

**LAW REFORM COMMITTEE**

**Inquiry into Coroners Act 1985**

Melbourne — 20 September 2005

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Dr I. Freckelton, barrister

**The CHAIR** — I welcome Dr Ian Freckelton, who is a barrister and academic, who is here to give us his submission. We appreciate you taking the time to lend your expertise to the committee. You are probably aware that the coroner and his deputy are also here, as are some family members and other people interested in this inquiry. This is a public hearing and Hansard is recording it. The transcript will form part of the public record, but you will get an opportunity to correct it. If you would like to talk to the committee for 15 or 20 minutes, then we can ask you some questions and can draw out some of the key issues that we are trying to get to.

**Dr FRECKELTON** — Thank you very much, and thank you for the opportunity to address you. First of all, let me apologise for not having provided you with a written submission. I have really got no-one I can blame for that. I could try to blame the coroner for keeping me so busy appearing in his court, but I am not sure that would be entirely fair. I should also indicate the capacity in which I am speaking to you. It was proposed that I speak on behalf of the Victorian Bar, and I partially settled some submissions yesterday for the committee, but I understand there has been a little distraction today amongst certain members of the Victorian bar on the basis of the appointment of Justice Crennan to the High Court of Australia, and the formal processes for my being approved to speak on behalf of the Victorian Bar have not been completed. So you should regard anything I say as my responsibility and not necessarily impute it to the Victorian Bar. I understand that what they are anticipating doing is scrutinising what I say to you and deciding which parts they will formally adopt and which parts they will distance themselves from.

Let me speak to you principally on the basis of having appeared for many years in coroners' courts here and elsewhere. What I propose to do is to say a few introductory things and then make my way through the questions which are usefully identified in the discussion paper and then answer such questions as you pose to me. First of all, can I say that this is a very important inquiry. Victoria has been in the vanguard of reform to coronial law and practice in Australia, and it is timely that the current Act be revisited, because many circumstances have changed, and thinking has become more sophisticated in new ways since the Coroners Act 1985. As I see it, this inquiry really constitutes an opportunity to reconsider how we want investigation of death to be undertaken in the modern era. Part and parcel of that is obviously the role of the coroner, but there is more besides.

The institution of the coroner has been an extraordinarily adaptable one since probably the 10th but certainly the 12th century. Coroners have had many roles in the past which they have shed with the passage of time, but the coroner as an institution has been a shape-shifting and extraordinarily flexible entity. The fact that this is so provides us perhaps with opportunities to mould and adjust the contemporary role of the coroner, and it seems to me that we should not hesitate to do just that. The institution of coroner is venerable and ancient, but it is one which has moved with the times consistently. One can identify very significant changes in the medieval period, the industrial revolution period, the 19th and early part of the 20th centuries, and it is now time for us to reflect on what we can do in accordance with our needs in the modern era, which are transformed by technology, by different experiences that we have and by the new types of input we have from the kinds of experts who have been appearing in front of you: Professors Cordner, Ranson and others. What I shall be raising with you are a variety of specific and more general conceptual propositions about how one might think of adjusting the coroner's role to meet what we need in terms of ascertaining the circumstances in which deaths have occurred and how most effectively we can move to respond in a way which will prevent avoidable deaths in the future.

I should identify an initial tension about these sorts of things. It is a tension that exists among lawyers, among coroners and among commentators about matters coronial. There are two perspectives on the role of the contemporary coroner. One is the limited one, which is basically that coroners should decide who died, when they died, the proximate circumstances of death and what the medical cause of death was. The more general one, championed by Mr Johnstone and many others in Australia, Canada and New Zealand, is that the most important contemporary role of a coroner is to identify those factors which can reduce lethality of behaviour in different contexts. However, that is not a uniform view and the appellate courts in many jurisdictions have been anxious and worried about the burgeoning jurisdiction of the coroner, which has been largely self-initiated by coroners seeking to emphasise this component of the process. It is certainly true that riders are an ancient component of coroners' decisions. They are currently represented in our statutory framework by the capacity to make suggestions — they are often called recommendations, and other terms are employed in other places. They have been used since very early times.

However, the modern emphasis upon that kind of orientation as a justification for coronership and for the driving force behind coronial practice is quite new. I am very sympathetic to that, but it seems to me that if that is to be a major influence on how we draft our legislation and how we conduct coroners' investigations, it is important to be

straightforward about it and to enunciate it clearly and precisely within legislation. The absence of that clarity has generated confusion and disuniformity of approach. The Harmsworth decision in 1989 in Australia and the Doogan decision a few weeks ago from the full court of the Australian Capital Territory Supreme Court are indicators of this ambivalence of approach from appellate courts. It is an ambivalence often generated by the fact that appellate courts in the adversarial tradition are not entirely comfortable with inquisitorial processes and courts, but it is more than that in terms of a jurisdiction whose parameters are not very clearly specified by legislation.

Going on then to some of the questions raised within your discussion paper, which I might say is a very useful and well-researched, well-constructed document — I think it is a helpful means of focusing inquiry — can I pass through some matters quickly and dwell upon others a little longer? The first question on page 12 raises a query as to whether doctors have a good understanding of what is meant by reportable deaths. General experience suggests that they 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. That observed, for myself I do not feel a great imperative to change the terminology because in essence it does capture the kind of death that the community probably does want looked into carefully, in terms of something that is unforeseen, seems strange and has occurred in circumstances such as to arouse concern in the broadest of senses. I would not be inclined to try to fetter that unduly by precise wording within legislation. I think the lack of clarity which generates low reporting rates and poor reporting of reportable deaths can probably be remedied to a considerable degree by combined work by the registrar of births, deaths and marriages, the Victorian Institute of Forensic Medicine and the Coroners Court itself. I think the issuing of further guidelines would be a constructive development as long as it is a cooperative, collaborative one. The Medical Practitioners Board, of which I am the lawyer member, would certainly be supportive of that exercise.

Question 2 raises whether there is an under-reporting of deaths. 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. I shall advance specific propositions in relation to how one might remediate that exercise a little bit later on under cover of making submissions about the sequelae of *Re Shipman* and the Luce reports.

Question 3 raises the issue of anaesthesia deaths. My own experience is that there is a lack of clarity about what even constitutes anaesthesia. I understand that submissions have probably been made about that subject by Associate Professor Ranson and Professor Cordner. In my view it would be constructive to be clearer as to what it is that we as a community want in terms of reportable deaths in that regard. There are a few anomalies in the categories of reportable deaths that are historically explicable. In terms of anaesthesia it was because there was tremendous community concern about anaesthesia in the second half of the 19th century and so there was a mandate in due course for any deaths that occurred during or immediately after anaesthesia to constitute reportable deaths. Not all that many deaths come through in that form now but 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 quite 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.

Question 4 raises the issue of deaths in care and custody. This constitutes a very sensitive and substantial part of coronial investigation. It is a sensitive one because once again there are potentially different interpretations as to what constitutes a death in care especially, for instance whether a person on a community treatment order or a person who has reasonably recently been in a hospital in an involuntary capacity should be regarded as a death in care or whether such deaths escape the reportable death definition.

My own view, and this will not be consistent with all of the propositions advanced to you, is that in general terms the categories are sufficient for the moment, and that when survivors — persons related to individuals who have died in these peripheral or slightly extended circumstances — are concerned about the circumstances of a persons it is open to them, of course, to urge the coroner to hold an inquest, and that happens with some regularity. Coroners do constitute inquests where they deem it appropriate in the interests of community openness that there should be a fuller inquiry into such matters. As long as that flexibility remains, it seems to me that that is probably sufficient. It

is appropriate to place some reliance on the capacity of family members and other concerned members of the community to draw issues to the attention of the coroner, and when they are drawn to the attention of the coroner they are investigated and decisions are made.

For the moment I do not propose to say anything about question 5. I do not think question 6 needs a great deal said about it. The decision-making by coroners is on the Briganshaw sliding scale standard, which means that coroners need to be comfortably satisfied about all matters on which they are required to find and where there are issues which have major ramifications that level of confidence goes up notches. It is a standard which is well utilised within the law. Coroners are comfortable with it and they regularly explain it within their decisions, so I do not think there needs to be anything formal by way of guidelines in that regard. Likewise, I doubt that there needs to be specific guidance in terms of the degree of certainty and diagnosis advanced by diagnoses from persons working at the Institute of Forensic Medicine.

The new category of reviewable deaths in my view is a constructive addition to the Coroners Act. It caters to a very unusual scenario, however, and fortunately it will only be very occasionally that the situation arises where there is a death of a second or subsequent child of a parent. We need to recognise that there remains a touch of ambiguity about this, and perhaps with the evolution of tragedies we will think further as to the extent to which persons who have a less than absolutely direct connection with family circumstances where there is more than one death need to be incorporated. At this stage it is too early to say but the enunciation of the category of reviewable deaths seems to me to be a constructive one and not at this stage to require further adjustment.

There are provisions which mandate the reporting of notifiable deaths to the coroner. The level of awareness within the general community of those — I suspect but cannot prove — is not high. They are enforced by criminal sanctions in principle but they are not sanctions which our system would readily follow up. Again, the routes by which deaths are reported to the coroner are essentially twofold, and this is a subject to which I shall return very soon. They are police and they are medical practitioners. Every now and again there are other members within the community who report deaths to the coroner because they are concerned about them or because they have an agenda — a proper one, sometimes not a proper one. The reality then is that those are the two routes by which the information comes on the basis of which coroners need to make their decisions about their investigations and whether to hold an inquest. There are no other serious options. The challenge for our system is to devise a mechanism by which those routes of information provision are monitored and audited so that they achieve objectives which we now set for them in the era after Shipman and Patel and a range of other phenomena, but I will come back to that very soon. I am not qualified to talk about death certification so I will say nothing about it and move on to the issues to do with the post-Shipman era. The Shipman scandal needs to be seen in perspective, and I would like to say a few things about that. The Shipman tragedy is truly awful and gruesome, and its repercussions are still resonating very profoundly within the United Kingdom. Shipman is not the first homicidal doctor; there are quite a number of examples of other homicidal medical practitioners over the last century in different countries and there has been more than one in the United Kingdom.

There is the peculiar facility for engaging in mass homicide if one is possessed of the advantages that accrue by reason of being a medical practitioner — the resort to drugs and the capacity to hide homicidal behaviour. However, dreadful as the Shipman homicides are, it is important not to construct an entire system on the basis of one serial killer. There have been other examples in reasonably recent times — Swango in the United States is another example — and it is said that Dr Patel's deficits in 'skills' have resulted in a number of deaths which should not have occurred. It remains to the inquiries to the north of us to determine whether that is actually so or not. The point is twofold: that doctors have the capacity to hide incompetence and deaths that should not have occurred, and they certainly have the capacity to hide homicidal behaviour. So what should we do in terms of fashioning a system in recognition of those facts to more effectively identify poor quality medical provision which has caused avoidable deaths and also as best we can to pick up the Shipman phenomenon if tragically it is repeated here?

What can be said already is what Professor Corder has identified, namely that if a Shipman were to emerge in Victoria, he or she could be reasonably successful in their activities for a long while. It was florists, undertakers and colleagues who finally most effectively blew the whistle on Dr Shipman, so the challenge is how to do it better. Three options are identified here and they are all thoughtful and worthwhile ones coming out of the United Kingdom, but they have their problems. The first one, option A identified on page 31, is that:

All deaths should be reported to a coroner so that the coroner makes the decision about which deaths require further investigation —

the coroner being responsible for certifying all deaths. The difficulty here is that coroners, with the greatest of respect, have their limitations. Our system has legally qualified coroners. It would require a massive reshaping and rethinking of the resourcing of coroners' officers to have coroners the recipients of the reporting of every single death and coroners, through some kind of a system, deciding which ones require further investigation. We are talking really substantial money to have such a response.

Likewise the Luce report proposes that coroners should be informed only of notifiable, reportable deaths but that all death certificates should be scrutinised by an assessor within the coroner's office. Again, this is a fine idea, but there are substantial numbers of deaths every day and week and for there to be a meaningful assessment it would need to be by a qualified person who functioned as the assessor. It would need to be a team of medically, and suitably medically, qualified personnel.

One would not want to have a system where there was a rubber-stamping exercise; one would want to have one where they had a good look at the documentation, where they could inquire if it looked problematic on its face, or if anything was putting the assessor on notice of something anomalous or odd; and also one would want them to be able to look from an epidemiological perspective as to whether there were strange trends in terms of causes of death or incidents of death or of a particular kind of death. Again, that is a reasonably sophisticated exercise. It would take time in respect of every death if it were to be done properly and if one were to accomplish anything constructive. I would imagine it would need a panel of a considerable number of doctors working hard every day to accomplish this objective.

Option C, the proposal of the United Kingdom government in 2004, is similar but a touch different, namely that doctors should continue to certify the cause of death but two doctors should be required to certify, the second doctor being attached to the coroner's office. Again, the same kind of process would need to be undergone in respect of the second analysis of what the first doctor decided. All of the proposals are fine in principle but, I would suspect, fiscally completely impractical.

There is a need for us to do more than we are doing because a great many deaths are slipping through the system; and while the coroner's office here, to its credit, has established some processes for auditing and review and identification of trends, those processes are very limited. That brings me to an early point which I should like to make — that there is a problem in terms of the resourcing of the coroner's office. We have at times grandiose and unrealistic expectations of what we want from contemporary coroners in Victoria, and if we want them to be sophisticated investigators of death we need to think about who is doing the job, who is doing different parts of the job, and we need to ensure that they have the resources necessary to undertake it.

If they are going to use database systems and they are going to draw in a meaningful sense upon public health personnel and epidemiologists as well as pathologists, those individuals have to be made available, either in the coroner's office or in the Victorian Institute of Forensic Medicine in significantly greater numbers. The coroner's office — and I am free to say this as a member of counsel appearing regularly before the court — is inadequately resourced. The staff are very good: they are responsive and sensitive and they do what they can, but there is a ludicrous lack of availability of even resources like transcript. It needs considerable improvement. That is not a legislative change but it is an important parameter within which any inquiry is looking at things, and there needs to be money spent on those basic facilities before one starts even contemplating sequelae of the kind being looked at in the United Kingdom at the moment.

However, if one is to look at a death investigation system which more effectively picks up trends, anomalies and problems within death certification and investigates them, first money needs to be spent and then one needs to decide where to situate those who do the work. My own view differs from that of the State Coroner. I would prefer to see that work done within an institute of forensic medicine. I should prefer to see a disaggregation of roles of the coroner. This is an issue that is being looked at in the context of all of the health regulation boards in Victoria, and there are 12 of them. As I understand it, legislation will be introduced into state Parliament very soon which is likely to disaggregate the investigative, prosecutorial and adjudicative roles of those boards. That is done to maximise skills and confidence within the system.

Some of the same issues arise in the context of coroners. Right now we ask an extraordinary amount of coroners. We expect some of them to be on call 24-hours a day — perhaps we can do that. But we also expect them to be sophisticated investigators, as well as very good adjudicators. We expect them to write their reasons in a sophisticated and full way, utilising a whole range of tools. I would like to make a few points in relation to that.

First of all, it is just not realistic. Some magistrates do the task very well and we are fortunate to have their services, and two of them are sitting here right now. But not all of them are able to do it. Being a coroner is a very different role to being a magistrate. Some manage the adjustment well; many do not. Right now it requires drawing upon many, many different skills in terms of searching, investigating, identifying, working with professionals from many different walks of life including occupational health and safety people, police — of course, crime scene individuals, toxicologists, pathologists, radiologists, odontologists and epidemiologists and others, to name only a few. It also requires decision making which is signally different from that which takes place in a magistrates court, which is a quick and dirty jurisdiction to resolve reasonably straightforward cases; few of them last more than a couple of hours. But a great many coroners' inquests do. So one is looking at different sorts of skills amongst those who are able to be appointed to the role. Nothing I am saying should be regarded as critical of any individual fulfilling the office now or recently.

**Mr DALLA-RIVA** — Or in the future?

**Dr FRECKELTON** — Absolutely. 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. Secondly, we should take a leaf out of the legislation which endeavours constructively to elevate the status of the senior magistrate in the Children's Court and constitute her — as it currently is — a judge of the County Court. It recognises the importance of the role of that jurisdiction, and has been important in perception management. I propose that that be done routinely in relation to the State Coroner and also in relation to the Deputy State Coroner. It enables appointment from persons with significant diverse experience and skill sets suitable for the jurisdiction, particularly managing lengthy hearings and being called upon to write substantial decisions and justify them in a way we demand as members of the community of coroners.

The other issue is the investigative 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.

Certainly it is not having the coroner involved in a nuts and bolts way with the evolution of the investigation requiring direction, continuing involvement and the potential for misunderstanding about what takes place out of a public site. The decision of the Full Court of the Australian Capital Territory Supreme Court in the Doogan matter just a few weeks ago is an example of where confidence waned, unfairly, in relation to a complex inquiry. It is an example of where the work done by coroners is not well understood because much of it is removed from public gaze and can be misinterpreted even by persons who are aware of the way in which coroners function. I urge the inquiry to give consideration to disaggregation of the roles of the coroner, and to bestow at least a significant part of the investigative responsibilities upon a separate officer, for instance, to be termed an investigations officer, appointed from senior levels within the legal world whose responsibility it would be to construct coronial briefs and to exercise the coercive powers which would then attach to that office rather than specifically to the coroner.

The advantage would be that it would recognise the limitations of any individual and give a clearly focused investigation process. It might well make a lot of sense to site that within an institute of forensic medicine, recognising that so many of the issues are going to be medically related, and in that way keep the coroners' court separate from the preliminary phase of work that is inquisitorial. That would not detract from the inquisitorial component of the inquiry of the inquest; that can be maintained. But it seems to me that that would be a substantial and constructive kind of an exercise.

I have spoken about the appointment of coroners. In terms of the period, it seems to me that it is a jurisdiction that takes appointees a little while to adapt to, and a period in the order of five years would make sense with maintenance of judicial or magisterial tenure for the remainder of the full appointment period of the individual. I do not have anything to say about the coroner's powers of investigation generally. In terms of guidelines for coroners' investigations, in my view that is the responsibility of the state coroner. It might well be constructive for there to be

more construction of guidelines so that matters are clearer in terms of public access and public perception about how the office works, but ultimately that is a matter for the senior judicial officer within the area, as in all others.

In terms of police assistance, inevitably coroners are going to be very substantially dependent upon police to do investigations. There is no feasible alternative to that. The important issue is that coroners have sufficient access to police, and sufficient powers to ensure that investigations are undertaken as they require them to be. My observation, and I would defer in this regard to what the State Coroner says, is that by and large that system works quite well, that is by reason of constructive cooperative arrangements which have been forged over a long while. There are circumstances where it is problematic for investigations to be undertaken by police. Obviously deaths in police custody are examples of those, but there is not an easy option in that regard. Investigating police from the outside does not have an effective or happy lineage. 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.

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. It is not a matter of powers; it is a matter again of resources.

I have no submissions to make in relation to mandatory inquests nor upon discretionary inquests. By and large the circumstances in which inquests can be convened are exercises of discretion save with those categories where they have to be constituted. There are processes by which representations can be made, and they are regularly made, to coroners advancing circumstances in which in the public interest an open inquiry ought to be constituted. My own experience is that coroners are responsive to those and where there is an issue in the public interest that is of significant compass, of major community concern or where there needs to be clarification of matters that are not clear on the papers, inquests are constituted. There are not all that many circumstances where family members are aggrieved at the absence of an inquest.

Again there is considerable flexibility under our current system as to whether inquests should be re-commenced particularly where there is new evidence or matters have not been fully resolved, for instance in a criminal trial. That works reasonably well. I do not think anything particularly needs to be said in relation to multiple death inquests. They are quite unusual. Coroners have substantial powers at inquests. The only matter I would like to address in this regard is the privilege against self-incrimination. This is a fraught and difficult issue and something upon which reasonable people differ. I know there is the diversity of views within the Victorian Bar about this matter. First of all, the Law Reform Commission of Victoria is at the moment reflecting upon whether to recommend that the uniform evidence acts of the Commonwealth, New South Wales and Tasmania be implemented in this state. It may very well be that that will be its recommendation in a short while. There is a different system in terms of the privilege against self-incrimination under that scheme in terms of the certification exercise. That is the law in New South Wales specifically in relation to inquests as well.

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.

There is one other major issue I should like to address and then I am very happy to receive any questions. I apologise for talking in a monologue for longer than is ideal. It is the role of recommendations and the purposes of inquests. Under the Victorian legislation as it currently is the purposes of inquests are reasonably limited under section 1:

## 1. Purpose

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.

The contrast, for instance is section 15 of the Coroners Act 1988 in New Zealand which sets out much more extensive philosophical purposes for coroners and for the jurisdiction generally. The Law Commission of New Zealand is recommending more of that in its recent report into coroners.

My recommendation with respect to the committee is that thought be given to setting out more extensively the purposes of not just 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 de facto prophylactic role of the coroner system as it is currently functioning. For myself, I would not recommend that there be different findings available to coroners. In New Zealand it is legitimate for an inquest to be convened in order to enable recommendations to be made. That is actually quite an important contrast to the legislation in Australia. I would urge that consideration be given to that. The general view, as I apprehend it, amongst lawyers who appear at inquests here and interstate is that it is important that coroners' inquests not function as a free-ranging quasi royal commission — that was certainly Justice Nathan's view in the Harmsworth decision and the Full Court's view in the ACT's Supreme Court in Doogan. This should not be changed.

It is important that there be some nexus between recommendations and findings, but there is considerable social advantage in utilising the informed perspective that coroners acquire by reason of their conduct of inquests to encourage them to make recommendations where that is a feasible and constructive exercise. There is a disinclination amongst some coroners to do this. It is generated by a number of factors. One is the concern about whether there really is encouragement to do it under section 19(2) of the current legislation. Another is the concern that they may be extrapolating unduly from the specific to the general and not have sufficient information before them to do so and are at risk of recommending things which may not be feasible. This is the tension in relation to the recommendatory rider function of coroners.

It seems to me if we are going to spend considerable sums of money on death investigation, if we are going to consider appointing persons of County Court judicial status, if we are going to look at improving the sophistication and extent of investigatory processes along the lines of the proposals being advanced in England or the kinds of proposals I have put to you, then we need to facilitate this very important vehicle for avoiding avoidable deaths in this state. It needs to be done well, effectively resourced in a sophisticated way and with temperance. That means we should recognise the importance of the function by legally constituting it and enabling inquests to take place and parts of inquests to be focused overtly and legitimately upon the information assembly to allow recommendations to be made to avoid avoidable deaths.

There is a further matter I should like to raise with you that flows straight out of that. It goes again to what we as a contemporary community expect of the sequelae of inquests. Findings are made; recommendations are advanced in a certain percentage of cases. If the kinds of proposals I have advanced to the committee were to be adopted, one could expect a modest increase in the incidence of recommendations. 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.

However, the other issue is this: should there be a mandated response from those who are the subject of suggestions, comments, recommendations? There is a modest obligation in that regard in the Northern Territory and the Australian Capital Territory in respect of Indigenous deaths in custody. In my view it is a very constructive



phenomenon. It does not coerce people into simply applying what the coroner recommends, because that would be inappropriate, but it does mandate them in certain very limited categories of inquests to indicate whether they propose to implement what has been recommended by the coroner and to let the coroner know. It would be very helpful to know what the implementation rate is of coroners' recommendations. I do not believe there is any way of identifying that right now, here or elsewhere in Australia. There are some recommendations made by coroners, not those present of course, which are not amenable to implementation because they are ill-informed and unrealistic. If that is happening to a significant degree, we as a community need to know about it and they need some guidance in terms of feedback about unsatisfactory advancement of recommendations. However, if good recommendations amenable to implementation are being advanced and ignored, we as a community need to know that as well. The bodies who are potentially affected by recommendations need to have a ready mechanism for knowing what is taking place. The coroner's office here has implemented a variety of very innovative things — they have published a quasi-journal, there are bulletins that are sent out, there are liaison committees — but none of them are able to address the aftermath of recommendations.

I urge the committee to give consideration to implementation and extension of the regimes in the Northern Territory and the Australian Capital Territory mandating at least instruments of government to respond within a sensible time frame — 12 months or whatever — as to whether they propose to implement the proposals of the coroner and to enable the coroner to publish those responses in a report to Parliament so that Parliament itself can have a constructive overview of what is taking place within the coroners court and the phenomenon of recommendations and implementation of and responsiveness to recommendations. Again, that would start to enable data-informed decision making about how to adjust and evolve the coroner's jurisdiction in this state. Finally, I make the point that there is a need for better and more consistent funding for family members seeking to participate in inquests. Why don't I stop there for the present?

**The CHAIR** — Thank you very much for that submission. It was very thorough. Some of us are in a difficult position, including myself, in that I have another commitment which I have to be at because I have to speak at it. I do not know whether any of my colleagues wish to ask questions at this point but there may well be some things from your submission and from reviewing the transcript where we would like to follow up with you, if we could.

**Dr FRECKELTON** — Of course.

**The CHAIR** — Unfortunately we are out of time — we are well over time.

**Dr FRECKELTON** — Does this mean I have escaped the testing process of being cross-examined by the committee? I have engineered that well then.

**The CHAIR** — You were very clear.

**Mr LUPTON** — I have to say, Ian, you answered most of the questions during your submission.

**Dr FRECKELTON** — I am glad to hear it.

**The CHAIR** — At the risk of asking a question and therefore prompting an answer, there was one area. You toyed with both Shipman and Luce but I did not think you actually gave us an answer to the question of what is a reasonable basis for more effective death certification in light of Shipman. You toyed with various possibilities but I was not totally clear at the end of that as to what you were actually recommending.

**Dr FRECKELTON** — If money is not going to be a major fetter on this — —

**The CHAIR** — Money is always an issue.

**Mr LUPTON** — Perhaps a practical solution.

**Dr FRECKELTON** — I do not think it is the Home Office one or Luce because it would require such a considerable employment of personnel. I think the answer is probably the employment of additional personnel within the Institute of Forensic Medicine to enable a meaningful review of death certificates, and a campaign to have doctors more readily seeking advice and airing concerns and anxieties about deaths to other medical practitioners within the Institute of Forensic Medicine. That in turn would feed into the Coroners' Court where things could come to light. It would be a public health-oriented, epidemiology-oriented, pathology and

medicine-informed exercise. It would be very nice to have a medically qualified practitioner looking at every death certificate and checking over every death but I fear that would be such a resource-demanding exercise that it is not feasible.

**The CHAIR** — So you are saying, in effect, an auditing system.

**Dr FRECKELTON** — We need an auditing system.

**The CHAIR** — A random auditing system or a selective auditing system?

**Dr FRECKELTON** — It needs to be selective so that specific things, when notice is drawn to them, can be followed up effectively. I would prefer that to be done out of an Institute of Forensic Medicine rather than the Coroners Court because it will be doctors principally who are the most effective agents for doing it, and it is cleaner having the front end being medical. So it needs to be selective; if it could be random as well, that would be good. I suspect that an absolutely comprehensive all-encompassing one is not feasible.

**Mr DALLA-RIVA** — Does that not defeat the purpose? We have heard time and again about police investigating police, and now you want doctors investigating doctors.

**Dr FRECKELTON** — But there is no real option. It will not be very helpful to have florists investigating doctors — it does not work.

**Mr DALLA-RIVA** — We have heard evidence about doctors covering. I just do not think you need to be flippant about it, because that has been a real issue that has been raised by people. I just do not think we need to be flippant. We have heard time and again from people who have been involved.

**Dr FRECKELTON** — I hear what you are saying.

**Mr DALLA-RIVA** — I think you have to be careful about those comments.

**Dr FRECKELTON** — I understand what you are saying. The difficulty is this: just as it is very difficult to investigate police or corrections from the outside, one needs to have the information and informedness of persons aware of those areas of work. It is the same with medical deaths. It is very difficult to have persons who are not medically qualified effectively investigating the subtleties of death aetiology. Someone has to have at least significant input, I think, from persons who are medically qualified. Let me answer you, partly arising out of my own experience as a lawyer member of the Medical Practitioners Board — I am not speaking on its behalf, but utilising that experience. We have found at that board that it is absolutely essential to have a considerable number of the investigators health trained, preferably medically trained, because they can informedly pare away the irrelevancies and see through where false scenarios are being created, understand the terminology, ask the right questions and engage the practitioners effectively. I think that has to be a crucial component of it — not necessarily the only one, but it has to be a really important part of it in terms of the efficacy of investigation.

**The CHAIR** — Thank you for appearing before the committee. I think we would probably like to continue the conversation, but we cannot. There may be some areas we would like to follow up further with you. We appreciate you bringing your considerable expertise and experience before the committee and thank you for your submission today.

**Dr FRECKELTON** — Thank you very much.

**Mr DALLA-RIVA** — There is a written submission coming too, is there not?

**Dr FRECKELTON** — There will be a written submission from the Victorian bar.

**Committee adjourned.**