriate removal, retention and disposal of organs and tissues removed at autopsies has been at the centre of public scandals overseas and in Australia.<sup>2317</sup> The most significant scandal in terms of coronial practice took place in the UK and became known as the Redfern Inquiry, and there have been recent body parts scandals in Australia, resulting in, for example, the Walker Inquiry in New South Wales and the Selway Inquiry in South Australia. <sup>2318</sup> The Australian inquiries found that autopsy practice in Australia has been consistent with legislation in the majority of cases. However, such practice has not always reflected what the community now regards as acceptable. <sup>2319</sup> Most of the difficulties relate to retention of material for therapeutic, medical or research purposes without the consent of the family of the person who died.

In Victoria, the removal of organs and tissues during coronial autopsies is dealt with by the *Coroners Act 1985* and the *Human Tissue Act 1982*. Section 27(2) of the *Coroners Act 1985* provides that:

A coroner may direct VIFM, a pathologist or a doctor performing an autopsy to cause to be preserved for such period as the coroner directs any material which appears to the Institute, pathologist, or doctor to bear upon the cause of death.<sup>2320</sup>

Thus the Act is unclear about what kind of material may be removed from a body, the uses to which it may be put and the period of retention. The Act also does not require

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<sup>&</sup>lt;sup>2316</sup> David Ranson, 'Tissue and Organ Retention at Autopsy: What are the Benefits?' (2001) 8 *Journal of Law and Medicine* 368, 370.

<sup>&</sup>lt;sup>2317</sup> See for example Bristol Royal Infirmary Inquiry, *Learning from Bristol: The Report of the Public Inquiry into Children's Heart Surgery at the Bristol Royal Infirmary 1984-1995*, Government Printer, Bristol, 2001; Ian Freckelton and David Ranson, *Death Investigation and the Coroner's Inquest* (2006) 383.

<sup>&</sup>lt;sup>2318</sup> Ian Freckelton and David Ranson, *Death Investigation and the Coroner's Inquest* (2006) 383.

<sup>&</sup>lt;sup>2319</sup> Australian Health Ministers' Advisory Council Subcommittee on Autopsy Practice, *A National Code of Ethical Autopsy Practice*, May 2002. Available at www7.health.gov.au/code.pdf.

<sup>&</sup>lt;sup>2320</sup> Coroners Act 1985 s 27(2).

the coroner to inform the next of kin that tissues, body parts or organs have been retained following the autopsy. Nor does the Act require a coroner to tell the next of kin how long the tissue or organ will be retained or what will happen to it at a later stage.

There is also a lack of any such requirements in the *Human Tissue Act 1982*. Section 27(1) of the *Human Tissue Act 1982* provides:

If the designated officer for a hospital or, in a case to which section 26(2) applies, the registered medical practitioner or the authorized person has reason to believe that the circumstances applicable in relation to the death of a person are such that a coroner has jurisdiction under the Coroners Act 1985 to investigate the death of the person, the designated officer or the registered medical practitioner or the authorized person, as the case may be, shall not authorize the removal of or remove tissue from the body of the deceased person unless a coroner has given his consent to the removal.<sup>2321</sup>

However, section 30(3) of the *Human Tissue Act 1982* provides:

An order by a coroner under the Coroners Act 1985 directing a post-mortem examination is, subject to any order to the contrary by a coroner, authority for the use, for therapeutic, medical or scientific purposes, of tissue removed from the body of the deceased person for the purpose of the post-mortem examination.<sup>2322</sup>

Thus the *Human Tissue Act 1982* effectively provides for removal and retention of tissues and organs at a coronial autopsy, and the subsequent use of such material for multiple purposes, without requiring the consent of the family.<sup>2323</sup> This feature of the legislation resulted from recommendations made in 1977 by the Australian Law Reform Commission (ALRC) report on human tissue transplants, which stated:

[T]he procedures and characteristics of normal autopsies and the beneficial uses to which they may be put are such that the Commission unhesitatingly recommends some departure from the general principle of consensual giving upon which this report is based.<sup>2324</sup>

Dr Freckelton and Associate Professor Ranson note that this 'paternalistic' approach was taken up by most states and territories in Australia with the introduction of various human tissue legislation.<sup>2325</sup> The authors consider that the position of Australian

<sup>&</sup>lt;sup>2321</sup> Human Tissue Act 1982 27(1).

<sup>&</sup>lt;sup>2322</sup> Human Tissue Act 1982 s 30 (3).

<sup>&</sup>lt;sup>2323</sup> Ian Freckelton and David Ranson, *Death Investigation and the Coroner's Inquest*, Oxford University Press, Melbourne, 2006, 348. In contrast, the position in relation to medical, ie non-coronial, autopsies is quite different, in that consent must be sought from families or must have been given in writing by the person who died: *Human Tissue Act 1982* (Vic), s 28.

<sup>&</sup>lt;sup>2324</sup> Australian Law Reform Commission, *Human Tissue Transplants*, Report no. 7 (1977), para 165.

<sup>&</sup>lt;sup>2325</sup> Ian Freckelton and David Ranson, *Death Investigation and the Coroner's Inquest* (2006) 348. See for example, *Human Tissue Act 1983* (NSW); *Human Tissue Act 1985* (Tas); *Human Tissue Act 1982* (Vic); *Human Tissue and Transplant Act* 1982 (WA).

human tissue legislation with regard to the use of autopsy tissue is out of date and inconsistent with evolving community attitudes in relation to consent in the medical arena. <sup>2326</sup> VIFM has expressed a similar view. <sup>2327</sup> The Committee notes that VIFM's practices and procedures involve paying careful attention to issues of communication with families and obtaining consent in relation to the use of autopsy tissue for medical or research purposes unrelated to the investigation. However, these considerations are not enshrined in the applicable legislation.

The Committee considers that caution needs to be exercised in relation to making recommendations about the laws governing retention of organs and tissues at autopsy. Over the years many pathologists and other members of the medical profession have rightly stressed the importance of such material for therapeutic, medical or scientific purposes. The medical profession has at times expressed concern that a reduction in the amount of tissue retained at autopsies could 'lead to an adverse outcome in respect to diagnosis, therapeutics and medical research'.<sup>2328</sup> However, as Associate Professor Ranson has observed:

Any discussion about the value to society of retaining organs and tissues at autopsy has to be clearly distinguished from discussion regarding how such retention of tissues is to be legally authorised or regulated.<sup>2329</sup>

In any analysis of the significance of the retention of human tissues and organs at autopsy, it is important not to confuse the arguments for the scientific need for retention with the moral and ethical expectations that the community places on the medical profession regarding the maintenance of community health in a setting of the social need for fully informed consent.<sup>2330</sup>

Thus, while there are public health benefits to the community relating to organ and tissue retention, an important issue from the community's perspective is that such retention take place with fully informed consent. The Committee notes that the notion of informed consent in this context can be a complex one.<sup>2331</sup> It is also of great importance to families that the body of a relative who has died is treated with dignity.

Dr Freckelton and Associate Professor Ranson argue that the most important consideration with respect to organ and tissue retention at autopsy is the communication that takes place with the family and next of kin and how this is

<sup>&</sup>lt;sup>2326</sup> Ian Freckelton and David Ranson, *Death Investigation and the Coroner's Inquest* (2006) 349.

<sup>&</sup>lt;sup>2327</sup> Victorian Institute of Forensic Medicine, Submission no. 40, 4.

<sup>&</sup>lt;sup>2328</sup> David Ranson, 'Tissue and Organ Retention at Autopsy: What are the Benefits?' (2001) 8 *Journal of Law and Medicine* 368, 372.

<sup>&</sup>lt;sup>2329</sup> Ibid 369.

<sup>&</sup>lt;sup>2330</sup> Ibid 370.

<sup>&</sup>lt;sup>2331</sup> For example, where retained organs and tissues may be stored and used for teaching and research some time in the future, so that it is impossible to truly obtain informed consent to future possibilities regarding the use of such material: ibid.

handled.<sup>2332</sup> This has certainly been recognised by VIFM, which has published guidelines stating that tissue removed at a coronial autopsy will not be used for medical or research purposes without consent.<sup>2333</sup> The experience of VIFM has been that approximately two thirds of families consulted in advance about retention of tissue at autopsy for research purposes have been willing to donate such tissue.<sup>2334</sup>

# Other jurisdictions

Three Australian jurisdictions address this issue in their coronial legislation. In Queensland, section 24 of the *Coroners Act 2003* sets out in detail the rights of the family in relation to retained body parts and tissues:

- 24 Removing tissue for autopsy testing
- (1) This section applies if during an autopsy of a body, the doctor conducting the autopsy removes tissue from the body for testing.
- (2) If the tissue removed is a whole organ or foetus, the doctor must inform the coroner before the coroner orders the body's release.
- (3) The coroner, knowing that the tissue has been removed, may nevertheless order the release of the body.
- (4) However, if a whole organ or foetus has been removed, the coroner must not order the release of the body unless satisfied that--
- (a) if practicable, a family member of the deceased person has been informed of the removal of the organ or foetus; and
- (b) the retention of the organ or foetus is necessary for the investigation of the death, despite any concerns raised with the coroner about the retention of the organ or foetus.
- (5) If tissue kept for testing is an organ or foetus, the coroner must, at not more than 6 monthly intervals after the date of the order for the autopsy, decide whether the tissue--
  - (a) still needs to be kept for--
    - (i) the investigation of the death; or
    - (ii) proceedings for an offence relating to the death; or
  - (b) may be disposed of.

<sup>&</sup>lt;sup>2332</sup> Ian Freckelton and David Ranson, *Death Investigation and the Coroner's Inquest* (2006) 350.

<sup>&</sup>lt;sup>2333</sup> Victorian Institute of Forensic Medicine, Submssion no. 40, Attachment D. 2.

<sup>&</sup>lt;sup>2334</sup> David Ranson, 'Tissue and Organ Retention at Autopsy: What are the Benefits?' (2001) 8 *Journal of Law and Medicine* 368, 372.

- (6) Specimen tissue as defined under the *Transplantation and Anatomy Act 1979* must be kept indefinitely by the entity that turned the tissue into specimen tissue.
- (7) A person must not dispose of any other tissue kept for testing, except under the order of a coroner.

Maximum penalty--100 penalty units.

- (8) If a coroner orders the disposal of the tissue, the entity that has the tissue must--
  - (a) if a family member of the deceased person has told the coroner that he or she wishes to bury the tissue--release the tissue to the family member, or the family member's representative, for burial; or
  - (b) otherwise--arrange for the tissue to be buried. 2335

In Western Australia the coronial legislation permits removal of tissue from the body at an autopsy for purposes other than investigating the death only with the written permission of the deceased, or with the written informed consent of the senior next of kin specifying the tissue which may be removed and the purpose (therapeutic, medical or scientific) for which the tissue may be removed.<sup>2336</sup> In contrast, the legislation provides that any tissue removed during an autopsy for the purpose of investigating the death is to be dealt with according to the coroner's directions and any relevant guidelines.<sup>2337</sup>

In South Australia, the relevant human tissue legislation<sup>2336</sup> has been amended recently<sup>2339</sup> in response to concerns raised by families about organ and tissue retention.<sup>2340</sup> The amendments include a requirement for the State Coroner, before authorising the use for therapeutic, medical or scientific purposes of tissue removed from a person who died, to be satisfied that the senior next of kin has given consent to such use, and that the person who died did not during his or her lifetime express an objection to such use.<sup>2341</sup> These amendments were introduced to 'bring South Australia's autopsy practice legislation into line with the National Code of Ethical Autopsy Practice'.<sup>2342</sup>

<sup>&</sup>lt;sup>2335</sup> Coroners Act 2003 (Qld) s 24.

<sup>&</sup>lt;sup>2336</sup> Coroners Act 1996 (WA) s 34(3).

<sup>&</sup>lt;sup>2337</sup> Coroners Act 1996 (WA) s 34(6).

<sup>&</sup>lt;sup>2338</sup> Transplantation and Anatomy Act 1983 (SA).

<sup>&</sup>lt;sup>2339</sup> Transplantation and Anatomy (Post-Mortem Examinations) Amendment Act 2005 (SA).

<sup>&</sup>lt;sup>2340</sup> Hon P Holloway, Minister for Industry and Trade, Transplantation and Anatomy (Post-mortem Examinations)

Bill, Legislative Council Second Reading Speech, 10 November 2005, 28.

<sup>&</sup>lt;sup>2341</sup> Transplantation and Anatomy (Post-Mortem Examinations) Amendment Act 2005 (SA), s 27(3).

<sup>&</sup>lt;sup>2342</sup> Hon P Holloway, Minister for Industry and Trade, Transplantation and Anatomy (Post-mortem Examinations)

Bill, Legislative Council Second Reading Speech, 10 November 2005, 29.

In New Zealand, the *Coroners Act 2006* contains extensive provisions relating to the removal of body parts and samples.<sup>2343</sup> These require a coroner to notify a family, on or before release of the body, of the retention or proposed retention of a body part or sample.<sup>2344</sup> Such notice must identify the part or sample to be retained, explain the authority and reasons for retention, indicate how long the pathologist expects to retain it for those reasons, and indicate (if known to the coroner) whether the part or sample is likely to be destroyed while being used for the purpose for which it is being retained.<sup>2345</sup> Importantly, these notification provisions, unlike the equivalent Queensland provisions noted above, extend to minute body parts or samples taken for microscopic or other analysis.<sup>2346</sup> The provisions state that families are able to request, within five working days of the notice, the return (to the extent permitted by the Act) of the body part or sample once it is no longer needed.<sup>2347</sup>

## Law reform agencies

The most significant recent inquiry in relation to organ and tissue retention became known as the Redfern Inquiry. It reviewed practices at the Royal Children's Hospital in Liverpool, England, and proposed that, if a decision is made to authorise a post-mortem, coroners should ensure that next of kin are advised of:

- the reasons for authorising the post-mortem examination;
- their right to ask the coroner that the examination be carried out by a pathologist independent of the hospital in which the person died;
- the place and time of the examination and the identity of the pathologist;
- the nature of the examination, including the need to open the body and to remove and weigh organs;
- the need for samples and retention of organs;
- their option to delay the funeral, while the pathologist fixes and examines organs, to enable the return of organs to the body for burial or cremation;
- their option for a funeral without the return of the organs, in which case they should be invited to consent to the respectful disposal of the organs by the coroner;
- their option to make their own arrangements for respectful disposal of the organs.

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<sup>&</sup>lt;sup>2343</sup> Coroners Act 2006 (NZ), ss 40–46.

<sup>&</sup>lt;sup>2344</sup> Coroners Act 2006 (NZ), ss 43B(1)–(2).

<sup>&</sup>lt;sup>2345</sup> Coroners Act 2006 (NZ), ss 43B(1)–(2).

<sup>&</sup>lt;sup>2346</sup> Coroners Act 2006 (NZ), s 43B(1).

<sup>&</sup>lt;sup>2347</sup> Coroners Act 2006 (NZ), s 43B(3).

Dr Freckelton and Associate Professor Ranson have commented that the Redfern Inquiry's recommendations have proved highly influential in coronial jurisdictions in many parts of the world and represent the emerging approach in relation to the respect to be accorded to people who have died and their next of kin.<sup>2348</sup>

In 2001 in New South Wales, Bret Walker SC conducted an inquiry into autopsy practices at the Institute of Forensic Medicine at Glebe in Sydney. While the inquiry at the institute in New South Wales has no bearing on autopsy practices in Victoria, the report made a number of recommendations which are relevant to this inquiry. In his report Mr Walker recommended that the disposal of autopsy tissue should be regulated and that it should be returned to the next of kin or disposed of in a dignified way.<sup>2349</sup> He also recommended that the wishes of the person who died should govern the use of autopsy tissue (excluding microscopic amounts of tissue which are preserved on blocks and slides).<sup>2350</sup>

A National Code of Ethical Autopsy Practice was released in May 2002 by the Australian Health Ministers' Advisory Council Subcommittee on Autopsy Practice.<sup>2351</sup> The code of practice states that it is important to acknowledge that, while the agreement of the family is not required in coronial autopsies, wherever possible the coroner should give regard to the family's wishes.<sup>2352</sup> It further states that families should be given information about the need to retain samples and the options for dealing with tissues and organs. VIFM informed the Committee that a revised version of the code will soon be published.

#### Retention of tissue blocks and slides

It is common at forensic autopsies for biopsy material to be retained in the form of wax histology blocks or glass microscope slides. Laboratory standards often require such material to be kept for long periods, usually many years. The policy of VIFM is to retain this material indefinitely, and any research is subject to ethics review.<sup>2353</sup> The retention of blocks and slides allows tissue diagnosis to be reviewed in light of new disease discoveries or scientific investigation techniques. The material may also be needed for legal purposes relating to allegations of misdiagnosis. Another possibility is that the DNA component of the material may be used for identification purposes. The material can also be a valuable teaching and research resource for decades.

<sup>&</sup>lt;sup>2348</sup> Ian Freckelton and David Ranson, *Death Investigation and the Coroner's Inquest* (2006) 384.

<sup>&</sup>lt;sup>2349</sup> Bret Walker, *Inquiry into Matters Arising from the Post-Mortem and Anatomical Examination Practices of the Institute of Forensic Medicine — Report*, August 2001, Recommendation 3, 96. Available at www.health.nsw.gov.au/pubs/i/forensic/pdf/pmreport.pdf.

<sup>&</sup>lt;sup>2350</sup>Ibid 434; Recommendation 5, 96.

Australian Health Ministers' Advisory Council Subcommittee on Autopsy Practice, A National Code of Ethical Autopsy Practice, May, 2002. Available at www7.health.gov.au/code.pdf.
 Ibid 13.

<sup>&</sup>lt;sup>2353</sup> Victorian Institute of Forensic Medcine, Submission no. 40, 33.

An issue that arises here is whether families should have the right to be informed about the retention of tissue blocks and slides. A related issue is whether they should be informed about the retention of DNA for long periods of time, and its potential use for identification or other purposes. The Victorian Privacy Commissioner's observations on this topic are discussed later in this chapter. In its submission VIFM did not state whether family members are informed that tissue blocks and slides containing DNA information will be retained indefinitely.

One of the recommendations of the UK Redfern Inquiry was that coroners should ensure that families are informed about the need for the retention of samples and possibly organs. The Redfern Inquiry also recommended that all retained organs, tissues, blocks and slides should be specified in any preliminary and final autopsy reports. As noted earlier, Dr Freckelton and Associate Professor Ranson have commented that early communication with families is the most important consideration with respect to organ and tissue retention at autopsies.<sup>2354</sup>

The Committee has made recommendations below in relation to the information which should be provided to the family of the person who died about retained tissue, which in the Committee's view should include information about minute samples such as tissue blocks and slides. The Committee considers that Victoria should adopt the New Zealand model insofar as a coroner's obligation to inform families extends to minute samples, 2355 rather than the Queensland model, which only requires families to be informed about the retention of whole organs or foetuses.

The *Coroners Act 2006* provides two procedures for dealing with body parts. It provides that any body parts and samples which are larger than minute can only be retained by the pathologist with the written authority of the coroner.<sup>2356</sup> Retention of minute body parts does not require such authority; however, in all cases the coroner must notify the immediate family of the intention to retain any parts or samples.<sup>2357</sup> This requirement is facilitated by a requirement that pathologists notify the coroner in writing of any parts or samples to be retained following the return of the body.

Last, the Committee does not consider that the requirement to include details of retained tissue specimens in the autopsy report, as suggested by the UK Redfern Inquiry, needs to be prescribed in the Act. The Committee's view is that this is a subject more appropriate for relevant guidelines.<sup>2358</sup>

<sup>&</sup>lt;sup>2354</sup> Ian Freckelton and David Ranson, *Death Investigation and the Coroner's Inquest* (2006) 350.

<sup>&</sup>lt;sup>2355</sup> Coroners Act 2006 (NZ), s 43B.

<sup>&</sup>lt;sup>2356</sup> Coroners Act 2006 (NZ), s 43.

<sup>&</sup>lt;sup>2357</sup> Coroners Act 2006 (NZ), s 43A.

<sup>&</sup>lt;sup>2358</sup> For example, the National Pathology Accreditation Advisory Council guidelines state: 'Records shall be kept of organs and tissues retained for microscopic or other examination after the completion of the autopsy': National

#### **Donor Tissue Bank**

The Donor Tissue Bank of Victoria (DTBV) was set up by VIFM soon after its establishment in 1988 to provide a centralised service for the acquisition, preparation, storage and distribution of autopsy tissue for transplantation. 2359 The donation of organs and tissues for transplantation is seen as offering relatives the opportunity to salvage something positive from the death, as an aid in the grieving process. The DTBV has expertise in retrieving corneas, heart valves, skin and skeletal tissue for transplantation. VIFM has stated that the DTBV makes a vital contribution to the health of the Victorian community, and that since its inception it has provided Victorians and other Australians with life enhancing and in some cases life saving tissue. In addition, some families are offered the opportunity to donate tissues for research projects approved by the VIFM Ethics Committee. The approaches are made by trained Transplant and Family Liaison Coordinators in the first 24 hours after the death, in cases where it is considered appropriate to do so. At present the DTBV is permitted by the State Coroner to approach families for consent, but VIFM expressed concern that the DTBV has no right of access to families and that a future coroner might be less supportive. Therefore, VIFM submitted that the Act should be amended to provide the DTBV with the right to approach families in a timely manner to offer them the opportunity to donate tissue for transplantation or research.<sup>2360</sup>

In Western Australia, section 53A of the *Coroners Act 1996* allows the State Coroner to provide to a 'human tissue donation agency' certain information in respect of a person whose death is subject to investigation by the coroner. The information to be provided includes the name and age of the deceased, the circumstances of the death and the contact details of the person's next of kin.<sup>2361</sup> The section also prescribes that the information provided by the coroner is to be destroyed within two days of being provided.<sup>2362</sup>

## Evidence received by the Committee

In its submission VIFM stated that it has developed comprehensive policies and procedures relating to the retention and use of human tissue removed at autopsy for the purposes of diagnosis of cause of death.<sup>2363</sup> Questions regarding the retention of tissue for research and education purposes are currently determined by the VIFM

Pathology Accreditation Advisory Council, *Guidelines for the Facilities and Operation of Hospital and Forensic Mortuaries* (2004), guideline 11.1.2, 21.

<sup>&</sup>lt;sup>2359</sup> Victorian Institute of Forensic Medicine, Submission no. 40, 27.

<sup>&</sup>lt;sup>2360</sup> Ibid 28.

<sup>&</sup>lt;sup>2361</sup> Coroners Act 1996 (WA) s53A(1). Subsection (3) provides that a 'human tissue donation agency' means an office or organisational unit coordinating or encouraging tissue transplantation under the *Human Tissue and Transplant Act 1982* (WA) that is within the Department of Health.

<sup>&</sup>lt;sup>2362</sup> Coroners Act 1996 (WA) s53A(2).

<sup>&</sup>lt;sup>2363</sup> See Appendix 8 to this report.

Ethics Committee process<sup>2364</sup> with State Coroner oversight. VIFM believes that this process is preferable to codification in legislation, as it is flexible and involves community representation. VIFM submitted that the process is therefore more responsive to changes in community expectations than a process prescribed in legislation, as demonstrated in VIFM's view by the failure to amend the *Victorian Human Tissue Act 1982*.<sup>2365</sup>

A similar view was expressed by the Royal College of Pathologists of Australasia, which considers that reliance on documents such as its policy statement 'Autopsies and the Use of Tissues Removed at Autopsy', <sup>2366</sup> supplemented by Ethics Committee oversight, and regulatory mechanisms within the practice of medicine such as medical boards is preferable to a legislative approach to regulating tissue retention. <sup>2367</sup>

To the extent that legislative change is necessary, VIFM submitted that any issues relating to the removal or retention of tissue should be dealt with within the context of the *Human Tissue Act 1982* rather than the *Coroners Act 1985*, which it considers is overdue for review. VIFM submitted that review of certain provisions of the *Human Tissue Act* was effectively agreed to by all States and Territories during their involvement in the development and endorsement of the National Code of Ethical Autopsy Practice in 2002. It was agreed as part of the code that 'legislation at State and Territory level will need to be reviewed once the Code is approved to ensure consistency with the Code'. <sup>2368</sup> VIFM observed that some States and Territories have since undertaken such amendments but Victoria has not. VIFM noted that its practice is consistent with the code and that such practice predated the code's development.

Lawyers representing the Medical Negligence Practice Group of Maurice Blackburn Cashman (MBC) submitted that they have acted for a number of families adversely affected by past practices of removing body organs and tissues and not informing families that this has occurred. MBC's experience is that it is vital for families to be informed of the retention of organs and tissues. MBC considers that Victoria should adopt the requirements of section 24 of the *Coroners Act 2003* (Qld), as referred to above.<sup>2369</sup>

The Committee received little evidence from families regarding organ and tissue retention. However, those witnesses who did comment raised the same issues of information, consent and dignity which have been major themes in other inquiries into the retention of body parts. Ms Carol Smith submitted:

<sup>&</sup>lt;sup>2364</sup> See Appendix 9 to this report.

<sup>&</sup>lt;sup>2365</sup> Victorian Institute of Forensic Medicine, Submission no. 40, 28.

<sup>&</sup>lt;sup>2366</sup> Royal College of Pathologists of Australasia, *Submission no. 65*, 1, Appendix 1.

<sup>&</sup>lt;sup>2367</sup> Ibid 1

<sup>&</sup>lt;sup>2368</sup> Victorian Institute of Forensic Medicine, *Submission no. 40*, 33.

<sup>&</sup>lt;sup>2369</sup> Maurice Blackburn Cashman, Submission no. 42, 10.

[T]he body belongs more to the family than the State and they should have every right to know in detail what happens to it at every stage including organs or tissue that is no longer required.<sup>2370</sup>

The Committee considers it likely that most families would have a similar view that the body of a person who dies belongs to the person's family and not, in the absence of consent to research or other uses of organs and tissues, to the medical profession.<sup>2371</sup>

Ms Storm submitted that the next of kin should be informed about retained organs and tissues and that, if the family does not want the person's remains returned, the remains should be disposed of with dignity.<sup>2372</sup>

SPFV submitted that the Act should require a coroner to inform the family that body parts have been retained after the autopsy and to explain why. SPFV also recommended that the coroner be required to advise the family of the availability of the organs once the coroner no longer has need of them. The options for disposal of these organs should lie at all times with the family. Communities represented by SPFV regard all parts of the body as sacred, and in some cases burial cannot take place until the parts have been returned.<sup>2373</sup>

#### Discussion and conclusion

The Committee considers that changes to both the *Coroners Act 1985* and the *Human Tissue Act 1982* would be necessary to address the issues raised in the above discussion and to give effect to the legislative changes recommended during the development of the National Code of Ethical Autopsy Practice.

The Committee considers that the *Coroners Act 1985* should include requirements in relation to organ and tissue retention which are similar to those contained in section 24 of the *Coroners Act 2003* (Qld).<sup>2374</sup> The Act should require a coroner to inform the family of the person who died that specified tissue is to be retained and why it is to be retained, to consider the necessity of the retention for the purposes of the investigation despite any concerns raised, and to review at regular intervals the necessity of retaining such tissue.<sup>2375</sup> The Act should also provide for the release to the family or respectful disposal of retained tissue at the end of the retention period. The Committee considers that these requirements should apply not only in relation to

<sup>&</sup>lt;sup>2370</sup> Carol Smith, Submission no. 25, 9.

<sup>&</sup>lt;sup>2371</sup> However, as a matter of law a body cannot be regarded as property: *Doodeward v Spence* (1908) 6 CLR 406, although in general an executor does have the legal right to custody and possession of the body until it is buried or cremated: *Smith v Tamworth City Council* (1997) (1997) 41 NSWLR 680.

<sup>&</sup>lt;sup>2372</sup> Caroline Storm, Submission no. 28, 7.

<sup>&</sup>lt;sup>2373</sup> South Pacific Islander Association of Victoria Inc, *Submission no. 54*, 23.

<sup>&</sup>lt;sup>2374</sup> Cf Coroners Act 2003 (Qld) s 24.

<sup>&</sup>lt;sup>2375</sup> Coroners Act 2003 (Qld) s 24.

whole organs or foetuses, as is the case in Queensland, but also to all tissue, including body parts and samples, as is the case in the *Coroners Act 2006 (NZ)*.<sup>2376</sup>

The Committee also considers that from the community's perspective it is increasingly important that informed consent be sought from families in relation to therapeutic, medical or scientific uses of tissue removed from a person who died. Legislation in some other jurisdictions, including the coronial legislation in Western Australia, now requires such consent to be given. The Committee considers that the Act in Victoria should require consent to be obtained for the use of tissue for therapeutic, medical, teaching or scientific purposes, as is the case in Western Australia.

VIFM has submitted that any issues relating to the removal or retention of tissue should be dealt with in the context of the *Human Tissue Act 1982*. However, the Committee considers that autopsy practice is integral to the coroner's jurisdiction, and so these issues also need to be addressed in the *Coroners Act 1985*. The recommended amendments to the Act in this area would necessitate corresponding amendments to the relevant provisions of the *Human Tissue Act 1982*. The Committee recommends that the *Human Tissue Act 1982* be amended for this purpose and to ensure its consistency with the National Code of Ethical Autopsy Practice endorsed by the States and Territories.

Finally, the Committee considered whether the *Coroners Act 1985* should be amended to include a provision enabling the State Coroner to provide information to the DTBV. However, the need for such authority has been addressed by recent amendments<sup>2377</sup> to section 45 of the *Human Tissue Act 1982*,<sup>2378</sup> and therefore the Committee makes no recommendation.

#### Recommendation 108. That the Coroners Act 1985 be amended to:

- a) require a coroner, where practicable, to inform the family of the person who died that tissue will be retained, specify the tissue to be retained, give reasons for its retention and indicate how long the tissue will need to be retained;
- b) provide that, prior to the retention of any tissue other than minute samples, the written consent of the coroner must be obtained;
- c) require a coroner to consider the necessity of the retention for the purposes of the investigation despite any concerns raised;
- d) require a coroner to review at six-monthly intervals the necessity of retaining such tissue; and

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<sup>&</sup>lt;sup>2376</sup> Coroners Act 2006 (NZ), s 43B.

<sup>&</sup>lt;sup>2377</sup> Coroners and Human Tissue Acts (Amendment) Act 2006 s 15.

<sup>&</sup>lt;sup>2378</sup> Human Tissue Act 1982 s 45(4)-(6).

e) provide for the disposal of the tissue at the end of the retention period, by release to the family or by other arrangements for respectful disposal by the entity that has the tissue.

Recommendation 109. That the *Coroners Act 1985* be amended to permit the removal of tissue from a body at an autopsy for purposes other than investigating the death only with the prior written permission of the person who died, or with the written informed consent of the senior next of kin specifying the tissue which may be removed and the purpose (therapeutic, medical or scientific) for which the tissue may be removed. Consent forms used for this purpose should be expressed in plain English, and a copy should be provided to the senior next of kin.

Recommendation 110. That the *Human Tissue Act 1982* be amended to ensure its consistency with:

- a) the recommendations in this report in relation to organ and tissue retention; and
- b) the National Code of Ethical Autopsy Practice.

## Release of the body

A coroner investigating a death must issue, as soon as reasonably possible, a certificate permitting burial or cremation.<sup>2379</sup>

Associate Professor Ranson stated in his submission that this provision appears to work well and that bodies are released in a timely manner in most cases. In some situations bodies must be retained for longer periods, usually where the death is the subject of a criminal investigation or involves a complex death scene. Another possible situation is a mass disaster where identification of the persons who died is a major issue.

However, some witnesses were concerned that bodies are not released soon enough to accommodate funeral requirements.<sup>2380</sup> SPFV submitted that there have been too many occasions when its communities have felt a sense of helplessness in relation to the need for the speedy release of the body of a person who died. SPFV stated that on some occasions its communities have had to wait up to five days for a body to be released into the care of the family. This problem is particularly prevalent over weekends and long weekends. Such delays affect SPFV communities negatively, since for cultural reasons they usually need to repatriate the body of the person who died, before which time relatives arrive from around the world to mourn with the

<sup>2380</sup> See for example South Pacific Islander Association of Victoria Inc, *Submission no. 54*, 24–5. See also Carol Smith, *Submission no. 25*, 9, and *Minutes of Evidence*, *22 August 2005*, in relation to the effect of autopsy objections.

<sup>&</sup>lt;sup>2379</sup> Coroners Act 1985 s 23.

family. SPFV submitted that the Act should address cultural needs for speedy release of bodies and that, to facilitate this, resources should be provided to ensure that a coroner is available on weekends and public holidays.

The Committee considers that the requirement in the Act that a coroner issue a certificate permitting burial or cremation as soon as possible can be strengthened by two Committee recommendations made earlier in this chapter: first, that coroners be required to have regard to the desirability of minimising distress to persons who, by reason of their ethnic origins, social attitudes or customs, or spiritual beliefs, customarily require bodies to be available to family members as soon as possible after death and, second, that all coroners must perform their duties without delay.

## **Exhumation**

An exhumation has the potential to be enormously distressing for family members, who may have been unaware that there was any issue necessitating exhumation, such as allegations of negligent injury, incompetent medical treatment or, in particular, homicide.<sup>2381</sup> Dr Freckelton and Associate Professor Ranson state:

Above all, an exhumation represents the dissolution of closure that had been brought about by the burial of the deceased. Accordingly, coroners have been slow to order disinterment of buried corpses.<sup>2382</sup>

In Victoria the State Coroner may order that a body be exhumed if s/he reasonably believes that it is necessary for the investigation of a death.<sup>2383</sup> The senior next of kin must be given at least 48 hours' notice of the order, unless the State Coroner is satisfied that it is not possible to do so.<sup>2384</sup> If the senior next of kin asks the State Coroner not to exhume the body,<sup>2385</sup> the body must not be exhumed until 48 hours after the request has been made.<sup>2386</sup> Within that 48-hour period the senior next of kin may apply to the Supreme Court for an order that the body not be exhumed.<sup>2387</sup> The Supreme Court will grant the order if it is satisfied that 'it is desirable in the circumstances'.<sup>2388</sup>

While this is not prescribed in the Act, usually the State Coroner will consult the family of the person who died regarding the proposed procedures for exhumation and the

<sup>2383</sup> Coroners Act 1985 s 30(1).

<sup>&</sup>lt;sup>2381</sup> Ian Freckelton and David Ranson, Death Investigation and the Coroner's Inquest (2006) 112.

<sup>&</sup>lt;sup>2382</sup> Ibid 374.

<sup>&</sup>lt;sup>2384</sup> Coroners *Act 1985* s 30(2).

<sup>&</sup>lt;sup>2385</sup> The regulations prescribe that a request for a body not to be exhumed must be made in writing and must specify the reasons why the body should not be exhumed: *Coroners Regulations 1996* reg 13(1).

<sup>&</sup>lt;sup>2386</sup> Coroners Act 1985 s 30(3).

<sup>&</sup>lt;sup>2387</sup> Coroners Act 1985 s 30(4).

<sup>&</sup>lt;sup>2388</sup> Coroners Act 1985 s 30(5).

subsequent reinterment of remains.<sup>2389</sup> It may also be necessary for the Coroner to assist the family by arranging a further funeral service at the time of reinterment.

The Committee notes that, in the ACT, where a coroner has issued a warrant for the exhumation of a body and as soon as s/he is satisfied that the exhumed body should be re-interred or the ashes returned to the person entitled to them, the coroner must by order direct a person to re-inter the body or return the ashes.<sup>2390</sup>

Witnesses to this inquiry did not raise any substantial concerns in relation to the current Victorian provisions regarding exhumation, which are more or less reflected in other jurisdictions. In his submission Associate Professor Ranson observed that the existing provisions in the legislation appear to be working well. He commented that exhumations are uncommon but that when they are required 'considerable effort and attention to detail is made by staff of the Coroner's Office ensuring that the family issues are carefully considered and resolved'.<sup>2391</sup>

While the Committee did not receive any detailed submissions on the subject of exhumations, it considers that the existing notification requirement may be insufficient in terms of the needs of next of kin. Given the trauma that an order for exhumation is likely to cause the family of the person who died, it would be consistent with the other rights recommended in this chapter for such families or a representative to be given the right to attend an exhumation.

Recommendation 111. That the Coroners Act 1985 be amended to:

- a) provide that, if a coroner orders an exhumation, the immediate family of a person whose body is to be exhumed or their representative has the right to attend the exhumation; and
- b) require a coroner who orders an exhumation to direct a person by order to re-inter the body or return the ashes to the person entitled to them, with the costs to be met by the Coroner's Office.

## Indigenous burial remains

When dealing with what may be Indigenous burial remains, a balance must be struck between the need to ensure the death was not a homicide and the need to avoid the unnecessary disturbance of Indigenous burial remains.<sup>2392</sup>

<sup>&</sup>lt;sup>2389</sup> Ian Freckelton and David Ranson, *Death Investigation and the Coroner's Inquest* (2006) 112.

<sup>&</sup>lt;sup>2390</sup> Coroners Act 1997 (ACT) s 30(1).

<sup>&</sup>lt;sup>2391</sup> David Ranson, Submission no. 19, 82.

<sup>&</sup>lt;sup>2392</sup> State Coroner's Guidelines — Version 0 December 2003, guideline 4.2. Available at <a href="http://www.justice.qld.gov.au/courts/coroner/pdfs/guidelines.pdf">http://www.justice.qld.gov.au/courts/coroner/pdfs/guidelines.pdf</a>.

Usually, human remains discovered in Victoria fall under the jurisdiction of the State Coroner and are investigated by police.<sup>2393</sup> When first discovered, the site of human remains must be treated as a crime scene until it can be deemed to the satisfaction of the police and the coroner that the remains are of Indigenous descent, of some antiquity and not connected with a crime.<sup>2394</sup> However, normally, that could result in all remains, once photographed, being gathered up and taken to a forensic laboratory. While that would enable tests which could show the age and ethnic origin of the remains, it could also cause unnecessary distress and offence to the descendants of the deceased, who naturally would prefer their ancestors' remains to be left undisturbed on their traditional land.<sup>2395</sup>

The definition in the Act of a 'reportable death' includes a death 'where the body is in Victoria' and is 'of a person whose identity is unknown'.<sup>2396</sup> In practice, this reporting requirement is applied by Aboriginal Affairs Victoria (AAV),<sup>2397</sup> the Coroner's Office and Victoria Police to all discoveries of ancient or historical human remains until investigation has established that such remains are Aboriginal and not of recent origin.<sup>2398</sup> Once that finding is reached, responsibility for the remains is usually transferred to AAV and the remains are dealt with under Aboriginal cultural heritage legislation.<sup>2399</sup> This is because the *Aboriginal and Torres Strait Islander Heritage Protection Act 1984* (Cth) also requires any person who discovers suspected Aboriginal remains in Victoria to report details of that discovery to the State Minister for Aboriginal Affairs. Such reports are received and investigated by AAV, which liaises with the relevant Aboriginal community over the assessment and management of the remains

The Victorian State Coroner's protocol states that, if it can be established reliably (by the on-call pathologist in consultation with a forensic anthropologist) that the reported

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<sup>&</sup>lt;sup>2393</sup> See Aboriginal Affairs Victoria, *Submission no. 80*, attachment 2, 'Protocol for Management of Aboriginal Skeletal Remains by the Coronial Services Centre'; cf State Coroner's Office, *Submission no. 70*, Appendix C1i, 'Protocol for Management of Skeletal Remains'.

<sup>&</sup>lt;sup>2394</sup> The State Coroner's protocol states: If it can be reliably established that reported remains are from an era prior to contact with Europeans, then CSC will transfer responsibility for the remains to Aboriginal Affairs Victoria: see Aboriginal Affairs Victoria, *Submission no. 80*, attachment 2, 'Protocol for Management of Aboriginal Skeletal Remains by the Coronial Services Centre'; State Coroner's Office, *Submission no. 70*, Appendix C1i, 'Protocol for Management of Skeletal Remains'.

<sup>&</sup>lt;sup>2395</sup> See *State Coroner's Guidelines* — *Version 0 December 2003*, guideline 4.2. Available at http://www.justice.qld.gov.au/courts/coroner/pdfs/guidelines.pdf.

<sup>&</sup>lt;sup>2396</sup> Coroners Act 1985 s 3.

<sup>&</sup>lt;sup>2397</sup> Aboriginal Affairs Victoria is an agency within the Department for Victorian Communities.

<sup>&</sup>lt;sup>2398</sup> Aboriginal Affairs Victoria, Submission no. 80, 1.

<sup>&</sup>lt;sup>2399</sup> The legislative regime is in the process of reform, as discussed below. See *Aboriginal and Torres Strait Islander Heritage Protection Act 1984* (Cth); Aboriginal and Torres Strait Islander Heritage Protection Bill 2005 (Cth); *Archaeological and Aboriginal Relics Preservation Act 1972* (repealed); *Aborginal Heritage Act 2006.* 

remains are Aboriginal and from an era prior to contact with Europeans,<sup>2400</sup> the Coronial Services Centre will transfer responsibility for those remains to AAV. On the other hand, Aboriginal remains from the period shortly after contact with Europeans may require more detailed assessment by the Coronial Services Centre before appropriate action can be determined.<sup>2401</sup>

### Other jurisdictions

The Tasmanian Act contains special provisions for the inspection of suspected Indigenous remains to be passed directly to the Aboriginal community instead of the coroner. Tasmania is the first state to have accorded this right to Indigenous Australians.

Section 23 of the Tasmanian Act provides:

- (1) The Attorney-General may approve an Aboriginal organisation for the purposes of this section.
- (2) If, at any stage after a death is reported under section 19(1) a coroner suspects that any human remains relating to that death may be Aboriginal remains, the coroner must refer the matter to an Aboriginal organisation approved by the Attorney-General.
- (3) If a coroner refers a matter to an Aboriginal organisation approved by the Attorney-General –
- (a) the coroner must not carry out any investigations or perform any duties or functions under this Act in respect of the remains; and
- (b) the Aboriginal organisation must, as soon as practicable after the matter is referred to it, investigate the remains and prepare a report for the coroner.
- (4) If the Aboriginal organisation in its report to the coroner advises that the remains are Aboriginal remains, the jurisdiction of the coroner under this Act in respect of the remains ceases and this Act does not apply to the remains.
- (5) If the Aboriginal organisation in its report to the coroner advises that the remains are not Aboriginal remains, the coroner may resume the investigation in respect of the remains.<sup>2402</sup>

These provisions were designed to ensure that proper respect is given to Aboriginal beliefs, law and custom<sup>2403</sup> and are supplemented by protocols developed in

<sup>&</sup>lt;sup>2400</sup> In New South Wales a coroner does not have jurisdiction to hold an inquest concerning a death or suspected death unless it appears to the coroner that, or that there is reasonable cause to suspect that, the death or suspected death occurred *within the last 100 years* (emphasis added): *Coroners Act 1980* (NSW) s13B.

<sup>&</sup>lt;sup>2401</sup> See Aboriginal Affairs Victoria, *Submission no. 80*, attachment 2, 'Protocol for Management of Aboriginal Skeletal Remains by the Coronial Services Centre'; State Coroner's Office, *Submission no. 70*, Appendix C1i, 'Protocol for Management of Skeletal Remains'.

<sup>&</sup>lt;sup>2402</sup> Coroners Act 1995 (Tas) s 23.

conjunction with the Tasmanian Aboriginal Land Council governing discoveries of human remains suspected to be of Aboriginal origin.<sup>2404</sup>

The Queensland Act also makes express provision for the treatment of Indigenous remains. In Queensland a coroner must stop investigating a death if 'the coroner's investigation shows that the body is Indigenous burial remains'. Under the legislation the Coroner is also required to issue guidelines designed to ensure best practice in the coronial system, and these guidelines must 'deal with investigations of deaths involving human remains found in a suspected traditional burial site, and in particular, must provide for the early notification and involvement of the Aboriginal or Torres Strait Islander community having a connection with the burial site'. 2406

#### **Aboriginal Heritage Act 2006**

The Committee notes that a new legislative regime has been enacted with respect to Aboriginal heritage protection in Victoria. Changes to the Commonwealth legislation proposed by the Aboriginal and Torres Strait Islander Heritage Protection Amendment Bill will repeal Part 11A to enable the Victorian Government to administer Aboriginal heritage protection directly through its own legislation. In Victoria, the *Aboriginal Heritage Act 2006* repeals the *Archaeological and Aboriginal Relics Preservation Act 1972* and establishes the new regime for protecting Aboriginal cultural heritage. This includes the establishment of the Victorian Aboriginal Heritage Council, which will advise the minister in relation to Aboriginal cultural heritage matters. Under the new regime Aboriginal parties can apply to the council to be registered as cultural heritage decision makers for an area.

Registered Aboriginal parties will be responsible for protecting and maintaining Aboriginal places and objects of cultural significance within their area, through establishing cultural heritage management plans, advising on heritage permits, entering into heritage agreements and negotiating the repatriation of Aboriginal human remains.<sup>2408</sup>

The *Aboriginal Heritage Act 2006* states clearly that nothing in it affects the operation of the *Coroners Act 1985.*<sup>2409</sup> However, Part 2, Division 2, of the new legislation deals

<sup>&</sup>lt;sup>2403</sup> Tasmania, *Parliamentary Debates*, Legislative Assembly, 5 October 1995, 71 (Braddon Cornish, Minister for Justice).

<sup>&</sup>lt;sup>2404</sup> The protocols were signed on 6 June 2002 by the Chief Magistrate, the State Forensic Pathologist, the Commissioner of Police and the Tasmanian Aboriginal Land Council: *Tasmanian Magistrates Court Annual Report* 2002–2003, 83.

<sup>&</sup>lt;sup>2405</sup> Coroners Act 2003 (Qld) s 12.

<sup>&</sup>lt;sup>2406</sup> Coroners Act 2003 (Qld) s 14.

<sup>&</sup>lt;sup>2407</sup> Explanatory Memorandum, Aboriginal and Torres Strait Islander Heritage Protection Bill 2005 (Cth) 4.

<sup>&</sup>lt;sup>2408</sup> John Thwaites, Minister for Environment, Aboriginal Heritage Bill (Vic), Second Reading Speech, 6 April 2006, 1033.

<sup>&</sup>lt;sup>2409</sup> Aboriginal Heritage Act 2006 s 9.

with 'Aboriginal Human Remains'. The provisions include a requirement that any person who knows of the existence and location of human remains and knows that these are likely to be Aboriginal human remains must report the existence of the remains to the Secretary of the Department of Victorian Communities.<sup>2410</sup> Following receipt of such a report, the Secretary must:

after taking reasonable steps to consult with any Aboriginal person or body the Secretary believes may have an interest in the Aboriginal human remains, determine the appropriate course of action to be taken in relation to the remains.<sup>2411</sup>

If the remains are not part of or contained within an Aboriginal place, they must be transferred to the Secretary, who must then transfer them to an Aboriginal person or registered Aboriginal party that the Secretary is satisfied is entitled to, and willing to take possession, custody or control of the remains.<sup>2412</sup> If there are no such persons or parties, the Secretary must deal with the remains in accordance with the reasonable directions of the Aboriginal Heritage Council,<sup>2413</sup> or in any other case transfer the remains to the Museums Board for safekeeping.<sup>2414</sup>

#### **Evidence received by the Committee**

AAV provided the Committee with a summary of the key issues in relation to the management of Indigenous burial remains.<sup>2415</sup> At present the Act does not address the treatment of Indigenous burial remains directly. However, the following provisions are particularly relevant to the treatment of Aboriginal remains: under the Act the State Coroner has a responsibility to ensure that all reportable deaths reported to a coroner are investigated;<sup>2416</sup> a person who has reasonable grounds to believe that a reportable death has not been reported must report it as soon as possible to a coroner or the officer in charge of a police station, who in turn must inform the State Coroner as soon as possible;<sup>2417</sup> and a person who reports a death (and any police officer who has relevant information) must give the investigating coroner any information which may help the investigation.<sup>2418</sup>

These provisions form the basis for advice that AAV provides to land developers, heritage consultants and decision makers (such as local government) in relation to projects that may result in the discovery of Indigenous burial remains. Its advice is

<sup>&</sup>lt;sup>2410</sup> Aboriginal Heritage Act 2006 s 17.

<sup>&</sup>lt;sup>2411</sup> Aboriginal Heritage Act 2006 s 18(2).

<sup>&</sup>lt;sup>2412</sup> Aboriginal Heritage Act 2006 s 20(a).

<sup>&</sup>lt;sup>2413</sup> Aboriginal Heritage Act 2006 s 20(b).

<sup>&</sup>lt;sup>2414</sup> Aboriginal Heritage Act 2006 s 20(c).

<sup>&</sup>lt;sup>2415</sup> Aboriginal Affairs Victoria, Submission no. 80.

<sup>&</sup>lt;sup>2416</sup> Coroners Act 1985 s 7.

<sup>&</sup>lt;sup>2417</sup> Coroners Act 1985 s 13.

<sup>&</sup>lt;sup>2418</sup> Coroners Act 1985 s 14.

frequently incorporated into the terms and conditions of planning and land development permits, and states that:

- if any suspected human remains are found, work in the area must cease and either the police or the Coroner's Office must be informed without delay; and
- if there are reasonable grounds to believe that the remains are Aboriginal remains, then the reporting requirements of the *Aboriginal and Torres Strait Islander Heritage Protection Act 1984* (Cth) also apply, and the remains should be reported to the Victorian Minister for Aboriginal Affairs. (In practice, reports in compliance with the Commonwealth Act are usually made to AAV, directly or via a 24-hour emergency contact telephone number.)

AAV states that the above procedures have helped to address previous problems in relation to the discovery of Indigenous burial remains, such as uncontrolled excavation and removal of remains without consideration for their potential cultural or historical significance, insensitive treatment of remains (including publication of photographs in the press), incorrect assumptions about the Aboriginality and antiquity of the remains, and lengthy delays before discoveries are reported to AAV and relevant Aboriginal communities.

However, AAV submitted that the advice it provides for managing discoveries of suspected human remains relies on an interpretation of the definition of 'reportable death' in the Act which is broad enough to accommodate reporting of human remains that may also be 'relics' under the *Archaeological and Aboriginal Relics Preservation Act 1972* (Vic) (although this has now been repealed)<sup>2419</sup> and 'Aboriginal remains' under the *Aboriginal and Torres Strait Islander Heritage Protection Act 1984* (Cth).<sup>2420</sup> AAV submitted that, if this interpretation is correct, the Act as currently drafted can support the established procedures for effective identification and management of Indigenous burial remains. However, given the importance of newly discovered remains to Aboriginal communities, the Committee considers that this important issue should be provided for expressly in the Act.

VALS provided the Committee with a supplementary submission dealing specifically with the question of Indigenous burial remains.<sup>2421</sup> That submission expressed the concern that the existing State Coroner's protocol transfers responsibility for burial remains to AAV ahead of Indigenous Australians. VALS submitted that there is growing distrust in the Indigenous Australian community of the handling of heritage

<sup>&</sup>lt;sup>2419</sup> The Committee notes that since receiving AAV's submission, the *Archaeological and Aboriginal Relics Preservation Act 1972* (Vic) has been repealed by the *Aboriginal Heritage Act 2006*, which refers to 'Aboriginal human remains', as discussed earlier.

<sup>&</sup>lt;sup>2420</sup> However, as noted earlier, changes to the Commonwealth legislation proposed by the Aboriginal and Torres Strait Islander Heritage Protection Amendment Bill 2005 will repeal Part 11A to enable the Victorian Government to administer Aboriginal heritage protection directly through its own legislation.

<sup>&</sup>lt;sup>2421</sup> Victorian Aboriginal Legal Service, Submission no. S571.

matters by AAV and stated that this distrust has been influenced by the Aboriginal Heritage Bill, which has been criticised as decreasing the authority of Indigenous Australians to make decisions in relation to their own cultural heritage.

VALS is concerned that the State Coroner's protocol does not make it clear that AAV will involve the Indigenous community when burial remains are discovered or that Indigenous Australians have any decision making power. VALS submitted that Indigenous Australians should be involved at an early stage and given decision making, investigation and management powers when Indigenous remains are discovered. It is unsatisfactory, according to VALS, for Indigenous Australians to have to rely on the goodwill of AAV to notify them of the remains. Positioning AAV as the middle man between the coroner and the Indigenous community creates a power imbalance as well as an inefficient line of communication.

Accordingly, VALS submitted that the model in the Tasmanian *Coroners Act 1995* could be adopted, where the coroner refers the matter to an Aboriginal organisation approved by the Attorney-General. VALS prefers this model, in which the investigation is performed not by the coroner but by the Aboriginal community, which prepares a report for the coroner.

In relation to the Queensland model, VALS believed that Indigenous Australians are not involved early enough in the process. While the legislation prescribes that guidelines be issued providing for the 'early notification and involvement of the Aboriginal or Torres Strait Islander community', the guidelines themselves give initial responsibility to the Department of Natural Resources and Mines, which then liaises with the appropriate Aboriginal or Torres Strait Islander community in relation to reburial and management of the remains.

Finally, VALS submitted that, if its suggestions were not adopted and the notification of burial remains comes from AAV, the requirement should at least be prescribed in the legislation 'to ensure accountability of AAV to the Indigenous Australian Community'. The Committee notes that this concern has been addressed to an extent by the *Aboriginal Heritage Act 2006* referred to above, which requires the Secretary to 'take reasonable steps to consult with any Aboriginal person or body the Secretary believes may have an interest in the Aboriginal human remains' before determining the appropriate course of action. An additional notification requirement in the *Coroners Act 1985* would conflict with or duplicate the above provision, and therefore it may not be appropriate.

#### Discussion and conclusion

The Committee considers that Victoria should follow Tasmania and Queensland by providing for the proper treatment of Indigenous remains in the Act. The Tasmanian

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<sup>&</sup>lt;sup>2422</sup> Ibid 4.

<sup>&</sup>lt;sup>2423</sup> Aboriginal Heritage Act 2006 s 18(2)(b).

approach seems preferable, in that it sets out prescribed procedures rather than referring to guidelines. However, the Committee has some reservations regarding the wording of the Tasmanian provision, whereby 'as soon as a coroner suspects' that remains may be Aboriginal that coroner loses his or her jurisdiction. The Queensland test — whether 'the coroner's investigation shows' that the remains could be Indigenous — retains a better balance between the need to ensure that the death was not a homicide and the need to avoid unnecessary disturbance of Indigenous burial remains.<sup>2424</sup>

VALS submitted that the Act should be amended to require the coroner to transfer control of Indigenous burial remains directly to an Aboriginal organisation approved by the Attorney-General, as is the case in Tasmania. However, the Committee is concerned that such an approach would be inconsistent with the provisions of the recently enacted *Aboriginal Heritage Act 2006* that require persons who know of the existence and location of Aboriginal human remains to report this information to the Secretary of the Department of Victorian Communities. Accordingly, the Committee's view is that the Act should be amended to incorporate the State Coroner's protocol, thus retaining the existing procedure of initially notifying and liaising with the Department for Victorian Communities. Such amendments would need to be consistent with the provisions of Part 2, Division 2, of the *Aboriginal Heritage Act 2006*.<sup>2426</sup>

Recommendation 112. That the *Coroners Act 1985* be amended to incorporate the procedures contained in the existing State Coroner's protocol in relation to the management of Indigenous burial remains, subject to any amendments necessary to achieve consistency with the provisions of Part 2, Division 2, of the *Aboriginal Heritage Act 2006*.

# The need for legal representation and advice

In this section of the chapter the Committee discusses the need for, and availability of, legal representation for families in relation to coronial matters. The issue is explored, first, in relation to the right of the senior next of kin to object to an autopsy and, second, in relation to representation of families at inquests.

<sup>&</sup>lt;sup>2424</sup> Cf the language used in New South Wales, where a coroner does not have jurisdiction to hold an inquest concerning a death or suspected death *unless it appears to the coroner that, or that there is reasonable cause to suspect that* (emphasis added) the death or suspected death occurred within the last 100 years: *Coroners Act 1980* (NSW) s13B.

<sup>&</sup>lt;sup>2425</sup> Aboriginal Heritage Act 2006 s 17.

<sup>&</sup>lt;sup>2426</sup> For example, while the protocol refers to Aboriginal Affairs Victoria, the new *Aboriginal Heritage Act 2006* requires Aboriginal remains to be reported to the Secretary of the Department for Victorian Communities.

# Objection to autopsy and the ability of families to access legal advice outside business hours

The ability to access legal advice outside business hours, particularly on weekends, is an important issue for families in relation to objections to autopsy. This is because of the short period of time within which a senior next of kin may object to an autopsy under section 29 of the Act. However, currently there is no 24-hour telephone service in Victoria to provide people with legal advice in relation to coronial matters.

#### **Evidence received by the Committee**

Given the urgency with which legal advice in relation to autopsies is required, during the public hearings the Committee asked the Law Institute of Victoria (LIV) whether it could suggest a means of providing such advice. LIV has told the Committee informally that it is not in a position to coordinate or fund such a service, given its current resources. LIV stated that it has a referral service which operates only during business hours, and it suggested that a family could perhaps obtain after-hours advice from the Office of the Public Advocate.

LIV also suggested at the public hearings that it may be possible for the VCAT 24-hour telephone advice service to be expanded to provide advice in relation to autopsies. That service frequently provides after-hours advice in relation to decisions by a hospital to cease treatment of a patient, where the patient's family does not agree with the medical opinion. LIV alternatively suggested that the Committee consider recommending that funding be provided to an appropriate organisation, such as Victoria Legal Aid or the Federation of Community Legal Centres to establish and operate a 24-hour, seven-days-per-week telephone advice service for coronial matters.<sup>2428</sup> The Committee considers that the VCAT service would be a more appropriate alternative, given that it is an existing service with experience in providing after-hours legal advice in comparably urgent circumstances.

The Committee was particularly concerned by the evidence of one witness to the inquiry, Ms Smith, in relation to her lack of access to legal information concerning autopsy objections. Ms Smith had experienced the death of two or her sons in separate road accidents in rural Victoria. She told the Committee that, following the death of her eldest son, she was told plainly yet incorrectly by both clergy and the police that she had no right of appeal against the autopsy process. Following the death of her second son, she objected to the performance of an autopsy, but felt that the circumstances were managed badly by police and coronial staff. She stated that the police had given her appeal forms but no information that explained the appeal process or the consequences of an appeal. The result of her objection was that the pathologists would not examine the body for 48 hours, which was a cause of great

<sup>&</sup>lt;sup>2427</sup> Email, Joanne Kumrow, Administrative Law and Human Rights Section Lawyer, Law Institute of Victoria, to Committee Legal Research Officer, 23 January 2006.

<sup>&</sup>lt;sup>2428</sup> Ibid.

distress in relation to the funeral arrangements. Withdrawing the appeal required a written statement, which was an extremely difficult task for the family to carry out at a stressful and traumatic time.

Ms Smith told the Committee that she did not receive the coroner's information booklet in either of the two cases, which she subsequently read and described as 'a great booklet'.<sup>2429</sup> She commented that, since both deaths happened at the beginning of weekends, it would not have helped her to have the booklet sent by post. Her recommendation was that information regarding objections to autopsy should be available from a range of places, such as funeral homes, hospitals and police stations.

#### Discussion and conclusion

The Committee considers that families should be able to access legal advice explaining their rights in relation to autopsies, and be able to do so after hours and on weekends. The Committee's view is that the State Government should consider whether the existing VCAT 24-hour telephone advice service could be adapted for this purpose.

The Committee also considers that the information booklet *The Coroner's Process: Information for Family and Friends* should be distributed and available more widely than it is now, as recommended later in this chapter.<sup>2430</sup>

In addition, the Committee considers that the booklet should be supplemented by a legal information kit that explains the legal rights of families in relation to coronial matters. The Committee's view is that the kit should be prepared by the Coroner's Office in conjunction with VIFM, published on the Coroner's Office website, and distributed widely in hard copy to relevant agencies and persons including police stations, funeral homes, hospitals, nursing homes, hospices, community legal centres and religious institutions. The material should include a form which can be used by people who wish to object to an autopsy. Finally, the information should also be available in languages other than English.

Recommendation 113. That the existing Victorian Civil and Administrative Appeals Tribunal telephone service be expanded to provide after-hours legal advice for next of kin on how to object to an autopsy.

Recommendation 114. That the State Coroner's Office, in conjunction with the Victorian Institute of Forensic Medicine:

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<sup>&</sup>lt;sup>2429</sup> Carol Smith, *Minutes of Evidence*, 22 August 2005, 21.

<sup>&</sup>lt;sup>2430</sup> See below, under the heading, 'The need for families to be notified about available counselling'.

- a) develop, in addition to the booklet The Coroners Process: Information for Family and Friends, a separate legal information kit which explains the legal requirements for objections to autopsies, the rights of families in relation to coronial investigations, the rules and procedures relating to inquests, and other legal and practical information relevant to persons affected by a coronial death investigation;
- b) publish the legal information kit on its website;
- c) distribute the legal information kit to a wide range of relevant agencies and persons, including police stations, funeral homes, hospitals, nursing homes, hospices, community legal centres and religious institutions;
- d) ensure that the legal information kit includes a hard copy and a downloadable form which can be used by people who wish to object to an autopsy; and
- e) make the information available in languages other than English.

### Representation at inquests

As discussed in chapter five, under the Act a person with a sufficient interest may appear at an inquest, or be represented by a lawyer or, with the permission of the coroner, any other person. However, the Act does not require the coroner to inform family members that they are entitled to obtain such representation.<sup>2431</sup>

## Law reform agencies

The RCADC made the following comment in its report:

It is a trite observation that the possession of any legal right, such as the right to representation, is meaningless unless it can be exercised.<sup>2432</sup>

In relation to deaths in custody, the RCADC recommended that the family should be entitled to legal representation at the inquest and that the (federal) government should pay the reasonable costs of such representation through legal aid schemes or otherwise.<sup>2433</sup>

In England, the Luce Report made the following observation:

We have had a considerable number of representations to the effect that it is unfair to a family if, for example, at an inquest into a hospital death, the NHS [National Heath Service] Trust is

<sup>&</sup>lt;sup>2431</sup> Coroners Act 1985 s 45(3).

<sup>&</sup>lt;sup>2432</sup> Royal Commission into Aboriginal Deaths in Custody, *National Report* (1991) vol 1, para 4.6.45.

<sup>&</sup>lt;sup>2433</sup> Ibid, Recommendation 23.

represented by a barrister or solicitor paid for from the NHS budget but the family is on its own.<sup>2434</sup>

The report recommended that an inquest should, so far as possible, be conducted in a style that is accessible to unrepresented lay people and that the current criteria for granting legal aid be broadened.<sup>2435</sup>

## **Evidence received by the Committee**

[L]egal representation is absolutely crucial. We have seen over and over again the quality of investigations, inquests and findings being raised by the involvement of appropriate legal representation asking the right questions, digging a little further and raising the right issues.<sup>2436</sup>

Many witnesses considered that the findings from a coronial inquest may not reflect the facts surrounding a death if a family is not legally represented. Witnesses were particularly concerned about legal representation at inquests where the conduct of a well-funded organisation was at issue; for example, inquests into deaths in hospitals. The Committee heard that families who could not afford to be represented often felt intimidated at inquests by teams of senior barristers representing the interests of hospitals, doctors, insurers and the Department of Human Services.<sup>2437</sup> Families were frustrated by this disparity in legal representation, which they considered resulted in distortions of the truth designed to protect certain parties from future claims of negligence and medical malpractice. For example, Mr and Mrs Kaufmann told the Committee:

We felt this battery of barristers (trained in the adversarial system) went against the spirit of the inquiry...It was clearly visible that the barristers were defending their client's actions or inactions rather than trying to get to the truth.<sup>2438</sup>

Similarly, at the inquest into the death of her mother in a nursing home, Ms Lynette King was disappointed with the 'so-called' evidence presented to the inquest by lawyers for the facility. She told the Committee that, in hindsight, she would have engaged legal representation to probe the circumstances surrounding the death more fully.<sup>2439</sup>

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<sup>&</sup>lt;sup>2434</sup> United Kingdom, *Death Certification and Investigation in England, Wales and Northern Ireland: The Report of a Fundamental Review*, Cm 5831 (2003) 147. Available at

www.official-documents.co.uk.

<sup>&</sup>lt;sup>2435</sup> Ibid 148.

<sup>&</sup>lt;sup>2436</sup> P Spencer, Federation of Community Legal Centres, *Minutes of Evidence*, 19 September 2005, 114.

<sup>&</sup>lt;sup>2437</sup> See for example Graeme Bond, *Minutes of Evidence*, 22 August 2005, 4.

<sup>&</sup>lt;sup>2438</sup> David and Margrit Kaufmann, Submission no. 71, 6.

<sup>&</sup>lt;sup>2439</sup> Lynette King, Submission no. 3.

Indeed, the Committee heard evidence from some families who were able to afford legal representation and chose to do so at great personal expense to ensure that their concerns were heard by the investigating coroner.2440 However, an important issue in relation to legal representation, aside from the issue of cost, is that in many cases family members are not made aware of their right to be legally represented at an inquest.<sup>2441</sup>

A number of family witnesses were disappointed with the unrestrained adversarial nature of the proceedings at inquests. The Committee heard that in some cases lawyers representing hospitals attempted to cast aspersions on the treatment of the person who died by that person's own family. For example, the Committee heard that, at the inquest into the death of her daughter from suicide following discharge from a hospital, Ms Storm was cross-examined for three hours by the hospital's barrister and a theme of the questions was:

If you knew she was so ill, why didn't you save her?2442

Similarly, Mr Graeme Bond told the Committee that, at the inquest into his son's death, barristers for the hospital and doctors sought to shift the blame for the death onto Mr Bond and his ex-wife by implying a lack of cooperation between them in getting their son admitted to hospital. These barristers spoke consistently of internecine conflict between Mr Bond and his ex-wife, despite there being no evidence from any witness at the inquest of any such conflict.<sup>2443</sup> Mr Bond stated:

They mocked our grief and the coroner let it happen.<sup>2444</sup>

The Committee considers that such events are highly unsatisfactory in terms of human rights and natural justice. An issue discussed during the public hearings was whether such combative hearings, and the disparity in legal representation that occurs at them, could be overcome by having inquests that were more inquisitorial than adversarial in nature. Witnesses from the Springvale Monash Legal Service (SMLS) suggested that to create a more inquisitorial system would require specialist accredited lawyers with sufficient training enabling them to engage in a different style of practice at inquests, in contrast to their practice in the courts. It was suggested that such lawyers might be able to facilitate the transparency required to prevent future deaths, instead of taking an over-defensive and adversarial approach to the issues raised by other parties.<sup>2445</sup> However, the SMLS considered that it would not be feasible to promote an inquisitorial atmosphere at inquests by simply prohibiting the presence

<sup>&</sup>lt;sup>2440</sup> See for example Caroline Storm, *Minutes of Evidence*, 22 August 2005, 16.

<sup>&</sup>lt;sup>2441</sup> See for example Myndscape Consulting, Review of the Coroner's Act 1985: Final Report, March 2006, 70.

<sup>&</sup>lt;sup>2442</sup> Caroline Storm, *Minutes of Evidence*, 22 August 2005, 12.

<sup>&</sup>lt;sup>2443</sup> Graeme Bond, *Minutes of Evidence*, 22 August 2005, 5.

<sup>&</sup>lt;sup>2444</sup> Ibid 3.

<sup>&</sup>lt;sup>2445</sup> D Taylor and B Hodgson, Springvale Monash Legal Service, *Minutes of Evidence*, 20 September 2005, 141–2.

of legal representatives, as they have an essential probative role in the fact-finding process.<sup>2446</sup>

Witnesses gave many examples of situations where the availability to families of legal representation had a substantial impact on the outcome of an investigation. For instance, the Committee heard evidence from Brimbank Melton Community Legal Centre (BMCLC) in relation to the investigation into the fatal shooting of Gary Whyte by a prison guard in May 2002.<sup>2447</sup> Mr Whyte had been remanded on burglary charges and was receiving medical treatment at St Vincent's Hospital. He was unarmed and handcuffed when he was shot while trying to escape from custody. The prison officer was discharged at committal in November 2003, as the magistrate essentially accepted that he had acted in self-defence. BMCLC submitted that the prosecution had not made its case satisfactorily at the committal and thus the charges had been 'thrown out'.

At the subsequent coronial inquest, BMCLC represented Mr Whyte's wife and children, and Victoria Legal Aid represented his mother. In January 2005 Coroner Byrne delivered findings to the effect that Whyte presented no real or immediate threat to the prison guard and that the escape could have been prevented easily without the use of a firearm. A short time after the inquest Corrections Victoria released an amended version of its firearms policy. BMCLC argued that this case demonstrates how important it is for a family to be represented at an impartial coronial investigation. The family sought the truth and was able to have the assistance of senior counsel, who extracted critical evidence through cross-examination of the prison officer's partner. It was the view of BMCLC that the hearing resulted in significant findings of fact that would not have been achieved if the family had not had proper legal representation.

Thus the need for legal representation for families can be met in some cases if the coroner grants standing to public interest intervenors at inquests. Witnesses from community legal centres observed that there are many organisations with specialist knowledge about areas such as psychiatric care and incarceration which can provide useful information to an inquest. For example, the Committee heard that, during the inquest into the Kew Cottages fire, the Villamanta Legal Service provided a wealth of knowledge in relation to intellectual disability which assisted the coroner in examining a very difficult area.<sup>2448</sup> The Federation of Community Legal Centres pointed out that the test for standing under the Act is not a public interest test but a sufficient interest test and that therefore the standing of such persons to appear depends on a liberal interpretation of the sufficient interest test by the coroner.<sup>2449</sup> An example of the problems this may cause was given by the SMLS: it had made a submission at a

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<sup>&</sup>lt;sup>2446</sup> D Taylor, Springvale Monash Legal Service, *Minutes of Evidence*, 20 September 2005, 142.

<sup>&</sup>lt;sup>2447</sup> H de Kretser, Brimbank Melton Community Legal Centre, *Minutes of Evidence*, *19 September 2005*, 109.

<sup>&</sup>lt;sup>2448</sup> P Spencer, Federation of Community Legal Centres, *Minutes of Evidence*, 19 September 2005, 114.

<sup>&</sup>lt;sup>2449</sup> C Singh, Federation of Community Legal Centres, *Minutes of Evidence*, 19 September 2005, 116.

recent inquest only to find that the coroner could not take it into account in making his findings, on the basis that the SMLS did not have sufficient interest. The SMLS told the Committee that it would assist the coronial investigation process if special interest groups and others with valuable information were able to participate.<sup>2450</sup>

In light of the discussion above, it is not surprising that many witnesses considered that adequate funding should be provided for legal representation, particularly at inquests where government agencies and departments are represented at taxpayer expense:

The right to legal representation is important. Currently the taxpayer is often funding a cover-up. DHS and the hospitals and doctors employ barristers and solicitors whose purpose there is to deflect any criticism and blame from the system. Families are left to fund a case that is actually serving the public interest by seeking to expose systemic failures. This is perverse and unconscionable.<sup>2451</sup>

Accordingly, various witnesses suggested to the Committee that additional funding should be provided to VLA and that its criteria for granting legal aid for coronial inquests should be broadened.<sup>2452</sup> In its submission VLA stated that its current guidelines provide for assistance at coronial inquests if:

- a) there is a reasonable likelihood that the applicant will be charged with a serious offence, for example murder, manslaughter or culpable driving; or
- b) it is in the public interest for the applicant to be represented. <sup>2453</sup>

VLA stated that, due to funding constraints, it has been obliged to adopt a narrow construction of 'public interest'. In 2003–04 VLA funded legal representation in 23 inquests, out of 37 677 grants for legal representation in that year. VLA supports the RCADC's recommendation that the federal government provide additional funding to enable the current criteria for granting aid to be broadened. VLA noted that other State legal aid commissions already have broader criteria. For example, in NSW legal aid may be granted where the inquest relates to deaths in prisons, mental hospitals, child care centres, community welfare centres, juvenile detention centres or police custody.

However, several witnesses suggested to the Committee that, even where legal representation is made available through funding by Legal Aid or organisations such as the Public Interest Law Clearing House, it is unlikely to match the seniority and

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<sup>&</sup>lt;sup>2450</sup> P Giliberto, Springvale Monash Legal Service, *Minutes of Evidence*, 20 September 2005, 138.

<sup>&</sup>lt;sup>2451</sup> Graeme Bond, *Minutes of Evidence*, 22 August 2005, 4.

<sup>&</sup>lt;sup>2452</sup> See for example Jason Rosen, *Submission no. 79*, 29.

<sup>&</sup>lt;sup>2453</sup> Victoria Legal Aid, Submission no. 34.

<sup>&</sup>lt;sup>2454</sup> Ibid 2 and 7.

experience of legal representation for large organisations such as hospitals and government departments.<sup>2455</sup>

Another possible solution proposed to the Committee during the public hearings was the appointment of one or more permanent counsel at the Coroner's Office whose role is to represent the interests of families at inquests. Mr Jack Forrest QC, representing the Victorian Bar, told the Committee that the problem of inequality of legal representation referred to by many of the family witnesses might be solved by the availability of a competent permanent counsel. Mr Forrest said that the Victorian Bar would endorse such a proposal.<sup>2456</sup>

Finally, in spite of all the difficulties referred to above, the Committee notes the observation by Associate Professor Ranson that, in his experience, the State Coroner takes great pains to counteract the effects of inequality of legal representation and will assist unrepresented individuals wherever possible.<sup>2457</sup>

### Consultants' research findings

An important theme emerging from the research is that most lay participants in an inquest felt that they were not adequately prepared for 'the day in court', with very little information provided to them before the actual hearing. Participants were therefore unaware of the court process and, as a result, found the process extremely daunting. Most participants would have appreciated information before the day, including the opportunity to visit the courtroom to gain a feel for the process and an idea of what to expect. Given the lack of such information, it is not surprising that several participants felt confused, anxious, helpless and utterly unprepared during the proceedings. Many participants were not aware of their rights in the courtroom and several could not understand the legal terminology. Some participants also commented that having the hearing in a courtroom did not lend itself to the coronial process, which is not adversarial in nature.<sup>2459</sup>

Another key finding in relation to participants' experiences at inquests relates to legal representation on the day of the hearing. Despite their right to representation, most participants were not represented by a lawyer or aware that they had the right to engage legal representation. Most felt that having legal representation would have been helpful not in an adversarial sense but in order to provide information on courtroom proceedings and family rights during the inquest, as well as interpret legal

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<sup>&</sup>lt;sup>2455</sup> See for example Maurice Blackburn Cashman, *Submission no. 42*, 11.

<sup>&</sup>lt;sup>2456</sup> Jack Forrest, Victorian Bar, *Minutes of Evidence*, 5 December 2005, 287.

<sup>&</sup>lt;sup>2457</sup> David Ranson, Submission no. 19, 44.

<sup>&</sup>lt;sup>2458</sup> The Committee notes that, unlike in some other jurisdictions, in Victoria the legislation does not establish a coronial court.

<sup>&</sup>lt;sup>2459</sup> The Committee refers to the physical location of inquests (eg magistrates courts in rural areas) in chapter 5.

<sup>&</sup>lt;sup>2460</sup> Myndscape Consulting, Review of the Coroner's Act 1985: Final Report, March 2006, 47, 70.

terms and ensure that the family knew what was going on. Similar findings were made in UK research, which also suggests that families were unaware of their rights to legal representation. In the UK research participants suggested that there should be a right to representation funded by legal aid, since it would be unjust if some could afford representation and some could not.<sup>2461</sup>

#### Discussion and conclusion

The Committee considers that the availability of adequate legal representation in coronial matters is an important need for many families, and also for the community, in that a full examination of the circumstances surrounding a death facilitates the prevention of similar deaths in the future.

Legal representation at an inquest is also consistent with the principles of natural justice. Not all inquests will require representation for all parties for this to be achieved, but a problem arises when there is disparity in the representation of various parties.

The Committee acknowledges that some families may be unrepresented at an inquest because they are unable to afford legal representation or obtain legal aid. However, as the Victorian Bar observed in its submission, the problem is not easily solved without an increase in legal aid funding. The Committee notes that the current VLA guidelines are drafted carefully in light of widespread demand for funding in many areas of law, and that additional funding for coronial inquests, while desirable, may be unrealistic. VLA would require a substantial increase to its funding pool to justify broadening its guidelines in relation to coronial cases, which otherwise could only occur by narrowing the guidelines for other areas of law.

In limited circumstances family members may be able to take advantage of pro bono legal advice. However, due to the means tests, pro bono advice is available only if the family has insufficient means to afford private legal representation.<sup>2463</sup>

One suggestion in relation to the need for better legal representation for families is the appointment of a permanent counsel to represent the interests of families at inquests. The Committee's view is that such a proposal is unrealistic due to a range of practical and resource considerations. The Committee believes however that the feasibility of providing legal advice and assistance to families affected by a coronial investigation, where such advice or assistance is necessary to enable them to effectively participate in the investigation, should be investigated by the Government.

<sup>&</sup>lt;sup>2461</sup> Ibid 48, 70.

<sup>&</sup>lt;sup>2462</sup> Victorian Bar, Submission no. 81, 22.

<sup>&</sup>lt;sup>2463</sup> Pro bono schemes run by the Law Institute of Victoria and the Victorian Bar are means tested. The Victorian Government's 'Policy Guidelines for the Delivery of Pro Bono Services for an Approved Cause under the Government Legal Services Contract', issued in March 2003, specify that work performed for persons who would otherwise be able to afford to pay for the service is not considered to be pro bono work.

The Committee considers that a partial solution to the problems in this area is to increase the standing of specialist advocacy organisations to appear at inquests, as recommended by representatives from community legal centres and other witnesses. In chapter five the Committee discussed the issue of standing to appear at inquests and recommended that the Act be amended to define the test of 'sufficient interest' such that specialist advocacy organisations (for example, community legal centres) have standing in investigations and inquests, particularly where such agencies have expertise in relation to the subject of the inquiry.

Evidence from several witnesses suggested to the Committee that there is a need to ensure that families are informed that they have the right to be legally represented, however this is funded. As various witnesses have demonstrated, some families are prepared to make great financial sacrifices in order to exercise this right and have their concerns heard, while others do not know that they can do so. The Committee has already made a recommendation in this area under the heading 'Notification'.

Finally, research shows that it is important for families to have a degree of familiarity with the inquest process so that they know what will happen. The Committee acknowledges the assistance that is already provided in this area by the Counselling and Support Service at the Coroner's Office, volunteers from Court Network, and others.<sup>2464</sup> The Committee considers that this need should also be addressed by the development of a self-help legal information kit so that families are better prepared for the day of the inquest. The Committee has already recommended earlier in this chapter, in relation to autopsy objections, that such a kit be developed.

Recommendation 115. That the Government investigate the feasibility of providing legal advice and assistance to families affected by a coronial investigation where this is necessary to enable them to effectively participate in the investigation.

# **Privacy**

A Coroner's office is a source of much personal information. Much of it is health related, and much of it is delicate in other respects. A coroner collects and handles personal information about deceased persons as well as the living.<sup>2465</sup>

As discussed at the beginning of this chapter, privacy is a major source of concern for the family of a person whose death is the subject of a coronial investigation. Research in the UK as well as by consultants engaged by the Committee has found that breaches of privacy can add to the trauma of families involved in coronial matters.<sup>2466</sup>

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<sup>&</sup>lt;sup>2464</sup> The work of the Court Network Volunteers is discussed further below.

<sup>&</sup>lt;sup>2465</sup> Privacy Commissioner, Submission no. 60, 1.

<sup>&</sup>lt;sup>2466</sup> Lucy Biddle 'Public Hazards or Private Tragedies? An Exploratory Study of the Effect of Coroner's Procedures on Those Bereaved by Suicide' (2003) *Social Science & Medicine* 56, 1036; Myndscape Consulting, *Review of the* 

There is a strong public interest in protecting health privacy<sup>2467</sup> and in protecting the privacy of families against unwarranted intrusion in times of grief and distress.<sup>2468</sup>

Therefore, as part of this inquiry, the Committee considered whether to make recommendations for changes to the Act and the Regulations to govern the release of personal information (including health information) of dead and living persons which may be contained in coronial and medical files in a coroner's possession.

Earlier in this chapter the Committee discussed the rights of families to access information in a coroner's possession. As discussed, the legislation gives a coroner wide powers to release information in the coronial file. In this part of the chapter, the Committee examines the extent to which privacy laws and principles restrict, or ought to restrict, the release of information by a coroner. The Committee was assisted in this area by the submission of the Privacy Commissioner.<sup>2469</sup>

## Privacy of personal or health information

In Victoria the two relevant statutes are the *Information Privacy Act 2000* (IPA) and the *Health Records Act 2001* (HRA). The IPA sets standards for the responsible collection and handling of personal information in the Victorian public sector. These standards consist of 10 Information Privacy Principles (IPPs) contained in the schedule of the IPA and deal with collection, use, disclosure, storage, access to and destruction of personal information.

Unlike the HRA, the IPA does not protect information about persons who have died and only applies to information about living natural persons. Thus it potentially covers personal information about, for example, the family, relatives, employers and colleagues of the deceased person. It also potentially covers other persons involved in coronial processes associated with the person who died, such as medical personnel and police officers. The IPA does not protect health information, which is covered under complementary legislation, the HRA.

## Uncertain application of privacy legislation to the Coroner's Office

According to section 9, the IPA applies to the Coroner's Office as a body 'established for a public purpose by or under an Act',<sup>2470</sup> to coroners as 'persons holding an office or position established by or under an Act',<sup>2471</sup> and, insofar as the Coroner's Office constitutes 'a court or tribunal', it is expressly bound by the IPA under section 9(1)(h).

Coroner's Act 1985: Final Report, March 2006, 52. See also Health Services Commissioner, Minutes of Evidence, 20 September 2005, 182.

<sup>&</sup>lt;sup>2467</sup> See for example Re People First of Ontario v Niagara (Regional Coroner) 85 DLR (4<sup>th</sup>) 175, 196.

<sup>&</sup>lt;sup>2468</sup> Privacy Commissioner, *Submission no. 60*, 2.

<sup>&</sup>lt;sup>2469</sup> Privacy Commissioner, Submission no. 60.

<sup>&</sup>lt;sup>2470</sup> Information Privacy Act 2000 (Vic) s 9(1)(s).

<sup>&</sup>lt;sup>2471</sup> Information Privacy Act 2000 (Vic) s 9(1)(q).

However, section 10 of the IPA exempts from the application of the IPA, 'in relation to the exercise of its or his or her judicial or quasi-judicial functions', a court or tribunal, the holder of a judicial or quasi-judicial office, and the registry or other office (and the staff of such registry or other office) of a court or tribunal.

Thus, as the Privacy Commissioner has advised the Committee, a coroner, when carrying out coronial inquests and inquiries, is likely to be exempt from the IPA due to the judicial/quasi-judicial exemption contained in section 10 of the IPA. A similar exemption is contained in section 14 of the HRA.<sup>2472</sup>

However, there are some uncertainties regarding the jurisdictional nature of the coroner's functions. While the question of whether the coroner's role is administrative or judicial in nature is discussed in detail in chapter five of this report, a few points should be raised here.

Although the *Coroners Act 1985* does not establish a 'coroner's court' as a distinct entity, cases have regarded the coroner when conducting inquiries as constituting a court of record.<sup>2473</sup> However, the courts have expressed uncertainty on the issue of whether a coroner carries out a 'judicial function', as compared to an executive or ministerial function. Both the Privacy Commissioner and the Health Services Commissioner submitted to the Committee that this issue needs to be clarified in Victoria. The Health Services Commissioner stated that, for the purposes of administering the HRA, she requires the nature of the coroner's role to be clarified in relation to the exemption contained in section 14 as well as the purpose of statutory interpretation where there is an inconsistency between the Act and the HRA.<sup>2474</sup>

The Coroner's Office has published a privacy statement on its website, which states:

That the functions of the State Coroner's Office [...] when exercising jurisdiction under the Coroners Act 1985, are exempt in relation to their judicial or quasi-judicial functions (i.e. normal business operations).<sup>2475</sup>

However, this view is open to debate. In *Harmsworth v The State Coroner*, Nathan J took the view that, under the Act, coroners' powers are inquisitorial and not curial.<sup>2476</sup> Accordingly, Ms Heffey submitted that the coronial role is an administrative one.<sup>2477</sup> Indeed, while the Coroner's Office website refers in various places, such as the page

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<sup>&</sup>lt;sup>2472</sup> Victorian Privacy Commissioner, *Submission no. 60*, 1.

<sup>&</sup>lt;sup>2473</sup> Ibid. The Committee discusses this issue further in chapter 9.

<sup>&</sup>lt;sup>2474</sup> Health Services Commissioner, *Minutes of Evidence*, 20 September 2005, 178.

<sup>&</sup>lt;sup>2475</sup> www.couronerscourt.vic.au

<sup>&</sup>lt;sup>2476</sup> Harmsworth v The State Coroner [1989] VR 989, 992.

<sup>&</sup>lt;sup>2477</sup> Jacinta Heffey, Submission no. 33, 12.

of information about inquests, to the 'Coroner's Court', the Coroner's Office acknowledged in its submission that it is not a court.<sup>2478</sup>

#### Other Jurisdictions

The Privacy Commissioner suggested that, for the purpose of clarifying the application of privacy legislation to coronial functions, section 6 of the *Privacy and Personal Information Protection Act 1998* (NSW) is a useful model:

- (1) Nothing in this Act affects the manner in which a court or tribunal, or the manner in which the holder of an office relating to a court or tribunal, exercises the court's or the tribunal's judicial functions.
- (2) ...
- (3) In this section, "judicial functions" of a court or tribunal means such of the functions of a court or tribunal as relate to the hearing of determinations or proceedings before it, and includes:
  - (a) ...
  - (b) in relation to a coroner such of the functions of the coroner as relate to the conduct of inquests and inquiries under the Coroners Act 1980.

If section 10 of the IPA and section 14 of the HRA were amended to include similar provisions, that would clarify the application of the exemptions to coronial inquests and inquiries.

The Privacy Commissioner noted that section 6 of the IPA should also be considered in relation to the application of the privacy legislation to coronial functions. Section 6 provides that, where a provision of the IPA is inconsistent with a provision of another statute, the provision of the other statute overrides the IPA provision to the extent of any inconsistency. Those other statutes would include, for example, the *Coroners Act* 1985 and the *Public Records Act* (1973).

# Is personal or health information in a coroner's possession protected by the Act or the Regulations?

In contrast to the principles contained in the IPA and HRA, there are no comparable guidelines or principles in the Act which regulate the way coroners disseminate personal or health information contained in the coronial file or the hospital medical file which is in the possession of the Coroner's Office. The Act provides little guidance on managing access to records, leaving disclosure of medical and other records to the discretion of the coroner.

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<sup>&</sup>lt;sup>2478</sup> State Coroner's Office, Submission no. 70, 93.

Before the completion of an investigation or inquest, under section 45 of the Act a coroner has the power to make 'statements' available to any person that s/he considers has a sufficient interest.<sup>2479</sup> This is in contrast to broader powers in regulation 24 which allow a 'coroner's file' to be made available 'to such people or class of people as the coroner directs, before the inquest or investigation is completed',<sup>2480</sup> without any requirement for the person requesting access to demonstrate that they have a sufficient interest in the investigation.

After the completion of the investigation or inquest, regulation 24 provides that 'the coroner's record and file is to be open to public access unless the coroner orders otherwise'. All In practice this means that, at the end of a coronial investigation, medical records, autopsy reports, graphic death scene photographs and other such information are on the public record as part of the coronial file. Thus a member of the public can go to the Coroner's Office and access such information without needing to demonstrate a sufficient interest in the case.

Thus it appears that when a coroner is acting in a quasi-judicial capacity s/he is not only exempt from the privacy provisions in the *Information Privacy Act* and the *Health Records Act* but has broad unrestricted powers under the Regulations to release personal and health information.<sup>2483</sup> These powers include the power to release personal information to anyone the coroner directs, without the requirement that the person requesting access demonstrate that they have a sufficient interest to justify access to the information.

Further, as is the case with management of case files of courts and tribunals (for which provision is generally made in rules of procedure or practice notes), the management of records of coronial inquests is likely to be incidental to the carrying out of quasi-judicial functions by a coroner<sup>2484</sup> and therefore is not likely to be subject to regulation by the IPA.

The Federal Privacy Commissioner determined that records which contain information about the judicial function of a court including records containing litigants and court judgments are "judicial records". Whereas records which are of an administrative nature and over which the Commissioner has jurisdiction include personnel records, operations and financial records, freedom of information records, complaint files and mailing lists used to send judgments and other published material about the court. See also, *NZ v Attorney General's Department* [2005] NSWADT 103 in which the New South Wales Administrative Decisions Tribunal held that the handling of court files

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<sup>&</sup>lt;sup>2479</sup> Coroners Act 1985 s 45(1).

<sup>&</sup>lt;sup>2480</sup> Coroners Regulations 1996 reg 24(1).

<sup>&</sup>lt;sup>2481</sup> Coroners Regulations 1996 reg 24(2).

<sup>&</sup>lt;sup>2482</sup> Victorian Institute of Forensic Medicine, Submission no. 40, 13.

<sup>&</sup>lt;sup>2483</sup> See for example Elizabeth Kennedy, Royal Women's Hospital, *Minutes of Evidence*, *19 September 2003*, 100–4.

<sup>&</sup>lt;sup>2484</sup> See for example, *I v Commonwealth Agency* [2005] PrivCmrA 6. Available at http://www.austlii.edu.au/cases/cth/PrivCmrA/2005/6.html).

The Committee's view is that the current situation, in which the coroner has broad, unregulated powers to release personal and health information, is unsatisfactory. The Committee also agrees with the Privacy Commissioner's view that 'given the sensitivity that is often attached to information collected during a coronial inquiry, personal privacy should be expressly included in any statutory list of factors that must be considered by a coroner when handling requests for access by third parties'.<sup>2485</sup>

#### Other jurisdictions

In Queensland Part 3, Division 4, of the *Coroners Act 2003* contains detailed provisions which deal with the issue of privacy by prescribing the types of documents which cannot be accessed, including the following section:

- 52 Documents that can not be accessed
- (1) A coroner must not give a person access to an investigation document to the extent that the document
  - (a) is the subject of legal professional privilege; or
  - (b) contains information that is likely to -
    - (i) prevent a person from receiving a fair trial; or
    - (ii) prejudice the investigation of a contravention or possible contravention of the law;
    - (iii) enable the existence or identity of a confidential source of information, in relation to the enforcement or administration of the law, to be ascertained; or
    - (iv) prejudice the effectiveness of a lawful method or procedure for preventing, detecting, investigating or dealing with a contravention of the law; or
    - (vii) facilitate a person's lawful escape from custody; or
- (d) contains information about a living or dead person's personal affairs, including, for example, information about the person's health, unless the information is relevant to a matter mentioned in section 45(2);<sup>2486</sup> or

by a local court registry was a "judicial function". The Tribunal accepted the respondent's submission that the phrase should be interpreted broadly such that the function of giving access to documents of this kind, and to any personal information they may contain, is a function that "relates" to the exercise by the court of its judicial functions: Victorian Privacy Commissioner, *Submission no. 60*, 9.

<sup>&</sup>lt;sup>2485</sup> Victorian Privacy Commissioner, Submission no. 60, 3.

<sup>&</sup>lt;sup>2486</sup> Section 45 (2) of the *Coroners Act* 2003 (Qld) s 45(2) requires a coroner to determine who died; how, when and where the person died; and what caused the death.

(e) contains information that was obtained from a person under a requirement in another Act that compelled the person to give the information.<sup>2487</sup>

However, section 53 of the Queensland Act enables the State Coroner to consent to access to investigation documents by 'genuine researchers', provided that all information that identifies anyone is obliterated, unless (a) the person's identity is necessary for the research to be effective, and (b) the opportunity for increased knowledge to be gained from the research outweighs the need to protect the privacy of any living or dead person.<sup>2488</sup> Further, section 54 of the Queensland Act provides for access to documents for purposes other than research, with the consent of a coroner, where the person seeking access has a sufficient interest in the document in question (such as an immediate family member of the person who died).

In South Australia, the legislation contains restrictions on the divulging of information obtained in the coronial jurisdiction.<sup>2489</sup> The provisions are less detailed than those contained in the Queensland legislation.

#### Access to sensitive medical records attached to the coronial file

When a person dies at a hospital and the death is reported to the coroner, it appears that the usual practice is for the original hospital medical file to accompany the body to the morgue. If this is not possible, the hospital usually sends the file to the Coroner's Office as soon as is practicable or the police investigators request the file.<sup>2490</sup>

However, sometimes the coroner also has the medical files of living persons. Case examples include:

- the medical files of a woman who had a late-term abortion. Allegations were made that the foetus had been born alive. The matter was referred to a coroner who, in considering whether she had jurisdiction to investigate the 'death' of the foetus, <sup>2491</sup> accessed the woman's hospital file. This case will be discussed further below.
- neonatal deaths. Medical files of the surviving mother may be relevant to an investigation of the baby's death where there are questions concerning the medical treatment of the mother.

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<sup>&</sup>lt;sup>2487</sup> Coroners Act 2003 (Qld) s 52 (emphasis added).

<sup>&</sup>lt;sup>2488</sup> Coroners Act 2003 (Qld) s 53.

<sup>&</sup>lt;sup>2489</sup> Coroners Act 2003 (SA) s 34.

<sup>&</sup>lt;sup>2490</sup> Elizabeth Kennedy, Royal Women's Hospital, *Minutes of Evidence*, *19 September 2005*, 104. Cf William O'Shea, Bayside Health, *Minutes of Evidence*, *28 November 2005*, 214 and M Way, Austin Health, *Minutes of Evidence*, *28 November 2005*, 232.

<sup>&</sup>lt;sup>2491</sup> The Committee has discussed the issue of a coroner's jurisdiction in relation to stillbirth cases in chapter five.

- the medical files of a person with a psychiatric condition who may have caused the death of another person.
- the medical files of patients who have 'survived' a particular medical treatment in similar circumstances to those in the case the coroner is investigating; for example, over-prescription of a drug, which causes death or injury.<sup>2492</sup>

The disclosure of the medical files of both dead and living persons has the potential to cause considerable distress for family members and, in the case of living persons, the person themselves.

The potential for sensitive information to be disclosed via access to coronial files was illustrated by the controversy surrounding the State Coroner's 2001 release to Senator Julian McGauran of the hospital medical records of a woman who had a late-term pregnancy termination.<sup>2493</sup> The abortion, carried out in February 2000 at the Royal Women's Hospital, was performed on the 40-year-old woman because she was suicidal after learning that her baby may have skeletal dysplasia, or dwarfism.<sup>2494</sup>

After receiving a brief from the homicide squad (in relation to the foetus rather than the woman, who survived), coroner Heffey ruled that she had no jurisdiction to investigate because the case involved a stillbirth and not a death. While coroner Heffey was investigating whether there had been a death, in order to establish jurisdiction,<sup>2495</sup> the State Coroner released the medical file to Senator McGauran, who later provided extracts from the file to the media and tabled an extract of the file in the Federal Parliament. An article in *The Weekend Australian* described these events:

A police brief was prepared for the coroner, who used a discretionary power to rule the case beyond his jurisdiction: to investigate a death there must be a life...Before sealing the file, coroner Graeme Johnstone approved a request from McGauran for a copy of the police brief,

http://www.abc.net.au/stateline/vic/content/2005/s1400106.htm.

and ABC's Radio National transcript dated 29 June 2005, available at

http://www.abc.net.au/pm/content/2005/s1403433.htm.

See also, for example, Jamie Berry and Jesse Hogan 'Hospital Slams Abortion Files Ruling', *The Age* (Melbourne), 29 June 2005, available at http://www.theage.com.au/news/national/hospital-slams-abortion-files-ruling/2005/06/29/1119724672326.html; Kate Legge 'Hospital to Fight Abortion File Order', *The Australian,* (Sydney), 30 June 2005, 3; Catharine Munro, 'Coroner Hit Over Abortion Records', *The Age* (Melbourne) 20 March 2004, 1.

<sup>2495</sup> Coroner's Case No. 2107/00.

<sup>&</sup>lt;sup>2492</sup> *Grace v Saines (in his capacity as Coroner),* Supreme Court of Victoria, (Unreported, Williams J, 29 June 2004).

<sup>&</sup>lt;sup>2493</sup> See *Royal Women's Hospital v Medical Practitioners Board* [2005] VSC 225. See also, for example, transcript of Stateline Victoria's broadcast dated 1 July 2005, in which the Health Services Commissioner was interviewed about the release of the coronial information, available at

<sup>&</sup>lt;sup>2494</sup> Ibid.

which was handed over, private medical documents and all. A similar application by one of the doctors was rejected. McGauran was "surprised and delighted" at his trove and used it to lodge a formal complaint with the Medical Practitioner's Board.<sup>2496</sup>

The broad powers of the coroner to release information under Regulation 24, the lack of appropriate privacy principles in the Act, and the exemptions to the IPA and HRA outlined above, together explain how the State Coroner permitted Senator McGauran to access the woman's hospital medical records. To date the question of why the records were released has not been articulated. The Coroner's Office did not comment on the McGauran matter explicitly in its submission to the Committee. <sup>2497</sup>

LIV told the Committee that in response to this case it had called on the Attorney-General to draft strict guidelines, regulations or a code of practice to determine the circumstances in which court documents may be made available to the public.<sup>2498</sup> The State Government's response was that the Victorian Courts Consultative Committee was in the process of considering a protocol in relation to the release of court documents.

In his submission to the Committee, Associate Professor Ranson observed that the saga of Senator McGauran's accessing the coroner's file had demonstrated the importance and sensitivity of privacy issues in the coronial context. Associate Professor Ranson commented that in part the problems lay in the absence of clear guidance in the legislation with respect to whether the deaths of unborn children are reportable, as well as the absence of guidance as to the status of a coroner's case file in a death which, following initial investigation, has been determined not to lie within the coroner's jurisdiction.<sup>2499</sup>

Associate Professor Ranson submitted that public access to documents such as personal medical files contained in a coroner's file may be necessary in a variety of situations, but that such access should be authorised only by a coroner or in some situations only by the State Coroner.<sup>2500</sup> The decision should not be made as part of ordinary administrative office processes. Associate Professor Ranson commented that there is a real risk that uncontrolled access to coroner's files might cause harm to families in some cases, particularly where those files contain personal information about living persons. The need to limit such harm must however be weighed against the principle of open justice, which requires the deliberations of a court to be publicly accessible. For a coroner to be effective as a truly independent external death

<sup>&</sup>lt;sup>2496</sup> Kate Legge, 'Abortion Case a Kafkaesque Nightmare', *The Weekend Australian*, 26 March 2005, 1.

<sup>&</sup>lt;sup>2497</sup> However, the Committee notes that the State Coroner's Office has recommended that the definition of death in s 3 of the *Coroners Act 1985* be amended to exclude stillbirth: State Coroner's Office, *Submission no. 70*, 65.

<sup>&</sup>lt;sup>2498</sup> Law Institute of Victoria, Submission no. 58, 5.

<sup>&</sup>lt;sup>2499</sup> David Ranson, Submission no. 19, 73.

<sup>&</sup>lt;sup>2500</sup> Ibid.

investigator the results of a coroner's investigation as well as the information upon which the coroner's finding has been based needs to be in the public arena.

During the public hearings Ms Elizabeth Kennedy, corporate counsel for the Royal Women's Hospital, drew the Committee's attention to the fact that the Regulations are drafted more broadly than the Act in relation to the release of information. She observed that the Act gives a coroner a very limited ability to release information, whereas the Regulations allow a coroner a very wide discretion. Ms Kennedy submitted that in this respect the Regulations may be ultra vires, and that the Committee, in reviewing the Act, should also review the Regulations.<sup>2501</sup>

Ms Kennedy also suggested to the Committee that a hospital medical file is a completely different category of document to a 'statement', and that the legislation should limit rights of access to statements on a coroner's file or record. Further, the medical file should be kept physically separate and secure when in the coroner's jurisdiction, and it should not be regarded as part of a coroner's file or record. Medical files should only be available to interested persons or their legal representatives where the files are connected in some way to the matter under investigation. Otherwise there should be no access without the express permission of the hospital (in most cases the patient will have died and the hospital or coroner would need to contact the patient's family for permission). Ms Kennedy submitted that such files should certainly not be available to persons who cannot demonstrate a sufficient interest, such as Senator McGauran in the case referred to above. Finally, Ms Kennedy also submitted that penalties should apply to coronial staff who breach confidentiality requirements, just as there are penalties for hospitals and their staff under the *Health Services Act 1988* for such breaches.<sup>2504</sup>

Similarly, Health Services Commissioner Beth Wilson submitted that the Act should restrict access to sensitive documents to persons with a sufficient interest and that, for others, access should only be available with the consent of the next of kin of the person who died or their legal representative. During the public hearings Ms Wilson cited the McGauran case as an example of the need for the Health Services Commissioner and the Privacy Commissioner to be involved in consultations with the State Coroner to draw up protocols or guidelines about when health information should and should not be released. However, Ms Wilson considered that the coroner should retain substantial discretion regarding what can be difficult privacy issues.

Ms Wilson suggested that no one should be given access to medical records that are in the care of the coroner unless the person seeking access is determined to have a

<sup>&</sup>lt;sup>2501</sup> Elizabeth Kennedy, Royal Women's Hospital, *Minutes of Evidence*, 19 September 2003, 100.

<sup>&</sup>lt;sup>2502</sup> Ihid 101

<sup>&</sup>lt;sup>2503</sup> Royal Children's Hospital, *Submission no. 17*, 9; Royal Women's Hospital, *Submission no. 18*, 7.

<sup>&</sup>lt;sup>2504</sup> Heath Services Act 1988 s 141. The penalty for a breach of this section is 50 penalty units.

<sup>&</sup>lt;sup>2505</sup> Health Services Commissioner, Submission no. 62, 9.

special interest, however defined.<sup>2506</sup> She did not think that anyone should have an automatic right of access to information, as access should be determined on a case-by-case basis. Ms Wilson cited the example of a complaint received by her office in a case where a dispute existed between neighbours. A member of one of the neighbouring families had a mental illness and committed suicide, and the opposing neighbours in the dispute 'simply waltzed down to the Coroner's Office' and obtained access to information concerning the person's mental health. This caused considerable distress to the family.<sup>2507</sup>

The 'sufficient interest' test was a source of concern for various witnesses from the medical fraternity. The Australian Medical Association (Victoria) (AMA Victoria) suggested that only in exceptional circumstances should coronial information which is to be considered at an inquest be available to unrelated third parties. AMA Victoria's view was that, as currently defined and applied, the 'sufficient interest' test is too broad and should be changed.<sup>2508</sup> Witnesses such as AMA Victoria stated that access to sensitive information held by the coroner, such as that contained in medical records, should be restricted to prevent misuse. This is consistent with the expectation by patients that private health information will be treated confidentially and not disclosed.<sup>2509</sup>

Similarly, the Medical Practitioners Board of Victoria (MPBV) submitted that the concept of 'any person with sufficient interest' was too broad and could lead to infringements of privacy and access to sensitive information by people 'for the purpose of pursuing particular causes'.<sup>2510</sup> However, the board acknowledged that, if information is going to be taken into account by the coroner in a way that is disadvantageous to a party with an interest in the proceedings, such material may need to be made available to them. The MPBV drew a distinction between investigations and inquests, saying that persons granted standing to appear at an inquest need access to relevant information to be able to ask questions and make submissions. However, when an investigation is taking place or after an inquest is closed, access to personal medical files should not be available without the coroner's express consent.<sup>2511</sup>

Austin Health submitted that sensitive information such as medical files should be released only with the consent of patients or family members, or otherwise as allowed for in the freedom of information and health records legislation.<sup>2512</sup>

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<sup>&</sup>lt;sup>2506</sup> Health Services Commissioner, *Minutes of Evidence*, 19 September 2005, 177.

<sup>&</sup>lt;sup>2507</sup> Ibid.

<sup>&</sup>lt;sup>2508</sup> Australian Medical Association (Victoria), Submission no. 38, 4.

<sup>&</sup>lt;sup>2509</sup> Ihid

<sup>&</sup>lt;sup>2510</sup> Medical Practitioners Board of Victoria, *Submission no. 56*, 5.

<sup>&</sup>lt;sup>2511</sup> Ibid

<sup>&</sup>lt;sup>2512</sup> Austin Health, *Submission no. 45*, 9.

Dr Shelley Robertson put forward the view that medical records should not be available at all unless completely de-identified.<sup>2513</sup> Dr Robertson submitted that access should be limited to a finding and available only to parties with a clearly defined and demonstrable interest. However, other parties should be able, in defined circumstances, to access de-identified versions of coroner's findings.

#### Medical records of dead persons and living persons

Ms Heffey submitted that she had no difficulty with medical files of dead persons being accessible on the same basis as 'statements' and for the same reasons.<sup>2514</sup> The only exception to this may be circumstances in which there is material on the medical records which does not relate to the death. An example is a maternal death in which the hospital file contains entries regarding previous presentations unconnected to the death.

Ms Heffey submitted that she had seen patients' files in which this is the case; for example, a file might contain entries relating to a previous pregnancy termination. She recommended that the offending entries should be removed prior to examination. However, this may prove difficult if the final presentation entries contain references to the patient's previous medical history. Ms Kennedy stated that a problem with this suggestion is that, after an in-hospital death, the full medical history of the patient must go with the body to the Coroner's Office, and then the entire medical history of the person is in the custody of the Coroner's Office.<sup>2515</sup>

Austin Health submitted that the coroner's ability to make available statements that s/he intends to consider at an inquest to 'any person with a sufficient interest' may in some cases jeopardise patient confidentiality. Austin Health gave as an example the situation where the person who died had HIV and this was not known to the family.<sup>2516</sup>

The Committee agrees with the submission by Ms Heffey that a different process should apply in relation to medical files of living persons.<sup>2517</sup> Once again, this may present difficulties in cases of neonatal death. In such cases, the surviving mother's medical management may be a highly relevant area of investigation. Another example is the medical files relating to a person who has caused the death of another and whose psychiatric management is at issue. In Ms Heffey's view the medical file in these circumstances should only be available on application to a coroner and only to a person who can demonstrate a sufficient interest in the course of the investigation. The file should not be photocopied or removed from the Coroner's Office.<sup>2518</sup>

<sup>&</sup>lt;sup>2513</sup> Shelley Robertson, Submission no. 35, 6–7.

<sup>&</sup>lt;sup>2514</sup> Jacinta Heffey, Submission no. 33, 27.

<sup>&</sup>lt;sup>2515</sup> Elizabeth Kennedy, Royal Women's Hospital, *Minutes of Evidence*, 19 September 2005, 100.

<sup>&</sup>lt;sup>2516</sup> Austin Health, Submission 45, 9.

<sup>&</sup>lt;sup>2517</sup> Ibid.

<sup>&</sup>lt;sup>2518</sup> Jacinta Heffey, Submission no. 33, 27.

Ms Heffey also submitted that, once an investigation is completed (by a preliminary investigation to determine whether there is jurisdiction or a subsequent coronial investigation completed by a chambers finding or an inquest finding), the medical file should be immediately returned to the hospital or the doctor, as the case may be. Once this investigation is complete, the file should not be available to any person. Any copies of medical records should be destroyed. If the medical files of a living person, or part of the files, have no bearing on the investigation, the material should be returned to the hospital or doctor, as the case may be, once it is determined that it is not relevant.<sup>2519</sup> Such a requirement for the prompt return of medical files relating to living persons may have prevented, for example, the controversial release of sensitive information to Senator McGauran.

#### Privacy of medical records once the investigation is complete

As discussed earlier, at the end of a coronial investigation the autopsy report and other medical files are on the public record as part of the coroner's file. This medical information can include infectious disease status, graphic photographs, and genetic information. VIFM expressed concern about this information being publicly available. It recommended that the Act be amended so that such information would not be available to the general public in the absence of a formal request to the State Coroner and a determination that the applicant has a legitimate interest in the information.

However, VIFM noted that there are certain parties who should be able to access information such as autopsy reports and other medical files. VIFM submitted that information from autopsy reports should continue to be available to family members (senior next of kin), for internal VIFM purposes (including research, subject to Ethics Committee oversight), to treating doctors and hospitals, to consultative councils and committees, and for data collection and use by the National Coroners Information System (NCIS). VIFM submitted that others with a legitimate interest should also be allowed access but that a process for assessing and approving such access would be necessary. VIFM's comments should be compared to the provisions in section 53 of the *Coroners Act 2003* (Qld), which enable access to coronial investigation documents by 'genuine researchers'. 2521

#### Discussion and conclusion

The Committee is concerned that the section 45 Act and the regulation 24 give a coroner broad, unregulated powers to release personal and health information in his or her possession. Further, the release of such information is not currently prevented by either the IPA or the HRA. Both Acts are subject to the judicial/quasi-judicial exemptions contained in sections 10 and 14 respectively. As the matter involving the

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<sup>&</sup>lt;sup>2519</sup> Ihid

<sup>&</sup>lt;sup>2520</sup> Victorian Institute of Forensic Medicine, *Submission no. 40*, 32.

<sup>&</sup>lt;sup>2521</sup> Coroners Act 2003 (Qld).

release to Senator McGauran of sensitive medical records illustrates, the level of privacy currently afforded by the legislation is simply inadequate.

The Committee considers that section 10 of the *Information Privacy Act 2000* and section 14 of the *Health Records Act 2001* should be amended so as to clarify the application of the exemptions in those sections to coronial functions that relate to the conduct of inquests and inquiries under the *Coroners Act 1985*.

The Committee considers that the ability of members of the public to access information in a coroner's possession needs to be restricted by appropriate privacy considerations. Therefore, it recommends that privacy principles be inserted into the Act which regulate the kind of information a coroner may release and to whom s/he may release it, modelled on the principles in Part 3, Division 4, of the *Coroners Act* 2003 (Qld).<sup>2522</sup> The Committee recommends that section 45 of the Victorian Act and regulation 24 be repealed and replaced by the new provisions.

In addition to such principles, the Committee's view is that appropriate protocols will need to be developed in order to provide further guidance. The Committee considers that privacy in the coronial context is a complex issue which requires the establishment of a consultative process, involving the Coroner's Office, the Privacy Commissioner and the Health Services Commissioner, to determine appropriate protocols.

The Committee also considers that the Act should be amended to require that medical files delivered to a coroner must be kept physically apart from the coroner's file in a secure place. Such files should only be accessed by persons with a sufficient interest and their legal representatives, unless the senior next of kin gives their consent to other persons to access the medical information.

Finally, the Committee considers that penalties should apply to coronial staff who allow public access to confidential information. These penalties should be similar to those which apply to hospitals and staff under the *Health Services Act 1988*.

<sup>&</sup>lt;sup>2522</sup> In contrast, the State Coroner has recommended that the Act be amended to include a section modelled on the *Coroners Act 2003* (SA) s 34. The Committee considers that such a provision would not adequately address the concerns raised by other stakeholders.

Recommendation 116. That section 10 of the *Information Privacy Act 2000* and section 14 of the *Health Records Act 2001* be amended so as to clarify the application of the exemptions in those sections to such coronial functions that relate to the conduct of inquests and inquiries under the *Coroners Act 1985*.

Recommendation 117. That section 45 of the *Coroners Act 1985* and regulation 24 of the *Coroners Regulations 1996* be repealed and that principles be inserted into the Act which regulate the kind of information a coroner may release and to whom s/he may release it, both before and after the completion of an investigation, modelled on the principles contained in Part 3, Division 4, of the *Coroners Act 2003* (Qld).

Recommendation 118. That a formal consultation process be established between the State Coroner, the Privacy Commissioner and the Health Services Commissioner to design privacy protocols in relation to the management of sensitive information by coroners and coronial staff.

Recommendation 119. That the *Coroners Act 1985* be amended to require that medical files delivered to a coroner must:

- a) be kept physically apart from the coroner's file in a secure place; and
- b) be accessed only by persons with a sufficient interest and their legal representatives, unless the consent of the senior next of kin is given to other persons to access the medical information.

Recommendation 120. That the *Coroners Act 1985* be amended to impose on coronial staff who allow public access to confidential information penalties similar to those which apply to hospitals and staff under the Health Services Act 1988.

Recommendation 121. That autopsy reports, graphic photographs, videos, suicide notes, diary excerpts, letters and other material that is sensitive or likely to cause distress to family members be placed in sealed envelopes within the coronial file to enable its removal prior to the file's being accessed by members of the public in appropriate circumstances.

## Privacy of coronial information: the impact of technology

The development of electronic means of disseminating data, such as the internet, creates 'a need to reconsider the application of the open justice principle and, where appropriate, to adjust procedures while maintaining this elemental principle'.<sup>2523</sup>

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<sup>&</sup>lt;sup>2523</sup> Privacy Commissioner, *Submission no. 60*, 3.

In the coronial context the public need for information will need to be balanced with the rights and interests of individuals in relation to privacy.<sup>2524</sup>

The public has online access to a number of 'Coronial Findings of Public Interest', which include detailed, identifiable information about deceased adults and children, and their families and friends and others associated with the death. <sup>2525</sup> As newspapers progressively digitise their archives and make them available for trawling by powerful search engines, far more personal information will become available for matching and profiling with other available information, including court records. <sup>2526</sup>

The Privacy Commissioner observes that these technological changes are not a reason to limit the open justice principle or proper media access within court rules, but that they are a reason for the media to pay particular care to how they report court proceedings (especially where they do not report every day of a given case, so that their archive may not be a complete record). He submitted that changing technology requires the Committee to tailor the recommendations in this report relating to privacy with greater attention to detail.<sup>2527</sup>

The Privacy Commissioner observed that contemporary privacy standards are a useful tool in determining the manner and extent of public access to court records. Such open access has the potential to invade privacy as well as undermine the proper administration of justice or, in the case of an inquest, prevent conclusive findings as to events leading up to a death. On the other hand, experience shows that some findings require re-examination and that journalistic investigation may be a precursor to official reconsideration of a matter.<sup>2528</sup>

Turning to other jurisdictions, US courts have revised their case reporting practices to take these issues into account, and the French privacy authority recommended that the names and addresses of plaintiffs and defendants be removed from decisions available on the internet. The Privacy Commissioner does not recommend the latter solution but advocates 'more technology-aware precision by the courts in the practical delivery of the theory of open justice'. 2529

The Privacy Commissioner identifies the following as key privacy issues to consider when determining questions of access to coronial data:

<sup>2524</sup> Ibid.

<sup>&</sup>lt;sup>2525</sup> By contrast, on the equivalent website in the Northern Territory names have been suppressed in a number of cases, as provided for in the *Coroners Act 1993* (NT) s 43(1)(c). See

http://www.nt.gov.au/justice/graphpages/courts/coroners.shtml.

<sup>&</sup>lt;sup>2526</sup> Privacy Commissioner, *Submission no. 60*, 3.

<sup>&</sup>lt;sup>2527</sup> Ibid.

<sup>&</sup>lt;sup>2528</sup> Ibid.

<sup>&</sup>lt;sup>2529</sup> Ibid 4.

- giving notice to affected persons, such as immediate family members, of the usual disclosure of personal information in coronial data, including inquest and investigation data uploaded onto coronial databases (see the comments under the heading 'Coronial databases', below);
- making disclosure proportionate to meet another public interest not all privacy need be lost;
- assessing the likelihood and gravity of any harm to other individuals by disclosure;
- giving consideration to cultural sensitivities surrounding information concerning persons who have died; and
- considering the timing of disclosure time can heal, and appropriate delays in disclosure are a feature of how society traditionally respects grief.<sup>2530</sup>

The Commissioner recommends that provision be made in the Act for the development of clear practice notes dealing with the management of coronial inquest data. These practice notes should incorporate privacy safeguards, including notice to persons whose privacy may be affected by the release of records and an opportunity to object to release. Guiding principles should be included in the statute, with details in the practice notes.<sup>2531</sup>

Additional suggestions for the handling of sensitive coronial data were made by the Assistant New Zealand Privacy Commissioner, Mr Blair Stewart, in the 1999 Law Commission of New Zealand review of the *Coroners Act 1988* (NZ).<sup>2532</sup> These suggestions were subsequently adopted by the Law Commission. The Victorian Privacy Commissioner suggested that the Committee may wish to consider whether some of the suggestions could be adapted to the Victorian context. The relevant recommendations can be grouped into three categories:

- information concerning the coronial inquest to be provided to the family of the deceased;
- publication and inspection of coronial inquest information; and
- ability to lodge with the chief coroner complaints about the carrying out by a coroner of his or her functions as they concern information handling.<sup>2533</sup>

The Victorian Privacy Commissioner stated that a chief coroner's role should include receiving and handling of general complaints concerning the exercise of a coroner's

<sup>2531</sup> Ibid.

<sup>&</sup>lt;sup>2530</sup> Ibid.

<sup>&</sup>lt;sup>2532</sup> Ibid, citing New Zealand Law Commission, *Coroners*, Report no. 62 (2000).

<sup>&</sup>lt;sup>2533</sup> Ibid.

powers (such as failing to give notice to the immediate family of a person who has died about a proposed adverse comment). The Privacy Commissioner believed that the chief coroner ought to be supervised by the courts, as now, but that it may be appropriate for this Committee to consider who ought to have standing to bring before a court, complaints about the chief coroner's handling of personal information.<sup>2534</sup>

He noted that the *Coroners Act 2006 (NZ)* contains provisions concerning a coroner's prohibition on the publication of any evidence or proceeding, <sup>2535</sup> a coroner's refusal to give authority to make public details of self-inflicted deaths; <sup>2536</sup> and offences, including one relating to contravening prohibitions on publishing information. <sup>2537</sup> The New Zealand legislation also contains a review mechanism in relation to a coroner's decision as to publication, <sup>2538</sup> unlike the position in Victoria.

The Commissioner suggested that it may be appropriate to include in the Act a mechanism by which the Coroner could seek the advice of the Privacy Commissioner and/or the Health Services Commissioner, as appropriate. The Act would make it clear that this advice would be non-binding and that the decision would in all cases be the Coroner's. When asked about the Commissioner's suggestion that the Health Services Commissioner's office could play a role in reviewing who gains access to information on coronial records, the Health Services Commissioner stated that she would like to be involved in drafting relevant protocols. 2540

Recommendation 122. That provision be made in the *Coroners Act 1985* for the development of clear protocols dealing with the management of coronial inquest data which incorporate privacy safeguards, including notice to persons whose privacy may be affected by the release of records and an opportunity to object to such release. Guiding principles should be included in the Act and more detailed instructions in the protocols.

# Privacy of information contained on the NCIS database

The National Coroners Information System (NCIS) is a national database of coronial information extracted from the coronial files of all Australian States and Territories, generally dating back to July 2000. The nature of the NCIS and its vital role in death and injury prevention is described in detail in chapter seven.

<sup>&</sup>lt;sup>2534</sup> Ibid.

<sup>&</sup>lt;sup>2535</sup> Coroners Act 2006 (NZ) s 64.

<sup>&</sup>lt;sup>2536</sup> Coroners Act 2006 (NZ) s 61.

<sup>&</sup>lt;sup>2537</sup> Coroners Act 2006 (NZ) s 127.

<sup>&</sup>lt;sup>2538</sup> Coroners Act 2006 (NZ), s 103.

<sup>&</sup>lt;sup>2539</sup> For an example of this model working in another context, see *Electoral Act 2002* (Vic) s 34.

<sup>&</sup>lt;sup>2540</sup> Health Services Commissioner, *Minutes of Evidence*, 20 September 2005, 184.

In short, the NCIS facilitates the role of coroners around Australia and aids third-party users in obtaining access to coronial data. It was developed by the Monash University National Centre for Coronial Information (MUNCCI), a consortium of three bodies: the Monash University Department of Epidemiology and Preventative Medicine, the Victorian Institute of Forensic Medicine, and the Monash University Accident Research Centre. Changes to the governance and management of the NCIS recently resulted in VIFM assuming responsibility for the management of the NCIS in 2005.<sup>2541</sup>

The IPA applies to VIFM and to other Victorian agencies involved in the NCIS as bodies established for a public purpose by or under an Act.<sup>2542</sup>

The NCIS includes a significant amount of personal information, mainly but not exclusively about persons who have died, including:

- name, age, sex, date of birth, place of usual residence, marital status and Indigenous identification;
- date of notification of death;
- period of residence in Australia, country of birth, employment status and usual occupation;
- details of the incident where it was work-related, time and location of incident, activity at time of incident, intent and mechanism of injury, object or substance involved, medical cause of death, vehicle type where motor vehicle—related, whether driver or passenger, and context.
- full text reports include the police narrative of circumstances, autopsy report, toxicology report, and finding.<sup>2543</sup>

Access to identifiable data and full text reports (for example, coronial findings and autopsy reports) is available to 'level 1 users', and 'level 2 users' are able to access non-identifying data sets. To be able to access the NCIS directly, a user must be a death investigator assisting the coroner (for example, coroners' officers, forensic scientists, pathologists and police officers) or fall within the definition of a third party user.<sup>2544</sup>

A third party user is an individual, organisation or agency with a statutorily mandated statistical function or with a role in research into or development of policy for public health and safety. This includes government departments and agencies, academic institutions (including research centres, departments and students), and other bona

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<sup>&</sup>lt;sup>2541</sup> Privacy Commissioner, *Submission no. 60*, 5. The Committee discusses the NCIS in chapter 7.

<sup>&</sup>lt;sup>2542</sup> Information Privacy Act 2000 s 9.

<sup>&</sup>lt;sup>2543</sup> Ibid.

<sup>&</sup>lt;sup>2544</sup> See http://www.vifp.monash.edu.au/ncis/web\_pages/faq.htm.

fide research agencies. These users are able to apply for access to level 1 or level 2 data, subject to ethics committee approval.<sup>2545</sup>

The access rules do not allow the NCIS to provide access to commercial organisations, including media organisations, <sup>2546</sup> or to private individuals who are not independent researchers for bona fide public health and safety, or death and injury prevention purposes. <sup>2547</sup>

State and Territory public sector agencies provide personal information to the NCIS under licence agreements containing access rules. These determine how the information is to be used by VIFM (previously by MUNCCI) and accessed by third parties.

The Privacy Commissioner notes that while some of the organisations participating in the NCIS may be bound to comply with the IPA or similar laws in other jurisdictions, other recipient organisations may not be regulated by privacy laws. This may affect or make uncertain Victorian agencies' compliance with IPP 9, which governs the sharing of personal information across state or territory and international borders.<sup>2548</sup>

Turning to other jurisdictions, New South Wales resolved this issue in 2002 when the New South Wales Privacy Commissioner made several public interest directions authorising the disclosure of NCIS information under section 41 of the *Privacy and Personal Information Protection Act 1998* (NSW).<sup>2549</sup> The current direction authorises disclosures of personal information by NSW public sector agencies to the NCIS which would otherwise breach the Act. The authorised disclosures are subject to the condition that each public sector agency disclosing information is satisfied that the use and disclosure by MUNCCI (which should now be VIFM)<sup>2550</sup> is consistent with the licence agreement or similar agreement entered into between the agency and Monash University.

Under the *Information Privacy Act 2000* the Victorian Privacy Commissioner does not have a function to make public interest directions. The Privacy Commissioner

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<sup>&</sup>lt;sup>2545</sup> Victorian Department of Justice, *Department of Justice Ethics Guidelines — March 2005 Version*, Appendix A. Available at

 $<sup>\</sup>label{lem:http://www.justice.vic.gov.au/CA256902000FE154/Lookup/Research\_Ethics\_Information\_Pdf\_2004/\$file/Application\_Guidelines\_March\_2005\_Version.pdf.$ 

<sup>&</sup>lt;sup>2546</sup> Cf Privacy Commissioner, *Submission no. 60*, 6.

<sup>&</sup>lt;sup>2547</sup> Victorian Department of Justice, Department of Justice Ethics Guidelines — March 2005 Version, 21.

Available at

<sup>&</sup>lt;sup>2548</sup> Privacy Commissioner, Submission no. 60, 6.

<sup>&</sup>lt;sup>2549</sup> Ibid.

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<sup>&</sup>lt;sup>2550</sup> The direction does not yet reflect the change in NCIS's management from MUNCCI to VIFM.

considers that in this context, as in many others, it would be better if the legislation provided this function to the Privacy Commissioner.<sup>2551</sup>

In the interest of ensuring that coronial data (as it relates to living persons or, under the HRA, to deceased persons) is handled in accordance with appropriate privacy standards, the Privacy Commissioner recommends that the NCIS project be given detailed, transparent and accountable legislative backing (in the *Coroners Act 1985* or other appropriate law).<sup>2552</sup> The IPA, which contains internationally applied standards for data quality and data security as well as access or disclosure standards, should apply, together with Privacy Commissioner (and Health Services Commissioner) oversight, augmented by a public interest directions power. (A code of practice under Part 4 of the IPA may also be appropriate for the NCIS.)

The Committee agrees with the Privacy Commissioner's recommendations insofar as they relate to the *Coroner's Act 1985*, and it notes that the Queensland coronial legislation now recognises the existence of a national coronial database and regulates disclosure and access to it using the concept of 'legitimate interest'.<sup>2553</sup> The Committee considers that the Victorian Act should also recognise the NCIS.

Recommendation 123. That the National Coroners Information System (NCIS) be recognised by detailed provisions in the *Coroners Act 1985* that are drafted so that the *Information Privacy Act 2000* applies to the NCIS.

Recommendation 124. That, following the implementation of recommendation 123 above, a code of practice under Part 4 of the *Information Privacy Act 2000* be developed for the NCIS.

# Collection, use and disclosure of genetic samples and tissues

Australia appears to be following the trend in other jurisdictions of permitting the steadily increasing collection of genetic samples and genetic information from a steadily broadening range of persons for a steadily widening range of reasons for use by a steadily growing group of organisations.<sup>2554</sup>

The relevance of genetic tissue in the coronial context has been highlighted particularly by the terrorist attack on the World Trade Centre in the US on 11 September 2001 and the bombing in Bali on 12 October 2002. These events created heightened awareness of the role of DNA – both in identifying victims and in investigating crime. The use of DNA in disaster victim identification has drawn

<sup>&</sup>lt;sup>2551</sup> Privacy Commissioner, Submission no. 60, 6.

<sup>&</sup>lt;sup>2552</sup> Ibid.

<sup>&</sup>lt;sup>2553</sup> Coroners Act 2003 (Qld) s 93.

<sup>&</sup>lt;sup>2554</sup> Privacy Commissioner, Submission no. 60, 6.

attention to the potential utility of existing stored tissue samples and newborn screening (or Guthrie) cards.<sup>2555</sup>

DNA may be used in the coronial context to assist in identification of unknown deceased persons and in determining the cause of death (including, potentially, the identity of an assailant).<sup>2556</sup> But DNA can potentially reveal much more about a person and his or her blood relatives, including paternity, ethnicity and Aboriginality, physical traits, and certain behavioural propensities. Accordingly, tissue or genetic data from deceased persons are likely to be of increasing value to third parties interested, for example, in investigating crimes, researching medical conditions or developing commercial products. Such uses may be unrelated to the matter that gave rise to the collection and retention of the tissue or data by the coroner.<sup>2557</sup>

The Privacy Commissioner submitted that, due to the growing sensitivity and power of genetic data, and the uses that can be made of that data, its collection by a coroner should be specifically regulated by law. Collection by a coroner should not be left to a general power of collection such as that provided for in section 26 of the Act.<sup>2558</sup>

However, while the Committee has made general recommendations earlier in this chapter regarding the retention of tissue from coronial autopsies, it considers that regulation specific to the collection, storage, access to or use of genetic samples and information should not form the subject of amendments to the Act. The Committee notes that the Australian Law Reform Commission (ALRC) has considered the options for such regulation in considerable depth in its report entitled *Essentially Yours: The Protection of Human Genetic Information in Australia*. The ALRC report recommended that the *Privacy Act 1988* (Cth) and similar state and territory health and information privacy legislation should be amended to cover genetic samples as well as the genetic information derived from them. The ALRC's view was that, until such time as the States' human tissue legislation is subject to comprehensive national review, the regulation of the collection, storage, access to or use of genetic samples should rely primarily on amendments to the *Privacy Act 1988* (Cth) rather than on amendment of the human tissue legislation.

<sup>&</sup>lt;sup>2555</sup> Ibid, 7.

<sup>&</sup>lt;sup>2556</sup> See for example Victorian Parliament Law Reform Committee, *Forensic Sampling and DNA Databases in Criminal Investigations* (2004) 156-158.

<sup>&</sup>lt;sup>2557</sup> Privacy Commissioner, Submission no. 60, 7.

<sup>&</sup>lt;sup>2558</sup> Coroners Act 1985 s 26. This section sets out a coroner's powers of entry, inspection and possession.

<sup>&</sup>lt;sup>2559</sup> Australian Law Reform Commission, *Essentially Yours: The Protection of Human Genetic Information in Australia*, Report No 96 (2003). Available at

http://www.austlii.edu.au/au/other/alrc/publications/reports/96/.

<sup>&</sup>lt;sup>2560</sup> Ibid Chapter 8.

<sup>&</sup>lt;sup>2561</sup> Ibid Chapter 20.

#### Collection and use of stored tissue samples

The Privacy Commissioner considers that a coroner's powers of access to stored tissue samples, such as newborn screening cards, should be expressly authorised. Where a coroner considers it appropriate to obtain a sample — for example, for identification purposes in connection with an inquest — a formal order under law should be made. This order should specify its purpose and contain clear requirements about persons responsible for providing the card and for its security and return.

Security, access to and use of tissue samples are matters of growing privacy significance, as the ALRC has made vividly clear.<sup>2563</sup> The Privacy Commissioner's view is that, generally, governments have been slow to protect the public interest in this field.<sup>2564</sup>

The Privacy Commissioner submitted that this review of the *Coroners Act* is but one of many aspects of public administration where an opportunity for improvement commensurate with the importance of the issue should be grasped.<sup>2565</sup>

#### Collection by a coroner of DNA for law enforcement purposes

In at least one jurisdiction the coroner has been expressly permitted by legislation to collect DNA from persons who have died for uses unrelated to coronial inquiries.

Western Australia's *Criminal Investigation (Identifying People) Act 2001* authorises the routine collection of DNA data of persons who have died and for the data to be included on a forensic database.<sup>2566</sup> Section 21 of that Act permits the State Coroner (on his or her own initiative or at the request of someone with a proper interest) to authorise the taking of identifying particulars (including DNA samples, fingerprints and photographs) from all deceased people (whether or not their deaths were reportable) or a specific class of deceased people for, or in connection with, a forensic purpose. Forensic purposes include the investigation of the death of a person, identifying a person who has died, investigating the whereabouts of a missing person or investigating any offence.

Where the DNA is taken from a deceased person whose identity is known, the legislation in Western Australia treats the sample (and any DNA profile derived from it) as if it were obtained by consent from a volunteer.<sup>2567</sup> The DNA profile can then be

<sup>&</sup>lt;sup>2562</sup> Privacy Commissioner, Submission no. 60, 7.

<sup>&</sup>lt;sup>2563</sup> See for example Australian Law Reform Commission, *Essentially Yours: The Protection of Human Genetic Information in Victoria*, Report No 96 (2003). The Privacy Commissioner's submission to the inquiry is available at www.privacy.vic.gov.au.

<sup>&</sup>lt;sup>2564</sup> Privacy Commissioner, *Submission no. 60*, 7.

<sup>&</sup>lt;sup>2565</sup> Ihid

<sup>&</sup>lt;sup>2566</sup> Criminal Investigation (Identifying People) Act 2001 (WA) s 21.

<sup>&</sup>lt;sup>2567</sup> Criminal Investigation (Identifying People) Act 2001 (WA) s 63(2).

included on a DNA database and may, at the coroner's discretion, be matched against DNA profiles obtained from offenders, suspects and unsolved crime scenes.

The Committee agrees with the Privacy Commissioner's view that, if DNA is to be routinely collected from deceased persons in Victoria (as authorised, for example, under Western Australia's laws), this should only occur after informed community debate, and only with express authority under legislation, continuing independent scrutiny and regular parliamentary review.<sup>2568</sup>

# Media suppression orders

In Victoria the Act contains the following section:

- 58. Restriction on Publication of Reports
- (1) A coroner must order that no report of an inquest or any part of the proceedings or of any evidence given at an inquest be published if the coroner reasonably believes that it would:
  - (a) be likely to prejudice the fair trial of a person; or
  - (b) be contrary to the public interest. 2569

The Act prohibits publication of reports contrary to such an order and imposes a penalty for contravention.<sup>2570</sup>

The State Coroner has indicated that the ability to make an order under section 58 restricting publication of a report is one to be used sparingly.<sup>2571</sup>

#### Other jurisdictions

In Tasmania and the Northern Territory, the restriction on publication of information from inquests has been extended to include circumstances that 'involve the disclosure of details of sensitive personal matters including, where the senior next of kin of the deceased has so requested, the name of the deceased'.<sup>2572</sup>

#### **Evidence received by the Committee**

The publication by the media of sensitive personal information can be traumatic for families involved in the coronial process, as discussed at the beginning of this chapter. Jason Rosen, President of the Association for the Prevention of Medical

<sup>&</sup>lt;sup>2568</sup> Privacy Commissioner, Submission no. 60, 8.

<sup>&</sup>lt;sup>2569</sup> Coroners Act 1985 s 58(1). The section is mirrored in Coroners Act 1996 (WA) s49.

<sup>&</sup>lt;sup>2570</sup> Coroners Act 1985 s 58(2).

<sup>&</sup>lt;sup>2571</sup> See for example Law Commission of New Zealand, *Coroners*, Report No 62 (2000), 123.

<sup>&</sup>lt;sup>2572</sup> Coroners Act 1995 (Tas) s 57(1); Coroners Act 1993 (NT) s 43 (1). Cf Coroners Act 2003 (Qld) s 41 and Coroners Act 1980 (NSW) s 44.

Errors (APME), observed in his submission that there is a valid community concern that unexpected or unexplained deaths be examined in a public forum, and a wider common law principle of open justice that requires a fair and public hearing by an independent and impartial tribunal.<sup>2573</sup> A corollary of the principle of open justice is that any newspaper may publish a fair and accurate report of proceedings without the fear of libel suits even if doing so may damage the reputation of individuals involved.<sup>2574</sup> The justification for publishing reports of inquests is strengthened by the coroner's preventive role in public safety.

However, as Mr Rosen observed, citing various examples, the courts and legislatures have recognised the need in prescribed circumstances to depart from the open justice principle.<sup>2575</sup> He noted the statement by the Coroner's Office that a balance must be reached, in relation to privacy considerations at coronial inquests, between the requirements of the investigation, the needs of a possible criminal trial, the principle of open justice, and matters of public health and safety.<sup>2576</sup>

The interests of family members are, however, 'conspicuously absent from this list of considerations'.<sup>2577</sup> By contrast, as Mr Rosen pointed out, there is a judicially recognised need to protect innocent parties to legal proceedings where nothing will be accomplished by publicising their names.<sup>2578</sup> In coronial inquests, where intricate and sometimes graphic details of an unexpected death are painstakingly revisited, family members often find the legal process traumatic.<sup>2579</sup> Media publication of distressing evidence, medical records and graphic details of a death is likely to exacerbate the pain and suffering of family members in the aftermath of an unexpected death. This hardship is compounded by the fact that in many cases families, who are innocent parties, do not have a choice as to whether an inquest takes place.<sup>2580</sup>

Name suppression orders are commonly used in other legal contexts to protect the identity of certain individuals.<sup>2581</sup> In the coronial context, Mr Rosen considers that name suppression orders, such as those referred to in the Northern Territory and Tasmanian provisions, would be an acceptable compromise between the interests of the family and other individuals on one hand, and the open justice principle on the

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<sup>&</sup>lt;sup>2573</sup> Association for the Prevention of Medical Errors, *Submission no.* 79, 30.

<sup>&</sup>lt;sup>2574</sup> Ibid 31.

<sup>&</sup>lt;sup>2575</sup> Ibid.

<sup>&</sup>lt;sup>2576</sup> State Coroner's Office, Submission no. 70, 163.

<sup>&</sup>lt;sup>2577</sup> Association for the Prevention of Medical Errors, Submission no. 79, 31.

<sup>&</sup>lt;sup>2578</sup> Hirt v College of Physicians and Surgeons (British Columbia) (1985) 60 BCLR 283, 286.

<sup>&</sup>lt;sup>2579</sup> See for example Lucy Biddle 'Public Hazards or Private Tragedies? An Exploratory Study of the Effect of Coroner's Procedures on Those Bereaved by Suicide' (2003) *Social Science & Medicine* 56, 1033, 1039.

<sup>&</sup>lt;sup>2580</sup> Coroners Act 1985 (Vic) s 17(1).

<sup>&</sup>lt;sup>2581</sup> For example, suppression orders are regularly made in criminal cases to protect the identity of alleged victims, without affecting the proper administration of justice: *Heading v M* (1987) 49 SASR 168, 170 (King CJ).

other.<sup>2582</sup> He stated that such action does not in any way frustrate the proper exercise of the public interest component or the preventative element of the coronial function.<sup>2583</sup> Mr Rosen submitted that inclusion of such a provision in the Act, which would only operate when the circumstances warranted it, would help protect families from suffering additional distress due to media publication of sensitive personal details.<sup>2584</sup>

Several other witnesses commented on the problems created by sensationalist and often inaccurate stories published by media organisations in relation to coronial inquiries after the release of sensitive information. This appeared to be of particular concern to members of the medical profession.<sup>2585</sup> A complaint from the medical profession was that often stories regarding an inquest into possible medical negligence would be published and cause damage to the reputation of the doctor concerned. The same doctor would be vindicated in the coroner's final findings, by which time media interest had subsided, so the results were not published and the harm could not be repaired. AMA Victoria stated:

[I]t seems that more effective means of managing the media's access to sensitive information is required so that reasonable, balanced reporting replaces the current sensational stories that are disseminated following the release of sensitive information.<sup>2586</sup>

Indeed, the Committee considers that, in addition to protecting families from disturbing media reports concerning a death, suppression orders have the potential to reduce the risk of unnecessary damage to professional reputations by irresponsible reporting.

Finally, the Committee notes that the Coroner's Office has recommended that section 58 of the Act be amended to enable the State Coroner to make or vary an order restricting publication of reports at any stage of an investigation.<sup>2587</sup> The Committee has not received any other submissions to this effect and is concerned that such a wide-ranging discretion may compromise the open justice principle.

#### Discussion and conclusion

The Committee agrees with Mr Rosen's view that, in addition to its existing concern that the publication of information might imperil the fairness of a later trial, the Act

<sup>&</sup>lt;sup>2582</sup>Email, Jason Rosen, President, Association for the Prevention of Medical Errors, to Committee Chair; Jason Rosen, *Submission no. 79*, 32, citing Colleen Davis, 'The Injustice of Open Justice' (2001) 8 *James Cook University Law Review* 92, 106.

<sup>&</sup>lt;sup>2583</sup> Ibid.

<sup>&</sup>lt;sup>2584</sup> Ibid.

<sup>&</sup>lt;sup>2585</sup> See for example Australian Medical Association (Victoria), Submission no. 38.

<sup>&</sup>lt;sup>2586</sup> Ibid 4.

<sup>&</sup>lt;sup>2587</sup> State Coroner's Office, Submission no. 70, 162.

should protect the interests of all parties: the public, the media, individuals involved in reportable deaths and the families of persons who have died. Therefore, the restriction on publication of reports that would prejudice a fair trial or are not in the public interest should be extended to cover 'sensitive personal matters' and should enable name suppression orders. Such orders would not hinder the collection of relevant coronial data by the NCIS or affect the ability of the media to publish a story, and thus would involve less infringement on the open justice principle than a full prohibition on the publication of particular coronial findings.

Recommendation 125. That section 58(1) of the *Coroners Act 1985* be amended to include a new sub-section (c), as adopted in Tasmania and the Northern Territory, that reads:

(1) A coroner must order that no report of an inquest or of any evidence given at an inquest be published if the coroner reasonably believes that it would –

. . .

(c) involve the disclosure of details of sensitive matters including, where the senior next of kin of the deceased has so requested, the name of the deceased.

# **Counselling and support services**

The most positive experience of the coronial process for me was the support I received from Sue Wilson, the manager of the counselling and support services at Southbank following the inquest hearing...the Counselling and Support Service is an indispensable and defining part of the coronial process for families.<sup>2588</sup>

There is currently no provision in the Act prescribing the provision of counselling and support for families, or requiring families to be notified about the availability of counselling at the Coroner's Office.

### Other jurisdictions

As in Victoria, the coroners' websites in New South Wales, South Australia, Tasmania and Western Australia refer to the availability of grief counselling services. However, Western Australia is the only jurisdiction to include provision for support services in its coronial legislation.<sup>2589</sup>

Section 16 of the Coroners Act 1996 (WA) provides:

- 16. Counselling
- (1) The State Coroner is to ensure that a counselling service is attached to the court.

<sup>&</sup>lt;sup>2588</sup> Marion Stevens, Submission no. 49, 6.

<sup>&</sup>lt;sup>2589</sup> Coroners Act 1996 (WA) s 20.

(2) Any person coming into contact with the coronial system may seek the assistance of the counselling service of the court and, as far as practicable, that service is to be made available to them.<sup>2590</sup>

In addition, section 20 of the *Coroners Act 1996* (WA) requires a coroner who has jurisdiction to investigate a death, as soon as practicable after assuming that jurisdiction, to inform the next of kin of the person who died that a counselling service is available.<sup>2591</sup>

# The need for and role of counselling in relation to the coronial process

The trauma, grief and upheaval experienced by relatives and friends of persons who die suddenly and unexpectedly can have implications for physical, mental and social health and wellbeing. The ensuing stress can affect motivation, eating and sleeping patterns, personal relationships, and self esteem. Clinical and anecdotal evidence indicates that the sudden death of a family member violates a person's sense of security and safety. The resulting distress and anxiety can overwhelm a person, leaving them in a state of extreme vulnerability. Experience in working with families following trauma or crisis has shown that providing affected people with information, support and practical assistance, as well as listening and helping to clarify the experience, are pivotal in restoring confidence so that they can begin their recovery.<sup>2592</sup>

Dr Freckelton and Associate Professor Ranson explain the need for, and role of, professional support services in the coronial system as follows:

In recent years there has been increasing recognition of the need for bereavement services to be available from within the coroner's jurisdiction. As noted above, the clients of the coroner's court who have closest involvement with the staff are most commonly the deceased person's family, who are experiencing a particularly stressful period in their lives. It is ironic that it is at this time that they have to make decisions about such matters as whether to object to an autopsy or donate tissues for transplantation, as well as deal with the logistical issues of arranging a funeral and assisting other members of their family and the deceased's friends. It may take some time and considerable patience to meet their needs adequately. Any contact with the family in this situation has a direct therapeutic context. Mistakes, insensitivities and poor assumptions made by staff may have serious ramifications for the health of members of the family and for the overall scope and quality of the investigation. It is clearly not possible for court clerks without formal training in bereavement counselling and support to provide a therapeutic service to relatives of the deceased on a regular basis. The work involved is time-consuming and would seriously impede the efficiency of the administrative process.

<sup>&</sup>lt;sup>2590</sup> Coroners Act 1996 (WA) s 16.

<sup>&</sup>lt;sup>2591</sup> Coroners Act 1996 (WA) s 20.

<sup>&</sup>lt;sup>2592</sup> State Coroner's Office, Submission no. 70, 56-57.

The introduction of a counselling service based at a coroner's court has the capacity to greatly enhance the services for family and friends of the deceased. In addition, a higher level of communication between the coroner's office and families usually results in an improved death investigation process. Grief counselling services are not usually designed to provide long-term bereavement care. They are usually fashioned around acute intervention to provide initial support, counselling and information in an environment that maximises the autonomy of the family. <sup>2593</sup>

The authors also commented that, while the administrative services in a coroner's office may resemble those of an ordinary court, due to the nature of the work performed by the administrative staff it is essential that they receive appropriate additional training. Staff at a coroner's office should be aware of the trauma suffered by grieving families and friends as well as the resources available to manage and assist those persons.

Indeed, the Committee considers that counselling and support services should not be viewed in isolation from their context. The evidence reviewed in this chapter suggests that in many cases the coronial system adds to the grief and trauma experienced by families. One author has suggested that specific improvements to the system, such as better information for families regarding their rights and the progress of investigations, better training of clerks and other coronial staff, and avoiding unnecessary autopsies, would make the coronial process as a whole more supportive to families. This would enhance the supportive effect that counselling staff strive to achieve.<sup>2594</sup>

### Currently available counselling and support services

The Counselling and Support Service (CSS) at the Coroner's Office in Melbourne provides support and information to families and friends as well as persons who have witnessed a death. The service provides free, short-term counselling to anyone affected by a death referred to the coroner. For country callers, the service provides a freecall telephone number.<sup>2595</sup>

Despite limited resources the CSS plays a vital role in supporting the needs of families involved in the coronial process. The CSS aims to reduce some of the psychological effects of the death and associated investigation, based on crisis intervention models:

In general terms, these models recognise the importance of early, timely and appropriate intervention in order to mitigate against some of the physical, psychological and emotional

<sup>&</sup>lt;sup>2593</sup> Ian Freckelton and David Ranson, *Death Investigation and the Coroner's Inquest* (2006) 103.

<sup>&</sup>lt;sup>2594</sup> Caroline Bray, 'General Model of Support Services in the Coronial System — Court Support and Advisory Services', *Proceedings* 24–5 March 1987.

<sup>&</sup>lt;sup>2595</sup> Telephone Direct to Counselling Service on 9684 4395 or 9684 4396, Freecall for Country Callers 1800 136 852.

impacts of a crisis event such as a sudden death. The program should be recognised as an emerging concept focused on building a family's own resources.<sup>2596</sup>

The CSS then aims to identify future psychological risk factors and associated prevention strategies, in order to decrease the likelihood of adverse psychological effects in the longer term.<sup>2597</sup>

The service provided includes:2598

- short-term counselling and support to any person affected by a death that comes to the attention of the coroner;
- telephone counselling;
- debriefing for individuals and groups after exposure to a death that occurs in traumatic circumstances;
- assistance in understanding the coronial process, including providing information to families regarding their legal rights (for example, in relation to objections to autopsies);<sup>2599</sup>
- assistance for those required to identify a body;
- advocacy on families' behalf with letters of support to employers, schools etc;
- assistance and support for families attending an inquest (here CSS may seek the help of the Court Network volunteers, referred to below);
- referral to community agencies for longer-term support; and
- help to professionals in the areas of education, training and secondary consultation.

On 1 March 2004 the pilot Family Contact Program was launched. Under this program counsellors make contact with and offer professional support to almost all families affected by reportable deaths that occur in Melbourne. The Family Contact Program aims to (1) strengthen the links between staff within the Coronial Services

<sup>&</sup>lt;sup>2596</sup> Document provided by Sue Wilson, Counselling and Support Service manager, State Coroners Office, 'C&SS Programmatic Work', (undated). The Committee notes that the available empirical research on the effectiveness of bereavement interventions appears to be unsatisfactory, and that the findings to date have been varied. It has been suggested an area which requires further research: see, for example, J Jordan and R Neimeyer, 'Does grief counselling work?' (1993) 27 *Death Studies* 765-786, cited in The Nucleus Consulting Group, *Review of Specific Grief and Bereavement Services funded by the Department of Human Services – Final Report*, July 2004.

<sup>&</sup>lt;sup>2598</sup> See http://www.coronerscourt.vic.gov.au, 'Counselling and Support Services'.

<sup>&</sup>lt;sup>2599</sup> State Coroner's Office, Submission no. 70, 111–12.

Centre, (2) streamline communication with families and (3) improve the services delivered to the community by the Coroner's Office. Ongoing support by the service is not limited to families but may extend to witnesses and others affected by the coronial process.

The Family Contact Program is not routinely available in regional Victoria, but a pilot implementation program is being undertaken in Moe. A state-wide service has not been possible due to the lack of a state-wide case management information system to track the progress of cases, and a lack of resources available to the CSS.<sup>2601</sup>

Under the program the CSS, in conjunction with counsellors from the Donor Tissue Bank (which is run by VIFM), makes contact with all families on the day of admission to inform them about the coronial process, their rights in relation to autopsies and tissue donation, and the availability of support services and short-term counselling. Other issues that may be raised include the availability of the autopsy report and the requirement to make a statement for investigators on behalf of the coroner. The CSS also maintains contact with families and interested parties throughout the coronial process and provides a telephone response service. In conjunction with Court Network, it also runs an inquest preparation seminar every three months for interested parties in cases likely to proceed by way of inquest.

In the period from January 2004 to June 2005, the CSS contacted 1759 families in the two days after the death of their relative was reported to the State Coroner. The Coroner's Office submitted that, anecdotally, feedback from families has been extremely positive. In particular, families appreciated receiving information at an early stage, during a time of confusion, regarding the coroner's involvement and likely processes. Families also expressed appreciation for being informed of their rights to object to autopsy, which assisted them to gain a sense of control over their situation and connection with the relative who died.

Interestingly, one of the issues this program was designed to address was that of complaints from family members that autopsies were being performed without their knowledge. In the past, statistics on these complaints were not formally recorded, but the Coroner's Office considered that these complaints were increasing and that this reflected changing attitudes of the community in regard to their rights. Since the pilot program was introduced the number of objections to autopsy has increased, which seems to indicate that, when informed, some families will exercise this right. The

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 $<sup>^{2600}</sup>$  It was identified as a key strategy within the Strategic Business Plan of the State Coroner's Office for the period 1 July 2004 — 30 June 2007.

<sup>&</sup>lt;sup>2601</sup> State Coroner's Office, Submission no. 70, 111.

<sup>&</sup>lt;sup>2602</sup> The CSS also conducted 555 face-to-face counselling sessions with family members (usually around five but up to 20 people per session) and 455 telephone counselling sessions, assisted with 22 identifications, sent out 870 Suicide Bereavement Information kits, conducted six Inquest Information Nights with a total of 130 attendees, and answered 276 professional queries: State Coroner's Office, *Submission no. 70*, 111.

Coroner's Office submitted that, in the 12-month period following the implementation of the program, only one complaint was received in relation to this issue.

Working closely with the CSS is the volunteer non-legal court support service operated by Court Network. Court Network operates its services on site in the Supreme, County, Coroner's, Family, Children's, and Melbourne and district Magistrate's Courts. Court Network also provides its services in most regional cities in Victoria. The service consists of on-site volunteer support for court users on the day of court attendance and is concerned solely and explicitly with the needs of court users. The volunteers do not play a professional counselling role but are able to provide services such as information about inquest processes, referral to legal services and community resources, emotional and practical support, assistance with arranging interpreters and disability access at the courts, pre-court tours for people to familiarise themselves with the courts, and access to the free state-wide Court Network telephone helpline. In recent years the service has assisted more than 1000 people a year in the coronial jurisdiction.<sup>2603</sup> Other volunteers such as the Salvation Army also play a supportive role in the coronial jurisdiction that complements the service offered by Court Network.

A number of support services external to the Coroner's Office are available to those affected by a death subject to coronial investigation. The Committee received a submission from Jesuit Social Services (JSS), which provides a support service specifically to those who are bereaved as a result of suicide. JSS described the service as the only one of its kind in Victoria. It noted that there is a generalist bereavement counselling service in the western suburbs of Melbourne, Mercy Western Grief Services, and that the Australian Centre for Grief and Bereavement at the Monash Medical Centre in Clayton provides bereavement counselling by its students. JSS stated that the Community Bereavement Service was closed in 2004 as part of the Department of Human Services (DHS) review of grief and bereavement services in Victoria. According to JSS, the DHS funding is now allocated to community health centres with long waiting lists and without specialist staff. JSS submitted that there are now very few services which cater to the specific needs of the bereaved. 2604

The Committee notes that various other organisations provide grief support services or referral information services, such as the National Association for Loss and Grief.<sup>2605</sup> The Coroner's Office website has a section that provides information for families regarding the counselling and self-help services available to them, from both the CSS and other agencies. The Committee has included the list of services from the website in Appendix 10 to this report. A further list is contained in a pamphlet

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<sup>&</sup>lt;sup>2603</sup> Court Network Annual Report (2004) 3, available at:

http://www.courtnetwork.com.au/downloads/CourtNetworkAR2004.pdf.

<sup>&</sup>lt;sup>2604</sup> Jesuit Social Services, Submission no. 32, 1.

<sup>&</sup>lt;sup>2605</sup> See <a href="http://www.nalagvic.org.au/">http://www.nalagvic.org.au/</a>.

published by the Coroner's Office entitled 'State Coroner's Office: Counselling and Support Service'.

A list of grief support services and their telephone numbers can also be found on the Better Health Channel website, which is published by the Victorian government and contains health and medical information for consumers. The Better Health Channel website also states that in most communities it is possible to access grief support services through various community organisations, agencies and groups, including hospitals and community health centres, palliative care agencies, volunteer groups, churches, and religious organisations. 2607

Another important issue in relation to support offered during the coronial process is the training of administrative staff. The Coroner's Office is of the view that the two-year rotational posting of coroner's clerks to the Coroner's Office from the Magistrates' Court needs review because the clerks are just beginning to gain experience when it is time for their transfer to another area in the Magistrate's Court system. Another issue is that, in some regional areas, coroner's clerks have little training in how to perform their role in the coronial jurisdiction.<sup>2608</sup>

# **Evidence received by the Committee**

The submissions to the Committee that addressed counselling will be discussed in relation to the need for families to be notified about the service and the need for increased funding and legislative recognition of the service.

#### The need for families to be notified about available counselling

While the Act does not require that family members be informed about the CSS, the Coroner's Office submitted that it is now the general practice of the Coroner's Office to inform families of the availability of the service.

The current information booklet entitled *The Coroner's Process: Information for Family and Friends* also provides information about the availability of the CSS. However, for reasons discussed earlier, this information may not arrive early enough, if at all, in some cases. For example, Ms Smith made the comment that 'most people would never know that the [counselling] service is available'.<sup>2609</sup>

Further, the Coroner's Office website contains an extensive list of support services, services for multicultural Australians, self-help services, support groups, telephone counselling services, and links to other websites with additional information regarding available support. However, some witnesses pointed out to the Committee that,

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<sup>&</sup>lt;sup>2606</sup> See http://www.betterhealth.vic.gov.au/bhcv2/bhcarticles.nsf/(Pages)/Grief\_support\_service?OpenDocument.

<sup>&</sup>lt;sup>2608</sup> State Coroner's Office, Submission no. 70, 104.

<sup>&</sup>lt;sup>2609</sup> Ms Carol Smith, Submission no. 25, 9.

particularly in rural areas, not everyone has access to the internet. Furthermore, as Ms Smith said, conducting research on the internet may not be an ideal option for a person who is suffering from trauma.<sup>2610</sup>

JSS considered that the Act should include a provision requiring families to be informed of the availability of the CSS. JSS submitted that the role of the coroner in regard to death investigation needs to be balanced with a support function 'that integrates good law with good practice', in order to ensure that the legislation can better assist those whom it is trying to serve.<sup>2611</sup>

Finally, the Committee heard from witnesses such as VALS that counselling and support services need to be culturally sensitive and that the counsellors should receive appropriate training in this regard. VALS also suggested that there is a need for a separate, simplified coronial information booklet tailored to the needs of the Indigenous Australian community that draws their attention to the counselling service, (and explains the coronial process generally) in a manner that is appropriate for that community.

# The need for increased funding for and legislative recognition of the counselling and support service

The Coroner's Office envisages that the Family Contact Program will remain a key strategy of the Coroner's Office in ensuring an accessible, responsive and sensitive court service for the community. The Coroner's Office also submitted that the CSS is essential to its ability to ensure that families and others involved in a recent death are provided with as much information as possible about the way the coronial process will affect them in a responsive, timely and culturally appropriate way. The Coroner's Office submitted that, in the future, it is important that a modern coronial service provide short-term counselling and support and, where appropriate, a referral service that is available throughout regional Victoria.<sup>2612</sup>

The Coroner's Office noted that, due to limited resources, few trained coronial support workers are available to assist families affected by death. Ms Sue Wilson, manager of the CSS, has indicated to the Committee that the service lacks sufficient funding and that greater funding would increase the level of support the service could provide to families. Ms Wilson also indicated that further funding would enable the service to be extended to rural coronial jurisdictions, where it appears that professional counselling and support are mostly unavailable at present. Similarly, the Coroner's Office recommended that:

<sup>2611</sup> Jesuit Social Services, Submission no. 32, 2.

<sup>&</sup>lt;sup>2610</sup> Ibid 4.

<sup>&</sup>lt;sup>2612</sup> State Coroner's Office, Submission no. 70, 57.

The Government continue to support the operation of the short term counselling and support program including its implementation across Victoria.<sup>2613</sup>

The Committee is strongly supportive of these views and of the CSS, and it agrees that additional funding is necessary both for the existing service and for its extension to regional Victoria.

A further issue is that there is no legislative requirement for the CSS to operate. The Coroner's Office recommended that the provision of support services for families and others affected by the coronial process be recognised as a core function of the jurisdiction and included as one of the purposes of the Act.<sup>2614</sup> This would underline the importance of the existing service and ensure its ongoing funding, as well as facilitating its extension across regional Victoria.<sup>2615</sup> However, the Coroner's Office considers that the needs of family members and others affected by a death vary from case to case and that therefore the type of support service to be provided should not be prescribed in the legislation. Several other witnesses also submitted that the provision of short-term counselling and support services to families and others affected by deaths subject to coronial investigation should be acknowledged in the Act.<sup>2616</sup>

The Committee was also informed that a short-term counselling and support service attached to the Coroner's Office is vital when a major disaster or terrorism event occurs. The Coroner's Office noted recent experience of the usefulness of a coronial counselling and support service in relation to terrorist bombings in Bali and the Boxing Day tsunami of 2004.<sup>2617</sup>

## Consultants' research findings

The Committee was concerned by the research findings of its external consultants that a significant proportion of the participants were not aware of the availability of counselling, and that this occurred in both regional cases and cases in metropolitan Melbourne.<sup>2618</sup>

The sample size of the study is not large enough to enable generalisations to be made about rural verses metropolitan experiences of counselling services. The results indicated that rural participants were offered more support, by the Coroner's Office and by other agencies, than metropolitan participants.<sup>2619</sup> However, this cannot

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<sup>&</sup>lt;sup>2613</sup> Ibid 116.

<sup>&</sup>lt;sup>2614</sup> Ibid 115–116.

<sup>&</sup>lt;sup>2615</sup> Ibid 11, 57.

<sup>&</sup>lt;sup>2616</sup> Ibid 179.

<sup>&</sup>lt;sup>2617</sup> Ibid 57.

<sup>&</sup>lt;sup>2618</sup> Myndscape Consulting, Review of the Coroner's Act 1985: Final Report, March 2006, 55.

<sup>&</sup>lt;sup>2619</sup> Ibid 56.

be taken as any indication of what usually occurs. Indeed, the Committee received significant evidence to the contrary from witnesses such as the State Coroner.<sup>2620</sup> It should also be noted that the research does not account for recent improvements in the counselling service, as it related to deaths which occurred prior to the implementation of the Family Contact Program.

#### Discussion and conclusion

The evidence received by the Committee suggests that access to counselling and support services is an essential need of families involved in the coronial process.

The Committee recommends that increased funding be provided to enhance the operation of the short-term counselling and support program in Melbourne and to enable its implementation across regional Victoria. The Department of Justice has recently informed the Committee that as a part of the State Coroner's Office Improvement Project,

The two clinicians engaged by the Department will be reviewing and recommending a new model for delivery of timely support services to bereaved families. The new model will be required to provide a quality service to families in both Melbourne and rural and regional Victoria. <sup>2621</sup>

The Committee also considers that the provision of counselling and support services should be provided for in the Act. The Committee has already recommended that the Act be amended such that one of its purposes is to accommodate the needs of, and provide support for, family, friends and others associated with a death subject to coronial investigation.<sup>2622</sup>

In addition, the Committee considers that the Act should be amended to include a provision similar to section 16 of the *Coroners Act 1996* (WA) requiring the State Coroner to ensure that a counselling service is attached to the jurisdiction.

The Committee notes that it has already recommended that the Act be amended to include a provision requiring a coroner who is investigating a death, as soon as practicable after assuming that jurisdiction, to inform the next of kin of the person who has died that a counselling service is available.<sup>2623</sup>

The Committee has already noted the improvement measures that the Department and the Coroner's Office are implementing in relation to communication and

<sup>&</sup>lt;sup>2620</sup> State Coroner's Office, Submission no. 70, 179.

<sup>&</sup>lt;sup>2621</sup> Department of Justice, *State Coroner's Office Improvement Project - Briefing for Victorian Parliament Law Reform Committee*, August 2006.

<sup>&</sup>lt;sup>2622</sup> See above under the heading, 'The needs of family members as a purpose of the Act'.

<sup>&</sup>lt;sup>2623</sup> See above under the heading, 'Notification'. For an example of such a provision in another jurisdiction, see *Coroners Act 1996* (WA) s 20(1)(j).

information practices at the Coroner's Office. These include a number of initiatives which will help to inform families about counselling services, as well as a review of the Family Contact Program by two expert clinicians engaged to provide advice on these initiatives.<sup>2624</sup>

In addition to these initiatives, the Committee recommends that the information booklet entitled *The Coroner's Process: Information for Family and Friends* should be distributed to a wide range of relevant agencies or persons, including police stations, funeral homes, hospitals and religious leaders, in order to ensure that families have access to information about available counselling as soon as possible after a death.

The work of coroners and staff occurs in a context which requires specialised skills and training on how to interact with grieving families in a sensitive and appropriate way. The Department of Justice has informed the Committee of measures which it is currently implementing for this purpose. These include the following:

- The Australian Centre for Grief and Bereavement will be providing training for coroners on grief and bereavement issues shortly.<sup>2625</sup>
- Along with a number of new management positions that have been created, a Programs and Services Manager position is being established. The Manager's responsibilities will include responsibility for community liaison and family support services.<sup>2626</sup>
- Staff position descriptions have been reviewed and departmental performance management systems implemented. Selection processes are also being revised to ensure that staff have the skills needed to work in such a complex and sensitive environment.<sup>2627</sup>
- The ASO Group has been engaged to provide a program on grief and bereavement for staff, with the first session scheduled in August 2006. Training will be included in the induction program for new staff and there will be regular 'refresher' programs.<sup>2628</sup>
- Staff have already completed the Department of Justice's Diversity Training program.<sup>2629</sup>

<sup>2626</sup> Ibid.

<sup>2627</sup> Ibid.

<sup>2628</sup> Ibid.

<sup>2629</sup> Ibid.

<sup>&</sup>lt;sup>2624</sup> Department of Justice, *State Coroner's Office Improvement Project - Briefing for Victorian Parliament Law Reform Committee*, August 2006, 1. The Committee has listed these initiatives earlier in this chapter under the heading 'Notification'.

<sup>&</sup>lt;sup>2625</sup> Ibid 3.

Finally, the Committee notes that following a review of grief bereavement counselling services, in August 2006 Health Minister Bronwyn Pike announced funding for a new specialist bereavement service in Victoria, with a main feature being increased services in rural areas. The service will be operated by the Australian Centre for Grief and Bereavement.<sup>2630</sup>

Recommendation 126. That increased funding be provided to enhance the operation of the short-term counselling and support program in Melbourne and to enable its implementation across regional Victoria.

Recommendation 127. That the *Coroners Act 1985* be amended to include a provision similar to section 16 of the *Coroners Act 1996* (WA) requiring the State Coroner to ensure that a counselling service is attached to the jurisdiction.

Recommendation 128. That the information booklet The Coroner's Process: Information for Family and Friends be distributed to a wide range of relevant agencies or persons, including police stations, funeral homes, hospitals, nursing homes, hospices, community legal centres and religious institutions.

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<sup>&</sup>lt;sup>2630</sup> Minister for Health, '\$2.5 Million for New Specialist Bereavement Service', (Media Release, 3 August 2006).

# CHAPTER NINE – THE CORONER'S OFFICE AND THE STATE CORONER

Having looked in detail at the present system and made recommendations for changes in many areas, the Committee now considers whether these changes to the system require corresponding changes to the way the Coroner's Office functions, its legal status and the status of the State Coroner.

#### The Coroner's Office

The Norris Report, the recommendations of which formed the basis for the *Coroners Act 1985*, noted that there was at that time no statutory provision constituting the Coroner's Court but that its constitution depended on the common law.<sup>2631</sup> The Report recommended codification of the law relating to coroners and, if this was done, that the Coroners Court be established as a court of record by statute.<sup>2632</sup>

While the 1985 Act does codify the law, it does not establish the Coroner's Office as a court. In addition, the Act excludes the operation of common law, <sup>2633</sup> which the Norris Report found was the basis of the pre-1985 Coroner's Court constitution. <sup>2634</sup> Hence the current Coroner's Office is not a court, although it is often referred to in this way.

#### Administrative status

The case of *Harmsworth v The State Coroner* confirms that a Victorian coroner does not exercise curial power.

I am satisfied that when conducting an inquest or making investigations, the state coroner is not a court. The Act is specific in its omission. A Coroner's Court has not been established. In its place the offices of State and deputy coroners have been created: Pt 2, ss. 6 to 8. The common law is to cease to have effect, viz s. 4

...

The second reading speech of the Attorney-General ... while making it apparent the Bill largely reflected the recommendations of the report into the *Coroners Act 1958* prepared by the

<sup>&</sup>lt;sup>2631</sup> John Norris, *The Coroners Act 1958 — A General Review* (1981) 6.

<sup>&</sup>lt;sup>2632</sup> Ibid 103.

<sup>&</sup>lt;sup>2633</sup> Coroners Act 1985 s 4.

<sup>&</sup>lt;sup>2634</sup> John Norris, *The Coroners Act 1958 — A General Review* (1981) 16.

Honourable J Norris QC formerly of this bench, did not set up the Coroner's Court as suggested by him.

A coroner's powers set out in s.7 are inquisitorial and not curial. A coroner does not have the power, formerly exercised, of committing persons for trial.

Despite the fact that the proceedings presently being conducted by the defendant have been referred to as 'the Coroner's Court', it is not. The previous cases and the common law which presumed the coroner to be exercising a curial role, no longer have any application.<sup>2635</sup>

#### Former coroner Ms Jacinta Heffey commented:

The function of a coroner is to investigate and to make specific findings at the conclusion of the investigation. This is an administrative function. ... There is no longer any power to prosecute, commit for trial or charge with criminal offences. The power to recommend and comment is not a judicial power.<sup>2636</sup>

# Other Australian jurisdictions

New South Wales<sup>2637</sup> and the Northern Territory<sup>2638</sup> have coronial systems which have an administrative status as in Victoria. All other Australian jurisdictions<sup>2639</sup> have established their coronial systems as courts or, in the case of Tasmania, as a division of the Magistrates Court.<sup>2640</sup>

### **Evidence received by the Committee**

The status of the Coroner's Office was not specifically addressed in the discussion paper; however, the Coroner's Office submission contained a recommendation that the Office should be established as a statutory coroner's court:

[T]he State Coroner's Office is of the view that the creation of a statutory Coroner's Court of Victoria with associated appointments of coroners and administrative staff would help achieve:

- real independence for the Office of State Coroner;
- consistency with recent interstate legislation and proposals in the United Kingdom;
- acknowledgement of the specialist nature of coronial work; and

<sup>&</sup>lt;sup>2635</sup> Harmsworth v The State Coroner (1989) VR 989, 992.

<sup>&</sup>lt;sup>2636</sup> Jacinta Heffey, Submission no. 33, 13.

<sup>&</sup>lt;sup>2637</sup> Coroners Act 1980 (NSW) s 4.

<sup>&</sup>lt;sup>2638</sup> Coroners Act 1993 (NT) s 4.

<sup>&</sup>lt;sup>2639</sup> Coroners Act 1997 (ACT) s 4; Coroners Act 1996 (WA) s 5; Coroners Act 2003 (Qld) s 64; Coroners Act 2003 (SA) s 10.

<sup>&</sup>lt;sup>2640</sup> Coroners Act 1995 (Tas) s 5.

- reality in the common misconception that the coronial system is already a court.<sup>2641</sup>

In relation to the specialist nature of the work, the Coroner's Office noted that 'staff are almost all appointed on a rotating basis from within the Magistrates' Court with no jurisdiction-related training'.<sup>2642</sup>

The Coroner's Office further submitted that, if this recommendation was not accepted, the word 'independent' should be included in the purpose of the Act in subsections 1(a) and (c) as follows:

- (a) establish the independent office of State Coroner
- (c) set out the procedures for *independent* investigations and inquests by coroners into deaths and fires. <sup>2643</sup>

Barrister Dr Ian Freckelton also believed that a separate court should be established, reaching this conclusion after suggesting that the current multiple roles of a coroner need to be disaggregated.<sup>2644</sup> In particular, he believed that the investigative role of the coroner needed to be undertaken by a separate officer.<sup>2645</sup> The Committee has considered this proposal in chapter five and concluded that it should be given further consideration. As an interim measure the Committee recommended that the Act should be amended to allow a coroner to appoint a special investigator. Dr Freckelton continued:

A few things follow from what I have said. Firstly, it seems to make a great deal of sense to constitute a clear coroner's court because we do not have one under the legislation. Everyone talks about a coroner's court, but it is not official in Victoria. <sup>2646</sup>

Although not directed specifically to this issue, comments made by Ms Heffey would suggest a contrary position in relation to the status of the Coroner's Office. In arguing that the State Coroner needed to be able to issue directions as to how an inquest is conducted she noted that clarification that this was an administrative matter may assist in gaining acceptance of this procedure:

The difficulty in Victoria is perhaps due to the fact that the State Coroner is also a magistrate as are the coroners in country areas. There may, therefore, be a reluctance to issue directions to

<sup>&</sup>lt;sup>2641</sup> State Coroner's Office, Submission no. 70, 50–1.

<sup>&</sup>lt;sup>2642</sup> Ibid 50.

<sup>&</sup>lt;sup>2643</sup> Ibid 42.

<sup>&</sup>lt;sup>2644</sup> Ian Freckelton, *Minutes of Evidence*, 20 September 2005, 204–5.

<sup>&</sup>lt;sup>2645</sup> Ibid.

<sup>&</sup>lt;sup>2646</sup> Ibid.

fellow judicial officers. If the position were clearly stated to be an administrative position and therefore the directions were administrative only, this might cure the problem.<sup>2647</sup>

These comments suggest that Ms Heffey favours the current arrangements, which in her view give greater control to the State Coroner over the coronial system. She sees this as particularly important in rural areas, where magistrates, who may have little experience in coronial matters, sit as coroners.

#### Discussion and conclusion

The Committee notes the points raised by the Coroner's Office in support of the establishment of a Coroner's Court and deals with them in turn.

The independence of the Coroner's Office is a matter which other stakeholders dealt with in terms of the appointment of coroners, which is discussed below. The Coroner's Office submission provides an example from New Zealand where a royal commissioner was found not to have provided natural justice to a key witness, amid allegations that the Prime Minister and the Chairman of the Air New Zealand Board had tried to influence the outcome of the Commission.<sup>2648</sup> The Committee's view is that a royal commissioner is quite different from a coroner, as they are appointed on an ad hoc basis and do not hold a long-term statutory office. The Committee does not believe that the independence of the Coroner's Office is significantly affected by its administrative status.

The Committee notes that most Australian jurisdictions now have coroners' courts<sup>2649</sup> and that these have generally been established within the last 10 years. It is not yet clear what the final form of the new UK Coroners Act will be. However, in its current form the UK Coroners Bill does not establish a coronial court.<sup>2650</sup>

The Committee agrees that the work of the Coroner's Office is specialised and it agrees that staff and coroners require specific training. Continuity of employment within the Coroner's Office (rather than on a rotating basis from the Magistrates' Court) would certainly assist in this regard, but the Committee believes that this outcome can be achieved by administrative means and does not require the establishment of a court.

Last, the Committee does not see the fact that there is a common misconception about the status of the Coroner's Office as a reason to adjust the status of the Office but rather as a matter which requires better public education.

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<sup>&</sup>lt;sup>2647</sup> Jacinta Heffey, Submission no. 33, 14.

<sup>&</sup>lt;sup>2648</sup> State Coroner's Office, Submission no. 70, 50.

<sup>&</sup>lt;sup>2649</sup> See Coroners Act 1997 (ACT) s 4; Coroners Act 2003 (Qld) s 64; Coroners Act 2003 (SA) s 10; Coroners Act 1995 (Tas) s 5; Coroners Act 1996 (WA) s 5.

<sup>&</sup>lt;sup>2650</sup> Coroners Bill 2006 (UK).

The Committee believes that the status of the Coroner's Office in terms of its administrative or judicial character needs to be considered in conjunction with the way in which its hearings, which in the coronial system means inquests, are held. A defining feature of the Victorian coronial jurisdiction since the 1985 Act was introduced is its inquisitorial rather than adversarial approach.<sup>2651</sup> The Committee next considers to what extent and how effectively the current coronial system operates in an inquisitorial manner.

### Inquisitorial rather than adversarial

Part seven of the Act relates to inquests, and section 44 specifies that the rules of evidence are not applicable at an inquest:

A coroner holding an inquest is not bound by the rules of evidence and may be informed and conduct an inquest in any manner the coroner reasonably thinks fit.

This section allows the coroner to conduct an inquest in an inquisitorial manner. Despite this section a number of rights and privileges in relation to witnesses and persons with standing still apply, and the Committee has discussed these in chapter five. The discussion here focuses on the actual practices of the coroner and other participants in an inquest, as reported by stakeholders and commentators. Practices will be influenced by many factors, and legislation may not be the appropriate mechanism for achieving change if change is found to be necessary.

### **Evidence received by the Committee**

Some reference has already been made in chapter eight to the views of family members, a number of whom believed that coronial inquests are unnecessarily adversarial.<sup>2652</sup>

#### Mr David Kaufmann commented:

It is our understanding that the coronial system is meant to be an inquisitorial system. However, it was plainly visible from the moment we entered the court that it was going to be adversarial, and that was exactly what it turned out to be. There were three separate legal teams defending the actions of various police parties. There was a separate legal team for mental health. ... We felt that the battery of barristers, trained in the adversarial system, went against the spirit of an inquiry — the inquisitorial system — and just reinforced the functioning of an adversarial system. It was clear that the barristers were defending their client's actions or inactions rather than trying to get to the truth.<sup>2653</sup>

<sup>&</sup>lt;sup>2651</sup> State Coroner's Office, Submission no. 70, 48.

<sup>&</sup>lt;sup>2652</sup> Caroline Storm, *Minutes of Evidence*, 22 August 2005, 12; Graeme Bond, *Minutes of Evidence*, 22 August 2005, 5.

<sup>&</sup>lt;sup>2653</sup> David and Margrit Kaufmann, *Minutes of Evidence*, 22 August 2005, 62.

A number of stakeholders considered that the main impediment to achieving a more inquisitorial inquest was the training and mindset of the legal representatives. Ms Pauline Spencer of the Federation of Community Legal Centres (FCLC), in response to a question as to whether lawyers should be excluded from some inquests, suggested:

Maybe the better idea is to look at who is practising in the jurisdiction and maybe we need to be looking at coronial specialists and having people who are appropriately trained to work in the jurisdiction who understand the nature of the jurisdiction, that it is an inquisitorial process.

In various inquests the coroners need to be quite forthright with the parties and set the scene and the temperature, I suppose, of the way that the parties are going to conduct themselves...<sup>2654</sup>

The Victorian Institute of Forensic Medicine (VIFM) commented that there was also a lack of understanding by legal representatives of the role of the coronial inquest:

I think it is part of the understanding of and training for what the coroners system is properly about, and I do think understandably the barristers and representatives who have on the day before been arguing the toss in the County Court or the Supreme Court do not necessarily understand what is at stake in the coroners court ... I think it is a little inimical to some of the aims of what the coroners system is trying to do...<sup>2655</sup>

#### VIFM identified the attitudes of coroners as another issue:

It is interesting if you look at coroners' jurisdiction as being an inquisitorial as opposed to an adversarial one, all coroners come from the adversarial system in one form or another and bring all the attitudes and habits that are bred and developed in that organisation into a system that is really different.<sup>2656</sup>

When asked for its views on how the coronial inquest could be less adversarial and more focused on the central inquisitorial purposes of the Act, the Victorian Bar responded:

Being perfectly candid, we think you are stuck with it [the adversarial approach] unless you make a recommendation that legal representation be done away with, which we doubt anyone would want ... it seems to us that once you have representation, part of the representation is to ensure that your client, be it hospital, a family or whatever, is not the subject of an adverse finding ... To do so you have to defend their interests. ... It seems to us it is just part of the process.<sup>2657</sup>

<sup>&</sup>lt;sup>2654</sup> Pauline Spencer, Federation of Community Legal Centres, *Minutes of Evidence*, 19 September 2005, 115.

<sup>&</sup>lt;sup>2655</sup> Stephen Cordner, Victorian Institute of Forensic Medicine, *Minutes of Evidence*, 19 September 2005, 130.

<sup>&</sup>lt;sup>2656</sup> Ibid 128.

<sup>&</sup>lt;sup>2657</sup> Jack Forrest, Victorian Bar, *Minutes of Evidence*, 5 December 2005, 286.

The Coroner's Office identified the coroner's function as investigative and inquisitorial rather than adjudicative and adversarial. The Office also identifies the active promotion of its inquisitorial function as one way in which it seeks to ensure that all relevant information is provided to the coroner, noting that:

To some degree this failure to be open and frank with the State Coroner's Office is the consequence of vestigial adversarial practices and the fear of the consequences of being found personally to have 'contributed' to the death. These are not now part of the coronial investigation system.<sup>2660</sup>

When asked whether coroners needed a more actively inquisitorial process to work in, the State Coroner responded:

A proactive coroner is an inquisitor. I am in the arena all the time ... It is my job to ask questions. 2661

#### Research

Dr Freckelton and Associate Professor David Ranson have commented that coronial practice has not necessarily changed despite legislative change:

Although flexibility is often asserted to be an advantage of the inquisitorial process of inquests, in fact coroners have been loath to move away from traditional adversarial processes in their courts.

...

It is surprising that, liberated from the constraints of the adversary system, as well as the rules of evidence and procedure, coroners have proved conservative and somewhat rigid in their processes. ... the result is that coronial procedures often remain mired in an adversarial model.<sup>2662</sup>

Commentator Mr Michael Hogan also notes the lack of substantial change in practices, in this case referring to the NSW system in 1988 (however, the comment is relevant, particularly in relation to the interrelationship between court status and court operation):

[T]he fact that coroners have usually also been magistrates has significantly influenced the 'modus operandi' of the coronial system, both in relation to the investigation and the inquest. ...

<sup>&</sup>lt;sup>2658</sup> State Coroner's Office, Submission no. 70, 98.

<sup>&</sup>lt;sup>2659</sup> Ibid 132.

<sup>&</sup>lt;sup>2660</sup> Ibid 131.

<sup>&</sup>lt;sup>2661</sup> Greame Johnstone, State Coroner, *Minutes of Evidence*, 19 September 2005, 80.

<sup>&</sup>lt;sup>2662</sup> Ian Freckelton and David Ranson, *Death Investigation and the Coroner's Inquest*, Oxford University Press, Melbourne, 2006, 734–5.

The traditional role of judicial officers in the Anglo-Australian justice system has been that of remote arbiters of proceedings between two parties whose legal rights are directly affected. The mode adopted has been a passive one. Yet an inquest is not strictly a proceeding between parties, nor is it a proceeding the findings of which bind a plaintiff or directly affect legal rights. As the term 'inquest' implies, the appropriate mode is an inquisitorial one. This is the mode that is the tradition of the coronial system not that of the courts of law.

The consequence then of the confirmation of judicial status is to entrench, in the absence of clear legislative guidance otherwise, an inappropriate role and mode in the coronial system.

#### **Discussion and conclusion**

The Committee believes that the inquisitorial nature of the coroner's jurisdiction needs to be strengthened and promoted. Significant evidence was received which attested to the continuing use of an adversarial approach in coronial inquests and its detrimental effects, particularly on family members. In addition, there is evidence that the adversarial approach prevents the full disclosure of information and the ability of the coroner to properly undertake a death investigation.

The Committee does not believe that this requires amendment to the legislation beyond that which has already been recommended in this report. The existing provisions allow the coroner sufficient discretion to operate in an inquisitorial manner. In addition, the Committee recommended in chapter five that the Act be amended to provide that a witness may be compelled to give evidence, even if it may incriminate that witness, provided that a certificate is granted by the coroner to prevent the evidence being used against that witness in other proceedings.

However, the Committee considers that judicial oversight of some decisions of a coroner and his or her findings is essential and it has concluded in chapter five that in appropriate circumstances appeals should be allowed to the Supreme Court, as is currently the case.

The Committee considers that the attitudes and practices of some coroners and legal practitioners need to change before the coronial inquest can become a properly functioning inquisitorial proceeding.

The Committee is concerned by evidence received that coroners do not do enough to ensure that inquests are run in an inquisitorial way, and it considers that this can partly be attributed to their training and long experience in adversarial hearings and a failure to properly appreciate the different approach required in an inquisitorial setting. The Committee acknowledges that this does not apply to all coroners and expects that it is more likely to be applicable to magistrates who infrequently act as coroners than to full-time coroners. Nevertheless, most of the evidence heard from family members relating to this issue concerned cases which took place in the Melbourne Coroners' Court.

The Committee believes that this issue can only be addressed by better training of coroners and of magistrates who will act as coroners. The training should specifically address the different processes which apply to an inquisitorial hearing.

Having dealt with coronial attitudes, the Committee now turns to legal representatives. From the evidence received it is clear that the attitudes of legal representatives also play a significant part in making the inquest a more adversarial process. The Committee notes particularly that the Victorian Bar considered it inevitable that the process is adversarial, as legal representatives were obliged to work in the interests of their clients.

Whilst accepting that these comments reflect the view of many practitioners, the Committee nevertheless notes the point made by the State Coroner and other commentators that the coronial jurisdiction has specifically been narrowed; for example, the power to commit for trial and the obligation on the coroner to make a finding that a person contributed to a death have been removed. These amendments were intended to enhance the jurisdiction's power to operate in an inquisitorial manner.

A coroner's recommendations and adverse findings do not have direct legal consequences. However, in recognition that reputations may be affected by adverse comments, the Committee has recommended in chapter seven that persons be given a right to respond to proposed adverse comments by a coroner before the coroner's findings are made. The Committee believes that these facts need to be given appropriate weight by legal representatives when advising and representing their clients.

The Committee agrees with the comments of the FCLC that specialist practitioners may improve the situation, as such practitioners are likely to develop expertise in the area in relation to both law and practice. The Committee notes that the Law Institute of Victoria recently ran a seminar on the coronial process. The Committee recommends that the Law Institute of Victoria consider making coronial law an area of accredited specialisation for its members, as well as continuing to provide training in this area.

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<sup>&</sup>lt;sup>2663</sup> The seminar was run on 15 June 2006 with the State Coroner, Graeme Johnstone, Ross Ray QC and Dr Ian Freckelton as speakers. Ms Nicole Greenwell, Program Coordinator, Professional Development, at the Law Institute advised that such courses are generally run infrequently and on request. They are unlikely to be held more than once a year in such a specialist field. Telephone conversation, Nicole Greenwell and Committee Executive Officer, 29 August 2006.

Recommendation 129. That the Law Institute of Victoria:

- a) consider making coronial law an area of accredited specialisation for its members; and
- b) continue to provide legal education courses in coronial law.

The Committee's conclusion in relation to the status of the Coroner's Office is that it should not be established as a court, as this would be likely to further entrench the attitude that adversarial practices are appropriate. In this regard it agrees with Mr Hogan's comments, noted above.

The Committee believes that the common perception that the Coroner's Office is a court is part of a general lack of accurate knowledge about the coroner and his or her role. Rather than this being a reason for changing the status of the Coroner's Office, the Committee considers it to be part of the problem. Enhanced education for both the public and the legal profession about the role and function of the Coroner's Office is necessary. This issue is addressed further below in discussion of the State Coroner's role. However, the Committee deals here with one aspect of the public face of the Coroner's Office.

The fact that there is a common misconception that the Coroner's Office is a court is hardly surprising when the building where inquests are held has a large sign on it identifying it as the 'Coroner's Court'. The official website of the Coroner's Office is <a href="https://www.coronerscourt.vic.gov.au">www.coronerscourt.vic.gov.au</a>, and there are numerous references on the site to the 'Coroner's Court'. It is not only the Coroner's Office which uses this terminology. The Attorney-General's Justice Statement of May 2004 also refers to a Coroner's Court. 2664

The Committee believes that, to facilitate a more informed public understanding of the Coroner's Office, the use of this terminology needs to cease and that an alternative way of describing the hearing location should be found. The website address should be changed and references to the Coroner's Court removed from it. Coroner's Office printed publications will also need to be amended. The Department of Justice will also need to assess its use of the term and make appropriate adjustments.

The Committee considers that a shift in attitude to and understanding of the role and practices of the Coroner's Office can only be achieved by clearly distinguishing its functions from those of a court. This work needs to start within the Coroner's Office itself.

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<sup>&</sup>lt;sup>2664</sup> Attorney-General's Justice Statement, 3.0: Modernising Justice (May 2004), 46.

Recommendation 130. That references to the 'Coroner's Court' be removed from the building, website and publications of the Coroner's Office, and from the website and publications of the Department of Justice.

## The State Coroner

The functions of the State Coroner are set out in section 7 of the Act:

- (a) to ensure that a State coronial system is administered and operated efficiently;
- (b) to oversee and co-ordinate coronial services;
- (c) to ensure that all reportable deaths reported to a coroner are investigated;
- (ca) to ensure that all reviewable deaths reported to the State Coroner are investigated;
- (d) to ensure that an inquest is held whenever it is desirable to do so;
- (e) to issue guidelines to coroners to help them carry out their duties;
- (f) such other functions as are conferred or imposed on the State Coroner under this Act. 2665

The general duties of a coroner, which also apply to the State Coroner and Deputy State Coroner, are contained in the main provisions of the Act.

These functions show the extent to which the coronial system has been brought under the leadership and administrative control of the State Coroner. However, there still exists some lack of clarity in the role of the State Coroner in relation to the independence of individual coroners and as to his or her status.

#### Status of the State Coroner

The discussion paper asked stakeholders to comment on the tenure and appointment of the State Coroner. Some witnesses also commented on the status of the State Coroner.

Under the Act, the Governor in Council may appoint a judge of the County Court, a magistrate or a barrister and solicitor to the position of State or Deputy Coroner. Magistrates, acting magistrates, barristers and solicitors may be appointed as coroners. 2667

In Melbourne the State Coroner, Deputy State Coroner and three full-time coroners investigate deaths which have been reported to the Coroner's Office. Outside

<sup>&</sup>lt;sup>2665</sup> Coroners Act 1985 s 7.

<sup>&</sup>lt;sup>2666</sup> Coroners Act 1985 s 6(1).

<sup>&</sup>lt;sup>2667</sup> Coroners Act 1985 s 8.

Melbourne, local magistrates who have also been appointed as coroners investigate local deaths which have been reported.

The Act itself does not specify the length of time that the State Coroner or the other coroners are appointed to their positions. This would however be specified in the terms and conditions of appointment. The recent practice has been for the Governor in Council to appoint the State Coroner for a period of three years.<sup>2668</sup> However, the current State Coroner was reappointed for a two-year term in December 2005.<sup>2669</sup>

#### Other Australian jurisdictions

The length of the period of office varies from jurisdiction to jurisdiction.<sup>2670</sup> In Queensland, South Australia and New South Wales, State Coroners are appointed for a fixed term specified in legislation.<sup>2671</sup> In Queensland and New South Wales the fixed term cannot exceed five years; however, the legislation allows reappointment for one further term. In South Australia the State Coroner is appointed for a fixed term of seven years and is eligible for reappointment.

In the other jurisdictions, as in Victoria, the term of the appointment of the State Coroner is not stated in the legislation.<sup>2672</sup>

In relation to the status of the chief coroner there is also some variation. In New South Wales the State Coroner must be a magistrate, and appointment does not affect tenure, rank or status as a magistrate. The State Coroner has a salary equivalent to that of a deputy chief magistrate. In Queensland the State Coroner must be a magistrate and is also eligible for the same salary and entitlements as a deputy chief magistrate. In Western Australia the State Coroner must be eligible for appointment as a magistrate and has the same salary and entitlements as the Chief Magistrate. 2675

In South Australia and the Northern Territory the State Coroners must be a magistrate, but the acts do not otherwise specify their status.<sup>2676</sup> In the ACT and Tasmania the Chief Magistrate is also the Chief Coroner.<sup>2677</sup>

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<sup>&</sup>lt;sup>2668</sup> It is understood that, if after three years a State Coroner is not reappointed to the position, he or she may return to the Magistracy: Caroline Swift QC, Leading Counsel to the Shipman Inquiry, seminar conducted with Professor Stephen Cordner, Director of VIFM, London, 16 January 2003. Available at <a href="http://www.the-shipmaninquiry.org.uk/transcript.asp?from=a&day=122">http://www.the-shipmaninquiry.org.uk/transcript.asp?from=a&day=122</a>, 14, lines 16-20.

<sup>&</sup>lt;sup>2669</sup> AG media release 20 December 2005.

<sup>&</sup>lt;sup>2670</sup> Butterworths, *Halsbury's Laws of Australia* (at 16 February 2005) 115 Coroners, 'Office of Coroner' [115-40].

<sup>&</sup>lt;sup>2671</sup> Coroners Act 2003 (Qld) s 70(2) and s 83(2); Coroners Act 2003 (SA) s 4(4)(a); Coroners Act 1980 (NSW) s 4A(5).

<sup>&</sup>lt;sup>2672</sup> In Western Australia the State Coroner holds office on the same terms as a magistrate: *Coroners Act 1996* (WA) s 6(4).

<sup>&</sup>lt;sup>2673</sup> Coroners Act 1980 (NSW) s 4A.

<sup>&</sup>lt;sup>2674</sup> Coroners Act 2003 (Qld) s 70.

<sup>&</sup>lt;sup>2675</sup> Coroners Act 1996 (WA) s 6.

<sup>&</sup>lt;sup>2676</sup> Coroners Act 2003 (SA) s 4; Coroners Act 1993 (NT) s 4.

### Law reform agencies

### Royal Commission into Aboriginal Deaths in Custody (RCADC)

The tenure and status of coroners was considered by the Royal Commission into Aboriginal Deaths in Custody (RCADC). In the final report in 1991, Commissioner Elliot Johnston QC recommended that:

the Coroner should be the person basically in charge of investigation of deaths within his or her jurisdiction and those responsibilities should be recognised. The terms and conditions attaching to Senior Coroner or State Coroner's Office should certainly not be less than that of a Judge of a District or County Court.<sup>2678</sup>

The Aboriginal and Torres Strait Islander Commission (ATSIC), in its report on Indigenous deaths in custody, submitted that State Coroners should be appointed on a lifetime basis:

In some jurisdictions, the State Coroner has tenure for only three years. This puts the State Coroner in an invidious position since the renewal of his or her tenure in the position is at the discretion of the executive government. This is in contrast to the position of the judiciary. The decisions of judicial officers do not as consistently deal with matters which are immediately sensitive to the government which appointed them. Coroners must be tenured to ensure their independence and the perception that they are able, fearlessly, to criticise the laws, policies and practices of any government.<sup>2679</sup>

### Luce Report

This report recommended that each national jurisdiction (England and Wales, and Northern Ireland) be led by a full-time Chief Coroner, suggesting that coroners' status should 'perhaps' be at circuit judge level in England and Wales. However, the draft Coroners Bill specifies only that the Chief Coroner have 10 years' general legal experience (as defined) and must retire at age 70.

#### Ontario Law Reform Commission

In 1995 in Canada the Ontario Law Reform Commission recommended that all coroners in Ontario 'should be, and should be perceived to be, independent of local institutions'. <sup>2681</sup>

<sup>&</sup>lt;sup>2677</sup> Coroners Act 1995 (Tas) s 7; Coroners Act 1997 (ACT) s 6.

<sup>&</sup>lt;sup>2678</sup> Royal Commission into Aboriginal Deaths in Custody, *National Report* (1991) vol 1, para 4.5.9.

<sup>&</sup>lt;sup>2679</sup> Aboriginal and Torres Strait Islander Commission, *Indigenous Deaths in Custody 1989–1996*. Available at http://www.atsic.gov.au/issues/law\_and\_justice/rciadic/indigenous\_deaths\_custody/chap12-2.asp.

<sup>&</sup>lt;sup>2680</sup> United Kingdom, *Death Certification and Investigation in England, Wales and Northern Ireland: The Report of a Fundamental Review*, Cm 5831 (2003) 186.

<sup>&</sup>lt;sup>2681</sup> Ontario Law Reform Commission, Report on the Law of Coroners (1995), 191.

Unlike the position in the Australian jurisdictions, in Ontario coroners hold office on a permanent tenured basis until they reach the age of 70.<sup>2682</sup>

### **Evidence received by the Committee**

The Coroner's Office did not specify what status and tenure it considered appropriate for the State Coroner, but it suggested that the Committee needed to consider three factors in relation to this issue: the increasing responsibility of the role; the status of the State Coroner in the community; and the type of work required to adequately perform the role:<sup>2683</sup>

[T]he jurisdiction has become more complex with previously unimportant issues arising such as the high number of police shootings ... and deaths in custody during the 1980s and early 1990s, the increased number and range of reported work-related deaths ... the current gangland killings, increased awareness of the number of preventable deaths occurring in health care facilities and the aging of the Victorian community leading to preventable deaths from agerelated factors such as fractured necks or femur frequently associated with falls in the elderly. 2684

The Coroner's Office suggested that the community sees the State Coroner as the head of an important jurisdiction and that his or her status should reflect this. It offered a summary of other jurisdiction heads in Victoria:

In Victoria, the Chief Magistrate has an appointment equivalent to a County Court judge including unlimited tenure. However, a Deputy Chief Magistrate appointed after amendment of the *Magistrates Court Act* 1989 in 2003 holds a renewable appointment for five years after which he or she may revert to a magistrates' position. The President of the Children's Court is a County Court judge on a renewable five-year appointment to the Children's Court. The State Ombudsman holds office for a term of 10 years and is not eligible to be re-appointed.<sup>2685</sup>

Last, the Coroner's Office notes the multidisciplinary skills required by a State Coroner, including investigatory, administrative, judicial, preventative and educational functions.<sup>2686</sup>

The Victorian Bar believed that fixed-term appointment was appropriate, as it is 'desirable to have the capacity for changes from time to time in the person of the State Coroner'. The Bar felt that 'some rotation is a good thing'. It believed that appointment should be for a fixed term of five years with a limit of one further term. It

<sup>&</sup>lt;sup>2682</sup> The Coroners Act. RSO 1990. c 37.

<sup>&</sup>lt;sup>2683</sup> State Coroner's Office, Submission no. 70, 92.

<sup>&</sup>lt;sup>2684</sup> Ibid 92–3.

<sup>&</sup>lt;sup>2685</sup> Ibid 94.

<sup>&</sup>lt;sup>2686</sup> Ibid 95.

<sup>&</sup>lt;sup>2687</sup> Victorian Bar, Submission no. 81, 6–7.

also felt that the role should be filled by a judge of the County Court, given the nature of the function and the level of judicial skill required.<sup>2688</sup>

Dr Freckelton, for similar reasons in relation to the skills required, also considered that the State Coroner should be a County Court judge and that appointment should be for five years.<sup>2689</sup>

VIFM agreed that the State Coroner should have 'the expertise and status of a senior judicial officer, preferably a County Court judge'. 2690 It did not comment on tenure.

Associate Professor Ranson believed that the status of the position should be at least that of a County Court judge. On the question of tenure he felt that, although indefinite appointment would be in the long-term interests of the jurisdiction, for practical, operational and policy reasons a fixed-term appointment was preferable. He suggested that a five-year term with the possibility of one reappointment would be appropriate. He noted that it was his view that a fixed-term contract would not compromise the independence of the State Coroner's Office.

Ms Heffey believed that a fixed-term appointment was appropriate and should be specified in the Act. She considered that a five-year non-renewable appointment would be appropriate.<sup>2693</sup>

In contrast, Victoria Legal Aid (VLA) felt that a fixed term had the potential to compromise the independence of the position, and it recommended that the RCADC recommendation be adopted giving coroners the same tenure as judges.<sup>2694</sup> The Victorian Aboriginal Legal Service (VALS) also took this view.<sup>2695</sup> Neither commented on the status question.

#### Discussion and conclusion

The Committee agrees with the majority of stakeholders that the appointment of the State Coroner should be for a fixed term of five years and should be specified in the Act. The Committee considers that this gives sufficient protection to the independence of the State Coroner while allowing a capacity for change over time if this is considered desirable. The Committee notes the many benefits which have accrued to the office over the long periods in which the current and previous State Coroners

<sup>2693</sup> Jacinta Heffey, Submission no. 33, 13.

<sup>&</sup>lt;sup>2688</sup> Jack Forrest, Victorian Bar, *Minutes of Evidence*, 5 December 2005, 283.

<sup>&</sup>lt;sup>2689</sup> Ian Freckelton, *Minutes of Evidence*, 20 September 2005, 205.

<sup>&</sup>lt;sup>2690</sup> Victorian Institute of Forensic Medicine, Submission no. 40, 34.

<sup>&</sup>lt;sup>2691</sup> David Ranson, Submission no. 19, 35.

<sup>&</sup>lt;sup>2692</sup> Ibid 35–6.

<sup>&</sup>lt;sup>2694</sup> Victoria Legal Aid, Submission no. 34, 3.

<sup>&</sup>lt;sup>2695</sup> Victorian Aboriginal Legal Service, *Submission no.* 57, 2.

have occupied the role. It therefore considers that there should also be provision for reappointment for one additional term, as this will allow for the retention of expertise and experience where appropriate.

In relation to the status of the State Coroner, the Committee notes that there is considerable agreement amongst stakeholders that the office should have the status of a County Court judge. The predominant reason given was the complexity and breadth of the role and the need to ensure that adequately qualified and experienced persons would be attracted to it. This status is also a recommendation of RCADC and is tentatively supported in the UK in the Luce Report.

Against this the Committee notes that no other Australian jurisdiction has given the State Coroner this status, despite several jurisdictions recently introducing new Coroners Acts. The closest to such a status elevation occurs in Western Australia, where the salary of the State Coroner is the same as that of the Chief Magistrate. However, in that state there is a significant difference between the salary of the Chief Magistrate and that of a District Court (County Court equivalent) judge.

The Committee has noted above its concerns that the inquisitorial nature of the coronial jurisdiction needs strengthening. It was partly for this reason that the Committee did not recommend that the Coroner's Office be established as a court. It has similar concerns that upgrading the position of State Coroner to that of a County Court judge will lead to the appointment of judicial officers even more inclined to bring with them a predisposition to run an adversarial type of hearing.

The Committee also notes the comparison with the status in Victoria of the Chief Magistrate and the President of the Children's Court. The Committee is conscious that the Victorian legal system has an established hierarchy, the basis of which is beyond the scope of this inquiry. It therefore does not consider it appropriate to make a recommendation as to which place in this hierarchy the State Coroner should occupy.

However, the Committee believes that, given the weight of stakeholder evidence supporting enhanced status for the State Coroner, the issue needs to be considered, including whether enhanced status should be achieved by equivalent judicial status, salary or other means. While the Committee has confined itself here to a discussion of the status of the State Coroner, it notes that the Coroner's Office considers that the same factors should be taken into account when considering the status of the Deputy State Coroner. The Committee believes that this issue can only be determined in tandem with consideration of the status of the State Coroner, and it recommends accordingly.

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<sup>&</sup>lt;sup>2696</sup> State Coroner's Office, *Submission no. 70*, 93.

Recommendation 131. That the *Coroners Act 1985* be amended to provide that the State Coroner be appointed for a term of five years, and may be reappointed for one further period of five years.

Recommendation 132. That the Department of Justice determine how the status of the State Coroner and the Deputy State Coroner can be enhanced, whether by equivalent judicial status, salary or other means, to better recognise the complexity and breadth of these roles.

### Coordinating role of State Coroner

The functions of the State Coroner as stated in section 7 of the Act include the following:

- (a) to ensure that a State coronial system is administered and operated efficiently;
- (b) to oversee and co-ordinate coronial services;

. . .

(e) to issue guidelines to coroners to help them carry out their duties;

The Act gives the State Coroner significant administrative and coordinating responsibilities. In the second reading speech for the 1985 Act the then Attorney-General said:

The State Coroner will oversee the coronial system and have general supervisory powers. At present, regional magistrates sit as coroners as required. There is no central co-ordination or regulation of the performance of those functions. It will be one of the principal duties of the State Coroner to ensure that there is a coronial system in place of the existing patchwork quilt.<sup>2697</sup>

The Committee has identified four areas which it considers need attention. These are:

- the delivery of coronial services in rural areas
- guidance and direction provided by the State Coroner to coroners, the effects of which are much more significant in rural areas
- lack of an effective state-wide case management system
- public awareness of the coronial process

### Delivery of coronial services in rural areas

The Coroner's Office identified this issue as one of its major challenges:

<sup>&</sup>lt;sup>2697</sup> Hon J K Kennan, Coroners Bill, Legislative Council Second Reading Speech, 16 October 1985, 370.

It has become clear to the State Coroner's Office that our third major hurdle is to find ways of delivering the coronial service enjoyed in Melbourne to communities in regional and rural Victoria. There, it seems, the Attorney General's 'patchwork quilt' remains in operation despite efforts to provide training, support and backup to country coroners, coronial staff, police investigators and pathologists. ...

There is already a problem with obtaining regional pathology services. Country magistrates frequently perform coronial duties and they would benefit from regular professional development courses in this jurisdiction. Police and court staff in the country are not necessarily focussed primarily on coronial investigations.<sup>2698</sup>

The evidence of a number of family members of their experiences in rural areas has been presented in chapter eight, along with recommendations aimed at alleviating the problems associated with their non-metropolitan location.

The Committee acknowledges that service provision in rural areas is a government-wide challenge in which resource availability inevitably plays a major role. The Coroner's Office's comments show that it is aware of the issue and suggest that the Office intends to increase its focus in this area. The Committee adds its recommendation to a process which it believes has already begun. Below it makes more specific recommendations in relation to the guidance and direction which should be provided to magistrates acting as coroners in rural areas.

Recommendation 133. That the Coroner's Office prioritise the improvement of the delivery of coronial services to rural areas.

### Guidance and direction provided by the State Coroner

Section 7(e) of the Act makes the issue of guidelines to coroners to help carry out their duties a specific function of the State Coroner. The State Coroner's guidelines have been discussed at length in chapter five. The Committee wishes to raise one further issue here which goes beyond the provision of guidelines.

Section 16 of the Act allows the State Coroner to:

give to a coroner directions about an investigation into a death (other than an inquest) and the manner of conducting it.

The Committee considers that this power could be used particularly effectively with new and inexperienced coroners, many of whom will be magistrates in rural areas acting infrequently in coronial matters. The State Coroner could in this way oversee the provision of coronial services, as provided for in his or her functions under the Act.

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<sup>&</sup>lt;sup>2698</sup> State Coroner's Office, Submission no. 70, 11.

### Evidence received by the Committee

The Committee did not receive evidence as to how often this power was exercised by the State Coroner; however, it appeared from other evidence that rural magistrates operated mostly independently when acting as coroners and that there was very little input into their work by the State Coroner. Former coroner Ms Heffey told the Committee:

There is no system of review of findings, let alone the quality of the investigations.

Melbourne Magistrates Court supplies relief magistrates to the country courts on a regular basis. These magistrates may be required to conduct inquests without training.

From my experience, the country courts conduct inquests in situations that would not warrant a formal inquest in Melbourne. Witnesses are called simply to adopt their statements. This does not occur in Melbourne.

I am very concerned that there is a wide discrepancy between the Melbourne investigated death and those in rural areas.<sup>2699</sup>

Ms Heffey raised a further issue that relates to coroners generally but is of particular relevance to magistrates acting as coroners in rural areas:

I can see no reason for the provision in section 16 which enables the State Coroner to issue directions as to the investigation of a death "other than an inquest". In my view the State Coroner should have the power to issue directions as to how an inquest is conducted. It is critical that there should be consistency and as little discrepancy as possible in terms of the quality of the investigation conducted into deaths investigated in rural Victoria and those in urban areas and of the quality of the inquest itself. Further, as I stated earlier, an inquest is only the last stage in an investigation. In most cases, it is not warranted. To list unnecessary inquests has a significant impact on resources and the convenience of witnesses.

In addition Ms Heffey commented on the need for a process whereby the State Coroner can review the investigation process.

The current appeal process is inadequate in that it is confined to determining whether there is a need for an inquest or is directed to determining whether the findings *at inquest* are in some way unsatisfactory. The whole investigation process should be reviewable. That is: the determination of whether a death is a reportable death; whether findings should/may be made without inquest; whether the investigation is adequate; whether the investigation is too far reaching for the purposes of the Act. As a first step, the State Coroner should be applied to by any person aggrieved and his determination should be reviewable after he has in turn reviewed the case.

<sup>&</sup>lt;sup>2699</sup> Jacinta Heffey, Submission no. 33, 14.

### Discussion and conclusion

On the evidence available the Committee believes that the State Coroner is not exercising the power to give directions to coroners as effectively as it could be used and that consideration should be given by the State Coroner to interpreting this power as placing an obligation on him or her to more actively monitor and supervise the coronial investigations of the state's coroners.

The Committee believes that part of this monitoring and supervisory role could be the review process suggested by Ms Heffey, whereby a person who felt that some part of the investigation process was inadequate could request that the State Coroner review the decisions and actions taken by a coroner. The Committee is of the view that the power to do this is already contained in the general functions of the State Coroner in section 7 of the Act but that the State Coroner should set up a formal procedure for dealing with requests for review, the existence of which should be publicised widely. The Committee notes that Ms Heffey suggests that further review of a decision made by the State Coroner should be possible. The Committee does not believe that this is desirable; it prefers that a final determination should rest with the State Coroner, but it notes that a number of decisions, including decisions not to hold an inquest, can already be appealed to the Supreme Court.

The Committee considers that the process suggested by Ms Heffey should however be incorporated into a wider complaints procedure for the entire coronial system. While under this proposal a request for review of a coroner's decision would be made to the State Coroner, the Committee believes that complaints about coronial staff or administrative processes at the Coroner's Office should also be dealt with in a formal and transparent way.

The Department of Justice has recently advised the Committee that the Coroner's Office is currently developing a process to deal with complaints and that a complaints policy and complaints procedures are expected to be finalised by the end of August 2006. The department has further advised that a statement of families' rights is being developed and that this is also expected to be finalised by the end of August 2006. In addition, it has advised that a permanent Quality Management Officer position is to be advertised shortly. As this matter is currently being addressed by the Coroner's Office the Committee does not make recommendations in relation to it, 2701 confining itself to addressing the issue of review of coroners by the State Coroner.

The Committee notes that an expansion of the State Coroner's monitoring and supervisory role should be considered in conjunction with the recommendations for improved and expanded coronial guidelines contained in chapter five. The Committee

<sup>&</sup>lt;sup>2700</sup> Department of Justice, *State Coroner's Office Improvement Project – Briefing for Victorian Parliament Law Reform Committee*, August 2006.

<sup>&</sup>lt;sup>2701</sup> The Committee notes that the Coroners Bill currently under consideration in the UK includes a Family Charter, which may be a useful resource.

believes that these guidelines should significantly improve the consistency of approach to coronial investigations and inquests and that therefore the need for the State Coroner to give directions in particular cases should be limited. Nevertheless the Committee considers that a more active monitoring role is required to ensure that where a need for direction exists, it is identified and addressed. Recommendations for an improved case management system, discussed below, will also improve the State Coroner's capacity to undertake this role.

The Committee also recommends that section 16 of the Act be amended so that the State Coroner may give direction to a coroner in relation to inquests as well as investigations. The Committee believes that such an amendment would further enhance the State Coroner's ability to carry out his or her functions under the Act.

Recommendation 134. That the State Coroner more actively monitor and supervise the coronial investigations of the state's coroners.

Recommendation 135. That the State Coroner set up a formal process for dealing with requests for review of a coronial investigation process, and that the availability of this review process be publicised widely.

Recommendation 136. That section 16 of the *Coroners Act 1985* be amended to remove the words '(other than an inquest)'.

The Committee also agrees with Ms Heffey's comments, quoted earlier in this chapter, that for the State Coroner to be able to make such directions in relation to inquests the status of an inquest will need to remain administrative. This is in keeping with the Committee's previous recommendation that the Coroner's Office should not be established as a court.

### A state-wide case management system

The lack of an adequate state-wide case management system has been identified in chapters five and eight. In chapter five the inadequacies of the current system meant that it was difficult to assess the effectiveness of aspects of the coronial system, as much basic information is not recorded. In chapter eight it was noted that a proper state-wide system would allow monitoring of progress of cases and better provision of information to families. The latter is particularly important given the substantial evidence the Committee received in relation to the adverse effect that long delays in finalisation of matters had on family members and the significance to families of being kept informed of progress. The Committee made a recommendation that the Coroner's Office investigate available systems and implement an appropriate state-wide system.

The Coroner's Office provided some information about its current case management system, which it acknowledges is not state-wide but covers only cases which come to the State Coroner's Office in Melbourne.

The Committee notes that this situation severely inhibits the State Coroner's ability to fulfil his or her functions of ensuring that the coronial system is administered and operated efficiently, and overseeing and coordinating coronial services. Without a centralised system of case management and the ready availability of data, the State Coroner cannot be properly informed as to what is taking place in non-metropolitan areas. The Committee believes that this situation needs to be addressed as a matter of urgency. Given that the Committee has already recommended that a state-wide system be established it does not do so again here.

The Committee notes the recent advice from the Department of Justice that the long term information technology and case management needs of the Coroner's Office are being considered as part of the Integrated Courts Management System project.<sup>2702</sup>

### Public awareness of the coronial process

The issue of how the Coroner's Office is perceived by the public has arisen throughout this inquiry. This issue arises in a number of ways:

- awareness of the obligation to report deaths dealt with in chapter four
- stigma attached to a coronial investigation and consequent reluctance to report cases – dealt with in chapters three and eight
- availability of information about the Office and its role dealt with in chapter eight
- misconceptions about the status of the Office as a court dealt with in this chapter
- accountability and transparency dealt with in chapters three, five, six and seven

The Committee notes that the Coroner's Office has made much progress in increasing public awareness of its role in recent years. Coronial decisions often attract considerable media attention, and good news public safety initiatives which result from coronial recommendations are publicised and promoted by the Coroner's Office.

There is also a considerable amount of information on the Coroner's Office website, and the booklet *The Coroner's Process: Information for Family and Friends* is available.

In addition to the specific recommendations in earlier chapters, the Committee notes that the Coroner's Office website needs to contain as much information as possible to ensure that access to information is easy and the coronial processes are transparent.

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<sup>&</sup>lt;sup>2702</sup> Department of Justice, *State Coroner's Office Improvement Project – Briefing for Victorian Parliament Law Reform Committee*, August 2006.

The Committee suggests that, to coordinate the many aspects of increased public awareness and accountability identified as needing attention in this report, the Coroner's Office develop a public awareness strategy to guide its future work in this area.

In chapter four the Committee made a recommendation for improved education for the medical profession and the public in relation to the obligation to report deaths. In this chapter the Committee makes a more general recommendation for a State Coroner's function to promote community awareness. The Committee recommends that the approach taken in the New Zealand Coroners Act 2006 should be adopted in Victoria. The NZ Act includes as a function of the Chief Coroner:

(I) to help, by education, publicity and liaison with the public, to promote understanding of, and co-operation with, the coronial system provided for by this Act<sup>2703</sup>

The Committee considers that placing the educative role of the State Coroner in the Act in this way would recognise the importance of this function and assist the State Coroner to further incorporate it into his or her work.

Recommendation 137. That the *Coroners Act 1985* be amended to include as a function of the State Coroner: to help, by education, publicity and liaison with the public, to promote understanding of, and co-operation with, the coronial system provided for by this Act.

### A coronial council

The Committee has referred in chapters four and five to the establishment of a coronial council. The context in chapter four was the need to establish whether particular kinds of workplace deaths should be reported to a coroner. Clarification was needed in relation to deaths which may have been workplace related, such as mesothelioma, but which occurred many years later, when the employee had left the workplace concerned. Such decisions were seen as matters of policy rather than strictly of law or medicine and hence it was thought appropriate that they should be made by an external expert body rather than the State Coroner.

This suggestion was put forward by VIFM, and the Committee considers that it has considerable merit. VIFM describes it as follows:

The UK Home Office position paper on "Reforming the Coroner and Death Certification Service" recommends that an advisory Coronial Council be established to provide advice to the Coronial Service. The Council would comprise representatives from professional stakeholders as well as lay organisations. A new model for the Victorian coronial jurisdiction would benefit from such a council which in effect would be giving an expanded role and representation to the Medical

<sup>&</sup>lt;sup>2703</sup> Coroners Act 2006 (NZ) s 5.

Advisory Group (see paragraph 2.1). The proposed Coronial Council is not intended to impinge on the independent judicial function of the Coroners Court, but to take on the role of reviewing research and providing the policy direction for death investigation. It could ensure an evidence-based approach to allocating resources to death investigation by examining coronial data on trends in death and determining public interest priorities.<sup>2704</sup>

The Committee considers that such a council would ensure that appropriate policy decisions relating to the Coroner's Office could have input from experts with medical and epidemiological expertise, as well as in other areas as deemed appropriate and depending on the council's mandate.

The UK Home Office position paper describes its proposed coronial council as follows:

We believe that the new system must be open to advice from those with whom it deals. We therefore propose to create an advisory Coronial Council ... on a statutory basis, whose members could be drawn from the various professional stakeholders as well as lay organisations. A Council could be an effective way to harness relevant experience and expertise to assist any new arrangements to deliver a responsive and informed service for all those affected by, or with a professional interest in, deaths. <sup>2705</sup>

In chapter five the Committee suggests that a coronial council could also play a role in the development of coronial guidelines and determining the training needs of coroners.

The scope of the councils envisaged by VIFM and the UK Home Office appear to be somewhat different. While the VIFM proposal focuses on medical expertise, suggesting that the council could be an expanded version of the existing Medical Advisory Group, the UK Home Office council appears to have more in common with a user group which would include a wider representation. The Committee believes that each would address different aspects of Coroner's Office work.

The Committee considers that such a council could serve the following purposes:

- provide advice to the government on an evidence-based approach to allocating resources to death investigation by examining coronial data on patterns and trends in deaths and reviewing research to determine public interest priorities
- set policy at the Coroner's Office in relation to issues where the legislation allows for some variation in interpretation and a decision could have significant resource implications — for example, the decision to require the reporting of all mesothelioma cases, as discussed in chapter four

<sup>&</sup>lt;sup>2704</sup> Victorian Institute of Forensic Medicine, *Submission no. 40*, 36–7.

<sup>&</sup>lt;sup>2705</sup> UK Home Office position paper, 'Reforming the Coroner and Death Certification Service', 18.

- develop protocols to regulate interaction with other agencies, particularly where their role has the potential to overlap with the coronial role
- develop guidelines, standards or other documents intended to regulate the activities of coroners or the Coroner's Office; for example, a complainants' procedure
- allow input from stakeholders and user groups, including professional and lay organisations

The Committee considers that, as well as the medical expertise recommended by VIFM (which would include VIFM representatives), the council should include the State Coroner, a magistrate representing rural coronial services, representatives of organisations related to specific safety issues such as road safety and workplace safety, and groups who can represent the interests of family members of those involved in the coronial process.

The Committee believes that a coronial council should be established in Victoria and that its final membership should be determined after more detailed work has been done to establish the specific purpose and focus of the council.

Recommendation 138. That the Department of Justice establish a coronial council.

## CONCLUSION — OVERVIEW OF AN IMPROVED DEATH INVESTIGATION SYSTEM

The Committee concludes this report with a summary of the new system which it believes will provide a better death investigation system for Victoria. The many suggested improvements to the system have been assessed and determined in the preceding chapters and specific recommendations made.

Here the Committee draws together these threads to provide an overview of what the new system would look like.

The key features of the system will be:

- Recognition of the needs of the family and friends of a person whose death is investigated by a coroner, and making the system more considerate of and responsive to those needs. This includes ensuring that cultural sensitivities are considered and rights enhanced.
- Expanded categories of reportable deaths to ensure that all deaths are investigated where the public interest is served in such an investigation. This particularly applies in relation to vulnerable groups in the care or custody, or under the auspices of, the state.
- Strengthened death-reporting requirements, including who may complete the medical certificate of the cause of death (MCCD) and in what circumstances — to address under-reporting and misreporting
- Removal of the auditing of MCCDs from the responsibility of the Registrar of Births, Deaths and Marriages — to ensure that medical expertise is applied to the task
- A stronger focus on medical input at the front end of the death investigation system, which will see an enhanced role for VIFM in determining which deaths require further investigation and in auditing MCCDs
- Better communication with and involvement of families in relation to a decision to conduct an autopsy
- Improved investigation procedures and the expansion of specialist assistance to coroners
- Improved use of electronic databases for recording, auditing and analysing deaths

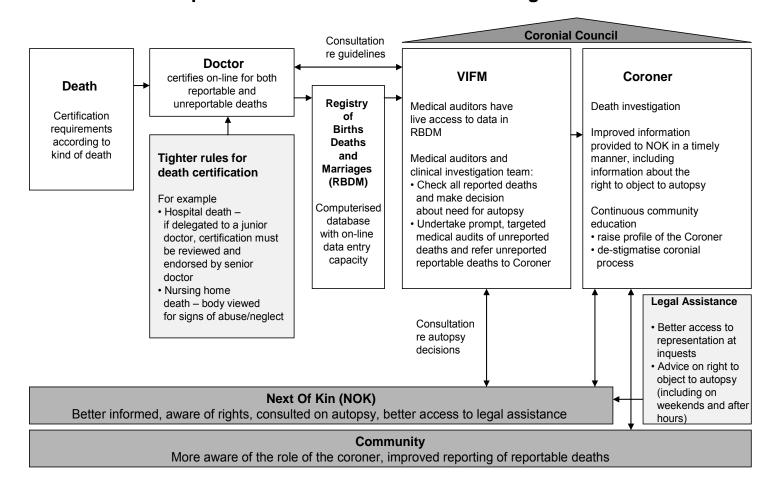
- A focus on improving inquest practices and outcomes through the adoption of a more inquisitorial approach and by abrogation of the privilege against selfincrimination in certain circumstances
- Improved accountability and transparency, provided through annual reports to Parliament and by key documents such as coronial policies, standards, protocols and guidelines being made publicly available
- Making the prevention of injury and death a specific purpose of the Act
- Strengthening the system of coronial recommendations by coordinating and centralising their content and release through the State Coroner
- Improved research capacity at the Coroner's Office
- The imposition of an obligation for mandatory responses to recommendations
- Enhanced supervisory and coordinating functions of the State Coroner to ensure better outcomes and consistency of coronial investigations, particularly in rural areas
- Enhanced training for coroners across the State
- The establishment of a state-wide case management system
- The establishment of a Coronial Council to determine policy direction
- Improved public awareness of the role, functions and practices of the coronial system

**Adopted by the Committee** 

4 September 2006

Figure 5 - Proposed Death Certification and Investigation Model

### **Proposed Death Certification and Investigation Model**



### APPENDIX 1 - LIST OF SUBMISSIONS

No.	Date of Submission	Name	Affiliation
1	11 April 2005	Mr Graeme Johnstone	State Coroner's Office
2	13 May 2005	confidential	
3	15 July 2005	Mrs Lynette King	Private individual
3S	21 September 2005	Mrs Lynette King	Private individual
4	8 June 2005	The Hon. Philip Ruddock MP	Commonwealth Attorney-General
5	8 June 2005	Mr Julian Knight	Private individual
6	20 June 2005	Dr Patrick van der Hoeven	Private individual
7	22 June 2005	Ms Lorraine Long	Medical Error Action Group
7S1	19 September 2005	Ms Lorraine Long	Medical Error Action Group
7S2	14 September 2005	Ms Lorraine Long	Medical Error Action Group
8	21 June 2005	Ms Dawn Staley	Private individual
9	Duplicate		
10	5 July 2005	Ms Barbara Friday	Family Services & Community Education Unit, SIDS and Kids Victoria
11	5 July 2005	Mr Cecil Watt	Private individual
12	18 July 2005	Dr David Westmore	World Federation of Doctors Who Respect Human Life
S 12	3 November 2005	Dr David Westmore	World Federation of Doctors Who Respect Human Life
13	13 July 2005	Mr Dave Taylor	Springvale Monash Legal Service Inc
14	3 July 2005	confidential	

15	7 July 2005	Ms Ella Lowe	Nurses Board of Victoria
16	4 July 2005	Prof Brian Tress	Radiation Advisory Committee
17	24 June 2005	Ms Elizabeth Kennedy	Royal Children's Hospital, Melbourne
18	13 July 2005	Ms Elizabeth Kennedy	Royal Women's Hospital, Melbourne
19	14 July 2005	Dr David Leo Ranson	Private individual
20	15 July 2005	Ms Emilia Arnus	Representing Constituents of East Yarra Province
21	13 July 2005	Mr Jonathan Rush	The Victorian Surgical Consultative Council
22	14 July 2005	Prof. Larry McNicol	Victorian Consultative Council on Anaesthetic Mortality and Morbidity
23	14 July 2005	confidential	
24	6 July 2005		Clinical Liaison Service, Coronial Services Centre
25	14 July 2005	Mrs Carol Smith	Private individual
26		Mrs Hazel Watt	Private individual
27	14 July 2005	Mr Paul Morgan	SANE Australia
28	12 July 2005	Mrs Caroline Storm	Private individual
29	15 July 2005	Ms Sarah Staub Alyena Mohummadally	Disability Discrimination Legal Service Inc (DDLS)
30	13 July 2005	Andrew & Karyn Kennedy	Private individuals
31	15 July 2005	Mr Neil Bibby	Country Fire Authority (CFA)
32	14 July 2005	Mrs Julie Edwards	Jesuit Social Services
33	12 July 2005	Ms Jacinta Heffey	Children's Court of Victoria
34	14 July 2005	Mr Tony Parsons	Victoria Legal Aid (VLA)

35	15 July 2005	Dr Shelley Robertson	Private individual
36	15 July 2005	Mr Peter David Mr Bob MacDonald	Volunteer Fire Brigades Victoria
37	18 July 2005	Dr Eleanor Flynn	Private individual
38	15 July 2005	Dr Paul Woodhouse	Australian Medical Association (AMA) - Victoria
39	15 July 2005	Mrs Jill Clutterbuck	Australian Nursing Federation (ANF) - Victorian Branch
40	19 July 2005	Prof Stephen Cordner	Victorian Institute of Forensic Medicine (VIFM)
41	15 July 2005	Mrs Vivienne Topp	Mental Health Legal Centre Inc
42	18 July 2005	Ms Kathryn Booth	Maurice Blackburn Cashman Lawyers
43	13 July 2005	Mrs Anne Anderson	Private individual
43S	22 August 2005	Mrs Anne Anderson	Private individual
44	18 July 2005	Mr Bill Newton	General Practice Divisions Victoria
45	19 July 2005	Dr Mark Garwood	Austin Health
46	15 July 2005	Ms Jennifer Williams	Bayside Health
47	15 July 2005	Mrs Helen Rowan	The Royal Children's Hospital, Melbourne
48	16 July 2005	Mr Graeme Bond	Private individual
49	25 July 2005	Ms Marion Stevens	Private individual
50	22 July 2005	Mr Kerry Power	Transport Accident Commission (TAC)
51	25 July 2005	Mr Dermot Casey	Australian Council for Safety and Quality in Health Care
52	25 July 2005	Mr David Nicholson	Metropolitan Fire and Emergency Services Board (MFB)

53	15 July 2005	Dr Bernadette Matthews	Life Saving Victoria - Royal Life
			Saving
54	15 July 2005	Ms Raina Smith	The South Pacific Foundation of Victoria Inc
55	22 July 2005	Ms Pauline Spencer	Federation of Community Legal Centres (Vic) Inc
56	26 July 2005	Mr Ian F X Stoney	Medical Practitioners Board of Victoria
57	25 July 2005	Mr Frank E Guivarra	Victorian Aboriginal Legal Service Co-operative Ltd (VALS)
S571	17 May 2006	Mr Frank E Guivarra	Victorian Aboriginal Legal Service Co-operative Ltd (VALS)
58	27 July 2005	Ms Victoria Strong	Law Institute of Victoria (LIV)
59	22 July 2005	Prof Napier Thomson	The Royal Australasian College of Physicians
60	2 August 2005	Mr Paul Chadwick	Office of the Victorian Privacy Commissioner
61	4 August 2005	Ms Barbara Minuzzo	The Victorian Safe Communities Network (VSCN)
62	29 July 2005	Ms Beth Wilson	Health Services Commissioner
63	25 July 2005	Dr Rosemary Bryant	Royal College of Nursing Australia
64	5 August 2005	Mr Bill Noonan	Transport Workers Union of Australia
65	19 August 2005	Dr Debra Graves	The Royal College of Pathologists of Australia
66	7 August 2005	Mr Leon Hain	Private individual
66S	13 September 2005	Mr Leon Hain	Private individual
67		confidential	
68	15 August 2005	Ms Kathleen Hurley	Private individual

69	16 August 2005	Prof Kathy Laster	Victoria Law Foundation
70	15 August 2005	Mr Graeme Johnstone	State Coroner 's Office
71	1 September 2005	David and Margrit Kaufmann	Private individuals
72	24 August 2005	The Hon Marsha Thomson, MP	Minister for Consumer Affairs
73	31 August 2005	Mr Philip Kostos	State Committee of the Royal College of Pathologists of Australasia
74	8 September 2005	Ms Fiona Williams	Office of the Emergency Services Commissioner
75	13 September 2005	Mr Peter Robinson	Transport Industry Safety Group, Knox City Council
76	20 September 2005	Mr Frank Diconi	Private individual
77	23 September 2005	The Hon. John Thwaites, MP	Minister for Victorian Communities
S771	13 December 2005	The Hon. John Thwaites, MP	Minister for Victorian Communities
S772	5 May 2006	Ms Helen Trihas	Department of Victorian Communities
78	7 October 2005	Ms Jenny Peachey	Victoria Police
79	28 October 2005	Mr Jason Rosen	Association for the Prevention of Medical Errors
80	14 November 2005	Hon. Gavin Jennings, MLC	Minister for Aboriginal Affairs
81	22 December 2005	Ross Nankivell	The Victorian Bar
82	26 January 2006	Martha and Nigel Baptist	Private individuals
83	24 March 2006	Ms Elaine Harrington	Private individual
84	27 July 2006	Dr James F King	Consultative Council on Obstetric and Paediatric Mortality and Morbidity

## APPENDIX 2 – LIST OF WITNESSES

No.	<b>Date of Meeting</b>	Witness	Affiliation
1	22 August 2005 Melbourne	Mr Graeme Bond	Private Individual
2		Mrs Caroline Storm	Private Individual
3		Ms Carol Smith	Private Individual
4		Ms Marion Stevens	Private Individual
5		Ms Katherine Brand	Private Individual
6		Dr Maartje Van-der-Vlies	Private Individual
7		Mrs Lynette King	Private Individual
8		Mrs Anne Anderson	Private Individual
9		Mr Leon Hain	Private Individual
10		Mr David Kaufmann	Private Individual
11		Mrs Magrit Kaufmann	Private Individual
12		Mr David Taylor	Springvale Monash Legal Centre
13	19 September 2005 <b>Melbourne</b>	Mr Graeme Johnstone	State Coroner
14	Weibourne	Mr Ian West	Deputy State Coroner
15		Mr Rick Roberts	Registrar State Coroner's Office
16		Ms Lorraine Long	Founder  Medical Error Action Group
17		Ms Isabell Collins	Director Victorian Mental Illness Awareness Council
18		Ms Elizabeth Kennedy	Corporate Counsel

19		Ms Helen Kane	Coordinator, Reproductive Loss Services Royal Women's Hospital
20		Ms Pauline Spencer	Executive Officer
21		Mr Charander Singh	Human Rights Advocacy Worker Federation of Community Legal Centres
22		Mr Hugh de Kretser	Principal Community Lawyer Brimbank Melton Community Legal Centre
23		Professor Stephen Cordner	Director
24		Associate Professor David Wells	
25		Ms Helen McKelvie	Manager, Medico-Legal Policy and Projects, Victorian Institute of Forensic Medicine
26	20 September 2005 <b>Melbourne</b>	Mr Dave Taylor	Community Development Worker, Springvale Monash Legal Service
27		Mr Mark Cannon	Student
28		Ms Pauline Giliberto	Student
29		Mr B. Hodgson	Student  Monash University
30		Mr Aron Gingis	Private Individual
31		Ms Alyena Mohummadally	Community Legal Education and Volunteer Coordinator
32		Ms Sarah Staub	Student Disability Discrimination Legal Service

33		Ms Raina Smith	Chair
34		Mr G. Hallett	Elder South Pacific Foundation, Victoria
35		Mr Bill O'Shea	Council Member
36		Mr A. Closey	Solicitor, Criminal Law And Litigation Lawyers Section, Law Institute of Victoria
37		Ms Beth Wilson	<b>Health Services Commissioner</b>
38		Dr Ian Freckelton	Barrister and Academic
39	28 November 2005 <b>Melbourne</b>	Mr Bill O'Shea	Corporate Counsel  Bayside Health
40		Professor Catriona McLean	Director of Anatomical Pathology <b>The Alfred</b>
41		Dr Eric Wigglesworth AM	Honorary Senior Research Fellow Monash University Accident Research Centre
42		Ms Margaret Way	Director Of Strategy, Risk and Clinical Governance
43		Dr Andrea Kattula	Medical Leader, Clinical Governance
44		Mr Simon Rosalie	Mortuary Scientist Austin Health
45		Associate Professor David Ranson	Deputy Director
46		Dr Noel Woodford	Forensic Pathologist
47		Ms Helen McKelvie	Manager, Medico Legal Policy Victorian Institute of Forensic Medicine (VIFM)

48		Professor Joseph Ibrahim	Research Manager
49		Ms M. Bohensky	Research Officer
50		Associate Professor David Ranson	Director, Clinical Liaison Service Clinical Liaison Service (joint service of VIFM and the State Coroner's Office)
51	5 December 2005 Melbourne	Acting Commander Trevor Carter	Policy and Secretariat Division, Corporate Strategy and Performance Department
52		Senior Sergeant Anthony O'Connor	Legal Policy, Corporate Strategy and Performance Department;
53		Senior Constable Susan Nolan	State Coroner's Assistants' Unit, Coronial Services Centre Victoria Police.
54		Mr Peter Davis	Executive Officer
55		Mr Bob MacDonald	Executive officer Volunteer Fire Brigade (VFB)
56		Commander Ian Hunter	Fire Investigation And Analysis Unit Metropolitan Fire and Emergency Services Board (MFB)
57		Mr Jack Forrest, QC	
58		Mr Ross Nankivell	Legal Policy Officer Victorian Bar Council.
59		Mr Mike Zaccaro	Civil Law Solicitor
60		Ms Greta Jubb	Research Officer Victorian Aboriginal Legal Service (VALS)
61		Mr Neil Bibby	Chief Executive Officer Country Fire Authority (CFA)

62	Ms Vivienne Topp	Lawyer  Mental Health Legal Centre.
63	Dr Shelley Robertson	Private individual
64	Ms Helen Trihas	Registrar Registry of Births, Deaths and Marriages
65	Ms P. Digby	Executive Director, Local Government Victoria and Community Information Division, Department for Victorian Communities.

### APPENDIX 3 – LIST OF MEETINGS

Tuesday 21 June, Toronto

### Office of the Chief Coroner

Dr Barry McLellan Chief Coroner for Ontario

Dr Jim Cairns Deputy Chief Coroner (Investigations)

Dr Bonita Porter Deputy Chief Coroner (Inquests)

### **Centre of Forensic Science**

Dr Ray Prime Director

Dr Joel Mayer Deputy Director, Scientific Affairs

Thursday 23 June, Halifax

### Office of the Chief Medical Examiner

Dr Mathew Bowes Acting Chief Medical Examiner

Mr Jonathan Davies QC Department of Justice, Legal Services Division

Ms Linda Mosher

### **Ministry of Justice**

Hon Michael Baker QC Minister of Justice

Mr Doug Keefe QC Deputy Minister of Justice

## Monday 27 June, London **Northern Ireland Court Service** Mr Eric Strain Coroners Service Branch **Manchester Coroner** Mr Leonard Gorodkin **INQUEST** Ms Helen Shaw Co-Director Ms Deborah Coles Co-Director **London Coroner** Dr Roy Palmer Tuesday 28 June, London **Department of Constitutional Affairs** Mr Tony Woolfenden Head of Coroners Unit Ms Judith Burnstein Mr Michael Dunkley **London Coroner** Dr Paul Knapman

### **Chair of the Shipman Inquiry**

Deputy Coroner

Dame Janet Smith

Ms Selena lynch

Thursday 30 June, Dublin	
Irish Coroners	
Dr Mary Flanagan	
Dr Brain Farrell	
Ms Helen Lucy	
Mr Eugene O'Connor	
Dr Desmond Moran	
Ms Mary Callahan	
Dr Dennis Cussack	
Dr Desmond Moran	
Civil Law Reform Division	
Mr Brendan MacNamarra	Principal Officer
Ms Caroline Murphy	Assistant Principal Officer
Mr Donica O'Sullivan	
Monday 4 July, Helsinki	
University of Helsinki, Depart	tment of Forensic Medicine
Dr Erkki Vuori MD	Professor, Head of Department
D. E. H. T	
Dr Erkki Tiainen MD	Senior Medical Examiner Provincial State Office of Southern Finland
Dr Phillipe Lunetta MD	Forensic Pathologist
Helsinki Police Department	

Police Officer

Mr Mika Tauru,

# APPENDIX 4 – MEDICAL CERTIFICATE OF CAUSE OF DEATH (MCCD) – REGISTRY OF BIRTHS, DEATHS AND MARRIAGES

bcm Medi	ersor	Certificate of aged 28 days or o	Marriages Victoria of Cause of Death over  a Act 1996 & Regulations 1997	SAMPLE
(Information about reportable No Go to question 2) Yes You cannot use	ole and  2. this fo	d reviewable deaths is prov	h Section 13 of the Coroners Act 1985 ided on the back page of this form) eath. The death must be reported as arge of a police station.	and BLOCK letters complete this form. These certificates produced on carbon
Details of the decease	ed p	erson		
2. Surname of the deceased p	person	1	Given name(s)	
		DLE		
3. Date of birth (dd/mm/yyyy)	SP	Age at death	Sex	
4. How was the deceased idea Personal knowledge			Male Female Name of relative dentification	
5. Date of death (dd/mm/yyyy)		Date last seen alive by y		
1 1		1 1		SAMPLE
7. Place of death (full address				Postcode
	of Abo	ding town/suburb)  priginal or Torres Strait Islam  Yes Aborig	nder origin?	
<ul><li>7. Place of death (full address</li><li>8. Was the deceased person on the property of the property of</li></ul>	of Abo	ding town/suburb)  priginal or Torres Strait Islam  Yes Aborig	nder origin?	Postcode  Both
<ul> <li>7. Place of death (full address</li> <li>8. Was the deceased person on the person of the pe</li></ul>	e BL	original or Torres Strait Islam Yes Aborig  OCK letters)	nder origin?	Postcode
7. Place of death (full address  8. Was the deceased person of No Go to question 9.  9. Cause of Death (us)  Part 1  Disease or condition directly leading to death This means the disease, injury or complication that caused death, not only the mode of dying, such as heart failure, respiratory failure etc  Antecedent causes (b) - (d)  Morbid condition, if any, giving rise	e BL	original or Torres Strait Islan Yes Aborig  OCK letters)  Description of causes	nder origin? inal Torres Strait Islander	Postcode  Both  Duration between onset & dea
7. Place of death (full address  8. Was the deceased person of No Go to question 9.  9. Cause of Death (us)  Part 1  Disease or condition directly leading to death This means the disease, injury or complication that caused death, not only the mode of dying, such as heart failure, respiratory failure etc  Antecedent causes (b) - (d)	e BL	original or Torres Strait Islan Yes Aborig  OCK letters)  Description of causes	nder origin? inal Torres Strait Islander   Due to	Postcode  Both
7. Place of death (full address  8. Was the deceased person of the property of	e BL	original or Torres Strait Islan Yes Aborig  OCK letters)  Description of causes	nder origin? inal Torres Strait Islander  Due to	Postcode  Both  Duration between onset & dea
7. Place of death (full address  8. Was the deceased person of the property of	(a) - (b) - (d) -	original or Torres Strait Islan Yes Aborig  OCK letters)  Description of causes	nder origin? inal Torres Strait Islander  Due to	Postcode  Both  Duration between onset & dea
7. Place of death (full address  No Go to question 9.  9. Cause of Death (us)  Part 1  Disease or condition directly leading to death This means the disease, injury or complication that caused death, not only the mode of dying, such as heart failure, respiratory failure etc  Antecedent causes (b) - (d)  Morbid condition, if any, giving rise to the above cause, stating the underlying condition last	(a) - (b) - (d) - (d) -	original or Torres Strait Islam Yes Aborig  OCK letters)  Description of causes	nder origin? inal Torres Strait Islander  Due to	Postcode  Both  Duration between onset & dea

. Is there a cardiac pacemaker	in the body of t	the decea	ased person?			
No Yes						
. Was an operation performed	on the decease	d within 4	weeks before death?			
No Go to question 12.			. 6			
Yes Specify the type of	foperation	1.	MPLE			
and disease/condi	tion	SP		AND THE ST		
Was the deceased pregnant v	vithin 12 month					
No Go to question 13.						
Yes Specify the timing	of pregnancy	Within 6	weeks of death	Between 6 wee	ks and 12 months of death	
. Who is organising the dispose	of the deceas	ed's hum	an remains?			
A funeral director Next of		icu s riuri	an remains:			
Specify the name, telephone in		drace of t	he funeral director or r	person disposing of	romaine	
Name	idiliber and ad	G1633 01 1	the fulleral director of p	Telephone numb		
Address				TOTOPHOTIO HUITE	331	
. Is the deceased person under	10 years of an	-0				
		le.				
No Go to question 15.						
(whether full or ha	If blood) of the	decease	d person. If the brothe	r or sister is decease	n and ages of any brothers and sisters sed, enter 'D' in the age column. If no	
born alive, enter 'SB	' in age column.	If more th	nan five brothers and s	isters, attach a sep	arate sheet with details.	
Name of brother or sister (given names and surname)	Date of birth (dd/mm/yyyy)	Age	Place of birth (State or country)	Name of parer Mother	nts (given names and surname) Father	
(given names and samane)	(dd///ii/yyyy)		(State of Country)	Motriel	rather	
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autification of Madical	D	PANIE NIII				
ertification of Medical	THE REAL PROPERTY.					
<ul> <li>I hereby certify that I am a cur</li> <li>I believe this death did not n</li> </ul>	rently registere	d Medica	Practitioner and that:			
. I have not acquired and do no	t anticipate acqu	uiring any	property or pecuniary o	r other benefit by rea	son of the death of the deceased; and	
<ul> <li>I was responsible for the me</li> <li>I examined the body of the a</li> </ul>	abovementione	e aboven d deceas	nentioned deceased pe ed person after death	erson immediately b and that the particu	pefore death; or lars and cause of death written	
above are true to the best of	f my knowledge	and beli	ef.			
Signature of of medical practition	oner	Full	printed name	MPLL	Date	
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X	Da	Daytime telephone number			Email address	
X MPBV registration number						
MPBV registration number						

#### APPENDIX 5 – DOCTORS AND DEATH: CERTIFICATES AND CORONERS

Stephen Cordner, Professor, Forensic Medicine, Monash University, Director of the Victorian Institute of Forensic Medicine.

Helen McKelvie, Manager, Medico-legal Policy and Projects, Victorian Institute of Forensic Medicine

#### 1. Introduction

Medico-legal matters are not generally appealing to doctors and it is therefore not surprising that the legal obligations adhering to a patient's death are not the most popular or well-understood part of medical practice. This article aims to remind and update doctors about their obligations in relation to death certificates and reporting certain deaths to the coroner. This comes at a time when death certification and coronial processes are under increased scrutiny – the public attention and concern arising from allegations that Dr Harold Shipman killed over 200 of his patients in the UK, (he was convicted of 15 murders), have led to the question being asked if such crimes could be similarly concealed here. The Victorian Parliamentary Law Reform Committee is currently considering this as part of a larger review of the Coroners Act 1985, and is due to complete its report by the end of June 2006. It is expected that the review will result in changes to improve the current requirements for certifying and reporting deaths, but it will be some time before they are finalized and implemented. In the meantime, it is important to make every effort to comply with the relevant requirements in a way that justifies the enormous trust placed in doctors in dealing with these significant matters.

#### 2. Death certificates

Most doctors instinctively understand their obligations when it comes to completing a death certificate. However, from time to time confusion arises, making it useful to revisit the relevant rules in the Births, Deaths and Marriages Registration Act 1996 ('the BDM Act') for completing a 'Medical Certificate Concerning Death of a Person aged 28 days or over' (the 'death certificate'). It is also worth noting that doctors are potentially liable for monetary penalties for not complying with these rules.

#### 2.1 Who is authorized to complete the death certificate?

#### A doctor

- who was responsible for a person's medical care immediately before death; or
- who examines the body of a deceased person after death.

#### Responsibility for medical care immediately before death

Before 1998, when the Act was changed, it was the doctor 'in attendance during the last illness' who was obliged to complete the certificate. This was construed as meaning the doctor who was treating the patient for the condition which caused the death. Now it's a doctor 'responsible for a person's care immediately before death', which widens the field of doctors who may now complete the death certificate. There is no requirement to have actually seen the patient or to have seen the patient within a specified period before death, so doctors working in partnerships or in hospitals, who share responsibility for their patients' medical care can complete a death certificate where the 'treating' doctor may be off duty or on holiday when the death occurs.

However, it goes without saying that the covering doctor must understand the history and the circumstances of the death sufficiently to provide the certificate, so if the patient is not personally known to them, or has not been seen for a long time, the doctor will probably be more cautious in certifying the cause of death. A cautious covering doctor may well wish to examine the body of the deceased (see below).

If more than one doctor has responsibility for the care of the patient, only one must complete a certificate, so the obligation lapses if another doctor has already done so.

#### Examining the body of a deceased person

When the Act was changed in 1998, it allowed for any doctor to complete a death certificate after examining the body of the deceased person. Such an examination is meaningless unless:

- sufficient reliable information about both the patient's medical history and the circumstances of the patient's death is available and considered;
- the actual examination of the body is such that potential reportable deaths are excluded. As a minimum this should probably include a visual inspection of the entire body surface – front and back.

As with any examination, good notes should be made and retained.

#### 2.2 How, and by when, to complete a death certificate

A death certificate must be completed using the form provided by the Registry of Births, Deaths and Marriages. The form requires details about the deceased person, the place and cause of death, including the disease or condition directly leading to death, antecedent causes and any other significant conditions. A copy of the certificate must be sent to the Registrar of Births, Deaths and Marriages within 48 hours after the death, and a copy given to the funeral director or other person responsible for disposing of the body.

Occasionally a medical practitioner is unsure of the degree of certainty s/he should have of the diagnosis of the cause of death before signing the certificate. One does not need to know the diagnosis as a fact – if this was the standard, then every death would require an autopsy. The doctor should have that degree of confidence or comfort that s/he has whenever it is believed that a good diagnosis has been made.

In relation to hospital (non-coronial) autopsies, the doctor can delay signing the certificate until the results of the autopsy are available. Such an autopsy can assist when a doctor does not have enough certainty about the cause of death to sign the certificate before the autopsy, but does not believe it should be reported to the coroner.

Completing the cause of death on a death certificate can be a difficult intellectual exercise and guidance is available from the booklet provided by the Australia Bureau of Statistics. Commonly there are two main errors in cause of death statements that can cause problems. The first of these is that organ system failures, such as cardiac failure, are not a disease entity that can be used as a cause of death. And secondly the death certificate is not a co-morbidity certificate. Accordingly, only current disease conditions that actually caused or contributed to the death should be included on the certificate.

#### 2.3 When NOT to complete a death certificate

A death certificate must not be completed in instances where the death is reportable to the coroner (see below). Since 1998, completing a death certificate and reporting a death to the coroner are mutually exclusive exercises. It is now an offence to complete a certificate if the death should be reported. This highlights the care doctors should take to ensure the death does not need to be reported before completing a certificate. If in doubt, the State Coroner's Office is contactable 24 hours a day on 9684 4444. If necessary, ask to speak to a coroner or one of the pathologists from the Victorian Institute of Forensic Medicine (VIFM).

Each year the Registrar of Births, Deaths and Marriages reports some 500 deaths to the State Coroner because the death certificate discloses information that indicates that the doctor should have reported the death and not completed a death certificate. By the time such deaths are reported the body has often been buried which may lead to an exhumation being required. This is usually a difficult and emotionally stressful

event for the family. If the body has been cremated further examination is, of course, impossible. Clearly it is to everyone's advantage if reportable deaths are reported at the time of death.

#### 3. Reporting deaths to the coroner

Under the Coroners Act 1985 the role of the coroner is to investigate reportable deaths and to find, if possible:

- the identity of the deceased
- how the death occurred
- the cause of death; and
- the particulars needed to register the death.

A coroner may comment on and/or make recommendations on matters relating to public health or safety or the administration of justice, but contrary to popular perception is not charged with finding someone to blame for reported deaths. The fulltime coroners in Melbourne have stated publicly that they are interested in identifying systemic problems that contribute to preventable deaths, not blaming.

#### 3.1 What is a reportable death?

A death should be reported to the Coroner if it:

- appears to have been unexpected, unnatural, violent or to have resulted directly or indirectly from accident or injury;
- occurs during an anaesthetic;
- occurs as a result of an anaesthetic and is not due to natural causes;
- was of a person who immediately before death was a person held in care (see below);
- was of a person whose identity is unknown; or
- has occurred and a 'death certificate' has not been signed; and
- is associated with the State of Victoria (usually this means deaths occurring in Victoria, but also includes Victorians dying elsewhere and deaths that happen elsewhere but are caused in Victoria).

Again, it is worth noting that you may be penalized for not reporting a 'reportable' death to the coroner.

#### 3.2 Commonly reported deaths

In practice most deaths are reported to the coroner because:

- The doctor does not think s/he knows the cause of death with sufficient certainty to sign the death certificate.
- The death is one due directly or indirectly to accident or injury. This category includes all homicides, suicides and accidental deaths. 'Injury' is widely construed to include not only the effects of trauma but also those of drugs, poisons, heat, cold and electricity. It is not so widely construed to include 'natural' deaths following tobacco or alcohol abuse for instance, carcinoma of the lung or cirrhosis of the liver, which should not be reported. However, in contrast, the State Coroner has indicated that he considers deaths from diseases caused by asbestos to be reportable.
- The death is intra- or post-procedural:
  - o any death occurring while the patient is under the effects of anaesthesia (anaesthesia is not defined further and therefore could include a general, regional or local anaesthetic or even simply sedation) must be reported to the Coroner.
  - where deaths occur as a result of anaesthesia and are not due to natural causes, they must be reported to the Coroner. This is meant to capture those deaths where there is an anaesthetic disaster (eg overdose, wrong gases administered, unrecognised oesophageal intubation etc) but the patient 'survives' the surgery, is sent to ICU with irreversible cerebral anoxia and dies some time later. Arguably, this is a death due 'directly or indirectly to accident or injury' but was regarded by the lawmakers as sufficiently important to specify. If however, a patient has a myocardial infarction during anaesthesia that was a complication of the patient's underlying coronary atherosclerosis, and the patient has cerebral anoxia as a consequence and dies in ICU some time later, then this death should not be reported. It is a natural death that did not occur as a result of the anaesthesia and a death certificate could therefore be completed. If the death had occurred from myocardial infarction as a result of the anaesthetic being administered, this must be reported. (It is acknowledged that this different handling by the law of a death from the same cause in the same setting simply because one was delayed, is inconsistent. It may be something that is remedied by the Parliamentary review of the requirements for reportable deaths.)

#### 3.3 Adverse event deaths

It is increasingly being understood that many patients in hospital are subject to adverse events and as a consequence, some die. How does the doctor evaluate this in terms of the obligations to complete a death certificate or report the death to the Coroner? The following comments can be made:

- A good baseline would be to ask (if the possibility of an adverse event arises) if this death may be 'directly or indirectly due to accident or injury'.
- The doctor should be mindful that in these circumstances later allegations
  of a 'cover-up' might arise. Understanding the family's preferences may be
  helpful here. If the family voices concerns about the adequacy of the
  patient's management while in hospital, a safe course would be to refer the
  death to the Coroner. (Pursuing this course does not necessarily mean that
  the Coroner will accept the report, or if it is accepted, that there will be an
  autopsy.)
- The possibility of a hospital autopsy should be considered (see above). The hospital, with its in-house knowledge of the patient and its existing lines of communication, is the best place to evaluate the patient's pathologies (and the medical management of these) when there is no specific identifiable accident or injury directly or indirectly causing death. If, during the course of the hospital autopsy, or later, it becomes evident that the death should be reported, then it is quite appropriate for the death to be referred at that stage. If the Coroner accepts the referral, the hospital autopsy report will usually be accepted. It should be noted that referring a death to a coroner in order to obtain an autopsy where the hospital is unable to perform one or where the family will not give consent is unethical and may be illegal.

#### 3.4 Deaths in care

Deaths of people held in care from any cause are reportable to the coroner. This includes people dying:

- in prison
- in police cells
- as a result of police action or while being detained (even if not yet arrested)
- in an 'approved mental health service within the meaning of the Mental Health Act 1986'
- in the care of the Department of Human Services (this includes children in foster care).

Some of these deaths may occur in hospital, but if the deceased was 'held in care' at the time when the event that led to their admission occurred, the death must be reported.

#### 3.5 Coroners jurisdiction over 'deaths'

Before the Coroners Act 1985, coroners had jurisdiction over bodies, now they have jurisdiction over deaths. The law regards life as starting when there is an existence separate from the mother. Stillbirths and abortions, where there is no life or existence separate from the mother, are not reportable to the Coroner. (This is not to say that any particular abortion is legal, only that the Coroner has no jurisdiction to enquire into an abortion where there has been no existence separate from the mother.) If there is an existence separate from the mother, the Coroners Act applies and if the death fits one of the categories of reportable death, it should be reported. Because the definition of a "death" in the Coroners Act includes a "suspected death" if there is doubt whether an infant was born alive or had an existence separate from the mother, and there are any other factors which would otherwise make the death reportable to the coroner, the case should be reported.

#### 3.6 Coronial autopsies

It should be understood that reporting the death to the coroner does not necessarily mean there will be an autopsy. Indeed today only about 60% of deaths reported to a coroner are investigated with an autopsy. For example, a last ditch attempt to rescue a patient from a ruptured atherosclerotic abdominal aortic aneurysm where the patient dies on the operating table is a death 'during an anaesthetic' and must be reported. If the death occurs in metropolitan Melbourne, the body and the medical record will be conveyed to the VIFM. A pathologist will read the record, see the surgeon's operation notes and provided there appear to be no issues and the family are content, the coroner will accept the pathologist's advice that there is probably little to be gained from a coronial point of view in requiring an autopsy.

Increasingly, families are objecting to autopsies – due in part to better information being provided by coroners staff about their right to object to an autopsy, and probably to heightened concerns about autopsy practice following the 'organ retention scandals' of other jurisdictions over the past few years. From the coroner's perspective an autopsy is necessary only to discharge his/her obligations in relation to the particular death (cause and circumstances of death, identity etc. as set out above), but these are not the same objectives that are in the mind of most doctors when considering an autopsy. So, for example, the presence of obvious fatal injuries that are visible externally (cause of death) in a person found in the driver's seat of a crashed car (how the death occurred) and whose identity is clear, will mean that the coroner may determine that an autopsy is not required, especially where the family are raising an objection. It is understood by pathologists, some coroners and some families that much information of potential value is being lost by not performing an autopsy, but that is not what the current law has determined the coroners system is for.

#### 4. Deaths reviewable by the coroner

This is a completely new category of death that must be referred to the coroner for investigation. After a review of cases of multiple child deaths in a family and the systems in place to deal with these cases, amendments were passed in 2004 to the Coroners Act 1985 and the Births, Deaths and Marriages Registration Act 1996. These amendments created a category of "reviewable" deaths which must be referred to the State Coroner, who has the same investigative powers in relation to a reviewable death as he has in relation to a reportable death. A reviewable death is the death of a child who ordinarily resided in Victoria at the time of death and is a death of a second or subsequent child of a parent.

The intention of the amendments is to ensure that Victorian systems and processes for handling deaths are capable of dealing effectively and humanely with all cases of multiple child deaths within a family. In doing so, the legislation seeks to balance the rights of grieving families with the public interest in ensuring that surviving children are protected in cases where intervention is necessary, and that families receive appropriate medical and social supports.

The State Coroner will usually refer a reviewable death case to the VIFM for investigation and assessment of the health and safety needs of living siblings of the deceased child and the health needs of the parents. The investigation may result in:

- referral of a family to specialist medical services;
- notification being made to the Victorian Child Protection Service; and/or
- a recommendation being made to the State Coroner that further investigation of the reviewable death is warranted.

New death certificate forms and those for perinatal deaths provided by the Registry now require information about deaths of siblings for the purpose of fulfilling the reporting requirements of reviewable deaths. The Coroners Act also requires doctors to report reviewable deaths and provide any information that may help with the investigation into the death. Where another doctor has reported the death, there is still an obligation to provide any information that may be helpful. Again, there is a potential penalty for not complying.

The State Coroner's Office and the Victorian Institute of Forensic Medicine are committed to helping doctors deal with the details of these issues. It is inevitable that in medicine the exercise of categorising deaths will produce uncertainty at the borders. Doctors should feel that they have a right to speak to a coroner or a pathologist if they think it is appropriate. Call 03 9684 4444 at any time for assistance.

April 2006

## APPENDIX 6 – RECOMMENDATIONS FROM THE WARRANT POWERS AND PROCEDURES REPORT

#### Report of the Victorian Parliament Law Reform Committee

#### **Recommendation 18**

That primary legislation be amended to require each agency with warrant powers to create and maintain a search warrants register and record the following information in it:

- a) number and dates of ordinary and telephone applications made, withdrawn, granted, rejected, including reapplications;
- b) details of the legislative provision authorising each warrant application;
- c) basis for the reasonable belief justifying each application;
- d) details of any offences relevant to each warrant;
- e) date of issue and name of issuing officer;
- date, time and duration of the execution of each warrant and name of executing officials;
- g) name(s), if known, of any person(s) present on the premises and any arrests;
- h) details of any use of force;
- results of the search, including description and details of any disposal of seized items;
- j) statistics on proceedings initiated as a result of the use of warrant powers;
- k) number of complaints received and how resolved;

and that the Government consider what other information should be recorded

#### **Recommendation 47**

That legislation be amended to require agencies to provide information about search warrants to persons in the place to be searched, and that such information must include, in plain English and other appropriate languages the following:

- a) why the warrant has been issued;
- b) who issued the warrant, where and when;
- c) who will execute the warrant;
- d) when the warrant may be executed and when it will cease to be valid;
- e) what is permitted under the warrant;
- f) what persons in the place subject to the warrant must do and the consequences for not doing so;
- g) the rights of persons in the place subject to the warrant;
- h) what persons in the place subject to the warrant may do if they are dissatisfied with any aspect of the warrant or its execution.

# APPENDIX 7 – ROYAL COMMISSION INTO ABORIGINAL DEATHS IN CUSTODY RECOMMENDATIONS IN RELATION TO CORONIAL INVESTIGATIONS

Royal Commission Recommendations and Implementation Status taken from the Victorian Implementation Review of the Recommendations from the Royal Commission into Aboriginal Deaths in Custody, Review Report (2005), 458-.462

	Recommendation	
4	That if and where claims are made in respect of the deaths based on the findings of Commissioners:  (a) Governments should not, in all the circumstances, take the point that a claim is out of time as prescribed by the relevant Statute of Limitation; and  (b) Governments should, whenever appropriate, make the effort to settle claims by negotiation so as to avoid further distress to families by litigation.	Classified as not relevant to the State Coroner (SCV)
5	That governments, recognising the trauma and pain suffered by relatives, kin and friends of those who died in custody, give sympathetic support to requests to provide funds or services to enable counselling to be offered to these people.	Fully implemented (MH-DHS)
6	That for the purpose of all recommendations relating to post-death investigations the definition of deaths should include at least the following categories:  (a) The death wherever occurring of a person who is in prison custody or police custody or detention as a juvenile;  (b) The death wherever occurring of a person whose death is caused or contributed to by traumatic injuries sustained or by lack of proper care whilst in such custody or detention;  (c) The death wherever occurring of a person who dies or is fatally injured in the process of police or prison officers attempting to detain that person; and  (d) The death wherever occurring of a person who dies or is fatally injured in the process of that person escaping or attempting to escape from prison custody or police custody or juvenile detention.	Fully implemented (SCV)
7	That the State Coroner, or, in any State or Territory where a similar office does not exist, a Coroner specially designated for the purpose, be generally responsible for inquiry into all deaths in custody. (in all recommendations in this report the words 'State Coroner' should be taken to mean and include the Coroner so specially designated).	Fully implemented (SCV)
8	That the State Coroner be responsible for the development of a protocol for the conduct of coronial inquiries into deaths in custody and provide such guidance as is appropriate to Coroners appointed to conduct inquiries and inquests.	Partially implemented (SCV)
9	That a Coroner inquiring into a death in custody be a Stipendiary Magistrate or a more senior judicial officer.	Fully implemented (SCV)
10	That custodial authorities be required by law to immediately notify the Coroners Office of all deaths in custody, in addition to any other appropriate notification.	Fully implemented (SCV)

11	That all deaths in custody be required by law to be the subject of a coronial inquiry which culminates in a formal inquest conducted by the Coroner into the circumstances of the death. Unless there are compelling reasons to justify a different approach the inquest should be conducted in public hearings. A full record of the evidence should be taken at the inquest and retained.	Fully implemented (SCV)
12	That a Coroner inquiring into a death in custody be required by law to investigate not only the cause and circumstances of the death but also the quality of the care, treatment and supervision of the deceased prior to death.	Partially implemented (SCV)
13	That a Coroner inquiring into a death in custody be required to make findings as to the matters which the Coroner is required to investigate and to make such recommendations as are deemed appropriate with a view to preventing further custodial deaths. The Coroner should be empowered, further, to make such recommendations on other matters as he or she deems appropriate.	Fully implemented (SCV)
14	That copies of the findings and recommendations of the Coroner be provided by the Coroners Office to all parties who appeared at the inquest, to the Attorney-General or Minister for Justice of the State or Territory in which the inquest was conducted, to the Minister of the Crown with responsibility for the relevant custodial agency or department and to such other persons as the Coroner deems appropriate.	Fully implemented (SCV)
15	That within three calendar months of publication of the findings and recommendations of the Coroner as to any death in custody, any agency or department to which a copy of the findings and recommendations has been delivered by the Coroner shall provide, in writing, to the Minister of the Crown with responsibility for that agency or department, its response to the findings and recommendations, which should include a report as to whether any action has been taken or is proposed to be taken with respect to any person.	No progress (SCV)
16	That the relevant Ministers of the Crown to whom responses are delivered by agencies or departments, as provided for in Recommendation 15, provide copies of each such response to all parties who appeared before the Coroner at the inquest, to the Coroner who conducted the inquest and to the State Coroner. That the State Coroner be empowered to call for such further explanations or information as he or she considers necessary, including reports as to further action taken in relation to the recommendations.	No progress (SCV)
17	That the State Coroner be required to report annually in writing to the Attorney-General or Minister for Justice, (such report to be tabled in Parliament), as to deaths in custody generally within the jurisdiction and, in particular, as to findings and recommendations made by Coroners pursuant to the terms of Recommendation 13 above and as to the responses to such findings and recommendations provided pursuant to the terms of Recommendation 16 above.	No progress (SCV)
18	That the State Coroner, in reporting to the Attorney-General or Minister for Justice, be empowered to make such recommendations as the State Coroner deems fit with respect to the prevention of deaths in custody.	No progress (SCV)
19	That immediate notification of death of an Aboriginal person be given to the family of the deceased and, if others were nominated by the deceased as persons to be contacted in the event of emergency, to such persons so nominated. Notification should be the responsibility of the custodial institution in which the death occurred; notification, wherever possible, should be made in person, preferably by an aboriginal person known to those being so notified. At all times notification should be given in a sensitive manner respecting the culture and interests of the persons being notified and the entitlement of such persons to full and frank reporting of such circumstances of the death as are known.	Fully implemented (SCV)
20	That the appropriate Aboriginal Legal Service be notified immediately of any Aboriginal death in custody.	Fully implemented (SCV)
21	That the deceased's family or other nominated person and the Aboriginal Legal Service be advised as soon as possible and, in any	Fully implemented (SCV)

	event, in adequate time, as to the date and time of the coronial inquest.	
22	That no inquest should proceed in the absence of appearance for or on behalf of the family of the deceased unless the Coroner is satisfied that the family has been notified of the hearing in good time and that the family does not wish to appear in person or by a representative. In the event that no clear advice is available to the Coroner as to the family's intention to be appear or be represented no inquest should proceed unless the Coroner is satisfied that all reasonable efforts have been made to obtain such advice from the family, the Aboriginal Legal Service and/or from lawyers representing the family.	Partially implemented (SCV)
23	That the family of the deceased be entitled to legal representation at the inquest and that government pay the reasonable costs of such representation through legal aid schemes or otherwise.	Partially implemented (SCV)
24	That unless the State Coroner or a Coroner appointed to conduct the inquiry otherwise directs, investigators conducting inquiries on behalf of the Coroner and the staff of the Coroners Office should at all times endeavour to provide such information as is sought by the family of the deceased, the Aboriginal Legal Service and/or lawyers representing the family as to the progress of their investigation and the preparation of the brief for the inquest. All efforts should be made to provide frank and helpful advice and to do so in a polite and considerate manner. If requested, all efforts should be made to allow family members or their representatives the opportunity to inspect the scene of death.	Partially implemented (SCV)
25	That unless the State Coroner, or a Coroner appointed to conduct the inquiry, directs otherwise, and in writing, the family of the deceased or their representative should have a right to view the body, to view the scene of death, to have an independent observer at any post-mortem that is authorised to be conducted by the Coroner, to engage an independent medical practitioner to be present at the post-mortem or to conduct a further post-mortem, and to receive a copy of the post-mortem report. If the Coroner directs otherwise, a copy of the direction should be sent to the family and to the Aboriginal Legal Service.	Partially implemented (SCV)
26	That as soon as practicable, and not later than forty-eight hours after receiving advice of a death in custody the State Coroner should appoint a solicitor or barrister to assist the Coroner who will conduct the inquiry into the death.	Partially implemented (SCV)
27	That the person appointed to assist the Coroner in the conduct of the inquiry may be a salaried officer of the Crown Law Office or the equivalent office in each State and Territory, provided that the officer so appointed is independent of relevant custodial authorities and officers. Where, in the opinion of the State Coroner, the complexity of the inquiry or other factors, necessitates the engaging of counsel then the responsible government office should ensure that counsel is so engaged.	Partially implemented (SCV)
28	That the duties of the lawyer assisting the Coroner be, subject to direction of the Coroner, to take responsibility, in the first instance, for ensuring that full and adequate inquiry is conducted into the cause and circumstances of the death and into such other matters as the Coroner is bound to investigate. Upon the hearing of the inquest the duties of the lawyer assisting at the inquest, whether solicitor or barrister, should be to ensure that all relevant evidence is brought to the attention of the Coroner and appropriately tested, so as to enable the Coroner to make such findings and recommendations as are appropriate to be made.	Partially implemented (SCV)
29	That a Coroner in charge of a coronial inquiry into a death in custody have legal power to require the officer in charge of the police investigation to report to the Coroner. The Coroner should have power to give directions as to any additional steps he or she desires to be taken in the investigation.	Fully implemented (SCV)
30	That subject to direction, generally or specifically given, by the Coroner, the lawyer assisting the Coroner should have responsibility for reviewing the conduct of the investigation and advising the Coroner as to the progress of the investigation.	Partially implemented (SCV)

31	That in performing the duties as lawyer assisting the Coroner in the inquiry into a death the lawyer assisting the Coroner be kept informed at all times by the officer in charge of the police investigation into the death as to the conduct of the investigation and the lawyer assisting the Coroner should be entitled to require the officer in charge of the police investigation to conduct such further investigation as may be deemed appropriate. Where dispute arises between the officer in charge of the police investigation and the lawyer assisting the Coroner as to the appropriateness of such further investigation the matter should be resolved by the Coroner.	Partially implemented (SCV)  Partially implemented (VicPol)
32	That the selection of the officer in charge of the police investigation into a death in custody be made by an officer of Chief Commissioner, Deputy Commissioner or Assistant Commissioner rank.	No progress (SCV) Fully implemented (VicPol)
33	That all officers involved in the investigation of a death in police custody be selected from an Internal Affairs Unit or from a police command area other than that in which the death occurred and in every respect should be as independent as possible from police officers concerned with matters under investigation. Police officers who were on duty during the time of last detention of a person who died in custody should take no part in the investigation into that death save as witnesses or, where necessary, for the purpose of preserving the scene of death.	Fully implemented (SCV)  Fully implemented (VicPol)
34	That police investigations be conducted by officers who are highly qualified as investigators, for instance, by experience in the Criminal Investigation Branch. Such officers should be responsible to one, identified, senior officer.	Partially implemented (SCV) Fully implemented (VicPol)
35	That police standing orders or instructions provide specific directions as to the conduct of investigations into the circumstances of a death in custody. As a matter of guidance and without limiting the scope of such directions as may be determined, it is the view of the Commission that such directions should require, inter alia, that:  (a) Investigations should be approached on the basis that the death may be a homicide. Suicide should never be presumed;  (b) All investigations should extend beyond an inquiry into whether death occurred as a result of criminal behaviour and should include inquiry into the lawfulness of the custody and the general care, treatment and supervision of the deceased prior to death;  (c) The investigations into deaths in police watch-houses should include full inquiry into the circumstances leading to incarceration, including the circumstances of arrest or apprehension and the deceased's activities beforehand;  (d) In the course of inquiry into the general care, treatment or supervision of the deceased prior to death particular attention should be given to whether custodial officers observed all relevant policies and instructions relating to the care, treatment and supervision of the deceased; and  (e) The scene of death should be subject to a thorough examination including the seizure of exhibits for forensic science examination and the recording of the scene of death by means of high quality colour photography.	Fully implemented (SCV)  Fully implemented (VicPol)
36	Investigations into deaths in custody should be structured to provide a thorough evidentiary base for consideration by the Coroner on inquest into the cause and circumstances of the death and the quality of the care, treatment and supervision of the deceased prior to death.	Partially implemented (SCV)  Fully implemented (VicPol)
37	That all post-mortem examinations of the deceased be conducted by a specialist forensic pathologist wherever possible or, if a specialist forensic pathologist is not available, by a specialist pathologist qualified by experience or training to conduct such post-mortems.	Fully implemented (SCV)

Appendix 7 – Royal Commission into Aboriginal Deaths in Custody Recommendations in Relation to Coronial Investigations

38	The Commission notes that whilst the conduct of a thorough autopsy is generally a prerequisite for an adequate coronial inquiry some Aboriginal people object, on cultural grounds, to the conduct of an autopsy. The Commission recognises that there are occasions where as a matter of urgency and in the public interest the Coroner may feel obligated to order that an autopsy be conducted notwithstanding the fact that there may be objections to that course from members of the family or community of the deceased. The Commission recommends that in order to minimise and to resolve difficulties in this area the State Coroner or the representative of the State Coroner should consult generally with Aboriginal Legal Services and Aboriginal Health Services to develop a protocol for the resolution of questions involving the conduct of inquiries and autopsies, the removal and burial of organs and the removal and return of the body of the deceased. It is highly desirable that as far as possible no obstacle be placed in the way of carrying out of traditional rites and that relatives of a deceased Aboriginal person be spared further grief. The Commission further recommends that the Coroner conducting an inquiry into a death in custody should be guided by such protocol and should make all reasonable efforts to obtain advice from the family and community of the deceased in consultation with relevant Aboriginal organisations.  That in developing a protocol with Aboriginal Legal Services and Aboriginal Health Services as proposed in Recommendation 38, the State Coroner might consider whether it is appropriate to extend the terms of the protocol to deal with any and all cases of Aboriginal deaths notified to the Coroner and not just to those deaths which occurred in	No progress (SCV)
	custody.	
40	That Coroners Offices in all States and Territories establish and maintain a uniform database to record details of Aboriginal and non-Aboriginal deaths in custody and liaise with the Australian Institute of Criminology and such other bodies as may be authorised to compile and maintain records of Aboriginal deaths in custody in Australia.	Fully implemented (SCV)

## APPENDIX 8 - VIFM PROCEDURES FOR RETENTION OF TISSUE FROM AUTOPSY FOR DIAGNOSTIC PURPOSES

#### Reasons for retention

Before or during an autopsy the pathologist may decide that more detailed examination of an organ or organs is necessary to more fully understand the deceased person's state of health for a proper diagnosis of cause death. The organs most commonly examined in more detail are the heart and the brain. Further examination can take up to a few weeks, as 'fixation' processes may be necessary (for a brain) and other specialist pathologists may be asked to provide an opinion.

#### **Consent for retention**

As soon as possible after the pathologist forms the opinion that more detailed examination is required, he or she makes a written request for tissue retention stating the reasons and estimated length of time for retention. This request is referred to a coroner via one of the Tissue and Family Liaison Coordinators in the DTBV. A coroner will normally grant permission for the Coordinator to approach the deceased's family. The reasons for retention are explained and the family's consent sought. The family response is communicated to the SCO and the pathologist.

There is an exception to this process in cases of homicide or suspicious deaths. In these cases families are informed about the retention of organs and are asked about their preference for disposal of the organ[s], but because of the importance of the autopsy results for the criminal justice process, there is no option for a family to object to the retention.

#### **Options for disposal**

The Coordinators will also discuss with the family the different disposal options once examination of the organ[s] has been completed. These include:

- retaining the body at VIFM until the examination is completed, so the organ can be reunited with the body for burial or cremation
- VIFM arranging for the organ to be cremated and the ashes returned to the family
- burying the organ subsequently in the same plot as the body, or
- VIFM arranging for the organ to be cremated and disposed of at the crematorium memorial park.

All these options are coordinated with funeral directors, with no cost to families. Any additional funeral expenses are covered by the SCO.

### APPENDIX 9 - VIFM'S ETHICS COMMITTEE PROCEDURES

#### Introduction

The Victorian Institute of Forensic Medicine Ethics Committee meets quarterly to consider applications to undertake research involving the Victorian Institute of Forensic Medicine (VIFM). The Committee considers applications for use of human tissue retrieved during or following autopsy at VIFM and for use of information generated and stored at the VIFM. All proposals for research projects to be undertaken within the VIFM must be submitted to the Ethics Committee and no research project may commence until approval has been given. The principal researcher or a member of the research team may be required to attend the Ethics Committee meeting at which the application will be considered, to answer questions arising from the application. Approval to proceed with the research is valid for up to three years.

#### Constitution of the Ethics Committee

The Ethics Committee is chaired by Professor Peter Sallmann QC and its current members include:

- Professor Stephen Cordner, Director, Victorian Institute of Forensic Medicine
- Mr Graeme Johnstone, State Coroner
- Associate Professor David Wells, Director, Clinical Forensic Medicine, Victorian Institute of Forensic Medicine
- Ms Jacinta Heffey, Magistrate
- Rev. Dr LD Fullerton, retired Minister of Religion
- Ms Felicity Broughton, Magistrate
- Mr S Nossal, Investment Banker
- Mrs A Simon, retired school teacher

#### **Authority for use of human tissues**

VIFM regards the use of tissue from deceased persons for research as a great privilege. In Victoria, this is acknowledged in the Human Tissue Act 1982 ("the Act") which gives authority for the use of human tissue removed after death for medical or scientific purposes in certain circumstances. In general the Act relies on the principle of consensual giving, but an exception is made for tissue removed for the purposes of an autopsy.

Section 26(2) of the Act provides that tissue cannot be removed for therapeutic, medical or scientific purposes unless:

- the deceased person had consented during his or her lifetime to the removal of tissue for this purpose after his or her death, or
- the senior next of kin consents to the removal of the tissue and there was no known objection by the deceased during his or her lifetime, or
- no next or kin of the deceased person can be ascertained and there was no known objection by the deceased during his or her lifetime.

Section 27 of the Act requires where a death is reportable to the Coroner under the Coroners Act 1985, tissue cannot be removed for therapeutic, medical or scientific purposes unless a coroner has given consent.

Section 30 of the Act provides that where the coroner has directed that VIFM undertake a post mortem examination of a deceased person, this is sufficient authority for a registered medical practitioner to conduct an examination of the body of the deceased person and to remove tissue from the body of the deceased person. This authority is also authority for the tissue removed for the purposes of the post mortem examination to be used for therapeutic, medical or scientific purposes, without specific next of kin consent.

#### Consent from senior next of kin of the deceased person

The above authorities given by sections 26, 27 and 30 of the Human Tissue Act 1982 mean that in the context of a coronial autopsy consent by the senior next-of-kin of the deceased person is not legally required for medical or research use of tissue removed for the purpose of the autopsy. However, VIFM always ensures that consent is obtained, as well as consent by a coroner, prior to any human tissue being made available to approved research projects. It is the function of the VIFM Ethics Committee to ensure that the proper processes are observed and that this privilege to use human tissue for research is not abused.

#### Approval from host institution HREC

The VIFM Ethics Committee is not constituted to assess a researcher's project for scientific merit and validity. It will therefore only consider applications that are accompanied by supporting documentation certifying that the project has scientific merit and validity and has been approved by the Human Research Ethics Committee ("HREC") at the institution of the project's principal researcher. If this institution does not have a Human Research Ethics Committee constituted under current National Health & Medical Research Council ("NH&MRC") guidelines, researchers are required to make arrangements for the Monash University Ethics Committee to assess the project proposal.

#### The NH&MRC National Statement

The VIFM Ethics Committee will consider applications in accordance with the NH&MRC National Statement on Ethical Conduct in Research Involving Humans. In particular, it will consider the application against the guidelines in Chapter 15 – "Use of Human Tissue Samples".

#### Agreement following approval

If an application is approved by the Ethics Committee, the researcher is required to enter an agreement with VIFM regarding practical matters associated with making the tissue or information available and the researcher's obligations with respect to acknowledgement and reporting back to the Ethics Committee.

Under the Agreement researchers are required to provide a report on progress and outcomes to the Ethics Committee twelve months after approval has been obtained for their research project and every twelve months thereafter until the project ceases. This is considered to be an important obligation under the Agreement, especially for projects involving use of human tissue. Most of the families that agree to retrieval of tissue for specific projects nominate to receive follow-up support and information, which includes information about the progress and outcomes of the research projects they have supported. This information is very meaningful to the families as it assists in reinforcing the positive benefits arising from their decision to donate tissue from their loved one's body. It is therefore critical that researchers provide these reports, as agreed, and that they use language that can be easily understood by the families, most of whom will not have training in science or medicine.

#### **Administration and Service Fees**

There is a \$500 (GST inc.) administration fee payable to VIFM to cover the costs of processing applications. Whilst there is no fee charged for the tissue itself, there is:

- a monthly service fee of \$300 to covers the screening of coronial cases to identify suitable potential donors, the time taken to approach the next-of-kin for consent to use tissue for your project and subsequent follow-up service to donor families, and
- a minimum \$10 (no set maximum) tissue processing fee which is negotiated with the researcher prior to commencement of use of tissue.

#### Alterations to research protocols

Researchers are required to notify the Executive of the Ethics Committee in writing if there are any alterations required to the research protocol. These amendments will then be forwarded to the Committee for consideration. Researchers may not commence projects requiring amendments until approval is received from the Ethics Committee. If the research project is abandoned, the Committee must be informed, as soon as practicable.

#### **Complaint procedures**

As required by the NHMRC Statement on Ethical Conduct Involving Humans, the VIFM Ethics Committee has developed a complaints procedure. The Ethics Committee will only attempt to resolve complaints that raise ethical issues. Complaints that do not involve ethical issues will be referred to a relevant person or organisation, depending upon the nature of the complaint (eg Director of the VIFM, Chair of the VIFM Council, head of the researcher's sponsoring Department). As a matter of fairness, those about whom a complaint has been made should be given an opportunity to respond to the complaint. In the first instance, an attempt should be made to resolve complaints by negotiation involving the Chair of the Ethics Committee, the complainant and the party complained about. Procedures for complaints from both donor families and researchers can be found on VIFM's website www.vifm.org under "Medical Legal" and "Ethics Committee".

### APPENDIX 10 - COUNSELLING AND SELF-HELP SERVICES

#### **National Association for Loss & Grief (NALAG)**

Ph: 9351 0358

The National Association for Loss and Grief is an information resource that provides a detailed list of accredited grief and loss counsellors, support/self help groups, education material, as well as information about common responses to grief and loss.

#### **Bereavement Counselling Service (Free Service)**

Ph: 9817 7266

The Service offers counselling sessions for individuals, families, or groups. appointments can be by calling the service between 9:30am - 4:30pm on Tuesdays, Wednesdays or Thursdays.

#### **Community Bereavement Service (Free Service)**

Ph: 1300 130 813

Appointments can be made by calling the service

Monday - Friday 9am - 5pm.

Services are provided throughout the Metropolitan Region of Melbourne. Requests from the rural regions will be responded to when required.

Also offers structured and open groups, including a suicide bereavement support group.

#### Mercy Western Grief Services (Free Service)

Ph: 9364 9838

The service provides counselling to anyone experiencing a bereavement who resides in the Western Metropolitan Region. Counselling is provided for individuals, families, or groups.

Counselling is by appointment Monday - Friday, 9am - 5pm.

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#### SIDS and Kids Victoria

This is a statewide service providing support for any family member who may have been impacted by the sudden death of a child from 0-6 years of age.

Ph: 1800 240 400

#### **Bendigo Centre for Loss and Grief**

Ph: 54 445 060

55 Wattle St, Bendigo

#### Help for Rural Men & Women

Horsham Office Ph: 53 826 789

Stawell Office Ph: 53 583 922

#### **Road Trauma Support Team**

A confidential support service for people affected by road trauma

Ph: 1300 367 797

#### **Urban Ministry Network**

(Industrial deaths support service)

Ph: 9827 8322

#### **Industrial Deaths Support and Advocacy**

Ph: 9309 4453

#### **Vietnam Veteran's Counselling Service**

290 Burwood Rd, Hawthorn.

Ph: (03) 9818 0388

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Or freecall 1800 011 046

#### **Victorian Aboriginal Health Services - Family**

Services (Free Service)

Ph: 9403 3300

Provide a family counselling service for families within the Aboriginal community.

#### **Barwon Paediatric Bereavement Program**

Ph: (03) 522 672 269 (B/H)

Ph: 1800 240 400 after hours & 24 hr crisis counselling Providing support for any person who has been affected at any time by the sudden and unexpected death of an infant, young child, or adolescent.

#### For Multicultural Australians

Initial areas of support may come from your ethnic community or religious group. The following services may also be able to help.

#### **Geelong Migrant Resource Centre**

153 Pakington Street, Geelong West VIC 3218

Ph: (03) 5221 6044

#### **Gippsland Migrant Resource Centre**

100-102 Buckley Street, Morwell VIC 3840

Ph: (03) 5133 7072

#### **Migrant Resource Centre North West Region**

45 Main Roard, West St Albans VIC 3021

Ph: (03) 9367 6044

#### **Migrant Resource Centre North East**

251 High Street, Preston VIC 3072

Ph: (03) 9484 7944

#### **Migrant Information Centre (Eastern Melbourne)**

333 Mitcham Road, Mitcham VIC 3132

Ph: (03) 9873 1666

#### **South Central Region Migrant Resource Centre**

40 Gratton Street, Prahran VIC 3181

Ph: (03) 9510 5877

#### **Oakleigh Outreach Service**

17 Chester Street, Oakleigh VIC 3166

Ph: (03) 9563 4130

#### **South Eastern Region Migrant Resource Centre**

Level 1, 314 Thomas St, Dandenong, VIC 3175

Ph: (03) 9706 8933; Fax: (03) 9706 8830;

#### **Migrant Resource Centre Westgate Region**

78-82 Second Avenue, Altona North VIC 3025

Ph: (03) 9391 3355

#### **Self-Help Services**

#### **The Compassionate Friends**

Ph: 9888 4944 or 1800 641 091

The Compassionate Friends is an organisation offering support and information to parents after the death of a child, regardless of age or cause of death. The service operates a Bereaved Parent Support Centre, Social Support Groups, 24 hour Grief Telephone Support Line, Newsletter, Grief information & Support groups (including a suicide bereavement support group). Monthly support groups also operate in various locations both rural and metropolitan.

#### Mental Illness Fellowship of Victoria Inc.

Ph: 9482 4189

The network offers both individual and group support for families who have a family member or someone close to them, who had a mental illness and suicided.

#### **Survivors of Suicide (SOS)**

Ph: 59 911 777

Meets monthly every Thursday Daytime 1pm - 3pm &

Evening 7pm - 9pm.

Salvation Army

1 New Holland Dve

Cranbourne

#### Suicide - Living with the impact

Ph: 52 298 866

Meets twice per month 2nd & 4th Tuesdays at 10:30am

The Wesley Centre

100 Yarra St, Geelong

#### **Support Groups**

#### Spring Support Group - For those bereaved through suicide

Ph: 9553 1000 or 9587 5959

Meets twice per month 1st & 3rd Wednesday at 7:30pm - 9:30pm

Our Lady of Assumption Church

9 Centre Dandenong Rd, Cheltenham.

#### **Telephone Counselling Services**

#### Life Line (24 hour Telephone Counselling Line)

Ph: 131 114

#### Life Line Suicide Line

(24 hour Telephone Counselling Line)

Ph: 1300 651 251

#### **Care Ring (24 hour Telephone Counselling Line)**

Ph: 136 169

#### **Grief Line (Telephone Counselling Line)**

Ph: 9596 7799

#### **The Compassionate Friends**

(24 hr Telephone Support Line)

Ph: 9888 4944

Or Toll free 1800 641 091

Mensline (Telephone Counselling Line)

Ph: 1300 789 978

#### **Kids Help Line (Telephone Counselling Line)**

Ph: 1800 551 800

#### You may also find support from the following:

- Local Doctor
- Your local place of worship
- Funeral Director
- School chaplain
- Hospital social worker
- Community health centre
- School psychologist

Private counsellors, psychologists and psychiatrists. Contact numbers for local health professionals can be found in the Yellow Pages or through the Health Info Network on 1300 135 030.

#### APPENDIX 11 - BIBLIOGRAPHY

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