



VICTORIAN PARLIAMENT
LAW REFORM COMMITTEE

Coroners Act 1985

Discussion Paper

April 2005

Parliament of Victoria, Australia

Coroners Act 1985

Law Reform Committee

ISBN—0 7313 5397 8

Printed on recycled paper.

This discussion paper is also available at www.parliament.vic.gov.au/lawreform

INVITATION TO MAKE A SUBMISSION

The Committee invites you to make comments and submissions about matters which could inform its general recommendations about the *Coroners Act*. Responses from family, friends and witnesses who have been involved in a coronial process are very welcome.

It is important to note that the scope of the inquiry is limited by the terms of reference which direct the Committee to consider an appropriate legislative framework. The Committee cannot investigate individual cases, or make findings about the conduct of cases.

There is no particular form or structure required in your written response and your submission can be as short or as long as you like. You do not need to answer all the questions in this paper—just the questions you would like to respond to. If you would like to discuss how to make a submission or need more information, please contact the Executive Officer at the address below.

Closing date for submissions—Friday, 15 July 2005

Responses to this discussion paper should be sent by post or email to—

The Executive Officer
Victorian Parliament Law Reform Committee
Level 8, 35 Spring Street
Melbourne VIC 3000

(Please also send a floppy disc copy if possible)

Email: VPLRC@parliament.vic.gov.au

(Please also send a separate signed authentication)

Fax: (03) 9651 3674

Phone: (03) 9651 3644

Website: www.parliament.vic.gov.au/lawreform.

Confidentiality

All submissions are treated as public documents which are available on the Committee's website, unless you request your submission to be kept confidential. If you would like the whole or part of your submission to be kept confidential, you should clearly identify the parts that you wish to be kept confidential when you send your submission. Please also let the Committee know why you would like it to be kept confidential. If you have any questions or concerns about confidentiality, please contact the Committee's Executive Officer before you make your submission.

Public Hearing

The Committee will also hear oral submissions and evidence at a public hearing in Melbourne later this year. A transcript of the hearing will be made available on our website. The dates of the public hearing will be advertised in *The Age* and on the Committee's website.

Private Hearing

Arrangements may also be made for the Committee to hear oral submissions and evidence in confidence. Any transcript of evidence given in confidence will remain confidential and will not be available on the Committee's website.

Parliamentary Privilege

All written submissions to the Committee and statements made at the public hearing are protected by parliamentary privilege.

Questions

If you have any questions about this discussion paper, please contact the Committee at the above address.

COMMITTEE MEMBERSHIP

Chair

Mr Rob Hudson, MLA

Deputy Chair

Mr Noel Maughan, MLA

Members

Hon Richard Dalla-Riva, MLC

Ms Dianne Hadden, MLC

Hon David Koch, MLC

Ms Dympna Beard, MLA

Mr Tony Lupton, MLA

STAFF

Executive Officer

Ms Merrin Mason

Research Officer

Ms Michelle McDonnell

Office Manager

Ms Jaime Cook

FUNCTIONS OF THE LAW REFORM COMMITTEE

Under section 12 of the *Parliamentary Committees Act* 2003 (Vic):

- (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.

TABLE OF CONTENTS

Chapter One – Introduction	1
Terms of Reference.....	1
Purpose of this Discussion Paper	2
The Coroner’s system in Victoria	2
The Inquiry process	2
Chapter Two –Reporting deaths to the Coroner	5
The current system for reporting deaths to the Coroner	5
<i>Doctors’ obligation to report</i>	5
<i>Deaths notifiable to a coroner by others</i>	24
Problems with the current system of reporting deaths	25
Alternative systems for reporting deaths	26
<i>England and Wales</i>	26
<i>Finland</i>	30
Chapter Three—Independent death investigation	33
Appointment and Tenure of the Coroner.....	33
<i>Other Australian jurisdictions</i>	34
<i>Other relevant law reform agencies</i>	34
Deaths investigated by the Coroner	35
<i>Jurisdiction to investigate</i>	35
<i>Scope of jurisdiction</i>	35
<i>Powers of investigation</i>	36
<i>Guidelines for Investigations</i>	39
<i>Assistance with Investigations</i>	41
Inquests	44
<i>Jurisdiction</i>	45
<i>Powers at the Inquest</i>	52
<i>Procedure and Rights of persons at the Inquest</i>	54
<i>Findings at the Inquest</i>	58
<i>Recommendations at the Inquest</i>	59
<i>New Inquests and Re-opening of Inquests</i>	59

Investigation of suspected deaths	62
Chapter Four—Independent Investigation of Fires	63
Investigating fires	63
Inquests into fires	64
Fire investigation in other Australian jurisdictions	64
Other kinds of investigations	66
Chapter Five—Coroner’s role in injury and death prevention.....	67
The Current system	67
<i>Effectiveness of the current system.....</i>	<i>71</i>
Alternative Systems	76
<i>The Ontario system</i>	<i>77</i>
<i>The system proposed in the Queensland review</i>	<i>77</i>
Chapter Six—Including the Family in the Coroner’s process.....	79
Needs of the community	79
Definition of “Family”	80
<i>Other Australian jurisdictions.....</i>	<i>80</i>
Rights of family members under the Act	81
<i>Right to view or touch the body</i>	<i>83</i>
<i>Right to inspect the scene of death</i>	<i>84</i>
<i>Right to access information considered by the Coroner.....</i>	<i>85</i>
<i>Notification of inquest</i>	<i>86</i>
Autopsies	88
<i>Objections to autopsy</i>	<i>89</i>
<i>Alternatives to autopsy</i>	<i>92</i>
<i>Right to be notified about retained body organs and tissues</i>	<i>93</i>
<i>Right to Autopsy</i>	<i>96</i>
<i>Release of the body.....</i>	<i>97</i>
Exhumation	97
Right to legal representation.....	97
<i>Law Reform Agencies</i>	<i>97</i>
Counselling	98
Your experience in the Coronial System	99
The Role of the Coronial System today.....	99

Select Bibliography..... 101
**Appendix 1— Royal Commission into Aboriginal Deaths in Custody—Recommendations
relating to coronial inquiries 105**
Appendix 2—Coroner’s Practice Directions 113

QUESTIONS FOR DISCUSSION

Chapter two

Question 1—Unexpected, unnatural, violent and accidental deaths (p. 12).

- (a) In your experience, do doctors have a good understanding of what is meant by this category of reportable deaths?
- (b) Do you think that Coroner issued guidelines would assist doctors' understanding? If so, who should be responsible for writing, updating, and publicising the guidelines and who should be consulted?
- (c) Do you think the current category needs to be revised in any way? If so, what kind of deaths should be included in the category?
- (d) Should the Act classify deaths from particular diseases as reportable deaths? What diseases do you think should or should not be included in this category? Are there any resource issues which would need to be considered?

Question 2—Deaths involving medical treatment (p. 14).

- (a) Do you think the Act gives doctors a clear indication of when to report a death involving medical treatment or do you think that it would be preferable to have a more detailed provision such as in the ACT or Queensland?
- (b) Is there currently an “under-reporting” of deaths involving medical treatment to the Coroner? If so, why do you think this is happening and how can this be changed?

Question 3—Deaths involving anaesthetics (p. 16).

Do you think this category of reportable deaths need to be more clearly defined in the Act or in Coroner's guidelines?

If so, how?

Question 4—Deaths in care and in custody (p. 19).

Do you think the current definitions in the Act of “deaths in custody” and “deaths in care” as categories of deaths reportable to a coroner are adequate or should the categories be extended in any way—for example, to include deaths of other vulnerable persons?

Question 5—Examination of bodies and medical records after death (p. 23).

- (a) Should there be a legal requirement as part of the death certification process that a doctor or some other person be required to physically view all bodies?
- (b) If so, who should conduct the examination and where should the examination take place?
- (c) Should there be any other requirements? For example should a doctor be required to consider recent medical records before certifying a death?

Question 6—Degree of certainty of cause of death (p. 23).

- (a) Should the Act or Coroner's guidelines be more specific as to the degree of certainty required for a diagnosis?
- (b) Do the current VIFM guidelines provide for an appropriate degree of certainty in diagnosis?

Question 7—Effectiveness of new category of reviewable deaths (p. 24).

- (a) In your experience, is the general community and the medical profession aware of the new category of reviewable deaths which must be reported to the State Coroner?
- (b) If not, who should be responsible for raising awareness of this new category?
- (c) How effective do you think the new provision will be in informing the State Coroner of situations where more than one child of a family dies?

Question 8—Awareness of public obligation to report deaths (p. 25).

- (a) How often are deaths reported to the Coroner by the general community?
- (b) Is the general community aware of their obligation to report notifiable deaths to the Coroner?
- (c) If not, who should be responsible for raising awareness? Should this be a function of the State Coroner? What kind of strategies could be used?
- (d) Should the Act impose a penalty on police officers who fail to report to a coroner information relevant to an investigation?

Question 9—Problems with the current system of death certification (p. 26).

Are there any other issues with the current system of death certification?

Question 10—Death certification system reform (p. 31).

Does the death certification system in Victoria need to be strengthened?

If so, how?

Some law reform options to consider include:

Option A. The system recommended by the Shipman Inquiry in its third report:

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.

Option B. The system recommended in the Luce Report:

The Coroner should continue to only be informed of notifiable deaths but that 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.

Option C. 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.

Chapter three

Question 11—Appointment of coroners (p. 35).

- (a) Does the practice of appointing a State Coroner for a fixed term of 3 years have the potential to compromise the independence of the position?
- (b) Should the Act be changed so that the State Coroner is appointed for a defined period? If so, how long should the appointment be for?

Question 12—Coroners' powers of investigation (p. 39).

- (a) Are there any problems or issues of concern with the current powers of entry, search and seizure?
- (b) Are you aware of any challenges to or criticisms of the exercise of these powers?

Question 13—Guidelines for Coroners' Investigations (p. 40).

- (a) Are there any issues or concerns in relation to the State Coroner's guidelines and investigation standards?
- (b) In your experience, are all Coroners in Victoria familiar with the standards and guidelines and do they consistently use and apply them when investigating a death?
- (c) Are coroners' investigations reviewed to assess whether the standards and guidelines are consistently applied?
- (d) Can the public readily access all of the State Coroner's guidelines and investigation standards? Are the current guidelines and investigation standards publicised in any way?
- (e) Do all newly appointed Coroners, including Magistrates in rural areas, participate in coronial training in death investigation?
- (f) Are there any other kind of investigations which need investigation standards or guidelines?
- (g) Should the Act specifically require Coroners to have regard to the recommendations of the Royal Commission into Aboriginal Deaths in Custody relating to the investigation of deaths in custody?

Question 14—Police Assistance with Coroners' investigations (p. 42).

- (a) Should Coroners have the power to require investigating police officers to report directly to Coroners and to issue directions to police officers concerning investigations, as recommended by the Royal Commission into Aboriginal Deaths in Custody in 1991?
- (b) In your opinion, are there any kinds of coronial investigations where it is not appropriate for the investigations to be undertaken by police officers? What alternatives could be considered? Are there any resource issues to consider?

Question 15—Legal assistance with Coroners' investigations (p. 43).

- (a) Do the State Coroner or coroners currently appoint lawyers to assist with investigations?
- (b) Should the law require coroners to appoint lawyers to assist inquiries in relation to the investigation of deaths in custody?
- (c) Should the law require the State Coroner to appoint lawyers to assist coroners with other kinds of investigations?

Question 16—Other Assistance with Coroners’ investigations (p. 44).

- (a) Do Coroners currently use other kinds of investigators? Are there any resource issues associated with using investigators?
- (b) Do you think that certain kinds of investigators should be appointed under the Act? What duties and obligations do you think this kind of investigator should have?

Question 17—Mandatory Inquests (p. 46).

- (a) Are there any issues or concerns with the current category of deaths in which an inquest is mandatory?
- (b) Should the current category of mandatory inquests be extended?

Question 18—Discretionary Inquests (p. 49).

- (a) Are there any issues or concerns with the current criteria coroners use to determine if a discretionary inquest should be held?
- (b) Are there any issues or concerns in relation to the appeal process to the Supreme Court following a coroner’s refusal to hold an inquiry?

Question 19—Coroner’s discretion not to hold, continue or recommence an inquest (p. 50).

- (a) Do you think that there are certain circumstances where it should be mandatory not to hold, continue or recommence an inquest?
- (b) Are there any issues or concerns regarding the way coroners currently exercise their discretion not to hold, continue or recommence an inquest?
- (c) Do you think the Act should indicate what factors a coroner should consider when exercising this discretion?
- (d) In your opinion, what factors should a coroner consider?

Question 20—Multiple death inquests (p. 52).

Should the Act define the circumstances in which multiple death inquests are permitted?

Question 21—Coroner’s powers at an inquest (p. 54).

Are there any issues or concerns in relation to a coroner’s powers at an inquest?

Question 22—Privilege against self incrimination (p. 57).

Is a change to the law limiting a person's right to claim privilege against self incrimination at coronial inquests justified?

Question 23—Rights of Appeal (p. 62).

- (a) Is the Supreme Court the most appropriate jurisdiction to hear appeals under the Coroners Act?
- (b) Should the power of the State Coroner be extended to include the power to review a coroner's findings made on investigation without an inquest?
- (c) Are there any other issues or concerns with the current grounds of appeal to the State Coroner and to the Supreme Court?

Question 24—Investigation of suspected deaths (p. 62).

Are there any issues or concerns with the way in which suspected deaths are reported to, and investigated by the Coroner?

Chapter four

Question 25—Investigations and Inquests into fires (p. 65).

- (a) Do you think that a modern coronial system should continue to investigate non-fatal fires or do you think that these kind of investigations could be undertaken by the fire authorities, such as in Queensland and Western Australia?
- (b) In your experience, does the Coroners system effectively investigate fires and make recommendations to prevent future fires and improve safety?

Question 26—Investigations and Inquests into disasters (p. 66).

- (a) Do you think the scope of a coroner's power to investigate should appropriately include the power to investigate disasters and to make recommendations in relation to disasters?
- (b) What kind of events do you think should be included in the definition of "disaster"?

Chapter five

Question 27—Systems for identifying similar kinds of deaths (p. 68).

- (a) How effective are the current systems for identifying similar kinds of death, such as the National Coroners Information System?

- (b) Are there any resource issues in relation to the National Coroners Information System?
- (c) Do all Coroners use the system when investigating deaths to establish whether there are also similar kinds of deaths to the death which they are investigating?

Question 28—Implementing RCADC recommendations (p. 71).

Do you have any comments regarding the implementation of the 1991 RCADC recommendations relating to coronial investigations?

Question 29—The Coroner’s role in death and injury prevention (p. 77).

- (a) How effective do you think the current system is in preventing death and injury?
- (b) Do you think that the preventative role of the Coroner should be expanded in any way? Should the preventative role of a coroner be a specific function of the Act?
- (c) Should the Act require a mandatory response to certain coronial recommendations? Should the State Government be required to provide a written response to certain Coronial recommendations within a specified time-frame? Should responses to recommendations be required to be tabled in Parliament?
- (d) Should anyone be responsible for monitoring the implementation of coroner’s recommendations? Who do you think should be responsible?
- (e) What are your views on alternative systems such as the Ontario system? Do you think this kind of system would be effective in Victoria?

Question 30—The Coroner’s role in improving safety in the health care system (p. 78)

- (a) Do you think that the Coroner’s current role allows an appropriate level of involvement in improving general patient safety in the Victorian health care system?
- (b) In your experience, are there any obstacles or issues preventing a coroner from fulfilling this role?
- (c) What strategies or system improvements could be implemented to overcome these obstacles?

Chapter six

Question 31—Needs of the community (p. 80).

- (a) In general terms, what do you identify as the needs of a member of the community who is involved in the coronial process following the death of a family member or friend?
- (b) Do you think that the Coroners Act is able to accommodate those needs? Are there any resource issues to consider?

Question 32—Right to be informed (p. 83).

- (a) Should the Act give family members the right to be informed or to be kept informed of certain events in relation to the inquiry?
- (b) Should the Act define the term “family member”? Who should be included in the definition?
- (c) Who should be required to inform the family? Should anyone be responsible for ensuring that this occurs?
- (d) Are there any resource issues to consider?

Question 33—Touching and viewing the body of the person who has died (p. 84).

- (a) Should the Act specifically give the family of the person who has died the option of viewing and touching the body while the body is under the control of the Coroner?
- (b) Should there be any limit to this right?

Question 34—Access to the scene of death (p. 85).

- (a) Should the Act give a coroner the specific power to restrict access to the place where a death occurred?
- (b) Should the Act give the immediate family of the person who has died the right to access the place where the death occurred?
- (c) Should there be any limit to this right?

Question 35—Accessing information (p. 86).

- (a) Are there any issues or concerns regarding the requirement in the Act that a coroner may make available any statements that the Coroner intends to consider at an inquest to “any person with a sufficient interest”?

- (b) Should the Act specify that family members should be able to access statements and other information as soon as it becomes available?
- (c) Should the Act place any restriction on the right to access certain sensitive documents such as medical files? Who, in your opinion should not have access to this information?

Question 36—Notification of Inquest (p. 88).

- (a) Should the Act require that before an inquest may be held, a coroner must consider:
 - whether a member of the immediate family has been notified of the time and place of the hearing; or
 - if a member of the immediate family has not been notified of the time and place of the hearing—whether reasonable efforts have been made to do so?
- (b) Should the Act require a coroner to have regard to the recommendations made by the Royal Commission into Aboriginal Deaths in Custody relating to notifying immediate family members regarding the inquest?

Question 37—Rights regarding autopsy (p. 93).

- (a) Should the Act require the 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 a direction that an autopsy be performed?
- (b) Should there be any circumstance in which a coroner may order an autopsy without first contacting an available senior next of kin to see if that person has any objections to the autopsy?
- (c) Should the Act permit anyone else besides the senior next of kin to object to the Coroner directing that an autopsy be performed?
- (d) Should the Act 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?
- (e) Do you think that the Supreme Court is the most appropriate appeal avenue for people wishing to object to autopsies? Are there any alternatives?

Question 38—Rights to removed organs and tissues (p. 95).

- (a) Should the Act require coroners to inform the senior next of kin
 - when tissue or a body part has been retained after the autopsy;

•what the options are when the Coroner decided that it is no longer necessary to retain the tissue or organ?

- (b) What options should the family have when the Coroner no longer requires the tissue or the organ?

Question 39—Rights to observe and attend autopsy (p. 96).

- (a) Should the Act allow a family member or their representative to attend the autopsy?
- (b) Should the Act permit the family to request that a second autopsy be carried out?

Question 40—Release of the body (p. 97).

Are there any issues or concerns with the operation of the requirement in the Act that a coroner investigating a death must issue as soon as reasonably possible, a certificate permitting burial or cremation?

Question 41—Exhumation (p. 97).

Are there any issues or concerns in relation to the requirement in the Act which permits the State Coroner to order that a body be exhumed if he or she reasonably believes that it is necessary for the investigation of a death?

Question 42—Right to legal representation (p. 98).

Do you have any issues or concerns in relation to the right to legal representation at an inquest?

Question 43—Counselling Support Service (p. 98).

Should the Act require the State Coroner's Office to inform family members about the availability of the free counselling service?

Question 44—Other issues and your experience (p. 98).

Are there any issues relating to your experiences in the Coronial system that you would like to discuss?

Question 45—Functions of the Coroners Act (p. 98).

Should accommodating the needs of families be a specific function of the Act?

CHAPTER ONE – INTRODUCTION

The office of the Coroner is a very ancient one; the functions exercised by the holders of the office have changed over the centuries as the needs of the social order have altered. The social order remains in a process of development. It is consistent with the adaptability characteristic of the office of Coroner that the present and future needs of society should lead to a review of those functions and the conditions of their exercise in light of existing circumstances.¹

This is what Sir John Norris QC wrote in his 1980 review of Victoria's *Coroners Act* (1958). Following the last review, the State Coroner's Office has continued to develop its role in investigating notifiable deaths with an increased emphasis on accident prevention. Since 1980, there have been a number of inquiries in both Australia and overseas which have questioned aspects of the coronial system.

The Victorian Parliament Law Reform Committee will review the functions of the Coroner's Office and consider whether the current *Coroners Act* (1985) needs to be amended or modernised to better meet the needs of the community in 2005.

Terms of Reference

In December 2004, the Victorian Parliament Law Reform Committee (the Committee) received terms of reference to review the *Coroners Act* 1985 (the Act). Under the terms of reference the Committee is required to inquire into the effectiveness of the Act (excluding Part 9 of the Act which deals with the operation of the Victorian Institute of Forensic Medicine).

In particular the Committee is asked to consider whether the Act is an appropriate legislative framework for investigating fires and deaths and the making of recommendations to prevent these events and improve safety.

The Committee has also been asked to consider the appropriateness of the Act in providing support to the family and friends of the person whose death is investigated by the Coroner. In this regard the Committee is required to recommend areas where the Act should be amended or modernised to better meet the needs of the community.

The terms of reference require the Committee to examine coronial legislation and its operation in other jurisdictions.

¹ Norris J, *The Coroners Act 1958—A General Review*, Victorian Government Printer, 1980, p. 1.

Purpose of this Discussion Paper

The aim of this paper is to provide an outline and questions for discussion for anyone wishing to make a submission to the Committee.

The outline considers the effectiveness of:

- the system in which notifiable deaths are brought to the attention of the Coroner. (Chapter Two)
- the Act, case law and procedures which currently govern a coroner's investigations and inquiries. (Chapters Three and Four)
- the existing mechanisms which allow a coroner to make recommendations to prevent future death and injury. (Chapter Five)
- the way in which the present Act responds to and supports the families and friends of the person who has died. (Chapter Six)

By way of comparison, the outline also examines equivalent laws and alternative systems in other jurisdictions, along with various law reform recommendations.

The questions for discussion ask readers:

- about their experiences in the current coronial system; and
- their opinion on the various alternatives to the current system discussed in the outline.

The Coroner's system in Victoria

A coroner investigates deaths and fires which have been reported to the State Coroner's Office. The aim of investigation is to find out what happened and why. A coroner may also make recommendations aimed at preventing future deaths or fires.

As part of an investigation into a death, a coroner may direct that an autopsy be performed. In Melbourne, autopsies are performed by forensic pathologists at the Victorian Institute of Forensic Medicine (VIFM). Under the *Coroners Act*, VIFM provides forensic pathology services in Melbourne and oversees and co-ordinates these services throughout Victoria.

The Inquiry process

After the Committee has received written submissions, public hearings will be held in Melbourne later in the year.

Following the public hearings, the Committee will write its Final Report in which it will make recommendations to the State Government. The Final Report will also be tabled

in Parliament. The Government will then consider those recommendations and make a response within six months from when the Report is tabled.

CHAPTER TWO – REPORTING DEATHS TO THE CORONER

The Coroner only investigates deaths which are actually reported to the Coroner's Office. The *Coroners Act* 1985 does not require the Coroner to actively investigate deaths which are not reported. It is vital, therefore that there is an efficient system which ensures that all notifiable deaths are brought to the attention of the Coroner so that they may be appropriately investigated.

In this chapter, that system is examined beginning with a discussion of the circumstances in which the Act requires a doctor to notify the Coroner about the death of a person. The Committee asks whether the legal categories of reportable deaths are stated with clarity and whether any changes to these categories are justified. The Committee also examines the position in the other Australian jurisdictions.

Doctors are not solely responsible for notifying the Coroner. In certain circumstances the Act requires others to notify a coroner and this aspect of the Act is also discussed.

Finally, the Committee examines issues which have arisen in international jurisdictions and the various law reform options which have resulted. The Committee considers whether similar issues could occur in Victoria and whether the Victorian system needs change.

The current system for reporting deaths to the Coroner

Doctors' obligation to report

When a person dies and the death is *not* referable to the Coroner, the *Births, Deaths and Marriages Act* 1996 requires his or her doctor to complete a medical certificate stating the cause of death.² This process is known as "death certification". After the doctor has notified the Registrar of Births, Deaths and Marriages ("the Registrar") of the death, the Registrar then registers the death and issues a death certificate.³

² *Births, Deaths and Marriages 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.

³ *Births, Deaths and Marriages Act* 1996, s. 40 and s. 46.

However doctors are not required to report all deaths to the Registrar. Certain deaths must instead be reported to a coroner.⁴ The *Coroners Act* 1985 requires doctors who are “present at or after” certain kinds of deaths to report that death to a coroner.⁵

The Act requires doctors to notify a coroner if:

- the death is “reportable”;⁶
- the doctor does not view the body of the person who has died;⁷
- the doctor is unable to determine the cause of death;⁸
- no doctor attended the person within 14 days before the death and the doctor is unable to determine the cause of death from the deceased’s immediate medical history;⁹ or
- the death is “reviewable”.¹⁰

Reportable deaths

“Reportable death” is defined in the Act¹¹. There are two requirements. First, the Act requires that the death must be in some way “connected” with Victoria.¹²

Second, the death must meet one of the criteria set out in the Act. In general terms, reportable deaths include:

- unexpected, unnatural, violent and accidental deaths;
- deaths involving anaesthetics;
- deaths of persons in care or custody; and

⁴ *Coroners Act 1985*, s. 13(3). Under the *Births, Deaths and Marriages 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*.

⁵ If one or more doctors are present, then only one doctor is required to report to the Coroner: s. 13(4).

⁶ *Coroners Act 1985*, s. 13(3)(a). “Reportable death” is defined in s. 3(1).

⁷ *Coroners Act 1985*, s. 13(3)(b).

⁸ *Coroners Act 1985*, s. 13(3)(c).

⁹ *Coroners Act 1985*, s.13(3)(d).

¹⁰ *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.

¹¹ *Coroners Act* 1985, s. 3(1): definition of “reportable death”.

¹² i.e. 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.

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
- (l) 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 a doctor certifies a death, he or she 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 will need to be able to clearly understand and apply these definitions to every death which he or she certifies.

However the Act does not define what is meant by some of these terms and the Office of the State Coroner does not issue guidelines to doctors. The Victorian Institute of Forensic Medicine (VIFM) has however published a statement on reportable deaths which doctors can refer to. The statement is available on the Medical Practitioners Board of Victoria website.¹³

As part of this review, the Committee therefore will need to establish whether the legal categories of reportable deaths are stated with clarity and whether any changes to the categories are justified.

We will now examine the first three categories in further detail.¹⁴

Unexpected, unnatural, violent and accidental deaths

One commentator has pointed out that what is meant by an “unexpected death” in the Act is not clear.¹⁵ For instance, is the death to be unexpected by the treating doctor or by the family of the person who has died?¹⁶ The concept of what is an unexpected death, can at times be subjective as it sometimes depends on the amount of information a person has about the medical history of the person who has died.

Another concern is with the definition of “unnatural” death. Two commentators have questioned what the Act means when it refers to this term.¹⁷ For example: is a death from mesothelioma¹⁸, caused by industrial exposure to asbestos 40 years before, a natural or unnatural death?¹⁹ The Act and the Victorian Institute of Forensic Medicine

¹³ Victorian Institute of Forensic Medicine, *Statement on Death Certificates and Reportable Deaths*. Available at : <http://www.medicalboardvic.org.au/content.php?sec=42>

¹⁴ We do not include a discussion on the fourth category “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.

¹⁵ Ranson, D., “How effective? How efficient?—The Coroner’s role in medical treatment related deaths”, *Alternative Law Journal*, Vol. 23, No. 6, December 1998.

¹⁶ Ranson, D., “How effective? How efficient?—The Coroner’s role in medical treatment related deaths”, above note 15.

¹⁷ Lynch, M., “Natural Disease and the Coroner”, *Journal of Law and Medicine*, Vol. 7 May 2000, pp. 345-350 and Ranson, D., “How effective? How efficient?—The Coroner’s role in medical treatment related deaths”, above note 15.

¹⁸ Mesothelioma is a cancer which usually affects the outer membrane of the lungs (pleura). It is linked to exposure to asbestos. Further information is available from <http://www.cancervic.org.au/cancer1/patients/asbestos/mesothelioma.htm>

¹⁹ Ranson, D., “How effective? How efficient?—The Coroner’s role in medical treatment related deaths”, Above note 15.

(VIFM) statement on reportable deaths do not offer guidance to doctors faced with this question.²⁰

However, in a recent investigation into a death, the State Coroner explained that since January 2004 asbestos exposure deaths “have been required to be reported” as this kind of death occurs from an “accident or injury” or is from an “unnatural” cause.²¹ He reasons that “accident or injury” relates to the initial exposure to the asbestos fibres which eventually leads to the fatal disease, while “unnatural” relates to product creating the hazard (e.g. manufactured asbestos sheeting).²²

The State Coroner acknowledges that until recently very few cases of mesothelioma have been reported to the Coroner and he believes that this may perhaps have been due to the medical profession generally not classifying this disease as resulting from an unnatural process or injury in the first place.²³

VIFM offers the following advice to doctors as to what is meant by deaths appearing to result “directly or indirectly, from 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.²⁴

Other Australian Jurisdictions

Despite individual variances, the law as to deaths that are reportable to a coroner is similar throughout Australia.²⁵

In relation to the category “unexpected, unnatural, violent and accidental deaths”, the law in the Northern Territory, Tasmania, South Australia and Western Australia is similar to Victoria.²⁶

²⁰ 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, *Statement on Death Certificates and Reportable Deaths*. Available at : <http://www.medicalboardvic.org.au/content.php?sec=42>

²¹ *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.

²² *Record of Investigation into a Death*; above note 21, p. 1.

²³ *Record of investigation into a Death*, Case no. :1598/03, State Coroner’s Office, Victoria, 8 July 2000. Available at www.coronerscourt.vic.gov.au. The State Coroner cites Lynch, M., “Natural Disease and the Coroner”; above note 17 at 346 “the disease “mesothelioma” would have appeared on several hundred death certificates in Victoria in the last few years. However, between 1996 and 1998 only three deaths (...) were reported to the Coroner”.

²⁴ Victorian Institute of Forensic Medicine, *Statement on Death Certificates and Reportable Deaths*. Available at : <http://www.medicalboardvic.org.au/content.php?sec=42>

²⁵ Halsbury’s Laws of Australia, K Walker, *Coroners* [115-95] at 16 February 2005.

In New South Wales the law is also similar although that jurisdiction uses the term “sudden death, the cause of which is unknown” not “unexpected death”.²⁷ 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.²⁸

In the ACT however, an accidental death is only reportable if it appears to be *directly* attributable to the accident.²⁹ The ACT also does not use the term “unnatural” in its legislation. Instead like New South Wales, the ACT legislation, refers to these kinds of deaths as a “sudden death, the cause of which is unknown”.³⁰ Other types of deaths which are reportable in the ACT include the deaths of persons who are killed or found drowned.³¹

In Queensland, a reportable death includes a death which was “violent or otherwise unnatural” or where the “death happened in suspicious circumstances”.³² The Queensland State Coroner’s Guidelines³³ give an indication of the kinds of deaths reportable under these categories.³⁴ For violent or otherwise unnatural deaths, the Guide advises:

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

²⁶ *Coroners Act 2003 (SA)* s. 3 (definition of reportable death: also includes “unusual deaths” in this definition), Note: This Act commences on 31 July 2005 unless proclaimed before this date; *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 under 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 *Record of investigation into a death (without Inquest)*, Case no.:1598/03, State Coroner’s Office, Victoria, 8 July 2000.

Available at www.coronerscourt.vic.gov.au

²⁷ *Coroners Act 1980 (NSW)*, s. 12B(1)(b).

²⁸ *Coroners Act 1980 (NSW)*, s. 12B(1)(f).

²⁹ *Coroners Act 1997 (ACT)*, s. 13(1)(h).

³⁰ *Coroners Act 1997 (ACT)*, s. 13(1)(c).

³¹ *Coroners Act 1997 (ACT)*, s. 13(1)(a)-(b).

³² *Coroners Act 2003 (QLD)*, s. 8(3)(b)-(c).

³³ 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.

³⁴ *State Coroner’s Guidelines—Version 0 December 2003*. Paragraph 3.1.4. Available at <http://www.justice.qld.gov.au/courts/coroner/pdfs/guidelines.pdf>

occupations. (...) See Matthews P., Foreman J., *Jervis on the Office and Duties of Coroners*, Sweet & Maxwell, London, 11th edition, 1983 at p 136.

The Guidelines further explain that the conventional distinction between natural and unnatural deaths reflects the distinction adopted by the World Health Organisation 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 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).³⁵

According to the Guidelines, deaths should still be regarded as unnatural even where the causative event occurred a substantial period prior to 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.³⁶

International Jurisdictions

Unlike the practice in Australia (including Victoria until recently), Coroners in England and Wales routinely investigate deaths from industrial disease.³⁷ In some areas, according to Coroner Christopher Dorries:

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.³⁸

In Ireland, the Coroners Rules Committee has recommended that “any death due to accident at work, occupational disease or industrial poisoning” should be classified as

³⁵ *State Coroner’s Guidelines—Version 0 December 2003*; paragraph 3.1.4. Available at <http://www.justice.qld.gov.au/courts/coroner/pdfs/guidelines.pdf>

³⁶ *State Coroner’s Guidelines—Version 0 December 2003*; paragraph 3.1.4. Available at <http://www.justice.qld.gov.au/courts/coroner/pdfs/guidelines.pdf>

³⁷ *Record of investigation into a death (without Inquest)*, Case no.:1598/03, State Coroner’s Office, Victoria, 8 July 2000. Available at www.coronerscourt.vic.gov.au: citing C Dorries., *Coroner’s Courts: a guide to law and practice*, John Wiley & Sons, 1999, p. 106.

³⁸ Dorries; C, *Coroner’s Courts: a guide to law and practice*, John Wiley & Sons, 1999., p. 49 and note 52. Cited in *Record of investigation into a death (without Inquest)*, Case no. :1598/03, State Coroner’s Office, Victoria, 8 July 2000. Available at www.coronerscourt.vic.gov.au

a reportable death along with deaths due to Transmissible Spongiform Encephalopathy such as Creutzfeldt-Jakob disease(CJD).³⁹

The Committee considers that the present category of “unexpected, unnatural, violent and accidental deaths” may need to be revised and we would like your input on this issue.

Question 1—Unexpected, unnatural, violent and accidental deaths

- (a) In your experience, do doctors have a good understanding of what is meant by this category of reportable deaths?
- (b) Do you think that Coroner issued guidelines would assist doctors’ understanding? If so, who should be responsible for writing, updating, and publicising the guidelines and who should be consulted?
- (c) Do you think the current category needs to be revised in any way? If so, what kind of deaths should be included in the category?
- (d) Should the Act classify deaths from particular diseases as reportable deaths? What diseases do you think should or should not be included in this category? Are there any resource issues which would need to be considered?

Deaths involving medical treatment

Medical procedure related deaths are not a separate category of reportable deaths in the Act.⁴⁰ However, two other Australian jurisdictions have a special category of medical-related deaths which set out the criteria for when these kinds of deaths should be reported to the Coroner.

In Queensland a death is reportable to the Coroner if the death “was not reasonably expected to be the outcome of a health procedure”.⁴¹ “Health procedure” is defined as:

A dental, medical, surgical or other health related procedure, including for example the administration of an anaesthetic, analgesic, sedative or other drug.

The Queensland State Coroner’s Guidelines give further direction for doctors to consider when to report a death.⁴²

³⁹ Ireland, Department of Justice, "Report of the Coroners Rules Committee", 2003. Available at www.justice.ie

⁴⁰ 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.

⁴¹ *Coroners Act* 2003 (QLD); s. 8(3): definition of “reportable death”, schedule 2: definition of “health procedure”.

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.

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;

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.⁴³

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.

⁴² *State Coroner's Guidelines—Version 0 December 2003*. Available at <http://www.justice.qld.gov.au/courts/coroner/pdfs/guidelines.pdf>

⁴³ See *Coroners Act 1997* (ACT), s. 13(1)(e) which provides that a coroner has jurisdiction to hold an inquest for this kind of death. S. 77(1) creates the obligation to report a death in which the Coroner would have jurisdiction to hold an inquest.

- (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.⁴⁴

In Australia, there is some indication that some doctors may not be reporting all cases of reportable deaths occurring in hospitals.⁴⁵ The reasons for this are not clear but one possible explanation may be that the failure to report is based on a lack of understanding of when to report these kinds of death to a coroner.⁴⁶ The Committee therefore seeks your views on this issue.

Question 2—Deaths involving medical treatment

- (a) Do you think the Act gives doctors a clear indication of when to report a death involving medical treatment or do you think that it would be preferable to have a more detailed provision such as in the ACT or Queensland?
- (b) Is there currently an “under-reporting” of deaths involving medical treatment to the Coroner? If so, why do you think this is happening and how can this be changed?

⁴⁴ Coroners Regulations 1994 (ACT), s. 5.

⁴⁵ Ranson, D., “How effective? How efficient?—The Coroner’s role in medical treatment related deaths”, above note 15; p. 285. The author bases this conclusion from a *Quality in Australian Health Care Study* commissioned by the Commonwealth in 1994. He acknowledges that extrapolating from the study is extremely difficult but estimates that based on the study, it would be expected that there may be up to 3 000 deaths per year in Victoria which may have resulted from hospital treatment errors. However according to the author only approximately 300 hospital deaths per year are investigated by the Coroner.

⁴⁶ Ranson, D., “How effective? How efficient?—The Coroner’s role in medical treatment related deaths”, above note 15; p. 286.

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”. However, the Act does not define what is meant by the term “anaesthetic”.

VIFM offers advice to doctors on what kind of deaths should be reported to a coroner:

i) any death occurring while the patient is under the effects of anaesthesia (general anaesthesia, regional anaesthesia) must be reported to the Coroner.

ii) 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.⁴⁷

Other Australian jurisdictions

The Western Australian and the Northern Territory Acts are both identical to the Victorian Act⁴⁸ while the requirement in the Tasmanian Act is similar.⁴⁹

In the South Australian Act anaesthetic means “a local or general anaesthetic, and includes the administration of a sedative or analgesic”⁵⁰ 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;⁵¹

In New South Wales, the criteria is that:

f) 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

⁴⁷ Victorian Institute of Forensic Medicine *Statement on Death Certificates and Reportable Deaths*. Available at : <http://www.medicalboardvic.org.au/content.php?sec=42>

⁴⁸ *Coroners Act* 1996 (WA), s.3; definition of “reportable death”; *Coroners Act* 1993 (NT), s. 12.: definition of “reportable death”.

⁴⁹ *Coroners Act* 1995 (TAS); s.2; definition of “reportable death”. The only difference is the reference to “anaesthesia or sedation”.

⁵⁰ *Coroners Act* 2003 (SA); s. 3; definition of “anaesthetic”.

⁵¹ *Coroners Act* 2003 (SA); s. 3; definition of “reportable death”.

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.⁵²

In the ACT, there is no specific reference in the legislation to deaths involving anaesthetics.⁵³ These kinds of deaths would however be referable to the Coroner if it came under that Territory's category of reportable medical deaths.

In Queensland, deaths involving anaesthetics are also classed under reportable deaths associated with health procedures.

Law Reform Issue

The Victorian Consultative Council on Anaesthetic Mortality and Morbidity (the Council)⁵⁴ has expressed concerns with the current definition in Victoria:

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. (...)

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.⁵⁵

The Committee notes the concerns raised by the Council that doctors are unsure of when to report deaths involving anaesthetics to a coroner and is interested in your views and experience on this issue.

Question 3—Deaths involving anaesthetics

Do you think this category of reportable deaths need to be more clearly defined in the Act or in Coroner's guidelines?

If so, how?

⁵² *Coroners Act 1980 (NSW)*; s. 13(1)(f).

⁵³ *Coroners Act 1997 (ACT)*; s.13.

⁵⁴ The Council's terms of reference include monitoring, analysing and reporting on key areas of potentially preventable anaesthetic mortality and morbidity within the Victorian hospital system and to keep a register of anaesthetic mortality and morbidity within the Victorian hospital system.

⁵⁵ Statement from Council website. Available at <http://www.health.vic.gov.au/vccamm/vccamm2.htm>

Deaths in custody or care

The Act considers the deaths of all persons “in care” or “in custody” to be reportable deaths.⁵⁶

The full definition is set out below:

s.3(1) “reportable death” means a 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

(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*;

⁵⁶ *Coroners Act 1985*, s. 13, s. 3(1): definition of “reportable death”—para (i)-(ib).

The Act does not provide a definition of what is meant by “in the custody” 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. However, in its guidelines, VIFM advises doctors to report the death of a person which occurs as a result of police action or while being detained, even if the person had not been arrested at the time of the death.⁵⁷

In relation to paragraph (c), an “approved mental health service” only covers services which have been proclaimed or declared to be approved under the *Mental Health Act* 1986.⁵⁸

Other Australian Jurisdictions

In all jurisdictions, deaths “in custody” are also reportable, however the definition of “custody” is broad and usually extends to a person in the process of being detained or escaping from custody.⁵⁹ For example in Queensland, a person’s death is a “death in custody” if the person died while trying to escape from custody or trying to avoid being put in custody.⁶⁰ In the Northern Territory the 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.⁶¹

In both Queensland and News 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.⁶² This provides a broader definition of a person held in care than in Victoria.

Royal Commission into Aboriginal Deaths in Custody

Unlike Victoria, the ACT and Queensland have made substantive changes to their coronial legislation in response to the recommendations made by the Royal

⁵⁷ Victorian Institute of Forensic Medicine, *Statement on Death Certificates and Reportable Deaths*, above note 13.

⁵⁸ *Mental Health Act* 1986, s.3 (definition of “approved medical health service”); s. 94 and 94A.

⁵⁹ 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* (NSW)1980 s.13a, 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).

⁶⁰ *Coroners Act* 2003 (QLD) s.10.

⁶¹ *Coroners Act* 1995 (NT) s. 12(1A) (definition of “reportable death”).

⁶² *Coroners Act* 2003 (QLD) s.9 (definition of “death in care”); *Coroners Act* 1980 (NSW), s. 13AB(1)(e)-(f).

Commission into Aboriginal Deaths in Custody (RCADC) in 1991.⁶³ In relation to the definition of “death in custody”, the Royal Commission recommended that it 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.

International jurisdictions

The Committee examined the law in a number of jurisdictions and now briefly discusses some relevant laws and recommendations for consideration.

In Victoria, a death of a person in a nursing home where a doctor certifies it as a death due to natural causes, is not reportable. In Ireland, however, the Coroners Rules Committee has recommended that all deaths in nursing homes should be reported as deaths “in care”.⁶⁴ Deaths which occur in nursing homes in Ontario must also be reported to the Coroner in that jurisdiction.⁶⁵

The Committee is interested in your views on whether the current definitions of deaths “in care” and “in custody” are adequate.

Question 4—Deaths in care and in custody

Do you think the current definitions in the Act of “deaths in custody” and “deaths in care” as categories of deaths reportable to a coroner are adequate or should the categories be extended in any way—for example, to include deaths of other vulnerable persons?

⁶³ As an aid to readers, the recommendations relating to coroners inquests are listed in Appendix 1 to this Discussion Paper. A review of all the recommendations is currently being conducted on behalf of the Victorian Aboriginal Justice Forum by the Victorian Implementation Review at the Department of Justice.

⁶⁴ Ireland, Department of Justice, “Report of the Coroners Rules Committee”, 2003. Available at www.justice.ie

⁶⁵ *Coroners Act*, RSO 1990, C37, s. 10 (2.1).

Deaths where the doctor did not view the body of the person

Under s.13(3)(b) of the Act a doctor is required to refer a death to a coroner if he or she did not “view” the body. Despite this, the *Births, Death and Marriages Registration Act 1999* allows doctors in certain circumstances to certify deaths under that Act as deaths not reportable to a coroner—without actually “examining” the body.⁶⁶ 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 one which is reportable to a coroner. It appears that these two provisions are contradictory—a doctor can certify a death as from natural causes (without examining the body), yet, if the doctor did not view the body, the death should then instead, be reported to a coroner under s. 13(3)(b).

The Committee is interested in considering the issue of whether it is always possible for a doctor to accurately certify a cause of death without examining the body of the person who has died with suspicious signs 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.⁶⁷

In relation to what constitutes a “meaningful” examination, VIFM advises doctors that this requires that:

- i) sufficient reliable information about the patient’s medical history is available and considered.
- ii) sufficient reliable information about the circumstances of the patient’s death is available and considered.
- iii) 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.)⁶⁸

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

⁶⁶ *Births, Death and Marriages Registration Act 1996*, s. 37(1).

⁶⁷ Victorian Institute of Forensic Medicine *Statement on Death Certificates and Reportable Deaths*, above note 13. 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.

⁶⁸ Victorian Institute of Forensic Medicine *Statement on Death Certificates and Reportable Deaths*, above note 13.

body before a death is registered under the jurisdictions' *Births, Death and Marriages Registration Act*.⁶⁹

In Queensland, there is a general requirement that the doctor is able to form an opinion as to the probable cause of death.⁷⁰ In that jurisdiction, a doctor is not required by the *Births, Death and Marriages Registration Act* to have necessarily examined a person after death—it is sufficient that the doctor attended the person when he or she was alive or has considered information about the person's medical history and the circumstances of the death.⁷¹

International jurisdictions

In England and Wales, the Home Office has indicated in its recent position paper that the doctor who certifies a death (“the first certifier”) should also be required to specify when he or she last saw the person alive and why he or she is satisfied that they can certify the death accurately.⁷²

Law Reform Agencies

This issue was addressed in the UK review “Death Certification and Investigation in England, Wales and Northern Ireland: The Report of a Fundamental Review” (known as the “Luce Report”).⁷³ According to the Luce Report, the financial burden on the coroners 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.⁷⁴ As such, the inquiry recommended that there should be no general requirement that all bodies should be viewed by a certifying doctor. Instead, the

⁶⁹ *Births, Death and Marriages Registration Act 1997 (ACT)*; s. 35(1); *Births, Death and Marriages Registration Act 1996 (NT)*; s. 34(1); *Births, Death and Marriages Registration Act 1995 (NSW)* s. 39(1); *Births, Death and Marriages Registration Act 1996 (SA)*; s. 36(4); *Births, Death and Marriages Registration Act 1999 (TAS)* s. 35(1).

⁷⁰ *Births, Death and Marriages Registration Act 2003 (QLD)*, s. 30(1)(a)-(b).

⁷¹ *Births, Death and Marriages Registration Act 2003 (QLD)*, s. 30(1)(a)-(b).

⁷² United Kingdom, *Reforming the Coroner and Death Certification Service*, Cm 6159, 2004, p. 13. Available at www.official-documents.co.uk/document/cm61/6159/6159.htm

⁷³ 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”—this report is discussed in detail later in this chapter). Available at <http://www.official-documents.co.uk/document/cm58/5831/5831.htm>.

⁷⁴ 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”). Above note 73 p. 54. The inquiry based this conclusion on the assumption that a viewing would take place in a mortuary. It concluded that this would cost between £10-15 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”.⁷⁵

In contrast, another British 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.⁷⁶ For deaths occurring in hospitals, the Inquiry recommended that the whole body should be examined for signs of violence or neglect.⁷⁷ For other deaths, the Inquiry recommended that there should be an examination of the head, neck and arms to the elbow.

The Committee would like your views 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.

Question 5—Examination of bodies and medical records after death

- (a) Should there be a legal requirement as part of the death certification process that a doctor or some other person be required to physically view all bodies?
- (b) If so, who should conduct the examination and where should the examination take place?
- (c) Should there be any other requirements? For example should a doctor be required to consider recent medical records before certifying a death?

Deaths where the doctor cannot establish the cause of death

If a doctor is unable to determine the cause of death, he or she must refer the death to a coroner⁷⁸. The Act does not however, give doctors an indication of the degree of certainty required in their diagnosis.

VIFM offers the following as guidance 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.

⁷⁵ “Luce Report”, above note 72, p. 54.

⁷⁶ United Kingdom, *Death Certification and the Investigation of Death by Coroners*(Cm 5854, 2003). (The third report), p. 497. This report is also discussed in detail later in this chapter.

⁷⁷ The third report, above note 76; p. 497.

⁷⁸ *Coroners Act 1985* s.13(3)(c).

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 is able to form an opinion as to the “probable cause of death”.⁷⁹

Question 6—Degree of certainty of cause of death

- (a) Should the Act or Coroner’s guidelines be more specific as to the degree of certainty required for a diagnosis?
- (b) Do the current VIFM guidelines provide for an appropriate degree of certainty in diagnosis?

Reviewable deaths

In 2004, legislation amended the *Coroners Act* and introduced a new category of “reviewable” deaths into the Act which now must be reported to the State Coroner.⁸⁰ This new law arose as a result of concerns raised regarding the appropriate identification of situations where more than one child of a family dies.⁸¹ The Act now 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.⁸²

While this new legislation has only been in operation since 26 November 2004, the Committee is interested in assessing the effectiveness of the provision and seeks your views on this issue.

⁷⁹ *Births, Death and Marriages Registration Act 2003* (QLD), s. 30(1)(a)-(b).

⁸⁰ *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 well as any person who has reasonable grounds to believe that a reviewable death has not been reported.

⁸¹ Ranson, D., “Multiple Child Deaths; A New Direction in Death Notification” (2004) 12 *JLM*, p.157.

⁸² *Coroners Act 1985*, s.13(1): (definition of “reviewable death”). The Act also defines “parents”, “siblings” and “child”.

Question 7—Effectiveness of new category of reviewable deaths

- (a) In your experience, is the general community and the medical profession aware of the new category of reviewable deaths which must be reported to the State Coroner?
- (b) If not, who should be responsible for raising awareness of this new category?
- (c) How effective do you think the new provision will be in informing the State Coroner of situations where more than one child of a family dies?

Deaths notifiable to a coroner by others

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.

Penalty: 10 penalty units.⁸³

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.⁸⁴

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.⁸⁵

If a police officer has information relevant to an investigation, she or he must also report that information to the Coroner investigating the death.⁸⁶ There is, however, no penalty attached to the failure to comply with this requirement.

⁸³ *Coroners Act 1985*, s. 13(1).

⁸⁴ *Coroners Act 1985*, s. 13A(1).

⁸⁵ *Coroners Act 1985*, s. 13(5).

⁸⁶ *Coroners Act 1985*, s. 14(2).

Other Australian jurisdictions

All jurisdictions impose general obligations to report notifiable deaths to a coroner.⁸⁷ 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.⁸⁸ All jurisdictions also include deaths in custody as notifiable deaths.⁸⁹

Question 8—Awareness of public obligation to report deaths

- (a) How often are deaths reported to the Coroner by the general community?
- (b) Is the general community aware of their obligation to report notifiable deaths to the Coroner?
- (c) If not, who should be responsible for raising awareness? Should this be a function of the State Coroner? What kind of strategies could be used?
- (d) Should the Act impose a penalty on police officers who fail to report to a coroner information relevant to an investigation?

Problems with the current system of reporting deaths

The effectiveness of the Act is dependant on doctors correctly identifying deaths which should be reported and then notifying the Coroner of those deaths. It is difficult to assess the effectiveness of the system as it is difficult to establish whether all reportable deaths are reported. This is due in the large part to the absence of a requirement in the current system to undertake a comprehensive or indeed any audit.

However, small scale studies suggest that there may be some cause for concern.⁹⁰ One study in Victoria in 1995 examined the death certification process.⁹¹ The study involved doctors practising in non-metropolitan Victoria, including Resident Medical

⁸⁷ *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).

⁸⁸ *Coroners Act* (ACT)(1997); s. 77(2): The maximum penalty is 6 months imprisonment. *Coroners Act* (WA)(1996) s. 18(2). The maximum penalty is a \$1 000 fine.

⁸⁹ Halsbury's Laws of Australia, K Walker, *Coroners* [115-95] at 16 February 2005.

⁹⁰ Brumley, D., *Death Certification by Doctors in Non-Metropolitan Victoria*, (M.Sc (Primary Health Care) Thesis, Flinders University of South Australia, 1995; Weeramanthri, T., and Beresford, B., "Death Certification in Western Australia—classification of major errors in certificate completion", *Australian Journal of Public Health*, Vol. 16, no. 4., pp. 431-434. Swift, B., and West, K., "Death certification: an audit of practice entering the 21st century" *J Clin Pathol* , Vol 55, 2002, pp. 275-279.

⁹¹ Brumley, D., *Death Certification by Doctors in Non-Metropolitan Victoria*, Above note 90.

Officers (RMOs)⁹², hospital doctors, specialist physicians, surgeons and General Practitioners. It found that overall, 27 percent of certificates inaccurately represented the cause of death, with a higher inaccuracy rate of 51 percent for RMOs.⁹³ 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.⁹⁴ This figure is consistent with a study in the United Kingdom which found that 17.2 percent of General Practitioners who were surveyed would alter certificates to avoid referral to the Coroner.⁹⁵

Other jurisdictions such as England and Wales have had major problems with their death certification system and are in the process of radically overhauling that system. We discuss this new system in the next section of this chapter where we examine alternative systems of death certification.

The Committee would also like to establish if there are any other problems with the death certification system.

Question 9—Problems with the current system of death certification

Are there any other issues with the current system of death certification?

Alternative systems for reporting deaths

England and Wales

The current death certification system in England and Wales is similar to the system in Victoria. Both systems rely on one doctor to report notifiable deaths to the Coroner and there is no audit to ensure that all reportable deaths are in fact reported.⁹⁶

However, a comprehensive overhaul of the coronial system is currently underway in England and Wales. It follows multiple inquiries into the adequacy of the British death certification and coronial system. The reviews were prompted by the murder conviction of Dr Harold Shipman in 2000.⁹⁷

⁹² RMOs are junior doctors at a hospital.

⁹³ Brumley, D., *Death Certification by Doctors in Non-Metropolitan Victoria*, Above note 90.p. 10.

⁹⁴ Brumley, D., *Death Certification by Doctors in Non-Metropolitan Victoria*, Above note 90. p. 126.

⁹⁵ Maudsley., G and Williams, EM., "Death Certification by House Officers and General Practitioners—Practice and Performance *Journal of Public Health Medicine*, Vol 15(2), 1993, pp. 192-201. Cited in Brumley, D., *Death Certification by Doctors in Non-Metropolitan Victoria*, Above note 90. p. 126.

⁹⁶ United Kingdom, *Death Certification and the Investigation of Death by Coroners*, (The third report), Above note 76; p. 461.

⁹⁷ 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

R v Shipman

Dr Harold Shipman started as a family GP in Northern England in 1974 and as part of his practice, he made house calls to his elderly patients. Over the next twenty years, he deliberately killed a number of these patients by injecting them with fatal doses of diamorphine⁹⁸. As the treating doctor, he would give a medical certificate for the cause of death. To ensure that these deaths were never reported to the local Coroner, he stated on the certificate that the cause of death was due to “natural causes” or “old age”. He would then later add false illnesses to his victims’ medical records to support his claim that the patient had died a natural death.

Shipman continued to kill 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 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 3 patients were to die before he was finally arrested in 1999.

In 2000 Shipman was found guilty of murdering 15 of his patients and was sentenced to life imprisonment. He was found dead in his prison cell in 2004.

A clinical audit later established that during his medical career, Shipman issued 521 medical certificates of cause of death⁹⁹ while the Shipman Inquiry recently disclosed that he had killed about 250 patients, making him Britain’s worst known serial killer.¹⁰⁰

The Luce Report

In 2001 the British Home Office set up the first of many inquiries into the coronial and death certification process following the Shipman conviction. The inquiry chaired by Mr Tom Luce published its recommendations in 2003.¹⁰¹ It found that a critical weakness of the death certification and coronial processes was that the two processes were separate from each other:

⁹⁸ Diamorphine is an opiate drug (narcotic analgesic) also known as “prescription heroin”, used in medicine to relieve pain. It can be injected in liquid form: *Diamorphine Fact File* available at http://news.bbc.co.uk/1/hi/in_depth/uk/2000/the_shipman_murders/the_shipman_files/610787.stm

⁹⁹ “Audit further exposes UK’s worst serial killer”, *The Lancet*, Vol 327, 31 January 2001.

¹⁰⁰ United Kingdom, *Shipman: the Final Report*; 2005, para 28.

¹⁰¹ 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”). Above note 73.

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”.¹⁰²

The inquiry recommended that deaths should be audited by a Statutory Medical Assessor within the office of the Coroner.¹⁰³ It concluded that this would improve the quality of certification and encourage more attention and wariness being brought to the certification process.¹⁰⁴

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.¹⁰⁵ The Statutory Medical Assessor should be responsible for the appointment of a panel of doctors who would act as the second certifier.¹⁰⁶ The second certifier should be an experienced clinical doctor chosen for his or her skill and professional independence.

The Six Shipman Reports by Dame Janet Smith

Dame Janet Smith was appointed to conduct a public inquiry into the issues arising from Shipman’s convictions in 2001 (“the Shipman Inquiry”). By 2005 the inquiry had published six reports¹⁰⁷ and had concluded that:

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.¹⁰⁸

The Shipman Inquiry recommended a different certification system to the one recommended in the Luce Report. The Inquiry recommended a system (known as

¹⁰² Luce Report ; Above note. 73; p. 16.

¹⁰³ Luce Report ; Above note. 73; p. 220.

¹⁰⁴ Luce Report ; Above note 73; p. 50.

¹⁰⁵ Luce Report ; Above note 73; p. 221.

¹⁰⁶ Luce Report ; Above note 73; p. 51.

¹⁰⁷ 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 at: <http://www.the-shipman-inquiry.org.uk/reports.asp>.

¹⁰⁸ United Kingdom, *Death Certification and the Investigation of Death by Coroners*, (The third report), above note 76, p. 487.

“the Coroner’s Certification System”) in which all deaths would be reported to the Coroner and the Coroner would also be responsible for certifying all deaths.¹⁰⁹

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. This information 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 with the version in the medical records). If the investigator had 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 inquiry preferred this option to the one proposed in the Luce report on a number of grounds. Firstly, the Shipman Inquiry reasoned that the Coroner’s investigator would have a more independent role than that of a second doctor overseeing another doctor’s certification.¹¹⁰

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. Also, 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.

The third benefit of this system is that there would be a centralised coronial system in which all deaths, not just reported deaths, would be examined by the Coroner.¹¹¹

The UK Government Response

In March 2004 the Home Office released its position paper, “Reforming the Coroner and Death Certification Service”.¹¹² It acknowledged the need to build a better system of death certification and investigation so that tragedies like Shipman’s activities could never happen again.¹¹³ In what was described as the biggest overhaul of the Coroner system in 200 years,¹¹⁴ the Home Office proposed the implementation of a system similar to the one recommended in the Luce Report (although the Home Office proposed that the second certifier would be attached to the Coroner service so that the Coroner service could examine every death as opposed to only reported deaths, as at present).

¹⁰⁹ United Kingdom, *Death Certification and the Investigation of Death by Coroners*, above note 76, p. 502.

¹¹⁰ United Kingdom, *Death Certification and the Investigation of Death by Coroners*, above note 76, p. 502.

¹¹¹ United Kingdom, *Death Certification and the Investigation of Death by Coroners*, above note 76, p. 504.

¹¹² United Kingdom, *Reforming the Coroner and Death Certification Service*, above note 72.

¹¹³ United Kingdom, *Reforming the Coroner and Death Certification Service*, above note 72, p. 2.

¹¹⁴ Dyer, C., “New Coroner’s System will require two people to verify cause of death”, *British Medical Journal*, Vol 328, March 2004, p. 727.

The new system will require that two doctors certify the cause of death.¹¹⁵ 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 they are satisfied that they can accurately certify the cause of death. They 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 position paper indicated that a draft bill on the changes would be introduced by March 2005. To date, a draft bill has not been introduced.

Finland

Finland, unlike the Australian and British¹¹⁶ Coroners systems, investigates deaths through an alternative system known as the medical examiner system.¹¹⁷ This system of death investigation does not involve an investigation or inquest by a legally qualified person. Rather, a medical examiner, who, in Finland is a forensic pathologist, is responsible for the investigation of reported deaths.

In Finland, the medical examiner also audits all deaths certificates which are completed by doctors. Doctors undergo an extensive formal training process in death certification before they complete their medical studies. Finnish law requires that the certifying doctor consult relatives and carers about the circumstances of a person’s death.

While the medical examiner’s jurisdiction is limited to reportable deaths, a feature of the Finnish system is that the examiner can request the police to refer certain deaths to the examiner for further investigation.

Post-Shipman lessons for death investigation systems

In the aftermath of Shipman’s crimes, some commentators claimed that his crimes were “unique”. However it should be noted that Shipman was not the only doctor who has been able to unlawfully kill patients undetected over an extended period—there are other multiple medical murder cases that have come to light in other countries.¹¹⁸

¹¹⁵ United Kingdom, *Reforming the Coroner and Death Certification Service*, above note 72, p. 13.

¹¹⁶ It should be noted that in Scotland the task of death investigation is carried out by the Procurator Fiscal.

¹¹⁷ The Finnish system of death certification was examined by the Shipman Inquiry and information about the Finnish system is based on information presented to that Inquiry. Further information is available at http://www.the-shipman-inquiry.org.uk/tr_page.asp?ID=242

¹¹⁸ Kinnell, H., “Serial Homicide by Doctors: Shipman in Perspective”, *British Medical Journal*, Vol. 321, December 2000, pp. 1594 and 1596. The article cites other cases such as a Norwegian doctor who may have killed up to 138

In light of Shipman, it is therefore appropriate for this Inquiry to examine whether the kind of crimes he committed would have been detected in the current system in Victoria and whether, as a result, the system needs to be strengthened in any way.

As part of the Shipman Inquiry into Death Certification,¹¹⁹ representatives from a number of other jurisdictions, including Victoria, were invited to a seminar and asked to consider whether their respective system would have detected Shipman's unlawful killings.¹²⁰

Professor Stephen Cordner, Director of the Victorian Institute of Forensic Medicine (VIFM) attended the seminar as the representative from Victoria. He agreed with the Inquiry that the certification system in Victoria was similar to the English and Welsh system in that it is wholly dependent on the integrity of the certifying doctor.¹²¹ He also agreed that there was no audit or quality assurance of certification.¹²²

In relation to whether the Victorian system would have detected Shipman's activities, Professor Cordner gave his opinion that in Victoria the Shipman killings would also have remained undetected.

Question 10—Death certification system reform

Does the death certification system in Victoria need to be strengthened?

If so, how?

Some law reform options to consider include:

Option A. The system recommended by the Shipman Inquiry in its third report:

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.

of his patients over a 5 year period in the 1970s and two cases from the United States of America where doctors killed their patients with drugs in the 1960s and 1970s.

¹¹⁹ United Kingdom, *Death Certification and the Investigation of Death by Coroners*, (Cm 5854, 2003). (The third report).

¹²⁰ The Inquiry asked participants to consider a summary of the facts of four cases from the Shipman trial.

¹²¹ United Kingdom, *Death Certification and the Investigation of Death by Coroners*, above note 76, p. 461.

¹²² Kingdom, *Death Certification and the Investigation of Death by Coroners*, above note 76, p. 461.

Option B. The system recommended in the Luce Report:

The Coroner should continue to only be informed of notifiable deaths but that 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.

Option C. 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.

CHAPTER THREE — INDEPENDENT DEATH INVESTIGATION

This chapter discusses the law which governs a coroner's investigation and inquiry into a death. This involves examining relevant provisions in the Act as well as case law.¹²³ The Committee also considers procedural matters such as the State Coroner's Practice Directions.

The terms of reference for this inquiry ask the Committee to consider whether the Act provides an appropriate framework for the independent investigation of deaths. The Committee begins that consideration by examining the current tenure arrangements for coroners.

Next, the Committee discusses a coroner's powers to investigate deaths, conduct inquests and make findings. The Committee also considers the various rights and privileges of witnesses and others who may be adversely affected by a coroner's findings.

In the final part of the chapter, the Committee discusses the rights of appeal and the circumstances in which the Act permits an inquest to be adjourned or re-opened. Finally, the Committee considers the role of a coroner in the investigation of suspected deaths.

Appointment and Tenure of the 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.¹²⁴ Magistrates, acting magistrates, barristers and solicitors may be appointed as Coroners.¹²⁵

In Melbourne, the State Coroner, Deputy State Coroner and three full time Coroners investigate deaths which have been reported to the Office. Outside 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

¹²³ Case law is the law based on decisions made by judges in previous cases: Fitzroy Legal Service Inc. *The Law Handbook*, 2003 Edition, p. 835.

¹²⁴ *Coroners Act* 1985, s. 6(1).

¹²⁵ *Coroners Act* 1985, s. 8.

actual 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.¹²⁶

Other Australian jurisdictions

The length of the period of office varies from jurisdiction to jurisdiction.¹²⁷ In Queensland, South Australia and New South Wales, State Coroners are appointed for a fixed term specified in legislation.¹²⁸ In Queensland and in 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, like Victoria, the length of the term of the appointment of the State Coroner is not stated in the legislation.¹²⁹

Other relevant law reform agencies

RCADC

The tenure of Coroners was considered by the Royal Commission into Aboriginal Deaths in Custody (RCADC). In its 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.¹³⁰

The Aboriginal and Torres Strait Islander Commission (ATSIC) in its report into Indigenous Deaths in Custody, submits that State Coroners should be appointed on a life-time 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

¹²⁶ It is understood that if after three years, a State Coroner is not re-appointed 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 <http://www.the-shipman-inquiry.org.uk/transcript.asp?from=a&day=122>, p. 13, lines 16-20.

¹²⁷ Halsbury's Laws of Australia, K Walker, *Coroners* [115-40] at 16 February 2005.

¹²⁸ *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).

¹²⁹ In Western Australia, the State Coroner holds office on the same terms as a magistrate: *Coroners Act* 1996 (WA), s. 6(4).

¹³⁰ Royal Commission into Aboriginal Deaths in Custody, *National Report Volume 1* 1991, para 4.5.9.

independence and the perception that they are able, fearlessly, to criticise the laws, policies and practices of any government.¹³¹

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”.¹³²

Unlike the position in the Australian jurisdictions, in Ontario, coroners hold office on a permanent tenured basis until he or she reaches the age of 70 years.¹³³

Question 11—Appointment of coroners

- (a) Does the practice of appointing a State Coroner for a fixed term of 3 years have the potential to compromise the independence of the position?
- (b) Should the Act be changed so that the State Coroner is appointed for a defined period? If so, how long should the appointment be for?

Deaths investigated by the Coroner

Jurisdiction to investigate

All coroners have jurisdiction to investigate a death if it appears to the Coroner that the death “is or may be a reportable death”.¹³⁴ The State Coroner has jurisdiction to investigate a death that “is or may be a reviewable death”.¹³⁵ Coroners may also investigate deaths outside Victoria where the death has a territorial connection with Victoria.¹³⁶

Scope of jurisdiction

A coroner does not have unlimited jurisdiction to investigate—the line of inquiry must be relevant to the findings into the death which the Coroner is investigating.¹³⁷

¹³¹ 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

¹³² Ontario Law Reform Commission, *Report on the Law of Coroners*, 1995, p. 191.

¹³³ *The Coroners Act*, RSO 1990, c 37.

¹³⁴ *Coroners Act* (1985), s. 15(1).

¹³⁵ *Coroners Act* (1985), s. 15A(1). The State Coroner may also delegate jurisdiction to a coroner to investigate a reviewable death: s. 15A(6).

¹³⁶ *i.e.* the person’s body is in Victoria, 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).

¹³⁷ *Harmsworth v State Coroner* [1989] VR 989.

Powers of investigation

The Act gives wide powers to coroners to investigate reported deaths. A coroner has control over the body of a person who has died if their body is in Victoria and the death is reportable or reviewable.¹³⁸ 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.¹³⁹

Police officers may also exercise entry, inspection and seizure powers when authorised by a coroner in writing.¹⁴⁰ When exercising this power, a police officer is required to give a copy of the authority to the owner or the occupier of the place being searched. 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.¹⁴¹

However there is a limit on these investigation powers—a coroner must have a reasonable belief that it is necessary to exercise the powers for the particular investigation.¹⁴² The recent Supreme Court of Victoria decision of *Grace v Saines*¹⁴³ illustrates the scope of those powers:

Grace v Saines (in his capacity as Coroner)

A coroner was investigating the death of one of the plaintiff doctor's patients. Medical tests revealed that the patient had levels of morphine in her blood "consistent with excessive and potentially fatal use."

As part of the inquiry investigation, the Coroner received a report which made the suggestion that three other patients from the same surgery may have been prescribed morphine at an excessive rate. Two of these three patients had died but, the Coroner was not investigating these deaths.

The Coroner then decided to make an order under the Act, authorising police officers to seize the medical records of the other three patients at the doctor's surgery. The doctor challenged the order in the Supreme Court. The medical records were placed in a sealed envelope until the application was determined.

¹³⁸ *Coroners Act* (1985); s. 24: Control is subject to directions of the State Coroner and ends when the Coroner issues a certificate permitting burial or cremation.

¹³⁹ *Coroners Act* (1985); s.26(1). The Committee is currently undertaking a separate inquiry into warrant powers and procedures. Further information is available from the Committee's website at www.parliament.vic.gov.au/lawreform.

¹⁴⁰ *Coroners Act* (1985); s. 26(3).

¹⁴¹ *Coroners Act* (1985); s. 60. The maximum penalty is 3 months imprisonment.

¹⁴² *Coroners Act* (1985); s.26(2).

¹⁴³ *Grace v Saines (in his capacity as Coroner)*, Supreme Court of Victoria, (Unreported, Williams J, 29 June 2004).

Lawyers for the doctor argued that the Coroner did not have jurisdiction to investigate the circumstances of the other patients' deaths because those deaths had not been reported to him. The Coroner's lawyers, however, submitted that the Coroner could not make a decision as to the relevance of the three medical records until he had inspected them. According to the Coroner's lawyers, the reasonableness of the Coroner's belief as to the necessity to authorise seizure was determined by the records *potential* relevance to his inquiry. It was submitted that only if the records could not possibly be relevant to the permissible investigation would the order be beyond power.

The Court determined that the Coroner had acted within his power in making the order. Williams J was satisfied that it would have been reasonable for the Coroner to have held the belief that the extra records might contain material relevant to the possible finding the Coroner might make. He considered that a reference to a departure from a norm or standard in relation to the prescription of morphine might be relevant to the Coroner's determination of the cause of the first patient's death.

The Act also gives the power to coroners to direct that an autopsy be carried out where the Coroner reasonably believes that it is necessary for the investigation.¹⁴⁴ This will be discussed in further detail in chapter six.

The State Coroner may order that a body be exhumed if he or she reasonably believes that it is necessary for an investigation.¹⁴⁵ The State Coroner has the same investigative powers in relation to reviewable deaths.¹⁴⁶

Other Australian Jurisdictions

All jurisdictions have similar powers of investigation, however, coroners in the ACT and Queensland may only exercise entry, search and seizure powers under warrant.¹⁴⁷

In the ACT, a coroner may issue a warrant authorising a specified police officer to execute the warrant.¹⁴⁸ The warrant must state the reason why it is issued, the particular hours when entry is authorised and the date on which the warrant no longer has effect.¹⁴⁹

¹⁴⁴ *Coroners Act* (1985); s. 27(1).

¹⁴⁵ *Coroners Act* (1985); s. 30(1).

¹⁴⁶ *Coroners Act* (1985); s. 30A. "Reviewable death" is defined in s. 3(1).

¹⁴⁷ *Coroners Act* (1997) ACT, s. 66; *Coroners Act* 2003(QLD), s.13(3).

¹⁴⁸ *Coroners Act* (1997) ACT, s. 66(1)-(2).

¹⁴⁹ *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.

It must also include a description of the kinds of things the police are searching for, inspecting or seizing.¹⁵⁰ Police officers must also give a copy of the warrant to the owner or occupier of the premises.¹⁵¹ When an inquiry is completed, a coroner is required to take all practical steps to return things seized under a warrant.¹⁵²

In Queensland, legislation sets out standard rules which regulate all police warrant powers. This legislation also authorises and regulates warrants issued by a coroner.¹⁵³ 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 when the place may be entered; and
- the day and time when the search warrant ends (not more than seven days after the search warrant was issued).¹⁵⁴

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.¹⁵⁵

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.¹⁵⁶

¹⁵⁰ *Coroners Act (1997) ACT*, s. 66(4)(c).

¹⁵¹ *Coroners Act (1997) ACT*, s. 66(6).

¹⁵² *Coroners Act (1997) ACT*, s. 67(6).

¹⁵³ *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 s. 74(1)(a) to (e) and (g).

¹⁵⁴ *Police Powers and Responsibilities Act (2000) (QLD)*, s. 371AD(2).

¹⁵⁵ *Police Powers and Responsibilities Act (2000) (QLD)*, s. 74(1).

¹⁵⁶ *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.

Question 12—Coroners’ powers of investigation

- (a) Are there any problems or issues of concern with the current powers of entry, search and seizure?
- (b) Are you aware of any challenges to or criticisms of the exercise of these powers?

Guidelines for Investigations

One of the functions of the State Coroner is to issue guidelines to coroners to help them carry out their duties.¹⁵⁷ The Act gives the State Coroner discretion to give directions to coroners about an investigation and the manner of conducting it.¹⁵⁸

To this end, the State Coroner is in the process of establishing a number of investigation standards. For example, the State Coroner has recently released the *Coroner’s Investigation Standard into Deaths from Falls*.¹⁵⁹ Coroners should use this standard when investigating hospital fall-related deaths. The Investigation Standard includes questions which elicit information from hospitals on issues such as the hospitals’ system for falls management.

Other Australian Jurisdictions

In Queensland, legislation requires the State Coroner to issue investigation guidelines “to ensure best practice in the coronial system”.¹⁶⁰ Coroners are required to comply with the guidelines to the greatest extent possible.¹⁶¹ Under the Act, the State Coroner for Queensland is required to report annually to the Attorney-General on the State Coroner’s Guidelines and directions issued to coroners.¹⁶²

¹⁵⁷ *Coroners Act* (1985), s. 7(e).

¹⁵⁸ *Coroners Act* (1985), s. 16.

¹⁵⁹ The standards were developed in conjunction with the Clinical Liaison Service at VIFM: Emmett, S L., *Investigating Falls-Related deaths in Hospital: A Coronial Perspective* (Paper presented at the 15th World Congress on Medical Law, Sydney, 1-5 August 2004). Available at www.vifm.org/inclsconf2.phtml. The Standards are attached to the paper.

¹⁶⁰ *Coroners Act* (2003)(QLD), s. 14(1)(b). The guidelines are publicly available at <http://www.justice.qld.gov.au/courts/coroner/pdfs/guidelines.pdf>

¹⁶¹ *Coroners Act* (2003)(QLD), s. 14(4).

¹⁶² *Coroners Act* (2003) (QLD); s. 77.

The Act also requires the State Coroner, when preparing the guidelines, to have regard to the recommendations of the Royal Commission into Aboriginal Deaths in Custody which relate to the investigation of deaths in custody.¹⁶³

The Queensland Guidelines give the following advice to coroners regarding the investigation of a death in custody:

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.¹⁶⁴

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 in custody.¹⁶⁵ 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.¹⁶⁶

Question 13—Guidelines for Coroners' Investigations

- (a) Are there any issues or concerns in relation to the State Coroner's guidelines and investigation standards?
- (b) In your experience, are all coroners in Victoria familiar with the standards and guidelines and do they consistently use and apply them when investigating a death?
- (c) Are coroners' investigations reviewed to assess whether the standards and guidelines are consistently applied?
- (d) Can the public readily access all of the State Coroner's guidelines and investigation standards? Are the current guidelines and investigation standards publicised in any way?
- (e) Do all newly appointed coroners, including Magistrates in rural areas, participate in coronial training in death investigation?

¹⁶³ *Coroners Act* (2003)(QLD), s. 14(2). Royal Commission into Aboriginal Deaths in Custody, *National Report Volume 1* 1991. As an aid to readers, these recommendations are listed in Appendix 1 to this Discussion Paper.

¹⁶⁴ *State Coroner's Guidelines—Version 0 December 2003*, Above note 34, Paragraph 7.2.

¹⁶⁵ *Coroners Act* (1997) (ACT), s. 69-76.

¹⁶⁶ *Coroners Act* (1997) (ACT), s. 74.

- (f) Are there any other kind of investigations which need investigation standards or guidelines?
- (g) Should the Act specifically require coroners to have regard to the recommendations of the Royal Commission into Aboriginal Deaths in Custody relating to the investigation of deaths in custody?

Assistance with Investigations

Police Assistance

Coroners are assisted in their investigations by the Victoria Police State Coroner's Assistants Unit. This unit is assisted by specialist police units such as the Homicide Squad.¹⁶⁷

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.¹⁶⁸

Police Assistance in other Australian jurisdictions

Unlike Victoria, three other Australian jurisdictions 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,¹⁶⁹ while in Queensland, it is the legal duty of police officers to comply with requests or directions of a coroner.¹⁷⁰ 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.¹⁷¹ Police officers are also required to comply with a lawful direction of a coroner.¹⁷²

Law Reform Agencies

In 1991, the Royal Commission into Aboriginal Deaths in Custody 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

¹⁶⁷ Submission from the State Coroner to the Committee's Inquiry into Warrant Powers and Procedures, Submission No. 14, 1 October 2004; p. 2. Available at www.parliament.vic.gov.au/lawreform/Warrant/Submissions/

¹⁶⁸ *Coroners Act* 1985; s. 26(3). Halstead., B, "Coroners' Recommendations and the Prevention of Deaths in Custody: A Victorian Case Study, *Deaths in Custody, Australia, no. 10.*, Australian Institute of Criminology, 1995, p. 5. The Act does, however, require a police officer to report relevant information: s. 14(2).

¹⁶⁹ *Coroners Act* (1980) (NSW); s. 17C.

¹⁷⁰ *Police Powers and Responsibilities Act* (2000) (QLD); s. 371(1).

¹⁷¹ *Coroners Act* (1993) (NT); s. 25.

¹⁷² *Coroners Act* (1993) (NT); s. 25(2). Failure to comply carries a maximum penalty of 6 months imprisonment.

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.¹⁷³

The Australian Institute of Criminology in a research paper on a Victorian case study of deaths in custody also queried 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.¹⁷⁴

Question 14—Police Assistance with Coroners' investigations

- (a) Should coroners have the power to require investigating police officers to report directly to coroners and to issue directions to police officers concerning investigations, as recommended by the Royal Commission into Aboriginal Deaths in Custody in 1991?
- (b) In your opinion, are there any kinds of coronial investigations where it is not appropriate for the investigations to be undertaken by police officers? What alternatives could be considered? Are there any resource issues to consider?

Legal Assistance

There is no provision in the Act requiring coroners to appoint lawyers to assist with the investigation. However, the Act does provide that a coroner may be assisted by a lawyer or the Director of Public Prosecutions at an inquest.¹⁷⁵

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 deaths in custody.¹⁷⁶

¹⁷³ Royal Commission into Aboriginal Deaths in Custody, *National Report Volume 1* 1991. Above note 130; Para 4.5.6 and Recommendation no. 29.

¹⁷⁴ Halstead., B, "Coroners' Recommendations and the Prevention of Deaths in Custody: A Victorian Case Study", Above note 168, p. 4.

¹⁷⁵ *Coroners Act* (1985) s. 46(2).

¹⁷⁶ *Coroners Act* (1997) (ACT); s. 72.

Law Reform Agencies

The Royal Commission into Aboriginal Deaths in Custody made a specific recommendation that in relation to deaths in custody, the State Coroner should appoint a solicitor or a barrister to assist the Coroner who will conduct the inquiry.¹⁷⁷ 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.¹⁷⁸

Question 15—Legal assistance with Coroners' investigations

- (a) Do the State Coroner or coroners currently appoint lawyers to assist with investigations?
- (b) Should the law require coroners to appoint lawyers to assist inquiries in relation to the investigation of deaths in custody?
- (c) Should the law require the State Coroner to appoint lawyers to assist coroners with other kinds of investigations?

Other Assistance

The Act does require certain persons to give assistance to a coroner.¹⁷⁹ A person who reports a death to a coroner, such as a doctor, must give the Coroner any information which may help the investigation.

Although it is not required in the Act, the State Coroner's Office draws on the expert assistance of both internal and external agencies. The Clinical Liaison Service provides assistance in the form of expert medical assessment of reported cases involving hospital and other medical treatment. Outside the State Coroner's Office, expert assistance may be voluntarily provided by the Victoria WorkCover Authority, the Office of the Chief Electrical Inspector and the Office of Gas Safety.¹⁸⁰

¹⁷⁷ Royal Commission into Aboriginal Deaths in Custody, *National Report Volume 1* 1991. Above note 130, recommendation no. 26.

¹⁷⁸ Royal Commission into Aboriginal Deaths in Custody, *National Report Volume 1* 1991. Above note 130, recommendation no. 28.

¹⁷⁹ *Coroners Act* 1985; s. 14(1).

¹⁸⁰ Submission from the State Coroner to the Committee's Inquiry into Warrant Powers and Procedures, Above note 167.

Assistance in other Australian jurisdictions

As in Victoria, three jurisdictions require persons reporting deaths to assist a coroner by providing the Coroner with information relevant to an investigation.¹⁸¹

In South Australia and the ACT, unlike other Australian jurisdictions, the Attorney-General may appoint investigators under the Coroners Act.¹⁸²

Law Reform Agencies

The establishment of an independent coronial investigation unit was considered in the Review of Queensland Coronial Laws, prepared for the Indigenous Advisory Council.¹⁸³ However, in its Final Report, it concluded that such a unit may result in an expensive duplication of resources.¹⁸⁴

In England and Wales, the Shipman Inquiry proposed that coroner's investigators should be appointed to the Coroners Service for the purpose of death certification and investigation.¹⁸⁵

Question 16—Other Assistance with coroners' investigations

- (a) Do coroners currently use other kinds of investigators? Are there any resource issues associated with using investigators?
- (b) Do you think that certain kinds of investigators should be appointed under the Act? What duties and obligations do you think this kind of investigator should have?

Inquests

An inquest is a public hearing into a death of a person. In Melbourne, coroners hold inquests at the Coroner's Court at Southbank. Outside Melbourne, coroners, who are also Magistrates, hold public hearings at the local Magistrates Court.

An inquiry may take a few hours or even weeks, depending on the number of questions for witnesses and the amount of evidence that a coroner needs to

¹⁸¹ *Coroners Act* (1995) (Tas); s 20; *Coroners Act* (1993) (TAS); s.13 and s 36; *Coroners Act*(2003) (QLD), s. 15-16.

¹⁸² *Coroners Act* (2003) (SA); s. 9; *Coroners Act* (ACT) 1997; s. 59.

¹⁸³ Malbon, J, Airo-Farulla, G, and Banks, C., *Review of Queensland Coronial Laws —Final Report*; Department of Families Youth and Community Care, 1997. p. 37.

¹⁸⁴ Malbon, J, Airo-Farulla and Banks, C., *Review of Queensland Coronial Laws —Final Report*, Above note 183.

¹⁸⁵ United Kingdom, *Death Certification and the Investigation of Death by Coroners*. Above note 76.

consider.¹⁸⁶ Witnesses usually give evidence from the witness box. This involves the Coroner's assistant reading out the witness' written statement before a witness is asked questions about the statement.

When the Coroner has heard from all the witnesses, he or she will eventually make a finding—this is the Coroner's decision regarding the death of the person.¹⁸⁷

Jurisdiction

When an inquest must be held

The Act requires coroners to hold inquests for certain kinds of deaths which are connected with Victoria.¹⁸⁸ Inquests are mandatory where:

- the Coroner suspects homicide;¹⁸⁹
- the person who died was, immediately before death, a person held in care;¹⁹⁰
- the identity of the person who died is not known;¹⁹¹
- the death occurred in “prescribed circumstances”;¹⁹²
- the Attorney-General or the State Coroner directs a coroner to hold an inquest,¹⁹³ or
- the Supreme Court makes an order that an inquest be held.¹⁹⁴

¹⁸⁶ State Coroner's Office and Victorian Institute of Forensic Medicine, *When a Person Dies—The Coroner's Process*, 1999. p. 17.

¹⁸⁷ *Butterworths Concise Australian Legal Dictionary*, 2nd edition, 1998, p. 178.

¹⁸⁸ *Coroners Act* (1985); s. 17(1): the body of the person who has died must be in Victoria, or it appears to the Coroner that the death or the cause of the death occurred in Victoria.

¹⁸⁹ *Coroners Act* (1985); s. 17(1)(a). This is subject to s.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. This was discussed in the recent case of *Domaszewicz v The State Coroner* 2004, Supreme Court of Victoria (Unreported, Ashley J, 17 December 2004). His Honour was of the opinion [at 17] that the discretion in s.17(3) was broad, “to be considered in the context that a coroner is empowered to determine that an inquest not be held where otherwise it would be mandatory, criminal proceedings in connection with the death having been brought and concluded.”

¹⁹⁰ *Coroners Act* (1985); s. 17(1)(b). The definition of “in care” is discussed in chapter 2.

¹⁹¹ *Coroners Act* (1985); s. 17(1)(c).

¹⁹² *Coroners Act* (1985); s. 17(1)(d). The Coroners Regulations (1996) do not currently list any prescribed circumstances. This can be contrasted to the position in England and Wales where deaths which occur from certain prescribed causes, such as industrial disease and poisoning must be referred to the Coroner under the Registration of Birth and Death Regulations 1987(Eng); Reg. 41.

¹⁹³ *Coroners Act* (1985); s. 17(1)(e)-(f).

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 other jurisdictions as in Victoria, all deaths in care or custody must proceed by way of inquest.¹⁹⁵

In five of the eight jurisdictions, including Victoria, an inquest is mandatory where the Coroner suspects a death may be due to homicide.¹⁹⁶

Only two other jurisdictions besides Victoria require that an inquest to be held where the identity of the person who has died has not been established.¹⁹⁷

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.¹⁹⁸ An inquest must also be held where a person dies after an accident where the cause of death appears to be directly attributable to the accident or if the person dies and has not seen a doctor for 3 months before his or her death.¹⁹⁹

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.²⁰⁰

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 be sufficiently disclosed” or where it has not been sufficiently disclosed that the person has died.²⁰¹

Question 17—Mandatory Inquests

- (a) Are there any issues or concerns with the current category of deaths in which an inquest is mandatory?
- (b) Should the current category of mandatory inquests be extended?

¹⁹⁴ *Coroners Act* 1985) s. 18(3).

¹⁹⁵ *Coroners Act* (1997) (ACT), s. 13(1); *Coroners Act* (1993) (NT); s.15(1); *Coroners Act* (NSW) (1980) s. 14B(1); *Coroners Act* (QLD) (2003); s. 27; *Coroners Act* (2003)(SA); s. 21(1); *Coroners Act* (1985); s. 24(1).

¹⁹⁶ *Coroners Act* (1997) (ACT), s. 13(1); *Coroners Act* (NSW) (1980) s.14B(1)(a); *Coroners Act* (TAS) (1995); s. 24(1); *Coroners Act* (1996) (WA); s. 22(1).

¹⁹⁷ *Coroners Act* (1993)(NT); s. 15(1); *Coroners Act* (1995)(TAS); s.24(1).

¹⁹⁸ *Coroners Act* (1997) (ACT); s. 13(1)(b)-(d).

¹⁹⁹ *Coroners Act* (1997) (ACT); s. 13(h) and (g).

²⁰⁰ *Coroners Act* (1997) (ACT) s 13(1)(e); *Coroners Act* (1980) (NSW) s. 14C.

²⁰¹ *Coroners Act* (1980) (NSW) s. 14B(c)-(d).

When an inquest may be held

A coroner who has jurisdiction to investigate a death has the discretion to hold an inquiry if he or she believes it is “desirable”.²⁰² Also, any person may request a coroner to hold an inquest, provided the Coroner has jurisdiction to investigate the death.²⁰³ If a coroner refuses a 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.²⁰⁴

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 he or she can approach the Supreme Court:²⁰⁵

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.²⁰⁶

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.²⁰⁷

The following Court of Appeal case, *Clancy v West*²⁰⁸ illustrates circumstances which the Court may not regard as ‘necessary or desirable’:

Clancy v West

While in hospital, Mrs Santoro decided to alter her will so that both her daughter and son would inherit her property. Her previous will had favoured only her son. Some days after she made the alteration to her will, Mrs Santoro had a heart attack and died at the hospital.

²⁰² *Coroners Act* 1985; s. 17(2).

²⁰³ *Coroners Act* 1985; s. 8(1).

²⁰⁴ *Coroners Act* 1985; s. 18(1)(b).

²⁰⁵ *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, J.J.A; 14 December 1999).

²⁰⁶ *Coroners Act* 1985 s.18(2).

²⁰⁷ *Coroners Act* 1985 s.18(3).

²⁰⁸ *Clancy v West* [1996] 2 VR 674.

Her son later disputed the legality of the change to the will. In a legal action, he used the doctor who had attended Mrs Santoro, as a witness, to argue that Mrs Santoro did not have the legal capacity to make those changes to the will.

Mrs Santoro's daughter then complained to the Medical Board about her mother's medical treatment but the appeal was dismissed. The daughter's husband also wrote to the Coroner, requesting an inquest under s.18(2) of the *Coroners Act*.

The Coroner refused to hold an inquest and Mrs Santoro's son-in-law appealed to the Supreme Court.

The Supreme Court rejected the appeal, ruling that the Coroner was justified in regarding the request for an inquest as neither necessary nor desirable in the interests of justice. In reviewing the evidence, there was a suggestion that the real motive for the request for the inquest was to "perpetuate a family quarrel".

The Court remarked 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".²⁰⁹

Discretionary Inquests in other Australian Jurisdictions

In all jurisdictions, the Coroner has a discretionary power to dispense with holding certain types of inquests, this power being either explicit or implicit.²¹⁰ 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.²¹¹ A coroner in the ACT must not however dispense with holding a hearing if the Coroner has reasonable grounds for believing that a person died in custody or as a result of, or during an anaesthetic.²¹²

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.²¹³

²⁰⁹ *Clancy v West* [1996] 2 VR 674 at 656.

²¹⁰ Halsbury's Laws of Australia, K Walker, *Coroners* [115-140] at 16 February 2005, citing the following legislation: *Coroners Act* (1997) (ACT) s. 14(1), *Coroners Act* (1993) (NT) s. 16(1). *Coroners Act* 1980 (NSW) s. 14; *Coroners Act* (QLD)(2003) s. 28; *Coroners Act* (SA) (2003) s. 22(1)(a); *Coroners Act* (WA) s. 22(2).

²¹¹ *Coroners Act* (1997) (ACT) s. 14(1).

²¹² *Coroners Act* (1997) (ACT) s. 14(2).

²¹³ *State Coroner's Guidelines—Version 0 December 2003*. Paragraph 8.1. Above note 34.

Law Reform Agencies

The Luce Report in England and Wales compiled a list of the kinds of deaths which should be investigated by inquest.²¹⁴ In brief, they include the following:

- any traumatic work-place 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 about.

Question 18—Discretionary Inquests

- (a) Are there any issues or concerns with the current criteria coroners use to determine if a discretionary inquest should be held?
- (b) Are there any issues or concerns in relation to the appeal process to the Supreme Court following a coroner's refusal to hold an inquiry?

When an inquest may not be held, continued or recommenced

A coroner, in limited circumstances, has the discretion not to hold, continue or recommence an inquest, which would otherwise be mandatory.²¹⁵ A coroner must be satisfied that a person has either been charged, found guilty, 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.²¹⁶

²¹⁴ Luce Report ; Above note 73; p 80.

²¹⁵ *Coroners Act* (1985) s. 17(3).

²¹⁶ *Coroners Act* (1985) s. 17(3).

The Act does not indicate what factors a coroner should consider when exercising this discretion. However, in a recent Supreme Court decision, Ashley J made the following observation:

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.²¹⁷

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, the Coroner must not proceed or must adjourn the inquest or inquiry.²¹⁸ 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.²¹⁹ However, a coroner may commence a new inquiry after the criminal proceedings have been finalised.²²⁰

Question 19—Coroner's discretion not to hold, continue or recommence an inquest

- (a) Do you think that there are certain circumstances where it should be mandatory not to hold, continue or recommence an inquest?
- (b) Are there any issues or concerns regarding the way coroners currently exercise their discretion not to hold, continue or recommence an inquest?
- (c) Do you think the Act should indicate what factors a coroner should consider when exercising this discretion?

²¹⁷ *Domaszewicz v The State Coroner* 2004, Supreme Court of Victoria, (Unreported, Ashley J, 17 December 2004) at 26.

²¹⁸ Halsbury's Laws of Australia, K Walker, *Coroners* [115-150] at 16 February 2005. ACT, citing the following: (legislation and annotations: ACT *Coroners Act* 1997 s. 58(3), 58(4). If the inquest is resumed, the findings must not be inconsistent with the determination of the proceedings on indictment: *ibid* s. 58(5). QLD *Coroners Act* 2003 s. 29; SA *Coroners Act* 2003; s. 21(2), TAS *Coroners Act* 1995 s. 25. If the inquest is resumed, the findings must not be inconsistent with the determination of the proceedings on indictment: *ibid* s. 25(4); WA *Coroners Act* 1996 s. 53(1). If the inquest is resumed, the findings must not be inconsistent with the determination of the proceedings on indictment: *ibid* s. 53(2). There is no equivalent provision in the Northern Territory however note the prohibition on making a finding that a person is or may be guilty of an offence: (NT) *Coroners Act* 1993 s. 34(3).

²¹⁹ *Coroners Act* (NSW)(1980) s. 19(1)(a).

²²⁰ *Coroners Act* (NSW)(1980) s. 20.

(d) In your opinion, what factors should a coroner consider?

Multiple death inquests

The Act allows the State Coroner to direct that more than one death be investigated at one inquest.²²¹ 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.²²² He gives a number of examples of the types of deaths where joint inquests have been held, including separate deaths involving the same make of cars, tractor deaths on farms, the deaths of children in backyard swimming pools and railway level crossing deaths.²²³

Multiple death inquests in other Australian Jurisdictions

Besides Victoria, multiple death inquests are permitted by law in four other jurisdictions.²²⁴ 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.²²⁵

Multiple death inquests in International Jurisdictions

Ontario in 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.²²⁶

²²¹ *Coroners Act* 1985; s. 43.

²²² Johnstone, G., "An Avenue for Death and Injury Prevention" in Selby, H (ed); *The Aftermath of Death*, Federation Press, 1992, p. 160.

²²³ Johnstone, G., "An Avenue for Death and Injury Prevention". Above note 222; pp. 165-170.

²²⁴ *Coroners Act* (WA)(1996); s.40; *Coroners Act* (TAS) (1995) s. 50; *Coroners Act* (SA) (2003) s. 21(3); *Coroners Act* (QLD)(2003); s. 33. In the ACT the Chief Coroner may hold an inquiry into a disaster with the consent of the Attorney-General: *Coroners Act* (ACT)(1997) s. 19.

²²⁵ *Coroners Act* (QLD)(2003); s. 33.

²²⁶ *The Coroners Act*, RSO 1990, c. C.37, s. 25(2).

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.

Question 20—Multiple death inquests

Should the Act define the circumstances in which multiple death inquests are permitted?

Powers at the Inquest

The Act gives coroners broad powers at an inquest. They are set out below:

s.46. Powers of coroners at an inquest

(1) If a coroner reasonably believes it is necessary for the purposes of an inquest, the coroner may—

(a) summon a person to attend as a witness or to produce any document or other materials; and

(b) inspect, copy and keep for a reasonable period any thing produced at the inquest; and

(c) order a witness to answer questions; and

(d) order a witness to take an oath or affirmation to answer questions; and

(e) give any other directions and do anything else the coroner believes necessary.

(...)

(3) A person must obey a summons, order or direction under sub-section (1).

Penalty: 10 penalty units or imprisonment for three months.

(4) If a person to whom a summons is issued does not appear, the coroner may issue a warrant to apprehend the person.

(5) If a person is apprehended under a warrant issued under sub-section (4), the coroner may—

(a) commit the person to prison until the inquest or the further hearing of the inquest; or

(b) discharge the person on the person entering into a recognizance, for a reasonable amount, with or without sureties—

- (i) to appear at the inquest or the further hearing of the inquest; and
- (ii) if the person was summoned to produce documents or other materials, to produce all documents or other materials mentioned in the summons or warrant that are in the person's possession or control.²²⁷

The power of a coroner to order a witness to answer questions is not unlimited and this is discussed later in this chapter.

A coroner also had additional powers including the power to exclude persons from an inquest where it is in the interests of any person, the public or justice,²²⁸ while a person who interrupts an inquest may be fined or imprisoned.²²⁹ It is also an offence to hinder or obstruct a coroner, or any person acting under a coroner's authority in exercising powers under the Act.²³⁰

A coroner also has the power to award costs in limited circumstances. Where a coroner believes that a person or his or her legal representative has unreasonably delayed the inquest, the Coroner may make an order regarding the costs of other persons appearing at the inquest.²³¹

Inquest Powers in other Australian Jurisdictions

In all jurisdictions, like Victoria, there are provisions for summoning witnesses to an inquest and to produce documents.²³² There are also similar powers in all jurisdictions enabling penalties to be imposed when a person disturbs or interferes with the proceeding. Unlike Victoria and Western Australia, the legislation in other jurisdictions refers to behaviour such as interrupting proceedings as contempt.²³³

²²⁷ *Coroners Act* (1985); s. 46.

²²⁸ *Coroners Act* (1985); s. 47.

²²⁹ *Coroners Act* (1985); s. 48. The maximum penalty is three months imprisonment.

²³⁰ *Coroners Act* (1985); s. 60. The maximum penalty also is three months imprisonment.

²³¹ *Coroners Act* (1985); s. 49(2). The State Coroner's information booklet advises: "People who believe they are an "interested party" need to contact the Registrar (...) they will need to demonstrate their involvement and why they should formally participate in the hearing": State Coroner's Office and Victorian Institute of Forensic Medicine, *When a Person Dies—The Coroner's Process*; p. 17.

²³² Halsbury's Laws of Australia, K Walker, *Coroners* [115-150] at 16 February 2005. ACT: citing the following legislation and annotation: *Coroners Act* 1997 ss. 43(1), 44 (NT); *Coroners Act* 1993 s. 41(1); (NT) *Coroners Regulations* 1994 Sch 2 Form 10 (NSW); *Coroners Act* 1980 ss. 35-41(1), 36 (form of summons), 37 (manner of service) (QLD) *Coroners Act* 2003 s. 37(4) (SA); *Coroners Act* 2003 s. 23(1) (TAS); *Coroners Act* 1995 s. 53(1); (TAS) *Coroners Regulations* 1996 reg 21, Sch 1 Form 8 (WA) ; *Coroners Act* 1996 s. 46(1).

²³³ *Coroners Act* (ACT) 1997 s. 88; *Coroners Act* (1993) s. 42(4), s. 46; *Coroners Act* (NSW) (1980) s. 43, s 45(1); *Coroners Act* (QLD) (2003), *Coroners Act* (SA) (2003);s 23(4), s. 36; *Coroners Act* (Tas) (1995) s. 56(3), s. 65-66.

Question 21—Coroner’s powers at an inquest

Are there any issues or concerns in relation to a coroner’s powers at an inquest?

Procedure and Rights of persons at the Inquest

A coroner holding an inquest is not bound by the rules of evidence.²³⁴ Rules of evidence refers to the complex body of case law and legislation relating to the sort of evidence that a court can hear (i.e. consider in finding guilt or civil liability) in a case.²³⁵ Under the Act, a coroner may be informed and conduct an inquest “in any manner the Coroner thinks reasonably fit”.²³⁶ However the Act and the case law do require a coroner to observe a number of rights and privileges of persons such as witnesses, interested parties and others.

Rights of witnesses

Under the Act, “a person with a sufficient interest” has a number of rights. The Act does not define the term. Ian Freckelton, a legal commentator on coronial law is of the view that the term has been generally liberally interpreted.²³⁷ He cites examples where coroners have permitted the Council for Civil Liberties and the Public Advocate to be represented.

A coroner has the discretionary power to make available statements which he or she intends to consider, to a person with a sufficient interest.²³⁸ Also, a person with sufficient interest has a right to appear at the hearing or be represented by a lawyer.²³⁹ Additional rights under the Act include the right to call, examine and cross-examine witnesses and to make submissions.²⁴⁰

²³⁴ *Coroners Act* (1985) s. 44.

²³⁵ Malbon, J, Airo-Farulla, G, and Banks, C., *Review of Queensland Coronial Laws —Final Report*; Department of Families Youth and Community Care, 1997, vii.

²³⁶ *Coroners Act* (1985) s. 44.

²³⁷ Freckelton, I., “Inquest Law” in Selby, H. *The Inquest Handbook*; Above note 222, p. 9. *Barci v Heffey*, Supreme Court of Victoria Practice Court, (Unreported, Beach J, 1 February 1995), provides a useful discussion of the kinds of persons who would usually be considered to have a sufficient interest; at 4.

²³⁸ *Coroners Act* (1985) s. 45(1).

²³⁹ *Coroners Act* (1985) s. 45(3). A non-lawyer may also represent a person if permitted by the Coroner. The right to legal representation is however dependent on a person’s ability to afford legal representation. This is discussed in chapter six. 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*, 1999. p.20.

²⁴⁰ *Coroners Act* (1985) s.45(3). The Attorney-General also has these rights: s. 45(2).

The High Court of Australia in *Annetts v McCann*²⁴¹ has extended those rights to include the right of reply where a coroner is considering making a finding which is adverse to the interests of that person. The case is important because it held that a coroner has a duty to comply with the rules of natural justice and to act judicially.²⁴²

Annetts v McCann

A coroner held an inquiry into the deaths of two boys who were found dead in the West Australian desert. They had been working as jackeroos on a station owned by a pastoral company. The Coroner had granted the boys parents' the right to representation at the hearing. This was a right under the *Coroners Act* of Western Australia. However towards the end of the inquiry, 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 any finding adverse to the interests which the parents represented without giving them the opportunity to be heard in opposition to that finding.

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.

The State Coroner has issued practice guidelines indicating that an expert witness is not to be considered as an advocate for the person retaining the expert. He considers that the expert's paramount duty is to the Coroner.²⁴³

Privilege against self incrimination

Although it is not stated in the Act, the long standing common law privilege against self incrimination applies to the Coroner's inquest.²⁴⁴ This means that a witness may choose not to answer a question where it can be established that the answer may *tend* to expose that person to a criminal conviction despite s.46(1)(c) of the Act which gives a coroner the power to order a witness to answer questions.²⁴⁵

²⁴¹ *Annetts v McCann* (1990) 97 ALR 177.

²⁴² *Annetts v McCann* (1990) 97 ALR 177 at 179. Also *Harmsworth v The State Coroner* [1989] VR 989 at 994.

²⁴³ State Coroner's Office, *Coroner's Practice Directions—Guidelines for Expert Witnesses*; 1 June 2003. As an aid to readers, these practice directions are reproduced in Appendix 2 to this discussion paper.

²⁴⁴ *Re O'Callaghan* (1899) 24 VLR 957. Followed in *R v The Coroner; Ex parte Alexander* [1982] VR 731 at 35.

²⁴⁵ Heydon, JD, *Cross on Evidence*, 6th Australian Edition, Butterworths, 2000, para 25065.

Privilege in other Australian jurisdictions

In South Australia, the position is similar to Victoria although the privilege against self incrimination is stated in the Act.²⁴⁶ In Tasmania, unlike Victoria, the legislation specifically provides that a statement or disclosure is not admissible in evidence against that witness in both civil and criminal proceedings other than prosecution for perjury.²⁴⁷

In the other five jurisdictions, the relevant legislation permits witnesses to object to answering incriminating questions.²⁴⁸ However in four of these jurisdictions, unlike Victoria, 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.²⁴⁹ The evidence which the witness then gives the inquiry cannot later be used in evidence in criminal proceedings against that witness. The Coroner issues a certificate certifying that the evidence is inadmissible at those proceedings.²⁵⁰

In New South Wales, 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*):

²⁴⁶ *Coroners Act (SA)(2003)* s. 23(5).

²⁴⁷ *Coroners Act (TAS)(1995)* s. 54. Note s. 57(3) of the Victorian Act which does however provide that except as provided in s. 55AB of the *Evidence Act 1958*, a record is not evidence in any court of any fact asserted in it.

²⁴⁸ *Coroners Act (NT) (1993)* s. 38(1); *Coroners Act (NSW)(1980)* s. 33; *Coroners Act (QLD)(2003)* s. 39(1); *Coroners Act (SA)(2003)* s. 23(5)(a); *Coroners Act (WA)(1996)* s. 47(1).

²⁴⁹ These jurisdictions are the Northern Territory, Queensland, New South Wales and Western Australia.

²⁵⁰ *Coroners Act (NT) (1993)* s. 38(2)-(3); *Coroners Act (NSW)(1980)* s. 33AA; *Coroners Act (QLD)(2003)* s. 39(3); *Coroners Act (WA)(1996)* s. 47(2) and s. 47(3).

(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.

Law reform issue relating to the privilege against self incrimination

Ian Freckelton, a legal commentator on coronial law makes the following observation:

Witnesses at a coronial inquest are entitled to protections that may be claimed in other cases, civil and criminal. Thus, the coroner does not have an unfettered power to compel the provision of information. This can have a significant impact upon the evidence that is available to a coroner's court upon which a verdict may be made.²⁵¹

This issue was also discussed recently by the State Coroner at an inquiry.²⁵² The inquiry concerned the deaths of three men who died in a car crash during a police pursuit. On the basis of legal advice, the two police officers involved in the pursuit did not give evidence at the inquiry. While recognising the police officers' right to claim privilege against self incrimination, the State Coroner made the following observation in his 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.²⁵³

In his recommendations, the State Coroner requested that consideration be given in the review of the Act to adopting a provision similar to s. 33AA of the New South Wales Act.²⁵⁴

As part of this review, the Committee would like your views on whether there should be any changes to a witnesses' right to claim privilege against self incrimination at coronial inquests.

²⁵¹ Ian Freckelton, "Inquest Law" in Selby, H. (ed) *The Inquest Handbook*; Above note 222 , p. 11.

²⁵² State Coroner, Victoria, *A Police Pursuit Related Inquest: Findings* No. :1822/02; 1821/02; 1823/02; 29 January 2004. Available at www.coronerscourt.vic.gov.au.

²⁵³ State Coroner, Victoria, *A Police Pursuit Related Inquest: Findings*. Above note 252; p. 34.

²⁵⁴ State Coroner, Victoria, *A Police Pursuit Related Inquest: Findings*. Above note 252; p. 34.

Question 22—Privilege against self incrimination

Is a change to the law limiting a person's right to claim privilege against self incrimination at coronial inquests justified?

Findings at the Inquest

When a coroner has heard all the evidence and submissions at the inquest, the case is often postponed so that the Coroner can consider this information in the Coroner's findings.²⁵⁵ Findings are the decisions which the Coroner is required to make under section 19(1) of the Act²⁵⁶ which is set out below.

s.19. Findings and comments of coroner

(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*.

If a coroner has determined not to conduct or complete an inquest, the Coroner is only required to make a finding if the Coroner believes it is desirable.²⁵⁷

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.²⁵⁸ However, a coroner must refer the matter to the Director of Public Prosecutions if he or she believes that an indictable offence²⁵⁹ has been committed in connection with the death which the Coroner investigated.²⁶⁰

²⁵⁵ State Coroner's Office and Victorian Institute of Forensic Medicine, *When a Person Dies—The Coroner's Process*, 1999. p. 20.

²⁵⁶ *Anderson v Blashki* [1993] 2 VR 89 at 92.

²⁵⁷ *Coroners Act* (1985) s. 19(4).

²⁵⁸ *Coroners Act* (1985) s. 19(3).

²⁵⁹ An indictable offence is a serious crime which is generally triable before a judge and jury: Fitzroy Legal Service Inc. *The Law Handbook*, 2003 Edition, p. 840.

²⁶⁰ *Coroners Act* (1985) s. 21(3).

Before any finding of fact may be made by a coroner, the Coroner must be satisfied as to the relevant fact on the balance of probabilities.²⁶¹

Findings at the Inquest in other Australian jurisdictions

The findings which may be made in the other jurisdictions are the same as in Victoria,²⁶² except for Tasmania, where a coroner must also find the identity of any person who contributed to the cause of death.²⁶³ This requirement was removed from the Victorian Act in 1999.²⁶⁴ While a coroner may no longer make a finding that a person contributed to the cause of a death, in appropriate cases, a coroner may make general comments regarding the preventable nature of a death. This is discussed in chapter five. A case study in this chapter illustrates how a coroner is able to make comments on system failures rather than making findings that a certain person may have contributed the cause of the death of a person.

Recommendations at the Inquest

A coroner may comment on any matter connected with the death including public health or safety or the administration of justice.²⁶⁵ The Committee examines this in detail in chapter five.

New Inquests and Re-opening of Inquests

Right of appeal to Supreme Court

Any person may apply to the Supreme Court for an order that some or all of the findings of a coroner's inquest are void.²⁶⁶ 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 re-opened to re-examine the findings.²⁶⁷

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

²⁶¹ *Anderson v Blashki* [1993] 2 VR 89. Followed in *Munro v West*, Supreme Court of Victoria, (Unreported, Smith J, 7 February 1997).

²⁶² Halsbury's Laws of Australia, K Walker, *Coroners* [115-230] at 16 February 2005; citing the following: (ACT) *Coroners Act* 1997 s. 52(1); (NT) *Coroners Act* 1993 s. 34(1)(a); (NSW) *Coroners Act* 1980 s. 22(1); (QLD) *Coroners Act* 2003 s. 45(2); (SA) *Coroners Act* 2003; s. 25(1) (the Coroner is required to find the 'cause and circumstances of the event'); (WA) *Coroners Act* 1996 s. 25(1).

²⁶³ *Coroners Act* (TAS) (1995) s. 28(1)(f).

²⁶⁴ For background information see Kennedy, E; "Reform of the Coroners Act—a fair go all round", *Law Institute Journal*, March 1999, p. 11.

²⁶⁵ *Coroners Act* (1985) s. 19(2).

²⁶⁶ *Coroners Act* (1985) s. 59(1).

²⁶⁷ *Coroners Act* (1985) s. 59(2).

- (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.²⁶⁸

The phrase “consideration of evidence” was examined by Gobbo J, who described it as an “unclear, somewhat incomprehensible phrase”.²⁶⁹ He concluded that a coroner’s “consideration of evidence” must involve an error of law or misdirection of fact.²⁷⁰

In another case, Hedigan J 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”.²⁷¹

In order to establish that a coroner’s finding are “against the evidence and the weight of the evidence”, the Supreme Court must engage in the lengthy process of reviewing the evidence.²⁷²

Review by the State Coroner

A person may also apply to the State Coroner for an order that some or all of the findings of an inquest are void.²⁷³ The State Coroner, however, does not have jurisdiction to review if the Supreme Court has already refused to make an order based on the same, or substantially the same, grounds or evidence.²⁷⁴

The State Coroner may order that some or all of the findings of the inquest are void and may re-open, or direct another coroner to re-open, the inquest and re-examine any finding.²⁷⁵ However, the State Coroner may only make an order if he or she is satisfied that there is a mistake in the record of the findings or where it is desirable because of new facts or evidence.²⁷⁶

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

²⁶⁸ *Coroners Act* (1985) s. 59(3).

²⁶⁹ *Anderson v Blashki* [1993] 2 VR 89 at 92.

²⁷⁰ *Anderson v Blashki* [1993] 2 VR 89 at 92.

²⁷¹ *Chief Commissioner of Police v Hallenstein* [1996] 2 VR 1 at 13.

²⁷² *Munro v West*, Supreme Court of Victoria Causes, (Unreported, Smith J, 7 February 1997) at 4.

²⁷³ *Coroners Act* (1985) s. 59A(1).

²⁷⁴ *Coroners Act* (1985) s. 59A(4).

²⁷⁵ *Coroners Act* (1985) s. 59A(2).

²⁷⁶ *Coroners Act* (1985) s. 59A(3).

findings made on investigation without inquest.²⁷⁷

Rights of appeal in other Australian jurisdictions

Like 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.²⁷⁸ In that jurisdiction, the District Court may set aside a finding if satisfied that—

- (a) new evidence casts doubt on the finding; or
- (b) the finding was not correctly recorded; or
- (c) there was no evidence to support the finding; or
- (d) the finding could not be reasonably supported by the evidence.²⁷⁹

The Western Australian and Northern Territory provisions are identical to the Victorian grounds of appeal.²⁸⁰ Tasmania recently modified the grounds of appeal to the grounds which are 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.²⁸¹

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

²⁷⁷ *Domaszewicz v The State Coroner* 2004, Supreme Court of Victoria, (Unreported, Ashley J, 17 December 2004).

²⁷⁸ The District Court of Queensland is largely the equivalent of the Victorian County Court.

²⁷⁹ *Coroners Act* (QLD)(2003) s. 50(5).

²⁸⁰ *Coroners Act* (WA)(1996) s. 52. *Coroners Act* (NT)(1993) s. 44.

²⁸¹ *Coroners Act* (TAS)(1995) s. 58A.

or the interests of justice that the inquest or inquiry be quashed and that another inquest or inquiry be held (...).²⁸²

South Australian has a very general ground of appeal. The Supreme Court in South Australia may re-hear a matter if it is “in the interests of justice”.²⁸³

Question 23—Rights of Appeal

- (a) Is the Supreme Court the most appropriate jurisdiction to hear appeals under the *Coroners Act*?
- (b) Should the power of the State Coroner be extended to include the power to review a coroner’s findings made on investigation without an inquest?
- (c) Are there any other issues or concerns with the current grounds of appeal to the State Coroner and to the Supreme Court?

Investigation of suspected deaths

A coroner may investigate reported cases of suspected deaths.²⁸⁴ This is also the position in all other Australian jurisdictions.²⁸⁵ Before the current Act came into force in 1985, a coroner could only investigate a death where a body had been recovered.

The State Coroner recently announced a review of 81 suspected drowning deaths, including the death of former Prime Minister Harold Holt in 1967.²⁸⁶

Question 24—Investigation of suspected deaths

Are there any issues or concerns with the way in which suspected deaths are reported to, and investigated by the Coroner?

²⁸² *Coroners Act* (NSW)1980 s. 47(2); *Coroners Act* (ACT) 1997 s. 93(1)(b).

²⁸³ *Coroners Act* (SA)(2003) s. 27(5).

²⁸⁴ *Coroners Act* (1985) s. 3: The definition of “death” includes suspected death.

²⁸⁵ *Coroners Act* (ACT) (1997) s. 3, s. 13(3)(b); *Coroners Act* (NT) (1993) s. 3; *Coroners Act* (NSW)(1980) s. 13(1); *Coroners Act* (QLD)(2003) s. 11(5)-(6); *Coroners Act* (SA) (2003) s. 21(1)(b)(iii), *Coroners Act* (TAS)(1995) s. 3; *Coroners Act* (WA)(1996) s.3.

²⁸⁶ “Holt inquest to be held next year”, *The Age*, 15 November 2004.

CHAPTER FOUR — INDEPENDENT INVESTIGATION OF FIRES

The jurisdiction of a coroner also extends to the investigation of 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.²⁸⁷ In this chapter, the Committee examines the circumstances in which a coroner may investigate and hold inquests into fires. A comparison is made with the other Australian jurisdictions which permit coroners to investigate fires.

The Committee also discusses other kinds of investigations, such as inquests into disasters, which, unlike in Victoria, are permitted in a number of Australian jurisdictions.

Investigating fires

A coroner has jurisdiction to investigate fires which have a territorial connection with the state. The fire must occur in, or partly in Victoria.²⁸⁸

The Coroner may investigate these kinds of fires if he or she believes it is desirable or where the Metropolitan Fire Board or the Country Fire Authority requests the Coroner to investigate a fire.²⁸⁹ The Attorney General may also direct a coroner to investigate a fire.²⁹⁰

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.²⁹¹

The Joint Fire Investigation Police Procedure ensures that the agencies involved in fire investigations use the same fire investigation standards.²⁹²

²⁸⁷ Thatcher, P; "Fire!", in Selby, H (ed), *The Aftermath of Death* Above note 222, p. 132.

²⁸⁸ *Coroners Act* (1985) s. 31(1).

²⁸⁹ *Coroners Act* (1985) s. 31(1).

²⁹⁰ *Coroners Act* (1985) s. 31(2).

²⁹¹ *Coroners Act* (1985) s 32.

²⁹² Interview conducted with the State Coroner in "The State Coroner" *Victoria Police Association Journal*, June 2000, p. 18.

Inquests into fires

A coroner who has jurisdiction to investigate a fire may hold an inquest if the Coroner believes it is desirable.²⁹³ The Coroner must hold an inquest if the State Coroner or the Attorney-General directs an inquest to take place²⁹⁴.

A person may request a coroner to hold an inquiry into a fire.²⁹⁵ If the application is refused, a person has a right of appeal to the Supreme Court which, like death inquest appeals, may only be commenced three months after the initial request to the Coroner.²⁹⁶ 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.²⁹⁷

A coroner must make the following findings, where possible:

- the cause and origin of the fire; and
- the circumstances in which the fire occurred; and
- the identity of any person who contributed to the cause of the fire.²⁹⁸

As with death investigations, a coroner may comment on any matter connected with the fire including public health or safety or the administration of justice.²⁹⁹ Similarly, a coroner must not include in a finding or comment any statement that a person is or may be guilty of an offence.³⁰⁰

Fire investigation in other Australian jurisdictions

In all jurisdictions except Queensland and Western Australia, a coroner has the jurisdiction to hold inquests or inquire into the causes and origins of fires.³⁰¹ 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.³⁰² In Western Australia, the causes of non-fatal fires are investigated by the Fire and Emergency Services

²⁹³ *Coroners Act* (1985) s 34(3).

²⁹⁴ *Coroners Act* (1985) s 34(1)-(2).

²⁹⁵ *Coroners Act* (1985) s. 35(1).

²⁹⁶ *Coroners Act* (1985) s. 35(2).

²⁹⁷ *Coroners Act* (1985) s. 35(3).

²⁹⁸ *Coroners Act* (1985) s. 36.

²⁹⁹ *Coroners Act* (1985) s. 36(2).

³⁰⁰ *Coroners Act* (1985) s. 36(3).

³⁰¹ Halsbury's Laws of Australia, K Walker, *Coroners* [115-275] at 16 February 2005.

³⁰² Greg Reynolds, Area Director Kemp Place Fire Station, Queensland, [greynolds@emergency.qld.gov.au, 18 March 2005].

Authority.³⁰³ Recent major bushfires in north west Victoria were investigated by the Victorian Emergency Services Commissioner.

The Tasmanian legislation is similar to Victoria, however in Tasmania, a coroner may also investigate explosions.³⁰⁴ A person must also have standing in Tasmania to request an investigation. This means that a person must demonstrate a “sufficient interest” in relation to the fire or explosion.³⁰⁵

In the ACT, investigations into the cause and origin of a fire may be initiated by a coroner or the Attorney-General.³⁰⁶ However, unlike Victoria, only property owners or occupiers whose property is damaged may request an investigation into a fire.³⁰⁷

In the Northern Territory, a coroner has jurisdiction to investigate disasters.³⁰⁸ “Disaster” is defined as including a fire that causes substantial loss of, or injury to, property.³⁰⁹ Investigations into disasters may be initiated by the Attorney-General, or a coroner if “considered fit”.³¹⁰

A coroner in South Australia may inquire into fires which cause injury to persons or property, if directed to, by the Attorney General or the State Coroner.³¹¹

In New South Wales, a coroner has jurisdiction to investigate fires and explosions that have destroyed or damaged property in that state.³¹² 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 Fire Brigade, Commissioner of the Fire Service or the State Coroner.³¹³

Question 25—Investigations and Inquests into fires

- (a) Do you think that a modern coronial system should continue to investigate non-fatal fires or do you think that these kind of investigations could be undertaken by the fire authorities, such as in Queensland and Western Australia?

³⁰³ www.fesa.wa.gov.au

³⁰⁴ *Coroners Act* (TAS)(1995) s. 40.

³⁰⁵ *Coroners Act* (TAS)(1995) s. 42(1).

³⁰⁶ *Coroners Act* (ACT)(1997) s. 18(1).

³⁰⁷ *Coroners Act* (ACT)(1997) s. 18(2).

³⁰⁸ *Coroners Act* (NT)(1993) s. 28.

³⁰⁹ *Coroners Act* (NT)(1993) s. 3.

³¹⁰ *Coroners Act* (NT)(1993) s. 29-30.

³¹¹ *Coroners Act* (SA)(2003) s. 21(1)(b)(iv).

³¹² *Coroners Act* (NSW)(1980) s. 15(1).

³¹³ *Coroners Act* (NSW)(1980) s. 15(2)-(3).

- (b) In your experience, does the Coroners system effectively investigate fires and make recommendations to prevent future fires and improve safety?

Other kinds of investigations

Unlike Victoria, in the Northern Territory and the ACT, a coroner's powers of inquiry extend to "disasters": In the ACT, "disaster" is broadly defined to mean:

an occurrence in the Territory due to natural or other causes that—

- (a) caused or threatened to cause substantial—
 - (i) loss of life or property; or
 - (ii) injury or distress to persons or damage to property or the environment; or
- (b) in any way substantially endangered the safety of the public in any part of the Territory.³¹⁴

The Northern Territory definition is similar except that the definition does not extend to occurrences which only cause or threatened to cause substantial distress.³¹⁵

In South Australia, apart from deaths and fires, a coroner may also inquire into accidents that cause injury to persons or property.³¹⁶

Question 26—Investigations and Inquests into disasters

- (a) Do you think the scope of a coroner's power to investigate should appropriately include the power to investigate disasters and to make recommendations in relation to disasters?
- (b) What kind of events do you think should be included in the definition of "disaster"?

³¹⁴ *Coroners Act (ACT)(1997)* s. 3.

³¹⁵ *Coroners Act (NT)(1993)* s. 3.

³¹⁶ *Coroners Act (SA)(2003)* s. 21(1)(b)(iv).

CHAPTER FIVE — CORONER’S ROLE IN INJURY AND DEATH PREVENTION

“We speak for the Dead to protect the living”.³¹⁷

This is the motto of the State Coroner’s Office, Victoria and the Coroner’s Office in Ontario in Canada. In recent years, both jurisdictions have actively adopted a preventative role in coronial investigations.³¹⁸ 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 injury. The Committee compares the system in Victoria with the systems and legislation in other jurisdictions.

In the final part of the chapter, the Committee examines the effectiveness of the current system and considers alternative systems.

The Current system

Identifying similar kinds of deaths

The role of the Research Unit at the State Coroner’s Office is to help coroners identify “clusters” of similar cases. A valuable research tool used at the State Coroner’s Office is the National Coroners Information System (NCIS). This is a national database of coronial information which is managed by the Monash University National Centre for Coronial Information. The database is the first of its kind in the world.

NCIS contains information on all Australian coroners’ cases since it became operational in 2000.³¹⁹ It includes information such as the medical cause of death, the circumstances of a person’s death, toxicology³²⁰ and autopsy reports as well as the coronial finding.

³¹⁷ Attributed to Thomas D’arcy McGee, a nineteenth century Irish-Canadian politician.

³¹⁸ The State Coroner, Graeme Johnstone has been described as “probably Australia’s most cogent and passionate advocate of the prevention role for Coroners”: Malbon, J., “Institutional Responses to Coronial Recommendations”, *Journal of Law and Medicine*, Vol 6, August 1998. p. 39, note 34.

³¹⁹ Cases from Queensland were added to the system in 2001.

³²⁰ Toxicology refers to the examination of samples to detect and establish levels of alcohol, drugs and poisons.

Question 27—Systems for identifying similar kinds of deaths

- (a) How effective are the current systems for identifying similar kinds of death, such as the National Coroners Information System?
- (b) Are there any resource issues in relation to the National Coroners Information System?
- (c) Do all coroners use the system when investigating deaths to establish whether there are also similar kinds of deaths to the death which they are investigating?

The power to make recommendations

Under the Act, a coroner has the discretion to comment on any matter “connected with a death” including public health or safety.³²¹ The usual practice is for a coroner to make recommendations in cases he or she considers appropriate.

A coroner will issue written “findings” in relation to the death of a person.³²² In a separate section in the text, a coroner will in appropriate cases, make recommendations for change to prevent similar deaths or injury. This should occur where the Coroner considers that the death was, in some way, a preventable death.

However, the power of a coroner to comment in this way is limited to “any matter connected with a death”. This power is viewed as incidental and subordinate to the mandatory power to make findings relating to how a death occurred and the cause of the death.³²³ Also, the Act does not include “the making of recommendations to prevent injury or future death” as a listed function of the State Coroner.³²⁴

Position in other Australian jurisdictions

Like Victoria, coroners in all other Australian jurisdictions, have the power to make comments and recommendations. However, in some jurisdictions, unlike Victoria, the power to comment is a mandatory power, not an incidental one. In Tasmania, a coroner *must* make recommendations to prevent further deaths where appropriate.³²⁵

In Western Australia, a coroner is also required to comment on the quality of the supervision, treatment and care of a person who died while in care.³²⁶ In relation to

³²¹ *Coroners Act* (1985), s. 19(2).

³²² This is discussed in chapter 3.

³²³ *Harmsworth v State Coroner* [1989] VR 989 at 996.

³²⁴ See section 7 of the Act which sets out a list of the functions of the State Coroner.

³²⁵ *Coroners Act* (TAS)(1995) s. 28(2).

³²⁶ *Coroners Act* (WA)(1996) s. 25(3).

other kinds of deaths, a coroner in Western Australia has a discretionary power to comment.³²⁷ 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.³²⁸ In relation to other kinds of death, a coroner has a general power to comment.³²⁹

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.³³⁰ In South Australia, the power is also similar—a coroner may make a recommendation which might prevent or reduce the likelihood of a recurrence of a similar event.³³¹

Implementing recommendations

A coroner's recommendation does not have the same status as a judge's order—there is no sanction for non-compliance. Under the Act, a coroner may make recommendations to any Minister or public statutory authority.³³²

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.³³³ 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.³³⁴

In the inquiry, the State Coroner recommended that the James Hardie Group consider working with appropriate government safety agencies in a major programme to 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 Australian jurisdictions

Unlike Victoria, the ACT legislation requires certain groups to respond to particular coronial recommendations. After making a finding in relation to a death in custody, a coroner must report the finding to the Attorney-General, the custodial agency where the death occurred, the appropriate Minister and the Australian Institute of

³²⁷ *Coroners Act* (WA)(1996) s. 25(2).

³²⁸ *Coroners Act* (NT)(1993) s. 26(2).

³²⁹ *Coroners Act* (NT)(1993) s. 34(2).

³³⁰ *Coroners Act* (NSW) (1980) s. 22A.; *Coroners Act* (QLD)(2003) s. 46; *Coroners Act* (ACT)(1997) s. 52(4).

³³¹ *Coroners Act* (SA)(2003) s. 25(2).

³³² *Coroners Act* (1985) s. 21(2).

³³³ Interview conducted with the State Coroner in "The State Coroner" *Victoria Police Association Journal*, June 2000, p. 19.

³³⁴ *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

Criminology.³³⁵ The Coroner must also send the findings to an appropriate local Aboriginal legal service if the person who died was Indigenous.³³⁶

The custodial agency is required to report to the Minister responsible for the custodial agency within three months of receiving the report.³³⁷ In its written response, the custodial agency is required to include a statement of the action (if any) which is being taken regarding the finding.³³⁸ The Minister must then forward a copy of the response to the Coroner.³³⁹

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 appropriate Minister and Chief Executive as well as the Attorney-General.³⁴⁰ There is no requirement in the Act that these persons respond to the findings or comments.

The position in the other jurisdictions is similar to Victoria—a coroner has a discretionary power to make recommendations to Ministers but a response to the recommendations is not mandatory.³⁴¹

Law Reform issues

RCADC

The provisions in the ACT legislation relating to a death in custody were introduced in 1998 in response to recommendations by RCADC in 1991.³⁴² The Royal Commission also recommended 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.³⁴³

The Victorian Aboriginal Justice Forum (the Forum) is currently conducting 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

³³⁵ *Coroners Act* (ACT)(1997) s. 75(1).

³³⁶ *Coroners Act* (ACT)(1997) s. 75(1)(d).

³³⁷ *Coroners Act* (ACT)(1997) s. 76(1).

³³⁸ *Coroners Act* (ACT)(1997) s. 76(2).

³³⁹ *Coroners Act* (ACT)(1997) s. 76(3).

³⁴⁰ *Coroners Act* (QLD)(2003) s. 47.

³⁴¹ *Coroners Act* (NT)(1993) s. 27; *Coroners Act* (NSW)(1980) s. 22A; *Coroners Act* (SA)(2003) s. 25(4); *Coroners Act* (TAS)(1995) s. 30(2); *Coroners Act* (WA)(1996) s. 27(3).

³⁴² Royal Commission into Aboriginal Deaths in Custody, *National Report Volume 1*, 1991. Recommendations 14-18. As an aid to readers, these recommendations are listed in Appendix 1 to this Discussion Paper.

³⁴³ Recommendation 16.

in implementing the RCADC recommendations.³⁴⁴ One of the original RCADC recommendations recommended that the State Coroner be empowered to call for explanations or information as to further action taken in relation to the recommendations. The relevant Government department reported that there had been no further progress towards the implementation of this recommendation.³⁴⁵

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 2004, the Implementation Review Team published a discussion paper on the implementation of the RCADC recommendations.³⁴⁶ A final report is expected to be tabled in Parliament in the Autumn 2005 session. As an aid to readers of this paper, the recommendations of RCADC relating to coronial investigations are listed in Appendix 1 to this discussion paper. The Committee welcomes comments on the implementation of those recommendations.

Question 28—Implementing RCADC recommendations

Do you have any comments regarding the implementation of the 1991 RCADC recommendations relating to coronial investigations?

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.³⁴⁷

Effectiveness of the current system

The traditional view of the role of the Coroner has been that the Coroner is a “public messenger” whose task is completed on delivery of the message.³⁴⁸ What happens

³⁴⁴ 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, p. 4-6.

³⁴⁵ 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, p. 4.

³⁴⁶ 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

³⁴⁷ *Deaths in Custody at Port Phillip Prison* (State Coroner's Office, Victoria), Part 1, p. 208.

³⁴⁸ Hallenstein, H., *Suicide: the Coroner as Catalyst*, (Paper presented at AIC Conference No.13, July 1990). p. 177.

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.

It is difficult to determine how effective the current system is in preventing deaths as there is no provision in the Act for auditing the implementation rate of recommendations. A case study by Boronia Halstead in 1998 examined the administrative procedures for the implementation of coroner's recommendations in relation to deaths in custody.³⁴⁹ The study concluded that the ad hoc approach to the implementation of recommendations demonstrated through the case studies leads to great uncertainty and fails to secure accountability and transparency in the process of implementing recommendations.³⁵⁰

Improving hospital patient safety

The effectiveness of coroners' recommendations in improving hospital patient safety is yet to be established, as there has been no systematic review of the impact of coronial recommendations in the health care sector.³⁵¹ A study from 1995 however revealed the need to improve patient safety and there is recognition from a key health care safety agency that coroners have the potential to play an important role in death and injury prevention.

The study of over 14,000 hospital admission records in New South Wales and South Australia in 1995 showed that 16.6 percent of people admitted to hospital in the study experienced an "adverse event" associated with their care.³⁵² Half of the adverse events were considered preventable.³⁵³ The study also revealed that 4.9 percent of patients who suffered an adverse event died.³⁵⁴ Ten years after the study, there is insufficient information at a state or national level to determine whether there has been a general increase in safety in hospitals.³⁵⁵

³⁴⁹ Halstead, B., "Coroners' Recommendations following Deaths in Custody", in H Selby (Ed); *The Inquest Handbook*, Above note 222, pp. 186-206.

³⁵⁰ Halstead, B., "Coroners' Recommendations following Deaths in Custody", in H Selby (Ed); *The Inquest Handbook*, Above note 222, p. 186.

³⁵¹ Bugeja, L and Ranson, D., "Coroners; Recommendations: Do they lead to positive public health outcomes", *Journal of Law and Medicine*, Vol. 10, May 2003, p. 399. The authors note that there has been no systematic review of the impact of coronial findings that would be required to show that they have reduced death and injury rates or led to improvements in health care outcomes.

³⁵² Wilson RM et al, "The Quality in Australian Health Care Study", *Medical Journal of Australia*, Vol 163, 1995, p. 458-471.

³⁵³ Wilson R M et al, "The Quality in Australian Health Care Study", Above note 352; p. 458-471.

³⁵⁴ Wilson R M et al, "The Quality in Australian Health Care Study", Above note 352, p. 458-471.

³⁵⁵ Mel Wilson, R M, Van Der Weyden, M B, "The Safety of Australian Healthcare: 10 years after QAHCS", *Medical Journal of Australia*, Vol 182, No. 6, 21 March 2005.

In 1996, the State Coroner in a coronial finding, identified the need for the general medical system to share information concerning adverse medical events. In this finding, the State Coroner recommended that:

The Public Health Branch of the Department of Human Services consider developing a standardised investigation protocol for hospitals for all serious adverse medical events [injury or death]. Any system, if considered appropriate, also should include a data collection and reporting mechanism to ensure any problems identified are disseminated throughout the hospital medical system in a timely way.³⁵⁶

In March 2005, the Victorian Auditor-General released a report on managing patient safety in public hospitals in Victoria.³⁵⁷ The report found that clinical risk-management in the acute health area is unevenly developed.³⁵⁸ According to the report, a number of hospitals had poor systems for ensuring that errors were recognised, recorded and addressed.³⁵⁹ The Auditor-General found that in these hospitals there was also no effective mechanism to ensure that the same mistakes were not repeated in the future.³⁶⁰

Australian Council for Safety and Quality in Health Care

In 2000, the Australian Health Ministers established the Australian Council for Safety and Quality in Health Care (ACSQHC) with the aim of improving the safety and quality of health care and minimising the likelihood and effects of error. In its second report to Health Ministers in 2001, ACSQHC examined a study by VIFM involving 1,053 hospital deaths which were reported to the Coroner in 1999.³⁶¹ According to ACSQHC, VIFM concluded that 96 deaths were considered to have involved system-related adverse events.³⁶²

³⁵⁶ Record of Investigation into Death, Case No: 1835/94, State Coroner's Office, Victoria, 16 August 1996, p. 11-12.. Available at www.coronerscourt.vic.gov.au.

³⁵⁷ Auditor General Victoria, *Auditor-General's Report—Managing patient safety in public hospitals*, March 2005. Available at http://www.audit.vic.gov.au/reports_par/patient_safety_report.pdf

³⁵⁸ Auditor General Victoria, *Auditor-General's Report—Managing patient safety in public hospitals*, Above note 356, p. 3.

³⁵⁹ Auditor General Victoria, *Auditor-General's Report—Managing patient safety in public hospitals*, Above note 356, p. 3.

³⁶⁰ Auditor General Victoria, *Auditor-General's Report—Managing patient safety in public hospitals*, Above note 356, p. 3.

³⁶¹ Australian Council for Safety and Quality in Health Care, "Safety in Numbers" Attachment to *Safety in Practice—Making Health Care Safer, Second Report to the Australian Health Ministers' Conference*, 1 August 2001. p. 17.

³⁶² Australian Council for Safety and Quality in Health Care, "Safety in Numbers" Attachment to *Safety in Practice—Making Health Care Safer, Second Report to the Australian Health Ministers' Conference*, 1 August

ACSQHC noted that ensuring that all deaths are referred to the Coroner and that coronial findings are acted on has some potential to improve the safety of health care.³⁶³ It reported that there needs to be feedback on the findings of coronial investigations on reported deaths, with strategies in place to act on findings and to remedy any system failures.³⁶⁴

Clinical Liaison Service at VIFM and the State Coroner's Office

Following that report, ACSQHC commissioned VIFM to examine the role of the Coroner's investigation process in initiatives for improving quality and safety in health care. VIFM submitted its final report in May 2003.³⁶⁵

Dr Ibrahim from the Clinical Liaison Service (a joint service of VIFM and the State Coroner's Office) has expressed his views on the VIFM project.³⁶⁶ He noted that information from the Coroner's investigation process is an important resource for preventing in-hospital deaths and is an untapped resource in improving the health system.³⁶⁷ He considered the fact that the health care sector is under no obligation to respond to a coroner's findings and recommendations is an obstacle to a clearer focus on patient safety.³⁶⁸

Dr Ibrahim identified the following as options for reform:

2001. p. 17. In Appendix A to the report, the Council defines "adverse event" as "an incident in which harm resulted to a person receiving health care".

³⁶³ Australian Council for Safety and Quality in Health Care, "Safety in Numbers" Attachment to *Safety in Practice—Making Health Care Safer, Second Report to the Australian Health Ministers' Conference*, 1 August 2001. p. 16.

³⁶⁴ Australian Council for Safety and Quality in Health Care, "Safety in Numbers" Attachment to *Safety in Practice—Making Health Care Safer, Second Report to the Australian Health Ministers' Conference*, 1 August 2001 .p. 17.

³⁶⁵ Ibrahim, J.E., McMillan, N., Grech, C., Bugeja, L., Ranson, D.L. *The role of the Coronial process in initiatives for improving patient safety and quality of health care: Final report of a consultancy into the Coronial Death Investigation Process in Australia—its role in reviewing the safety and quality of health care provision*, 2003, Report submitted to the Australian Council for Safety and Quality in Health Care, Commonwealth Dept of Health and Ageing, Canberra. (Confidential Report).

³⁶⁶ Ibrahim, JE; *The Coroner, Safety and Health Care: Integrating the Coroner's investigation process into initiatives for improving safety and quality in health care* (Paper presented at the First Australian Conference on Safety and Quality in Health Care: Safety and Quality in Action, Perth, Western Australia, 16 July 2003). Available at http://www.aaqhc.org.au/pdf/resources/2003_ibrahim.pdf

³⁶⁷ Ibrahim, JE; *The Coroner, Safety and Health Care: Integrating the Coroner's investigation process into initiatives for improving safety and quality in health care*. Above note 365. p. 30.

³⁶⁸ Ibrahim, JE; *The Coroner, Safety and Health Care: Integrating the Coroner's investigation process into initiatives for improving safety and quality in health care*. Above note 365.

- improvements to administrative and legislative arrangements for information sharing between coroners, health departments and health care professionals; and
- changes to the Coroner's investigation process to ensure a consistent approach to reporting, investigating, communicating and following up recommendations.³⁶⁹

Case Study: Coroner's current role in preventing hospital deaths

A coronial finding from 2003 illustrates the Coroner's role in investigating and preventing further deaths.³⁷⁰

Coronial Finding and Recommendations: Case No. 2116/00

A patient was admitted to a Victorian hospital where she received a liver transplant. Although she was quite ill, the patient was improving following complications from the surgery and was about to be transferred from the Intensive Care Unit (ICU). The consulting doctor in the ICU noted that the patient had an infection and the liver transplant team requested that a catheter³⁷¹ in the patient's chest be changed in case the catheter was responsible for the infection. The patient was transferred to another ward and the catheter was replaced.

The next day, a radiologist took an x-ray of the patient's chest. However, the x-ray was never examined as the patient had been transferred from the ICU and the x-ray was still filed at the ICU.

Another specialist took responsibility for the patient's care and gave instructions that the catheter again be replaced. A junior doctor performed the catheter exchange. The senior supervising doctor advised that as the procedure was "uneventful", there was no need to check the positioning of the catheter with an x-ray. This was contrary to the unwritten hospital procedure and the catheter manufacturer's instructions.

The patient later died from cardio-respiratory arrest. A doctor certified that a factor in the cause of death was "unknown" yet the death was not initially reported to the Coroner.

³⁶⁹ Ibrahim, JE; *The Coroner, Safety and Health Care: Integrating the Coroner's investigation process into initiatives for improving safety and quality in health care*. Above note 365.

³⁷⁰ *Findings in relation to a death in 2000: Case No.: 2116/00*, State Coroner's Office, 18 March 2003. Available at www.coronerscourt.vic.gov.au.

³⁷¹ A catheter is a hollow tube which is inserted into a cavity via a narrow canal to discharge fluid from the cavity: *Blakiston's Gould Medical Dictionary*, Fourth Edition, p. 236.

The State Coroner later found that the patient had died from cardio-respiratory arrest which occurred after her heart was compressed as a result of the perforation of her heart following a catheter exchange.³⁷² He commented that the patient's death was "potentially preventable" had the hospital procedures been followed and a check x-ray been performed shortly after the catheter was exchanged.

In order to prevent future deaths, the State Coroner noted that all Victorian hospitals should be notified of the case and their attention drawn to the consequences of the failure to follow a manufacturer's instructions or hospital procedures. He recommended that the hospital should have written procedures which ensure that after a catheter is moved, an x-ray or fluoroscopy should be routinely and promptly performed to confirm that the catheter was in a satisfactory position.

The State Coroner further recommended that the hospital develop procedures relating to the checking of x-rays to avoid system errors as happened in this case. He also made the comment that where a cause of death is unknown or there is some uncertainty about how a patient died, the medical profession should report the matter to the Coroner.

Obstacles to improving patient safety

In his report, Dr Ibrahim noted the issue of possible under-reporting of deaths to the Coroner.³⁷³ The Committee notes with some concern that if a reportable death is not reported to a coroner, it may affect a coroner's ability to contribute to reducing the incidence of preventable deaths.

The issue of under-reporting was discussed in chapter two where the Committee asks readers for their views on how this potential problem can be addressed.³⁷⁴

Alternative Systems

The Committee examined relevant jurisdictions to consider whether there were any existing or proposed systems for implementing coronial recommendations. The system in Ontario and a model proposed in the review of Queensland Coronial law, based on the Ontario system, were identified by the Committee as possible alternative systems to consider in this paper.

³⁷² The actual finding expressed in medical terms was "1(a) Cardio-respiratory arrest 1(b) Cardiac Tamponade as a result of perforation of the heart following central venous catheterization.

³⁷³ Ibrahim, JE; *The Coroner, Safety and Health Care: Integrating the Coroner's investigation process into initiatives for improving safety and quality in health care*. Above note 365.

³⁷⁴ See p. 14.

The Ontario system

This system operates in such a way that organisations which have been the subject of recommendations enter into coronial agreements with the Coroner which stipulate the measures required to be taken to avoid future deaths.³⁷⁵ The agreements are public documents which are monitored for compliance, although there is no actual penalty for non-compliance. If, at a later stage another similar death occurs, the death will usually involve a public inquiry at which the organisation is required to account for why the person died.

The system proposed in the Queensland review

In the 1998 review prepared for the Queensland Indigenous Advisory Council, a similar system was proposed.³⁷⁶ 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 to be held.

Question 29—The Coroner’s role in death and injury prevention

- (a) How effective do you think the current system is in preventing death and injury?
- (b) Do you think that the preventative role of the Coroner should be expanded in any way? Should the preventative role of a coroner be a specific function of the Act?
- (c) Should the Act require a mandatory response to certain coronial recommendations? Should the State Government be required to provide a written response to certain Coronial recommendations within a specified time-frame? Should responses to recommendations be required to be tabled in Parliament?

³⁷⁵ Jarred, W, *The Coroners Bill 2002: Highlighting the important role of coroners in Accident Prevention*, Queensland Parliamentary Library, 2003., p. 4-5.

³⁷⁶ Malbon, J, Airo-Farulla, G, and Banks, C., *Review of Queensland Coronial Law —Final Report*; Department of Families Youth and Community Care, 1997. p. 9.

- (d) Should anyone be responsible for monitoring the implementation of coroner's recommendations? Who do you think should be responsible?
- (e) What are your views on alternative systems such as the Ontario system? Do you think this kind of system would be effective in Victoria?

Question 30—The Coroner's role in improving safety in the health care system

- (a) Do you think that the Coroner's current role allows an appropriate level of involvement in improving general patient safety in the Victorian health care system?
- (b) In your experience, are there any obstacles or issues preventing a coroner from fulfilling this role?
- (c) What strategies or system improvements could be implemented to overcome these obstacles?

CHAPTER SIX — INCLUDING THE FAMILY IN THE CORONER'S PROCESS

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.³⁷⁷

In this chapter, the Committee examines what rights the Act provides to the family of the person whose death is subject to a coronial investigation or inquest. By way of comparison, the Committee considers the position in other relevant jurisdictions. The Committee also examines the recommendations of relevant law reform agencies which have recommended changes to the legislation.

The Committee begins the chapter with a preliminary discussion on the needs of a family involved in the coronial process, before considering in detail, the rights which are provided to family members under the Act.

Needs of the community

The terms of reference require the Committee to consider whether the Act should be amended to better meet the needs of the community. At this early stage of the inquiry, the Committee has 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.

The Committee recognises that there may be issues which have been overlooked and therefore welcomes submissions on other needs which may not have been identified in this chapter.

³⁷⁷Glasscock., G, "Coping with Grief" in H Selby (Ed), *The Aftermath of Death*. Above note 222. p. 192.

Question 31—Needs of the community

- (a) In general terms, what do you identify as the needs of a member of the community who is involved in the coronial process following the death of a family member or friend?
- (b) Do you think that the *Coroners Act* is able to accommodate those needs? Are there any resource issues to consider?

Definition of “Family”

The Act gives certain rights to a family member considered to be the “senior next of kin”.³⁷⁸ Where the person who died had a spouse or partner, then this family member is considered the senior next of kin. “Partner” includes a same sex partner.³⁷⁹

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.

If the person who died did not have any adult children (or if all of the children were not available), then the senior next of kin is a parent of the person who died.

If a parent is not available, then the senior next of kin is an adult sibling. Where none of these people are 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.

Other Australian jurisdictions

The definition of “senior next of kin” in most jurisdictions is similar to the Victorian definition. The Tasmanian, ACT, Northern Territory and Queensland legislation however, also recognises Indigenous familial relationships.³⁸⁰

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.³⁸¹

In the ACT, the legislation gives certain rights to the “immediate family” which is defined as:

³⁷⁸ *Coroners Act* (1985) s. 29(5).

³⁷⁹ *Coroners Act* (1985) s. 3: Definition of “domestic partner”.

³⁸⁰ *Coroners Act* (TAS) s. 3: Definition of senior next of kin, *Coroners Act* (ACT)(1997) s. 3: Definition of “immediate family member”, *Coroners Act* (NT)(1993) s. 3: Definition of senior next of kin, *Coroners Act* (QLD)(2003) schedule 2: Definition of “ATSI family member”.

³⁸¹ *Coroners Act* (NSW) (1980) s. 4: Definition of “spouse”.

- (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.³⁸²

The Committee is interested in your views on the definition of “senior next of kin” and what rights that person should have. This will be considered in the next section of this chapter along with the issues of the rights of family members.

Rights of family members under the Act

The Committee recognises that staff at the Coroner's office and VIFM currently undertake an important role in communicating information to family members. For example, they have published an information booklet for family and friends on the Coroner's process.³⁸³

The booklet gives practical information such as that the Coroner's office will notify the contact family member (as well as any person listed on the file as an “interested party”) well in advance of the inquest.³⁸⁴ The booklet also informs family members of the right to object to an autopsy.³⁸⁵

Right to be informed

Under the Act the family of a 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.³⁸⁶

³⁸² *Coroners Act (ACT)(1997)* s. 3.

³⁸³ State Coroner's Office and Victorian Institute of Forensic Medicine, *When a Person Dies—The Coroner's Process*, 1999.

³⁸⁴ State Coroner's Office and Victorian Institute of Forensic Medicine, *When a Person Dies—The Coroner's Process*, p. 12.

³⁸⁵ State Coroner's Office and Victorian Institute of Forensic Medicine, *When a Person Dies—The Coroner's Process*, p. 15.

³⁸⁶ “Senior next of kin” is defined in s. 29(5). The Committee discusses the issue of autopsy later in the chapter.

In Western Australia however, the Coroner must provide the following information to the next of kin:

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.³⁸⁷

³⁸⁷ *Coroners Act (WA)(1996)* s. 20.

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 on-going advice concerning the coronial process.³⁸⁸

Question 32—Right to be informed

- (a) Should the Act give family members the right to be informed or to be kept informed of certain events in relation to the inquiry?
- (b) Should the Act define the term “family member”? Who should be included in the definition?
- (c) Who should be required to inform the family? Should anyone be responsible for ensuring that this occurs?
- (d) Are there any resource issues to consider?

Right to view or touch the body

A coroner has control over the body of a person who has died,³⁸⁹ yet under the Act, family members do not have the right to view or touch the body until the Coroner releases the body for the burial or cremation. For some communities, such as Pacific Islanders, it is important for relatives to be able to touch the body of the person who has died.³⁹⁰ When a person dies in custody, it may also be important for some members of the family of the person who died to view the body or have their own doctor or representative view the body before an autopsy is performed.

Other Australian 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 Western Australia, the next of kin may view the body while it is under the control of the Coroner.³⁹¹ They may also touch the body, unless the Coroner determines that it is undesirable or dangerous to do so.³⁹²

³⁸⁸ Law Commission of New Zealand, *Coroners*, Report no. 62, 2000, p. 76.

³⁸⁹ *Coroners Act* (1985); s. 24: Control is subject to directions of the State Coroner and ends when the Coroner issues a certificate permitting burial or cremation.

³⁹⁰ Vines, Prue, “Objections to post-mortem examination: Multiculturalism, Psychology and Legal decision making” *Journal of Law and Medicine*, Vol 7, May 2000, p. 42.

³⁹¹ *Coroners Act* (WA)(1996); s. 20(1)(f).

The Queensland Guidelines advise coroners that the family should be provided with an opportunity to view the body “if possible”.³⁹³

In the ACT, immediate family members or representatives involved in an inquest may make a request to the Coroner to view the body.³⁹⁴ If the person died in custody, the family may view the body unless the Coroner believes, on reasonable grounds that it would not be in the interests of justice.³⁹⁵

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 any autopsy is performed.³⁹⁶

The Royal Commission into Aboriginal Deaths in Custody (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.³⁹⁷

Question 33—Touching and viewing the body of the person who has died

- (a) Should the Act specifically give the family of the person who has died the option of viewing and touching the body while the body is under the control of the Coroner?
- (b) Should there be any limit to this right?

Right to inspect the scene of death

In Victoria, the Act does not give a coroner the specific power to restrict access to the place where a death occurred. The Act does, however, give the Coroner this power in

³⁹² *Coroners Act* (WA)(1996); s. 20(1)(c).

³⁹³ *State Coroner’s Guidelines—Version 0 December 2003*. Paragraph 3.4.1. Available at <http://www.justice.qld.gov.au/courts/coroner/pdfs/guidelines.pdf>

³⁹⁴ *Coroners Act* (ACT) (1997) s. 23(1)(a).

³⁹⁵ *Coroners Act* (ACT) (1997) s. 70(1)(a).

³⁹⁶ Law Commission of New Zealand, *Coroners*, Report no. 62, 2000, p. 89. A new Coroners Bill was introduced into the New Zealand Parliament in 2004 which proposes to permit the viewing, touching and remaining near the body, when authorised by the Coroner.

³⁹⁷ Royal Commission into Aboriginal Deaths in Custody, *National Report Volume 1* 1991. Recommendation 25. As an aid to readers, the recommendations relating to coroners inquests are listed in Appendix 1 to this Discussion Paper. A review of all the recommendations is currently being conducted on behalf of the Victorian Aboriginal Justice Forum by the Victorian Implementation Review at the Department of Justice.

relation to the investigation of a fire—a coroner may restrict access to the place where a fire occurred.³⁹⁸

Unlike Victoria, in Queensland and the ACT, where a coroner has the power to restrict access to a place where a death has occurred, the immediate family may, in certain circumstances, inspect the scene of the death.³⁹⁹

In Queensland, the Coroner's guidelines advise that the power to restrict access should be exercised sparingly but, that forensic examination of suspected crime scenes should be given priority.⁴⁰⁰

Question 34—Access to the scene of death

- (a) Should the Act give a coroner the specific power to restrict access to the place where a death occurred?
- (b) Should the Act give the immediate family of the person who has died the right to access the place where the death occurred?
- (c) Should there be any limit to this right?

Right to access information considered by 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”.⁴⁰¹ The Act does not specify at what time a coroner is required to make this information available.

Before an inquest, the police collect all the information for the Coroner in what is called the “brief”.⁴⁰² This contains copies of witness written statements, police statements, medical files, the autopsy report (if an autopsy has been performed), photos and any other material which may be an exhibit at the inquest.⁴⁰³

³⁹⁸ *Coroners Act* (1985) s. 40(1).

³⁹⁹ *Coroners Act* (ACT)(1997) s. 23(1)(b); s.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).

⁴⁰⁰ *State Coroner's Guidelines—Version 0 December 2003*. Paragraph 3.4.2. Available at <http://www.justice.qld.gov.au/courts/coroner/pdfs/guidelines.pdf>

⁴⁰¹ *Coroners Act* (1985) s. 45(1).

⁴⁰² State Coroner's Office and Victorian Institute of Forensic Medicine, *When a Person Dies—The Coroner's Process*, 1999. p. 18.

⁴⁰³ State Coroner's Office and Victorian Institute of Forensic Medicine, *When a Person Dies—The Coroner's Process*, 1999. p. 18.

According to the Coroner's Office, a coroner will grant access to information in the police brief to any family member or other person who is an interested party.⁴⁰⁴

Other Australian jurisdictions

Like 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.⁴⁰⁵

In Queensland the 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.⁴⁰⁶

Question 35—Accessing information

- (a) Are there any issues or concerns regarding the requirement in the Act that a coroner may make available any statements that the Coroner intends to consider at an inquest to “any person with a sufficient interest”?
- (b) Should the Act specify that family members should be able to access statements and other information as soon as it becomes available?
- (c) Should the Act place any restriction on the right to access certain sensitive documents such as medical files? Who, in your opinion should not have access to this information?

Notification of inquest

The Act does not require that the family be notified of an investigation or that an inquest will take place.

⁴⁰⁴ State Coroner's Office and Victorian Institute of Forensic Medicine, *When a Person Dies—The Coroner's Process*, 1999. p. 18.

⁴⁰⁵ *Coroners Act* (ACT)(1997) s. 51, *Coroners Act* (WA)(1997) s. 42; *Coroners Act* (Tas)(1995) s. 52; *Coroners Act* (NT) (1993) s. 40(2).

⁴⁰⁶ *State Coroner's Guidelines—Version 0 December 2003*. Paragraph 3.2.3. Available at <http://www.justice.qld.gov.au/courts/coroner/pdfs/guidelines.pdf>

Other Australian jurisdictions

The ACT is the only Australian jurisdiction where 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.

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.⁴⁰⁷

In relation to a death in custody in the ACT, the legislation prohibits a coroner from conducting an inquest unless he or she 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.⁴⁰⁸

Law Reform Agencies

In relation to deaths in custody, 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.⁴⁰⁹

⁴⁰⁷ *Coroners Act (ACT) (1997) s. 37.*

⁴⁰⁸ *Coroners Act (ACT) (1997) s. 69.*

⁴⁰⁹ Royal Commission into Aboriginal Deaths in Custody, *National Report Volume 1 1991*. Recommendation 21.

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 by a representative.⁴¹⁰

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 and/or from lawyers representing the family.⁴¹¹

Question 36—Notification of Inquest

- (a) Should the Act require that before an inquest may be held, a coroner must consider:
- whether a member of the immediate family has been notified of the time and place of the hearing; or
 - if a member of the immediate family has not been notified of the time and place of the hearing—whether reasonable efforts have been made to do so?
- (b) Should the Act require a coroner to have regard to the recommendations made by the Royal Commission into Aboriginal Deaths in Custody relating to notifying immediate family members regarding the inquest?

Autopsies

If a coroner reasonably believes that an autopsy is necessary for an investigation of a death, the Coroner may direct that an autopsy be performed.⁴¹²

An autopsy is a detailed physical examination of a person's body after death.⁴¹³ It may include blood tests and x-rays, as well as 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.⁴¹⁴

⁴¹⁰ Royal Commission into Aboriginal Deaths in Custody, *National Report Volume 1* 1991. Recommendation 22.

⁴¹¹ Royal Commission into Aboriginal Deaths in Custody, *National Report Volume 1* 1991. Recommendation 22.

⁴¹² *Coroners Act* (1985) s. 27(1).

⁴¹³ State Coroner's Office and Victorian Institute of Forensic Medicine, *When a Person Dies—The Coroner's Process*; p. 13. An Autopsy is sometimes also referred to as a post mortem.

⁴¹⁴ Ranson, D., "The Autopsy" in H. Selby (ed), *The Inquest Handbook*; Above note 222, p. 108. This chapter also provides detailed information on the medical procedures involved in the internal examination.

Some members of the community have particular cultural or religious prohibitions about autopsies, including Orthodox Jews, Orthodox Christians and Indigenous people.⁴¹⁵

Objections to autopsy

A "senior next of kin"⁴¹⁶ may ask a coroner not to direct that an autopsy be performed. But, in order to object, this person must be informed that

- an autopsy will take place; and
- he or she has a right to object to the autopsy.

The Act however, does not require a coroner to give this information to the 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.⁴¹⁷

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.⁴¹⁸

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.

Two Supreme Court of Victoria decisions provide examples of situations in which the Court has determined that no autopsy 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 Johnstone⁴¹⁹

The senior next of kin was an Aboriginal man whose ten day old baby had died. The police determined that there were no suspicious circumstances involved with the

⁴¹⁵ Vines, Prue, "Objections to post-mortem examination: Multiculturalism, Psychology and Legal decision making". Above note 390, p. 424.

⁴¹⁶ This is discussed in the first section of this chapter.

⁴¹⁷ *Coroners Act* (1985) s. 29(1).

⁴¹⁸ *Coroners Act* (1985) s. 29(3).

⁴¹⁹ *Green v Johnstone* [1995] 2 VR 176

baby's death. One possibility was that the baby died from SIDS.⁴²⁰ 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.

Horvath v State Coroner of Victoria⁴²¹

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 their 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 decent burial 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 element. 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.⁴²²

⁴²⁰ Sudden Infant Death Syndrome.

⁴²¹ *Horvath v State Coroner of Victoria* Supreme Court of Victoria, (Unreported, Morris J, 11 October 2004).

⁴²² It should be noted that the Court did not consider that by making the costs order that the Coroner was wrong in concluding that there should be an autopsy.

Position in other Australian jurisdictions

In most jurisdictions, coronial legislation permits a senior next of kin to object to the direction that an autopsy take place.⁴²³ 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.⁴²⁴ Under the legislation, a coroner must take account of the concerns raised by the family member, wherever practicable. The relevant section is set out below.

- (4) Before ordering an internal examination of the body, the coroner must, whenever practicable, consider at least the following--
- (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.⁴²⁵

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* (QLD) (1990).

In New South Wales, unlike Victoria, persons other than the senior next of kin may also object to an autopsy.⁴²⁶

Law Reform Agencies

In the Report of RCDAC, the Commission stated:

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

⁴²³ *Coroners Act* (NSW)(1980) s. 48A(1), s. 48(2); *Coroners Act* (NT)(1993) s. 23(1); *Coroners Act* (TAS)(1995) s. 38(1), *Coroners Act* (WA)(1996) s. 37(1).

⁴²⁴ *State Coroner's Guidelines—Version 0 December 2003*. Paragraph 5.8. Available at <http://www.justice.qld.gov.au/courts/coroner/pdfs/guidelines.pdf>

⁴²⁵ *Coroners Act* (QLD)(2003) s. 19(4).

⁴²⁶ *Coroners Act* (NSW)(1980) s. 48B.

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.⁴²⁷

RCADC recommended that to resolve difficulties, the State Coroner should consult generally with the 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.⁴²⁸

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.

For example, in Manchester, England, the local Coroner, in appropriate cases, orders magnetic resonance imaging (MRI) as part of the autopsy process.⁴²⁹ This practice was established to alleviate the concerns of members the Jewish community who view surgical autopsy as a violation of the sanctity of the body.

Another example is from New South Wales. There, a Supreme Court Judge 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.⁴³⁰

In Queensland, unlike 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
- (iii) an external and full internal examination of the body.

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.

⁴²⁷ Royal Commission into Aboriginal Deaths in Custody, *National Report Volume 1* 1991. Para 4.6.21.

⁴²⁸ Royal Commission into Aboriginal Deaths in Custody, *National Report Volume 1* 1991. Para 4.6.24.

⁴²⁹ R Biset et al, "Post-mortem examinations using MRI imaging: four year review of a working service" *BMJ* Vol. 324, 2002, p. 1423.

⁴³⁰ *Krantz v Hands*, Supreme Court of NSW, Common Law Division 10948/99 (Unreported, Wood CJ, 23 April 1999).

Question 37—Rights regarding autopsy

- (a) Should the Act require the 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 a direction that an autopsy be performed?
- (b) Should there be any circumstance in which a coroner may order an autopsy without first contacting an available senior next of kin to see if that person has any objections to the autopsy?
- (c) Should the Act permit anyone else besides the senior next of kin to object to the Coroner directing that an autopsy be performed?
- (d) Should the Act 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?
- (e) Do you think that the Supreme Court is the most appropriate appeal avenue for people wishing to object to autopsies? Are there any alternatives?

Right to be notified about retained body organs and tissues

Under the Act, a coroner may direct that “material” from an autopsy be preserved.⁴³¹ The material may be preserved for as long as it appears to bear on the cause of death.⁴³²

The Act does not require the Coroner to inform the next of kin that tissue or a body part or organ has been retained following the autopsy. Nor does the Act require a coroner to inform the next of kin how long the tissue or organ will be retained or what will happen to it at a later stage.

Position in other Australian jurisdictions

Two Australian jurisdictions address this issue in their coronial legislation. In Queensland, a detailed provision sets out the rights of the family in relation to retained body parts and tissues. The provision is set out below:

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.

⁴³¹ *Coroners Act* (1985) s. 27(2).

⁴³² *Coroners Act* (1985) s. 27(2).

(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.

(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.

In Western Australia, the legislation provides that any tissue removed during an autopsy is to be dealt with according to the Coroner's directions and any relevant guidelines.⁴³³

⁴³³ *Coroners Act (WA)(1996)* s. 34(6).

Law Reform Agencies

The Walker Report

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 into the Institute in New South Wales itself has no bearing on the actual autopsy practices in Victoria, his report made a number of recommendations which are relevant to the discussion paper.

In his report, Bret Walker SC recommended that the disposal of autopsy tissue should be regulated and that it should be either returned to the next of kin or be disposed of in a dignified way.⁴³⁴ He also recommended that the wishes of the dead person should govern the use of autopsy tissue (excluding microscopic amounts of tissue which is preserved on blocks and slides).⁴³⁵

National Code of Ethical Autopsy Practice

A National Code of Ethical Autopsy Practice was released in May 2002 by the Australian Health Ministers' Advisory Council Subcommittee on Autopsy Practice.⁴³⁶ It states that it is important to acknowledge that in coronial autopsies, the agreement of the family is not required, but wherever possible the Coroner should give regard to the family's wishes.⁴³⁷ It further states that families should be given information about the need to retain samples and the options for how to deal with tissues and organs.

Question 38—Rights to removed organs and tissues

- (a) Should the Act require coroners to inform the senior next of kin
- when tissue or a body part has been retained after the autopsy;
 - what the options are when the Coroner decides that it is no longer necessary to retain the tissue or organ?

⁴³⁴ Walker, Bret SC, *Inquiry into Matters Arising from the Post-Mortem and Anatomical Examination practices of the Institute of Forensic Medicine—Report*, August 2001. Recommendation 3, p. 96, Available at www.health.nsw.gov.au/pubs/i/forensic/pdf/pmreport.pdf

⁴³⁵ Walker, Bret SC, *Inquiry into Matters Arising from the Post-Mortem and Anatomical Examination Practices of the Institute of Forensic Medicine—Report*, August 2001., Above note 434; Recommendation 5, p. 96

⁴³⁶ 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

⁴³⁷ Australian Health Ministers' Advisory Council Subcommittee on Autopsy practice, *A National Code of Ethical Autopsy Practice* above note 436, p. 13.

- (b) What options should the family have when the Coroner no longer requires the tissue or the organ?

Right to Autopsy

Under the Act, if a coroner has jurisdiction to investigate the death, a person may also request that a coroner direct that an autopsy be performed on the body.⁴³⁸ If the Coroner refuses the request, the person has the right to appeal to the Supreme Court.⁴³⁹

The Act does not give the senior next of kin the right to request that a second autopsy be performed or the right to be present or have a representative attend an autopsy.

Other Australian jurisdictions

In Western Australia, a coroner must allow a doctor chosen by the senior next of kin to attend the autopsy and must ensure that the doctor is informed of the details of where and when the autopsy is to take place.⁴⁴⁰

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.⁴⁴¹ However, the Coroner must, wherever practicable, consult with and consider the views of the family members.⁴⁴²

Law Reform Agencies

RCADC recommended that in relation to deaths in custody, the family should have a 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.⁴⁴³

Question 39—Rights to observe and attend autopsy

- (a) Should the Act allow a family member or their representative to attend the autopsy?
- (b) Should the Act permit the family to request that a second autopsy be carried out?

⁴³⁸ *Coroners Act* (1985) s. 28(1).

⁴³⁹ *Coroners Act* (1985) s. 28(2)-(4).

⁴⁴⁰ *Coroners Act* (WA) (1996) s. 35.

⁴⁴¹ *Coroners Act* (QLD)(2003) s. 21(1).

⁴⁴² *Coroners Act* (QLD)(2003) s. 21(2).

⁴⁴³ Commission into Aboriginal Deaths in Custody, *National Report Volume 1* 1991. Recommendation 25.

Release of the body

A coroner investigating a death must issue as soon as reasonably possible, a certificate permitting burial or cremation.⁴⁴⁴

Question 40—Release of the body

Are there any issues or concerns with the operation of the requirement in the Act that a coroner investigating a death must issue as soon as reasonably possible, a certificate permitting burial or cremation?

Exhumation

The State Coroner may order that a body be exhumed if he or she reasonably believes that it is necessary for the investigation of a death.⁴⁴⁵ 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.⁴⁴⁶ The right of appeal is to the Supreme Court.⁴⁴⁷

Question 41—Exhumation

Are there any issues or concerns in relation to the requirement in the Act which permits the State Coroner to order that a body be exhumed if he or she reasonably believes that it is necessary for the investigation of a death?

Right to legal representation

As discussed in chapter three, a person with a sufficient interest may appear or be represented by a lawyer.⁴⁴⁸ The Committee acknowledges that many families may be unrepresented at an inquest because they are unable to afford legal representation or obtain Legal Aid.

Law Reform Agencies

RCADC made the following comment in the 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.⁴⁴⁹

⁴⁴⁴ *Coroners Act* (1985) s. 23.

⁴⁴⁵ *Coroners Act* (1985) s. 30(1).

⁴⁴⁶ *Coroners Act* (1985) s. 30(2).

⁴⁴⁷ *Coroners Act* (1985) s. 30(4).

⁴⁴⁸ *Coroners Act* (1985) s. 45(3).

⁴⁴⁹ Royal Commission into Aboriginal Deaths in Custody, *National Report Volume 1* 1991, para 4.6.45.

In relation to deaths in custody, 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.

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 Health Service] Trust is represented by a barrister or solicitor paid for from the NHS budget but the family is on its own.⁴⁵⁰

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.⁴⁵¹

Question 42—Right to legal representation

Do you have any issues or concerns in relation to the right to legal representation at an inquest?

Counselling

The Counselling and Support Service at the State 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 free call telephone number.

While the State Coroner's brochure on the Coroner's process provides useful information about the Counselling and Support Service, the Act does not require that family members be informed about the service. Unlike Victoria and the other Australian jurisdictions, in Western Australia, next of kin must be informed that a counselling service is available.⁴⁵²

Question 43—Counselling Support Service

Should the Act require the State Coroner's Office to inform family members about the availability of the free counselling service?

⁴⁵⁰ United Kingdom, *Death Certification and Investigation in England, Wales and Northern Ireland: The Report of a Fundamental Review*, Above note 73; p. 147.

⁴⁵¹ United Kingdom, *Death Certification and Investigation in England, Wales and Northern Ireland: The Report of a Fundamental Review*, Above note 73; p. 148.

⁴⁵² *Coroners Act (WA)(1996)* s. 20(1)(j).

Your experience in the Coronial System

While the preceding discussion focuses on what rights should be specifically included in the Act, the Committee also wishes to hear about the experiences of family, friends and witnesses who have been involved in a coronial process. Without listening to these experiences, this inquiry would be very much incomplete. It is important to remember however that the scope of the inquiry is limited by the terms of reference which direct the Committee to consider an appropriate legislative framework. The Committee cannot investigate individual cases, or make findings about the conduct of cases. Rather it is interested in hearing about matters which could inform its general recommendations about the *Coroners Act*.

Question 44—Other issues and your experience

Are there any issues relating to your experiences in the Coronial system that you would like to discuss?

The Role of the Coronial System today

The primary purpose of the current Act is to provide a legislative framework for the reporting and investigation of notifiable deaths and fires. Accommodating the needs of the family in the coronial process is not currently identified as a specific function of the Act. A question the Committee would like to consider is whether accommodating the needs of families should be a specific function of the Act.

Question 45—Functions of the Coroners Act

Should accommodating the needs of families be a specific function of the Act?

SELECT BIBLIOGRAPHY

Legislation

Australian State and Territory legislation and some case law referred to in this discussion paper is available from the links at:

www.comlaw.gov.au/comlaw/comlaw.nsf/preview/othersitelinks

Acts referred to in this paper are as at 1 January 2005 unless otherwise identified.

Australian Coroners Legislation

Coroners Act (Australian Capital Territory) 1997.

Coroners Act (New South Wales) 1980.

Coroners Act (Northern Territory) 1993.

Coroners Act (Queensland) 2003.

Coroners Act (South Australia) 2003 [*Commences on 31/07/05 unless proclaimed sooner*].

Coroners Act (Tasmania) 1995.

Coroners Act (Victoria) 1985.

Coroners Act (Western Australia) 1996.

Case Law

Anderson v Blashki [1993] 2 VR 89.

Annetts v McCann (1990) 97 ALR 177.

Chief Commissioner of Police v Hallenstein [1996] 2 VR 1.

Clancy v West [1996] 2 VR 674.

Domaszewicz v The State Coroner, Supreme Court of Victoria, (Unreported, Ashley J, 17 December 2004).

Grace v Saines (in his capacity as Coroner), Supreme Court of Victoria, (Unreported, Williams J, 29 June 2004).

Green v Johnstone [1995] 2 VR 176.

Harmsworth v State Coroner [1989] VR 989.

Horvath v State Coroner of Victoria, Supreme Court of Victoria, (Unreported, Morris J, 11 October 2004).

Krantz v Hands, Supreme Court of NSW, (Unreported, Wood CJ, 23 April 1999).

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, JJ.A; 14 December 1999).

Munro v West, Supreme Court of Victoria, (Unreported, Smith J, 7 February 1997).

Re O'Callaghan (1899) 24 VLR 957.

R v The Coroner; Ex parte Alexander [1982] VR 731.

Reports and Discussion Papers

Ireland, Department of Justice, *Report of the Coroners Rules Committee*, 2003.

Law Commission of New Zealand, *Coroners*, Report no. 62, 2000.

Malbon, J, Airo-Farulla, G, and Banks, C., *Review of Queensland Coronial Laws—Final Report*; Department of Families Youth and Community Care, 1997.

Norris J QC, *The Coroners Act 1958—A General Review*, Victorian Government Printer, 1980.

Ontario Law Reform Commission, *Report on the Law of Coroners*, 1995.

Royal Commission into Aboriginal Deaths in Custody, *National Report*, Volume 1 1991.

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*, Cm 5854, 2003).

United Kingdom, *Reforming the Coroner and Death Certification Service*, Cm 6159, 2004.

United Kingdom, *Safeguarding Patients: Lessons from the Past—Proposals for the Future*, Cm 6394, 2004.

United Kingdom, *Shipman: The Final Report*, January 2005.

Walker, Bret SC, *Inquiry into Matters Arising from the Post-Mortem and Anatomical Examination practices of the Institute of Forensic Medicine at Glebe, New South Wales—Report*, August 2001.

Journal Articles

Biset, R, et al, "Post-mortem examinations using MRI imaging: four year review of a working service" *BMJ*, Vol. 324, 2002, 1423.

Hallenstein, H, *Suicide: the Coroner as Catalyst*, (Paper presented at AIC Conference No.13, July 1990, 177.

Halstead, B, "Coroners' Recommendations and the Prevention of Deaths in Custody: A Victorian Case Study", *Deaths in Custody, Australia*, no. 10., Australian Institute of Criminology, 1995.

Jarred, W, *The Coroners Bill 2002: Highlighting the important role of coroners in Accident Prevention*, Queensland Parliamentary Library, 2003.

Kinnell, H, "Serial Homicide by Doctors: Shipman in Perspective", *British Medical Journal*, Vol. 321, December 2000, 1594-1596.

Lynch, M, "Natural Disease and the Coroner", *Journal of Law and Medicine*, Vol. 7, May 2000, 345-350.

Ranson, D, "How effective? How efficient?—The Coroner's role in medical treatment related deaths", *Alternative Law Journal*, Vol. 23, No. 6, December 1998, 284-287.

Ranson, D, "Multiple Child Deaths: A New Direction in Death Notification" (2004) 12 *Journal of Law and Medicine*, 156-160.

Vines, Prue, "Objections to post-mortem examination: Multiculturalism, Psychology and Legal decision making", *Journal of Law and Medicine*, Vol 7, May 2000, 422-433.

Weeramanthri, T, and Beresford, B, "Death Certification in Western Australia—Classification of major errors in certificate completion", *Australian Journal of Public Health*, Vol. 16, no. 4, 431-434.

Books and on line services

Brumley, D, *Death Certification by Doctors in Non-Metropolitan Victoria*, M. Sc (Primary Health Care) Thesis, Flinders University of South Australia, 1995.

Butterworths Concise Australian Legal Dictionary, 2nd edition, 1998.

Butterworths, *Halsbury's Laws of Australia*, Vol. 115 at 16 February 2005, "Coroners".

Fitzroy Legal Service Inc. *The Law Handbook*, 2003 Edition.

Matthews, P, *Jervis on Coroners*, 12th Edition, 2002.

Selby, H (ed), *The Aftermath of Death*, 1992.

Selby, H (ed), *The Inquest Handbook*, 1998.

APPENDIX 1— ROYAL COMMISSION INTO ABORIGINAL DEATHS IN CUSTODY— RECOMMENDATIONS RELATING TO CORONIAL INQUIRIES

Recommendation 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.

Recommendation 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 Coroner so specially designated.)

Recommendation 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.

Recommendation 9:

That a Coroner inquiring into a death in custody be a Stipendiary Magistrate or a more senior judicial officer.

Recommendation 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.

Recommendation 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.

Recommendation 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.

Recommendation 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.

Recommendation 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.

Recommendation 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.

Recommendation 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.

Recommendation 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.

Recommendation 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.

Recommendation 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.

Recommendation 20:

That the appropriate Aboriginal Legal Service be notified immediately of any Aboriginal death in custody.

Recommendation 21:

That the deceased's family or other nominated person and the Aboriginal Legal Service be advised as soon as possible and, in any event, in adequate time, as to the date and time of the coronial inquest.

Recommendation 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.

Recommendation 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.

Recommendation 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.

Recommendation 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.

Recommendation 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.

Recommendation 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.

Recommendation 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.

Recommendation 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.

Recommendation 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.

Recommendation 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.

Recommendation 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.

Recommendation 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.

Recommendation 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.

Recommendation 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 watchhouses 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.

Recommendation 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.

Recommendation 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.

Recommendation 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.

Recommendation 39:

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 custody.

Recommendation 40:

That Coroners Offices in all States and Territories establish and maintain a uniform data base 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.

APPENDIX 2—CORONER’S PRACTICE DIRECTIONS

Guidelines for Expert Witnesses in investigations and proceedings in the State Coroner's Office

A copy of these guidelines will be provided to any expert engaged by the Coroner for the purpose of an investigation (including an inquest). Legal Practitioners should also give a copy of the guidelines to any expert they propose to retain for the purpose of giving a report and, possibly, giving evidence in an inquest. These guidelines are not intended to address all aspects of an expert's responsibilities.

Graeme Johnstone

State Coroner

1st June 2003

Guidelines

General Duty to the Coroner

An expert witness has an overriding duty to assist the Coroner on matters relevant to the expert's area of expertise.

An expert witness is not an advocate for a party.

An expert witness's paramount duty is to the Coroner and not to the person retaining the expert.

If an interested party intends to apply to call expert evidence, the application will not be considered before a written statement by the proposed witness has been received by the coroner. The statement must be provided to the coroner and all interested parties (or their legal representatives) at least 14 days prior to the date fixed for the hearing of the inquest.

Conflict of interest

Where an expert witness considers there may be a conflict of interest or potential conflict of interest the expert should immediately advise the Coroner (or the party engaging the expert).

Any conflict (or perceived conflict) should be noted in the expert witness's report, in sufficient detail to explain the circumstances.

The Form of the Expert Evidence

An expert's written report must give details of the expert's qualifications, and of the literature or other material used in making the report.

All assumptions made by the expert should be clearly and fully stated.

The report should identify who carried out any tests or experiments upon which the expert relied in compiling the report, and give details of the qualifications of the person who carried out any such test or experiment.

Where several opinions are provided in the report, the expert should summarise them.

The expert should give reasons for each opinion.

At the end of the report the expert should declare that "[the expert] has made all the inquiries which [the expert] believes are desirable and appropriate and that no matters of significance which [the expert] regards as relevant have, to [the expert's] knowledge, been withheld from the Coroner."

There should be attached to the report, or summarised in it, the following:

- i. all instructions (original and supplementary and whether in writing or oral) given to the expert which define the scope of the report;
- ii. the facts, matters and assumptions upon which the report proceeds;
- iii. the documents and other materials which the expert has been instructed to consider; and
- iv. the literature and other publications the expert has considered (copies of this information should be available, where practicable, for the Coroner).

If an expert's opinion is not fully researched because the expert considers that insufficient data is available, or for any other reason, this must be stated with an indication that the opinion is no more than a provisional one. Where an expert witness

who has prepared a report believes that it may be incomplete or inaccurate without some qualification, that qualification must be stated in the report.

The expert should make it clear when a particular question or issue falls outside his or her field of expertise.

Where an expert's report refers to photographs, plans, calculations, analyses, measurements, survey reports or other extrinsic matter, these should be provided to the Coroner (and/or to the other parties where appropriate).

If an expert witness changes his or her view on a material matter, having read another expert's report, during discussion, having viewed additional factual evidence, or for any other reason, the change of view should be communicated in writing (if practicable) to each party to whom the expert's report has been provided and, when appropriate, to the Coroner.

Expert may be requested to make suggestions on systems improvements

In appropriate cases, as a result of the expert's conclusions in the report, he or she may be requested to suggest improvements in systems or make suggested recommendations for the Coroner.

This guideline applies equally to experts engaged by a party as well as for the Coroner.

Experts' Conference

Where there are multiple experts for the Coroner and/or other parties, the Coroner may request a conference of experts and an exchange of reports. The following rules should generally apply in the case of exchange of reports:

If, after exchange of reports (or at any other stage), an expert witness changes his or her view on a material matter, having read another expert's report, during discussion, having viewed additional factual evidence, or for any other reason, the change of view should be communicated in writing to each party to whom the expert's report has been provided and, when appropriate, to the Coroner.

If experts retained by the parties and the Coroner meet at the direction of the Coroner, it would not be appropriate for an expert to be given or to accept instructions not to reach agreement. If, at a meeting directed by the Coroner, the experts cannot reach agreement on matters of expert opinion, they should specify their reasons for being unable to do so.