Acknowledgements

This submission has been written thanks to the hard work of a number of people in the State Coroner's Office. My appreciation goes to Coroner Jane Hendtlass who has worked tirelessly to put the document together. Along with the help of the Principal Registrar, Rick Roberts, Jane has spent many days writing, collecting information from staff and undertaking research in order to provide both a broad and detailed picture of how the office undertakes its task.

Also the other full-time coroners, Deputy State Coroner Iain West, Coroners Audrey Jamieson and Phil Byrne, have assisted in a team approach to the development of the document along with much joint discussion, editorial advice and comment.

My thanks also goes to my Personal Assistant, Ms. Katrina Beesley, who has helped by obtaining information and assisted with the collation of the submission. Also Andrea Daglis from the Chief Magistrate’s Office and Michael Bourne from Courts Division provided written material and research.

This submission could not have been completed without the tireless work of all those staff in the State Coroner's Office who professionally deal with tragedy on a daily basis. In the broader sense, appreciation must go to Senior Sergeant Paul Hayes and the police officers at the State Coroner's Assistants Unit and Professor Stephen Cordner and the staff at the Victorian Institute of Forensic Medicine. My thanks also go to the countless individuals and other agencies who help the coroner with the task of investigation, dealing with families and others affected by the death, or with some of the positive outcomes and learning stemming from coroners' investigations.

Finally, my appreciation goes to the families and others who have come into contact with the coronial process as a result of an individual tragedy. By their letters or comments made over the years, they have helped improve and shape our office. They have also assisted in providing our organization with the impetus to develop and respond to changing needs and directions in our community. Hopefully this submission reflects some of those suggestions and will help lead to future improvements.

Graeme Johnstone  
15 August 2005

State Coroner
# Table of Contents

Acknowledgements ........................................................................................................ 3
Table of Contents ......................................................................................................... 5
Foreword ....................................................................................................................... 9
Recommendations ......................................................................................................... 13
Chapter 1 ..................................................................................................................... 13
Chapter 2 ..................................................................................................................... 18
Chapter 3 ..................................................................................................................... 19
Chapter 4 ..................................................................................................................... 19
Chapter 5 ..................................................................................................................... 19
Chapter 6 ..................................................................................................................... 23
Chapter 7 ..................................................................................................................... 23
Introduction .................................................................................................................. 25
Background .................................................................................................................. 27
Demographics .............................................................................................................. 27
  - Fig. 1 Deaths Reported in Victoria ........................................................................ 28
Geographic Differences in Death Rate ........................................................................ 29
Changes in Ethnicity of Population ............................................................................ 29
  - Fig. 2 Country of Birth of Victorian Population .................................................. 30
Funding ......................................................................................................................... 31
  - Fig. 3. Operating Budget for State Coroner's Office. ........................................... 31
The Coronial Process ..................................................................................................... 32
  - Case Initiation and Processing ............................................................................. 32
    - Fig. 4 Coroners' Involvement in the Investigation Process at the Coronial Services Centre ................................................................................. 33
Case Investigation ......................................................................................................... 34
Case Determination and Communication of Findings .................................................. 37
Other Support Services ............................................................................................... 38
Chapter 1 ..................................................................................................................... 41
Preliminary .................................................................................................................... 41
The Purpose of the Act ................................................................................................. 41
  - The Office of State Coroner ............................................................................... 43
    - Australia .......................................................................................................... 47
    - Victoria ........................................................................................................... 48
Non-fatal Fires ............................................................................................................... 51
The Coroner’s Public Safety and Preventative Role ...................................................... 52
Support for Families and Other People ....................................................................... 55
  - RECOMMENDATION 1.1a ............................................................................. 58
  - RECOMMENDATION 1.1b ............................................................................. 58
Definitions used in the Act .......................................................................................... 59
Anaesthetic .................................................................................................................... 62
  - RECOMMENDATION 1.2 ............................................................................. 63
Autopsy ......................................................................................................................... 63
  - RECOMMENDATION 1.3 ............................................................................. 64
Death ............................................................................................................................. 64
  - RECOMMENDATION 1.4 ............................................................................. 65
Disaster and terrorism events ...................................................................................... 65
Domestic partner .......................................................................................................... 68
  - RECOMMENDATION 1.5 ............................................................................. 68
Family member ............................................................................................................. 68
Inquest........................................................................................................... 69
    Fig. 5 Melbourne and Regional Cases in 2003/2004......................... 70
RECOMMENDATION 1.6 .............................................................. 70
Natural causes death ............................................................................. 70
RECOMMENDATION 1.7 .............................................................. 72
Person held in care ................................................................................. 72
    A person under the control, care or custody of the Secretary of the
    Department of Human Services......................................................... 73
    A person in the legal custody of the Secretary to the Department of
    Justice or the Chief Commissioner of Police, or in the custody of a
    member of the police force or in the custody of a protective services
    officer appointed under the Police Regulation Act 1958................. 74
    A patient in an approved mental health service within the meaning of
    the Mental Health Act 1986;............................................................. 75
    Other categories of persons held in care........................................ 76
RECOMMENDATION 1.8 .............................................................. 76
Preventable Death .................................................................................. 77
RECOMMENDATION 1.9 .............................................................. 77
Reportable Death .................................................................................... 77
    A death that appears to have been unexpected, unnatural or violent or to
    have resulted, directly or indirectly, from accident or injury .......... 79
    Death that occurs during an anaesthetic........................................ 80
    Death that occurs as a result of an anaesthetic and is not due to natural
    causes ................................................................................................. 80
    Death of a person who immediately before death was a person held in
    care..................................................................................................... 80
    Death of a person under the control or care of the Secretary to the
    Department of Justice or a member of the police force................. 80
    Other categories of reportable death.............................................. 81
        Aged care deaths ...................................................................... 81
        Occupational disease ............................................................... 81
        Reviewable deaths ................................................................... 82
RECOMMENDATION 1.10 ............................................................... 82
Senior next of kin .................................................................................. 83
RECOMMENDATION 1.11 ............................................................... 84
The effect of common law on the operation of the Act ....................... 85
RECOMMENDATION 1.12a ............................................................. 88
RECOMMENDATION 1.12b ............................................................. 89
Chapter 2 ............................................................................................... 91
Coroners ................................................................................................. 91
    The State Coroner and Deputy State Coroner................................. 91
        The increasing responsibility of the role................................. 92
        The status of the State Coroner in the community................. 93
    The State Coroner’s workload ....................................................... 95
    RECOMMENDATION 2.1 ............................................................. 97
    RECOMMENDATION 2.2 ............................................................. 97
    RECOMMENDATION 2.3 ............................................................. 97
Coroners ................................................................................................. 98
RECOMMENDATION 2.3 ............................................................... 100
Delegations ........................................................................................... 100
Foreword

This Victorian Parliamentary Law Reform Committee's review of the Coroners Act 1985 stems from a reference made by the Attorney-General. These terms of reference are supported by the State Coroner's Office.

The terms of reference for the Committee's Review of the Act are consistent with the Attorney General's commitment to review the Coroners Act 1985 to improve the Coroner's Court's capacity to contribute to accident prevention and safety strategies and ensure the needs of families and others are appropriately met. In that Statement, the Attorney General said:

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

The Office of Coroner (or Crowner) is an ancient one, stemming back in English history to nearly 800, investigating deaths and working as a tax gathering office for the King. It appears to have had role in the prevention of death from very early times with coroners making recommendations over the years on public safety.

Recently, in some jurisdictions around the world, like England, coroners' work has been under some re-consideration and scrutiny as a result of high profile cases like Shipman and the deaths of infants in the Bristol Infirmary. This scrutiny has also been occurring in places like Queensland, New Zealand, and, as far a field as Northern Ireland. The coroners' system and its value to the community is now under more scrutiny, and subject to more debate, than it ever has been in its 1200 year history.

This international attention to the work of the coroner has also prompted a fresh look at Victoria's coroners' system.

The coronial investigation system in Victoria is a unified well established process that begins when a death is reported to the State Coroner through the Initial Investigations Office and ends when a coroner determines the identity of the deceased, the time and place of death, the cause of death and the other facts required for registration of the death by the Registrar of Births Deaths and Marriages. It is the envy of many who still work in environments where coronial work is secondary to their main job or is attached to the end of a large judicial organisation.

It was not always so.

In 1984, the Second Reading Speech for the Coroners Bill stated:

"At present, regional magistrates sit as coroners as required. There is no central coordination or regulation of the performance of these functions.

It will be one of the principal responsibilities of the State Coroner to ensure that there is a coronial system in place of the existing patchwork quilt.²

In 1988, the new Coronial Services Centre was opened in Southbank in Melbourne to co-locate coronial and forensic pathology services after the new Coroners Act 1985 came into operation. An innovative system of service delivery has developed around the management of bodies and coronial investigations which has allowed coroners and forensic pathologists to perform their essential roles with mutual professional interdependence within the legal hierarchy imposed by the Act.

The State Coroner's Office mission is to:

Speak for the dead to protect the living.

Historically, the secret to this success has been long-term commitment of State Coroners Hallenstein and Johnstone and the Chief Magistrates’ continuing dedication of legally trained magistrates to full-time work as coroners at the Coronial Services Centre. The specialist nature of coronial work and the need to work in an inquisitorial, investigatory, multidisciplinary environment means it is difficult for anyone to properly commit to coronial work when it is not their main job and the mortuary, pathology and other support services are physically separated from the coroners' workplace.

In a demographic environment where the numbers of reported deaths can be expected to rise, the State Coroner’s Office believes it is important to learn from and maintain this successful strategy, while at the same time identifying areas where there is most scope for improvement.

Significantly, the Attorney General has committed himself to developing the public safety and prevention capacity of the State Coroner’s Office. In particular, he has committed the Justice Department to increasing their emphasis in his 2004 Justice Statement and he has funded the State Coroner's Clinical Liaison Service and the State Coroner's Workplace Death Investigation and Resource Unit funded by Workcover to provide for expert investigations in two socially and numerically important categories of preventable death.

In this submission, the State Coroner's Office has recommended a number of changes to the Act, which are intended to facilitate this development. These include making public safety and prevention a core purpose for the State Coroner’s Office, allowing coroners to determine whether a death was preventable and requiring the State Coroner to report annually to Parliament.

The second main thrust of this submission is intended to support this public safety and prevention role of the State Coroner’s Office by ensuring the independence and authority of the State Coroner. The State Coroner’s Office has recommended that the Parliament create a Coroner’s Court, which is consistent with public perception that it already exists. Associated with this would be a changed funding and employment environment where appointments are not restricted by the same

limitations that apply in the Magistrates’ Court and the State Coroner’s Office can support its own independent specialist investigatory and research teams.

It has become clear to the State Coroner’s Office that our third major hurdle is to find ways of delivering the coronial service enjoyed in Melbourne to communities in regional and rural Victoria. There, it seems, the Attorney General’s ‘patchwork quilt’ remains in operation despite efforts to provide training, support and backup to country coroners, coronial staff, police investigators and pathologists. Further, although from a strictly numerical point of view, the demographic statistics suggest that the expected increased death rate is likely to be mostly centralised in Melbourne, death is a very personal, cultural event and coronial services must be properly delivered at the local level.

There is already a problem with obtaining regional pathology services. Country magistrates frequently perform coronial duties and they would benefit from regular professional development courses in this jurisdiction. Police and court staff in the country are not necessarily focussed primarily on coronial investigations.

Throughout this State, deaths are under-reported to the coroner, particularly in the hospital and nursing home areas. This submission identifies the requirement to address this issue by a number of measures which need to be used in combination. The State Coroner's Office recognises the importance of encouraging reporting of deaths by a system of public and professional education. There is a recommendation for surveillance and expert audit of death certificates in the Office of the Registrar of Births, Deaths and Marriages. There is also a recommendation for independent audit of reporting of deaths to the coroner. Significantly, added to these recommendations, is a process of oversight by the State Coroner's Office with a combined system of own initiative and special purpose investigations at the direction of the State Coroner and continuation of the co-operative work that is already happening between the State Coroner's Office and that of the Registrar of Births Deaths and Marriages.

Further, there are few trained coronial support workers who can assist families and others affected by the death and the coronial process. In order to underline the importance of existing coronial support services and extending the current Melbourne service to regional areas, this submission recommends that provision of short term counselling and support services to families and others affected by the death and the coronial process becomes acknowledged in the Act.

The State Coroner and the State Coroner's Office recognises that this inquiry will point to areas that require improvement and we accept the responsibility for trying to meet this challenge. However, it will also need Government and community support and good will.
Recommendations
In this submission, the State Coroner’s Office recommends:

Chapter 1

- **RECOMMENDATION 1.1a**

  That the Parliament of Victoria amend section 1 of the *Coroners Act 1985* to include:

  The purpose of this Act is to—
  
  (a) establish a Coroners Court in Victoria;
  
  (b) require the reporting of certain deaths;
  
  (c) set out the procedures for investigations and inquests by coroners into deaths and fires;
  
  (d) help to prevent deaths or fires from similar causes happening in the future by collecting and analysing data and enabling coroners to comment and make recommendations about certain matters connected with deaths or fires, including matters related to—
  
  (i) public health or safety; or
  
  (ii) the administration of justice;
  
  (e) provide support for families, friends and others associated with a death which is the subject of a coronial investigation;
  
  (f) establish the Victorian Institute of Forensic Medicine.

  or, in the alternative,

- **RECOMMENDATION 1.1b**

  That the Parliament of Victoria amend section 1 of the *Coroners Act 1985* to include:

  The purpose of this Act is to—
  
  (a) establish the independent office of State Coroner;
  
  (b) require the reporting of certain deaths;
  
  (c) set out the procedures for independent investigations and inquests by coroners into deaths and fires;
  
  (d) help to prevent deaths or fires from similar causes happening in the future by collecting and analysing data and enabling coroners to comment and make recommendations about certain matters connected with deaths or fires, including matters related to—
  
  (i) public health or safety; or
  
  (ii) the administration of justice;
(e) provide support for families, friends and others associated with a death which is the subject of a coronial investigation;

(f) establish the Victorian Institute of Forensic Medicine.

- **RECOMMENDATION 1.2**

  That Parliament amend section 3 of the *Coroners Act* 1985 to include the following definition:

  “anaesthetic” includes general anaesthetic, local anaesthetic, spinal or epidural anaesthetic, sedation, regional anaesthetic or any other procedure or administration of an anaesthetic agent which causes partial or complete loss of sensation for the purposes of medical treatment.

- **RECOMMENDATION 1.3**

  That Parliament amend section 3 of the *Coroners Act* 1985 to include the following definition:

  “autopsy” does not include external inspection of the body or taking of body fluids for toxicological analysis.

- **RECOMMENDATION 1.4**

  That Parliament amend the definition of death in section 3 of the *Coroners Act* 1985 to:

  “death” includes suspected death and excludes still birth.

- **RECOMMENDATION 1.5**

  That the Parliament revoke the definition of "domestic partner" in section 3 of the *Coroners Act* 1985.

- **RECOMMENDATION 1.6**

  That the Parliament amend the definition of inquest in section 3 of the *Coroners Act* 1985 to read:

  “Inquest” means a formal hearing which may be part of the coronial investigation process.

- **RECOMMENDATION 1.7**

  That Parliament amend section 3 of the *Coroners Act* 1985 to include the following definition:

  "natural causes death" occurs as the result of organ failure which is not caused or exacerbated by any outside influence such as violence, accident or injury (whether it appears to have resulted directly or indirectly), dental or medical intervention, medication, other drugs, poisons or toxins.
• RECOMMENDATION 1.8

That the Parliament amend the definition of ‘person held in care’ in section 3 of the Coroners Act 1985 to read:

“person held in care” means:

(a) A child in the custody of or guardianship of or held in detention by the Secretary of the Department of Human Services under the Children and Young Persons Act 1986 or placed in care under an order of the Children’s Court; 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
(iv) held in a detention centre under Commonwealth legislation;

(b) a patient in an assessment or treatment centre under the Alcoholics and Drug-dependent Persons Act 1968; or

(c) a person undergoing treatment for a psychiatric disorder as an inpatient in an approved mental health service or a hospital as defined under the registered private hospital; or

(d) a person with a disability defined under section 3 of the Disability Services Act 1992, who--

(i) was living in a residential care service or a supported residential service as defined under section 3 of the Health Services Act 1988; or
(ii) was receiving residential services operated, or wholly or partly funded, by the Department of Human Services.

• RECOMMENDATION 1.9

That the Parliament amend section 3 of the Coroners Act 1985 to include the following definition:

“preventable death” means a death that would not have occurred but for identified system failures.
RECOMMENDATION 1.10

That the Parliament amend the definition of 'reportable death' in section 3 of the Coroners Act 1985 to read

“reportable death” means any 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 person who ordinarily resided in Victoria at the time of death; or
(e) that is not a 'natural causes death', including a death
   (ea) that appears to have been unexpected, unnatural or violent or to have resulted, directly or indirectly, from accident or injury; or
   (eb) that occurs during an anaesthetic; or
   (ec) that occurs as a result of an anaesthetic and is not a natural causes death; or
   (ed) that was not reasonably expected to be the outcome of a health procedure; or
   (ee) that occurs in prescribed circumstances; or
(f) of a person who immediately before death was a person held in care; or
(g) of a person who is protected under the Guardianship and Administration Act 1986; or
(h) of a person under the control or care of the Secretary to the Department of Justice or a member of the police force or subject to orders requiring intensive supervision by a Community Corrections Officer but was not a person held in care; or
(i) 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;
RECOMMENDATION 1.11
That the Parliament insert a new definition of 'senior next of kin' in section 3 of the Coroners Act 1985 which reads:

"senior next of kin" in relation to the deceased person means the first person who is available from the following persons in the order of priority listed —

(a) a person who, immediately before death, was living with the person and was either —
   (i) legally married to the person; or
   (ii) of or over the age of 18 years and in a marriage-like relationship (whether the persons are different sexes or the same sex) with the person;

(b) a person who, immediately before death, was legally married to the person;

(c) a son or daughter, who is of or over the age of 18 years, of the person;

(d) a parent of the person;

(e) a brother or sister, who is of or over the age of 18 years, of the person;

(f) an executor named in the will of the person or a person who, immediately before the death, was a personal representative of the person; or

(g) any person nominated by the person to be contacted in an emergency.

• RECOMMENDATION 1.12a
That the Parliament amend the Coroners Act 1985 to include a new section:

" Incriminating evidence

(1) This section applies if a witness refuses to give oral evidence at an inquest because the evidence would tend to incriminate the person.

(2) The coroner may require the witness to give evidence that would tend to incriminate the witness if the coroner is satisfied that it is in the public interest for the witness to do so.

(3) The evidence is not admissible against the witness in any other proceeding, other than a proceeding for perjury.

(4) Derivative evidence is not admissible against the witness in a criminal proceeding.

(5) In this section--
‘derivative evidence’ means any information, document or other evidence obtained as a direct or indirect result of the evidence given by the witness; and

‘proceeding for perjury’ means a criminal proceeding in which the false or misleading nature of the evidence is in question.

or, in the alternative,

- **RECOMMENDATION 1.12b**

  That the Parliament review legislation which provides for indictable offences and where relevant, include provision that evidence provided to a coronial investigation is not admissible in proving the offence in another jurisdiction.

**Chapter 2**

- **RECOMMENDATION 2.1**

  That the Parliament amend section 6(1) of the *Coroners Act* 1985 to read:

  The Governor in Council may appoint a judge of the County Court, a magistrate or a barrister and solicitor as the State Coroner or as the Deputy State Coroner for ten years from the date of appointment.

- **RECOMMENDATION 2.2**

  That Parliament amend the *Coroners Act* 1985 to enable appointment of an Acting State Coroner when the State Coroner and the Deputy State Coroner are absent from duty.

- **RECOMMENDATION 2.3**

  That the Parliament amend section 7 of the *Coroners Act* 1985 to read:

  The functions of the State Coroner are as follows:

  (a) to ensure that a State coronial system is administered and operated efficiently;

  (b) to oversee and co-ordinate coronial services;

  (c) to ensure that all reportable deaths reported to a coroner are investigated;

  (ca) to ensure that all reviewable deaths reported to the State Coroner are investigated;

  (d) to ensure that an inquest is held whenever it is desirable to do so;

  (e) to issue guidelines to coroners to help them carry out their duties;

  (f) to report annually to Parliament; and
(g) such other functions as are conferred or imposed on the State Coroner under this Act.

• RECOMMENDATION 2.3
That coroners are supported by appropriate, specialist professional development courses and training programs.

Chapter 3

• RECOMMENDATION 3.1
The Government of Victoria continue to support the operation of a short term counselling and support program including its implementation across Victoria.

Chapter 4

• RECOMMENDATION 4.1
That the State Government commit resources to a major education campaign targeting doctors in hospitals and nursing homes to ensure they understand their obligations in relation to reporting deaths to the State Coroner.

• RECOMMENDATION 4.2
The State Government provide resources for computer surveillance systems and a specialist medical assessment team in the Office of the Registrar of Births, Deaths and Marriages to identify trends in deaths that may require investigation and to monitor Death Certificates for deaths that should have been reported to the coroner.

• RECOMMENDATION 4.3
That the State Government implement an independent audit system to address and monitor the under-reporting of deaths to the coroner.

• RECOMMENDATION 4.4
That Parliament amend the Coroners Act 1985 to provide for own initiative and limited purpose investigations on direction of the State Coroner.

Chapter 5

• RECOMMENDATION 5.1
That Parliament amend section 19 of the Coroners Act 1985 to insert a new subsection 19(2A):
“(2A) A coroner may find that the death was a preventable death.”
• RECOMMENDATION 5.2
That Parliament amend the Coroners Act 1985 to require government departments and statutory authorities to respond to coroners' recommendations within six months of delivery of the finding, recommendations and comments.

• RECOMMENDATION 5.3
That the Parliament amend section 17(1) of the Coroners Act 1985 to read:
“A coroner who has jurisdiction to investigate a death must hold an inquest if the body is in Victoria or it appears to the coroner that the death, or the cause of death, occurred in Victoria and the cause of death is unknown or is not due to natural causes-
(a) the coroner suspects homicide; or
(b) the deceased was immediately before death a person held in care; or
(d) the identity of the deceased is not known; or
(e) the death occurred in prescribed circumstances; or
(f) the Attorney-General directs; or
(g) the State Coroner directs.”

• RECOMMENDATION 5.4
That the Parliament amend section 17(3)(a)(i) of the Coroners Act 1985 to read:
“(i) the murder, manslaughter, infanticide, child destruction or arson causing death of the deceased;”

• RECOMMENDATION 5.5
That section 18(3) of the Coroners Act 1985 be revoked.

• RECOMMENDATION 5.6
That the Parliament replace the words "Coroners' clerk" with the word "Coroners' Registrar" throughout the Coroners Act 1985 and the Coroners Regulations 1996.

• RECOMMENDATION 5.7
That Parliament amend section 18A of the Police Regulation Act 1958 to read:
“18A. Assistance to coroners
The Chief Commissioner of Police shall direct that a sufficient number of members of the police force be present at any place at which a coronial investigation is being undertaken (whether or not an inquest is being held) whenever a coroner so requests.”
• RECOMMENDATION 5.8
That Parliament amend the Coroners Act 1985 to allow the State Coroner to appoint investigators (other than police).

• RECOMMENDATION 5.9
That Parliament amend the Coroners Act 1985 to include protection of data collection and analysis by an entity similar to the National Coroners' Information System.

• RECOMMENDATION 5.10
That the State Government provide adequate funding for a managed research unit in the State Coroner's Office.

• RECOMMENDATION 5.11a
That Parliament amend sub-sections 29(3) and (4) of the Coroners Act 1985 to read:

“(3) Within 48 hours after receiving notice of the decision, the senior next of kin may apply to the State Coroner for an order that no autopsy be performed.

(2) The State Coroner may make an order that no autopsy be performed if he or she is satisfied that the cause of death is able to be determined without an autopsy or it is otherwise desirable in all the circumstances.”

or in the alternative,

• RECOMMENDATION 5.11b
That Parliament amend sub-sections 29(3) and (4) of the Coroners Act 1985 to read:

“(3) Within 48 hours after receiving notice of the decision, the senior next of kin may apply to the Supreme Court for an order that no autopsy be performed.

(4) After hearing evidence from the forensic pathologist who performed the physical inspection of the body and advised the coroner, the Supreme Court may make an order that no autopsy be performed if it is satisfied that the cause of death is able to be determined without an autopsy or it is otherwise desirable in all the circumstances.”
• RECOMMENDATION 5.12
That Parliament amend the Coroners Act 1985 include a new clause in that reads:

"Confidentiality
A person must not divulge information about a person obtained (whether by the person divulging the information or by some other person) in the course of the administration of this Act, except—
(a) where the information is publicly known; or
(b) as required or authorised by this Act or any other Act or law; or
(c) as reasonably required in connection with the administration of this Act or any other Act; or
(d) for the purposes of legal proceedings arising out of the administration of this Act; or
(e) to a government agency or instrumentality of this State, the Commonwealth or another State or a Territory of the Commonwealth for the purposes of the proper performance of its functions; or
(f) to a bona fide research organisation or individual researcher for public health or safety purposes; or
(g) with the consent of the person to whom the information relates.

• RECOMMENDATION 5.13
That Parliament amend section 58 of the Coroners Act 1985 to allow the State Coroner to restrict publication of reports of an investigation or vary or set aside such an order if the State Coroner believes that publication would prejudice or compromise the investigation.

• RECOMMENDATION 5.14
That Parliament amend the Coroners Act 1985 to provide:
(1) Before completion of:
(a) an investigation or an inquest into a death; or
(b) an investigation or inquest into a fire...

a coroner's file or any part of it must be made available to such people or class of people as the coroner directs.
(2) After the completion of:
(a) an investigation or an inquest into a death; or
(b) an investigation or inquest into a fire...
the coroner's record and file is to be open to public access unless the coroner orders otherwise.

Chapter 6

- **RECOMMENDATION 6.1**
  That Part 6 continue to provide coronial jurisdiction to investigate non-fatal fires, particularly where issues of public health and safety arise.

- **RECOMMENDATION 6.2**
  That Parliament amend section 31(1) of the *Coroners Act 1985* to read:
  “31(1) A coroner has jurisdiction investigate a fire if the fire occurred in or partly in Victoria and the coroner believes it is desirable on the grounds of public health and safety or the Country Fire Authority or the Metropolitan Fire Service requests an investigation on the same grounds.”

- **RECOMMENDATION 6.3**
  That Parliament amend section 31(1) of the *Coroners Act 1985* to read:
  “36(1) A coroner investigating a fire must find if possible-
  (a) the cause and origin of the fire; and
  (b) the circumstances in which the fire occurred; and
  (c) whether or not the fire was a preventable fire.”

Chapter 7

- **RECOMMENDATION 7.1**
  That Victoria Legal Aid review its guidelines to provide for wider representation of families and other interested parties involved in coronial inquests.
Introduction

The Governor in Council has made a reference to the Law Reform Committee of the Parliament of Victoria (the "Committee") which requires the Committee:

"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 Victorian; and
(c) the provision of support for 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."

The terms of this reference are consistent with the Attorney General's commitment to review the Coroners Act 1985 to improve the Coroner's Court's capacity to contribute to accident prevention and safety strategies and ensure the needs of families and others are appropriately met. In that Statement, the Attorney General said:

"The Government believes that a review of the Coroner's Act is timely. It will undertake such a review to improve the Court's capacity to contribute to accident prevention and safety strategies, and meet the needs of families of deceased persons and others who may be affected by a sudden, unexpected and tragic incident."³

In April 2005, the Committee published a document called "Coroners Act 1985 Discussion Paper" (the "Discussion Paper") which sought to define the issues that it will consider and raised a number of questions that it will need to answer. In the Discussion paper and in the media, the Committee invited comments and submissions about matters which could inform its general recommendations about the Coroners Act 1985.

The current purpose of the Act is to establish the office of State Coroner, to require the reporting of certain deaths, set out the procedures for investigations and inquests by coroners into deaths and fires; and to establish the Victorian Institute of Forensic Medicine (the "Institute"). Therefore, in the role of lead agency under the Terms of Reference of the Inquiry, the State Coroner's Office is pleased to tender this submission to assist the Committee in its work.

---

Given the Committee's Terms of Reference relate to the Act, the first section of the submission provides the Committee with background statistics and a description of the way in which the current coronial system operates to address its current statutory obligations. The nine following chapters in this submission adopt the headings of the nine parts of the Act to discuss the way in which the jurisdiction operates. Each Chapter includes some historical and philosophical background, answers the questions raised in the Discussion Paper and makes recommendations about appropriate amendments to the Act and, where appropriate, the resource implications of those recommendations. There is some cross-referencing where issues relate to more than one Part of the Act.

In determining the scope and content of its submission, the State Coroner's Office has assumed that:

1. The Committee does not intend to address matters relating to the Institute except as they influence performance of the State Coroner's role;

2. The Committee's jurisdiction is restricted to making recommendations to amend the Act and considering the resource implications of these amendments;

3. The Committee accepts that under the Act, coroners derive their jurisdiction from the circumstances surrounding a reported death or fire rather than from the deceased person or the person who causes the fire;

4. The Committee is particularly concerned with the minimising the negative effect of coronial proceedings on families and other interested parties as distinct from providing services required to enable them to deal with their loss and grief.

The State Coroner welcomes this Inquiry. He believes the State Coroner's Office in Victoria already enjoys a good reputation for implementing public safety and prevention strategies in Australia and overseas. He is happy to cooperate with the Committee in any way he can to ensure that the Committee's work is productive and useful in recommending changes that will further increase the capacity of the State Coroner's office to improve the well-being and safety of the Victorian community.
Background

The role of the State Coroner’s Office is to implement the Coroners Act 1985 with respect to:

1. Accepting reports of deaths in or related to Victoria which occur in circumstances not usually associated with natural death.
2. Investigating these reported deaths, managing the bodies and responding to applications by interested parties and others, and
3. Determining the identity of the deceased, the cause of reportable deaths and the circumstances in which the death occurred.

As background to the State Coroner’s Office submission and to help the Committee to put the work of the State Coroner's Office into context, this section of the submission will provide some historical and demographic information about the way in which the number and characteristics of reportable deaths have changed in the twenty years since the operation of the Coroners Act 1985. It will also describe, in general terms, the way the State Coroner's Office currently responds to and manages reported deaths and factors which influence this response.

Demographics

Victoria now has a population of greater than five million people. The number of people living in Victoria grew by 60,900 in 2004 and, by 2021, is predicted to be between 5.56m and 5.78m people. Most of this increase will probably occur in the Melbourne metropolitan area with regional Victoria remaining close to 1.5m people. These changes in population have been compared with the numbers of deaths reported to the Registrar of Births Deaths and Marriages and deaths reportable to the State Coroner in Figure 1 below.

In 2004, over 13% of these Victorians were aged over 65 years. By 2042, this proportion is expected to double to 25.8%. Over the last 20 years, the number of Australians aged over 85 years has increased by 163% compared with a population growth of only 29% in the same period. The

---

number of Victorians aged over 85 years is expected to rise from 1.5% now to between 5% and 7% by 2040.9

*Fig. 1 Deaths Reported in Victoria*

These changes in longevity are reflected in decreases in the rate of death in the community.10 Figure 1 also indicates that the total number of deaths reported to the Registrar of Births Deaths and Marriages each year since introduction of the Act has generally declined. There were about 32700 deaths reported in Victoria in the 2004/5 financial year, an increase of 4.3% over twenty years compared with a 20.8% increase in the population.

However, there has been no parallel decline in the number of reportable deaths. Further, although the increase in the Victorian population is expected to slow, the shift of the large population cohort born in the post-war period (from 1946 onwards) into the later years of their lives over the next 30 to 40 years will significantly increase the number of deaths. By the mid-2030s, deaths are expected to outnumber births.11 The number of deaths each year of people aged over 65 years is expected to increase by between 65% and 100% by 2040.12

---


10 Australian Bureau of Statistics 3311.2.55.001 Demography, Victoria


Therefore, there is no reason to believe that the current demonstrable increase in use of coronial services will decline as population growth slows in Victoria. On the contrary, the requirement for coronial services will continue to increase until at least 2021 and beyond.

On the basis of these data, the State Coroner’s Office is of the view that changes to the *Coroners Act* 1985 must take into account a predicted increase in the number of reportable deaths of between 65% and 100% of today's figures over the next 20 years.\(^{13}\)

**Geographic Differences in Death Rate**

Many rural areas and small towns have a very high percentage of their aged population, caused by emigration of young people to the cities and overseas and the ‘ageing in place’ of older age groups. In regional Victoria 31.7% of people are aged 50 years or over, compared with 28.0% for Melbourne.\(^ {14}\)

The extent and timing of population ageing and consequent numbers and rates of death will vary for different regions, towns and suburbs depending on provision of aged care facilities and changes in location of extended families.\(^ {15}\)

Therefore, although the overall requirement for coronial services can be expected to grow, planning for provision of coronial services in regional Victoria will need to be localized and take into account changes in the age of local communities and factors likely to influence that change.

**Changes in Ethnicity of Population**

The State Coroner’s Office is acutely aware that death has important cultural and religious significance in the lives of families and everyone else involved.

The country of birth of Victorians has changed over the last 20 years (Fig. 2).\(^ {16}\) The number of Victorian residents who were born in the Middle East and Africa and in New Zealand grew between 1986 and 2001 at the same time as the number born in the United Kingdom and Europe has declined. The numbers born in Asia and Eastern Europe has stabilized. By 2011, 38% of Melbourne’s older population will be from culturally and linguistically diverse backgrounds, up from 29% in 1996.\(^ {17}\) Further, within the Australian-born population, indigenous Victorians have, on average, a much shorter lifespan than non-indigenous Victorians, and therefore may

---

\(^ {13}\) These figures do not take into account any improvements in reporting of or changes to the criteria for reportable deaths.


\(^ {16}\) Australian Bureau of Statistics, Census of Population and Housing.

require culturally appropriate coronial services at a relatively younger age.\textsuperscript{18}

\textit{Fig. 2 Country of Birth of Victorian Population}

As well, in the 2003/4 financial year, 0.5\% had overseas residential addresses.\textsuperscript{19} The State Coroner’s Office cooperates with the local funeral director to make arrangements for the bodies of these people to be sent home according to the requirements of their home countries. The most frequent visitor deaths were from New Zealand (four deaths reported) and United Kingdom (four deaths reported).

Most Victorians who were born overseas live in Melbourne and Melbourne already receives more than 90\% of the overseas migrants coming to Victoria. These proportions are expected to increase further in the next 30 years.\textsuperscript{20} However, some diverse populations including specific indigenous groups, with particular cultural rites and collective decision-making processes associated with death are based elsewhere in the State.

Therefore, the State Coroner’s Office is of the view that its emphasis on the cultural sensitivity of users of coronial services needs to continue, particularly in the metropolitan area. There is also a need to ensure that specific culturally-specific services are available in regional areas as required.


\textsuperscript{19} Deaths recorded on National Coronial Information System, includes country of birth and residential address unknown and unlikely to be known and not yet coded.

**Funding**

The State Coroner's Office is funded by the Department of Justice through the Court Services Division. Changes in this funding since 1997/98 bear little relationship to the increased number of "reportable deaths" or the evolving complexity of their investigation.

Although the number of reportable deaths has continued on an upward trend, the underlying Budget Base, which provides for the core administrative and operational services\(^{21}\), has decreased from $4.16 in 2001/2 to $4.07 in 2004/5 (see Figure 3). Once-off funding for counter terrorism and targeted funding for adverse events investigation by the State Coroner's Clinical Liaison Service has increased the total appropriations.

**Fig. 3. Operating Budget for State Coroner's Office.**

The State Coroner's Office is of the view that, as well as responding to expected changes in the frequency, geography and cultural diversity of the dying and the bereaved, funding of its services should take into account the influence that death has on everyone associated with it and the way in which adequate services can ameliorate the inevitable intervention of coronial processes on this grief and pain.

---

\(^{21}\) The underlying Budget Base excludes funding for country autopsies, AWA funding and special appropriations. It includes provision for long service leave, Workcover levy, Capital Asset charges and depreciation. No magistrates' salaries have been included in this information.
The Coronial Process

The Vision of the State Coroner's Office is:

“To be a leader in the investigation of reportable death and fire. In doing so, increase awareness of the valuable preventative role the Court plays in contributing to the general safety and wellbeing of the community.”

The coroner’s investigation begins as soon as a death is reported to the State Coroner. Often a coroner is involved at the scene of death or fire from the outset and directs aspects of the investigation. A well-defined and integrated system for handling the body and monitoring the investigation process has been developed to ensure that information relevant to the coroner’s enquiry is captured in a sensitive and timely manner. There are many alternative ways in which this information is collected but a simplified chart of the most usual Case Management and Investigation Processes that occur in Melbourne and the coroners’ role in these functions is provided on the next page. These include Case Initiation and Processing, Case Investigation and Case Finalisation and Communication. The functions and outcomes from each of these phases or processes are interdependent on each other and any changes to one must take into account the effect that will have on other parts of the system (see Figure 4).

In regional and country Victoria, the simplified chart is a useful model to follow but its operation varies depending on local circumstances and available support services. There, the coronial process is administered through the Magistrates’ Courts by the Magistrates’ Court clerks.

Case Initiation and Processing

As soon as a death is reported to the State Coroner’s Office in Melbourne on the 24-hour telephone line, a number of processes are initiated, including establishing a unique case number and a Case Summary computer file on the Coroner’s Case Management computer system. Most of this information is usually obtained from the telephone conversations the coroner’s clerks, most of whom are Registrars of the Magistrate’s Court, have with those reporting the case to them and from the Police Report to the Coroner which is also called a Form 83.

Associated with and linked to this process, the Counselling and Support Service at the State Coroner’s Office in Melbourne, in cooperation with the Donor Tissue Bank counsellors from the Institute, contacts families to make them aware of the process and their right to object to autopsy and/or consent to tissue donation for transplants or research (the “Family Contact Program”). This service is not routinely available in regional Victoria but a pilot implementation program is being undertaken in Moe.

---

22 State Coroner’s Office, Strategic Plan 2005-08.
23 See s 13 for reporting requirements.
Fig. 4 Coroners' Involvement in the Investigation Process at the Coronial Services Centre

Similar information is collected for cases reported to regional and country coroners but the detail and systems vary depending on local circumstances and available support services.
When formal identification and the autopsy are complete, the body is released to the family, usually through a funeral director, for burial or cremation. For the purposes of understanding the process, under the current structure where Deputy Registrars and Coroners' clerks are delegated to perform most of the coroners' administrative roles, although continuing to oversee the investigation, the coroners' personal involvement in the process usually begins when the written documentation file is transferred to the Senior Registrar's Office for processing and reporting of the death to the Registrar of Births Deaths and Marriages. During this process, the coroners' clerks and Deputy Registrars enter all subsequent communications relating to the case or referrals of the file into the Notes or Enquiry sections of the Case Summary Screen on the Case Management System.

**Case Investigation**

The first stage of the coroner's investigation of a reported death overlaps with the Case Initiation and Processing stage of the procedures and includes determination of whether the death is a reportable death. This usually involves preliminary assessment of the circumstances by police attending the scene, identification by the next of kin or another person who knows the deceased, and an autopsy to determine medical cause of death.

In metropolitan Melbourne, the forensic pathologists read the file and examine the body before they advise the clerks in the Initial Investigation Office whether they believe they can advise the coroner of the medical cause of death from an inspection of the body and the medical file without autopsy or whether an autopsy is required. In cases where the forensic pathologist believes an autopsy is required, the Family Contact Program discusses the issue with the family and, when no objection is raised, the clerks are delegated to authorise an autopsy to be performed. When there are any doubts, a coroner is consulted.

In regional Victoria, autopsies are usually performed at the local hospital. Coroners are involved in responding to applications that no autopsy be performed.

As soon as a death is reported to the State Coroner's Office, there may be direct, full-time\(^{25}\) coroner involvement. The after-hours on-duty coroner for Victoria (usually the State Coroner or Deputy State Coroner on weekly rotation) is available on a 24 hours a day, seven days a week basis to advise on cases reported and investigation issues, liaise with investigators and response agencies, advise regional coroners and reporting medical practitioners, organise body transport, tissue transplantation or research issues.

The after-hours on-duty coroner also attends scenes and advises on investigation or directs particular phases of the investigation from the scene. There is a list of types of reportable deaths that prompts an immediate contact via pager to the after-hours on-duty coroner. The list

\(^{25}\) "Full-time coroner" means a coroner working exclusively in the coronial jurisdiction.
includes deaths in custody, police related matters, multiple deaths in one incident, work-related deaths, aviation-related deaths, major structural fires and bushfires, disasters, etc. As indicated, there is a list which explains the paging instructions for the after-hours staff. This list is included in Appendix C.

All deaths in custody (including police-related incidents) require scene attendance by the after-hours on-duty coroner. A number of other deaths also require either scene attendance or coroner management of the investigation over the telephone with investigators at the scene. This response occurs after-hours as well as during business hours. Police from the State Coroner's Assistants Unit may attend scenes either with the coroner or on the coroner's behalf.

During business hours, there is an on-duty coroner at the State Coroner's Office who deals with initial investigation issues, objections to autopsy or requests for autopsy, tissue retention, transplantation or research issues. Full-time coroners also are involved in regular meetings on case-based issues with forensic pathologists, State Coroner's Assistants Unit and specialist investigators including the Victoria Police Major Collision Investigation Unit, Homicide or Arson Squads, Missing Persons Unit and WorkSafe

The second stage of the investigation of reportable deaths involves gathering of further evidence including obtaining statements from relevant witnesses and family members and obtaining files from hospitals and other institutions. This task is usually undertaken or overseen by the State Coroner's Assistants' Unit of Victoria Police or operational police in regional Victoria. The State Coroner's Assistants' Unit is integral to the investigatory process. It oversees the gathering of material in specific case types including aviation incidents, deaths in correctional custody and major fires. They are also part of the coroners' Clinical Liaison Service team (discussed later). They train, provide guidance and liaise with police throughout the State who are dealing generally with coronial investigations. The State Coroner's Assistants' Unit is part of the State's Disaster Victim Identification Team (DVI) and assists coroners in their function of finding the identity of multiple victims in incidents such as a motor vehicle collision, fire, explosion or major disaster.

Police and other investigators acting for the coroner may require a coroner's authorisation to enter, search and seize documents and other evidence. Most of this information is consolidated into an inquest brief. Some of the essential information is held on the Coroners Correspondence File, which is retained in the Registrar's office at the Coronial Services Centre in Melbourne. Coroners lose jurisdiction to investigate reported deaths when they determine the death is not a "reportable death".

In the third stage of the case investigation, the coroner assesses the inquest brief and decides whether he or she requires more evidence and/or whether the matter should be determined with or without inquest. If an inquest is ordered, the coroner also determines which witnesses are required. The coroner then hears the inquest if it is required or has been
ordered. The interested parties may also request the attendance of
additional witnesses and provide new information or expert reports for the
coroner to consider. If the information is relevant to the investigation, this
level of involvement is encouraged.

Most of the evidentiary material constituting the results of the coronial
investigation is contained in the inquest brief or brief for chambers finding
prepared for the coroner. A coroner undertaking an investigation with or
without holding an inquest is not bound by the rules of evidence and may
be informed and conduct an inquest in any manner the coroner
reasonably thinks fit.26

Under sections 27 and 66 of the Coroners Act 1985, pathology and
toxicology services must be provided or coordinated by the Victorian
Institute of Forensic Medicine to assist coroners in their investigation of
reported deaths. Further, as required by section 18A of the Police
Regulations Act 1958, coroners are assisted in their investigations by the
Victoria Police-State Coroner’s Assistants’ Unit and, through them, other
police such as the Homicide Squad, the Arson Squad and local uniform
police whenever a coroner so requests. In regional and country Victoria,
the coroner is assisted by the senior officer at the local police station. The
State Coroners' Clinical Liaison Service also provides expert medical
assessment of incidents that occur in hospitals and other healthcare
settings. Coroners can also be assisted in their investigations by a range
of other relevant agencies or experts such as Worksafe Victoria, Office of
the Chief Electrical Inspector, Office of Gas Safety, the Metropolitan Fire
Service and the Country Fire Authority, engineers and medical experts.
Special Federal arrangements apply to aviation deaths, deaths associated
with the armed forces or deaths of Victorian residents overseas. Coroners
also use information or reports from research organisations such as
University Departments (like Monash University Accident Research
Centre) as part of the investigation process.

Coroners' clerks continue to perform important coordinating and
administrative functions in relation to managing the file throughout the
investigation process. When a decision to determine the matter without
inquest is being considered, a letter is sent to interested parties informing
them of this decision. Responses to this letter are placed on the file and
may influence a coroner’s determination of the matter.

During the investigation process, families also often write either directly or
through their lawyers, to the coroner providing information that may need
further investigation. The general public sometimes provide information
about a particular investigation or specific safety issues of concern. If the
information appears relevant, it is followed up by the investigators under
the direction of the coroner. Experience has shown that valuable
information has been provided to the coroner through encouraging
communication and investigation requests from families and the general
public.

26 s 44 Coroners Act 1985 but see ss 57, 57A and 57B Road Safety Act 1986.
When an inquest brief or brief for chambers finding has been prepared, it is presented to a coroner for decision about whether it is complete and whether to proceed by way of inquest or chambers finding pursuant to sections 17(2) or 17(3) of the Act. Recommendations and comments on public health and safety can be made by the investigating coroner in an inquest finding or a chambers finding.

**Case Determination and Communication of Findings**

Each matter is determined when a coroner hands down a finding that includes determination of the identity of the deceased, the time and place of the death, the cause of death and the particulars required under the *Births Deaths and Marriages Registration Act* 1996. This finding is reported to the Registrar of Births Deaths and Marriages and coded into the National Coroners Information System. When the coroner makes a comment or recommendation in the finding, a copy is also provided to interested parties and may be distributed to the Attorney General and other relevant Ministers as directed by the coroner.

As a matter of practice, where recommendations are made, findings are also sent to the interested parties and other government agencies, industry or community groups that may have an interest in the safety or health issues. In some cases, this information is sent to all State and Chief Coroners in Australia. Occasionally, it is also directed to overseas coroners or agencies that may need to know about the safety issues identified during the Victorian coronial inquiry. This exchange of information across jurisdictions is important to help identify preventable deaths. There are a number of case examples where similar deaths have been regularly occurring interstate or overseas and also in Victoria. This exchange of information is to the benefit of Victorians. However, there is no structured system to ensure recommendations are actually considered by the agencies to whom they are directed.

Over 90% of case are finalised without an inquest. After a coroner has finalised a matter without inquest, the interested parties are notified of the proposed cause of death three weeks before the finding is confirmed to allow time for any responses to be taken into account.

When a coroner decides that the matter requires further investigation by way of inquest, it is listed and witnesses are called pursuant to the Act. The oral evidence is heard in open court, recorded and transcribed. Unless the coroner otherwise orders, the transcribed oral evidence and the file becomes a public document. The coroner’s finding also becomes a public document upon being handed down.

Coroner's determinations of identity of the deceased, how the death occurred, the cause of death, and the place and date of death are open to judicial review.

In the case of a chambers finding, a family may write to the coroner requesting further investigation after the finding is completed. A practical approach is taken to this additional information and its effect on the completed finding. The request is assessed by a coroner and, if appropriate, further investigation is undertaken. The results of this
additional investigation may necessitate an amendment to the chambers finding by the original coroner or, in some cases, an inquest. This practice may need some legislative clarity (similar to the State Coroner's power under section 59A of the Act to order that some or all of the findings of an inquest are void).

Following an inquest finding, if there is a mistake in the record of the findings or it is desirable because of new facts or evidence, the State Coroner can void some or all of the inquest findings and order that the inquest be re-opened. 27

**Other Support Services**

There are a number of other support services available at the Coronial Services Centre. Detailed information about many of these services is elsewhere in this submission.

These resources include:

- The National Coroner's Information System (NCIS) which is managed by the Institute on behalf of the various State/Territory Departments of Justice and Australian Coroners. NCIS provides timely data on all coroners' cases in Australia to help coroners in investigations and to identify trends and patterns in problem areas. The database was established in July 2000 and there were about 95,000 cases recorded by July 2005. Researchers and government agencies also have access to the data for research and prevention purposes.

- The State Coroner considers that research is an important part of any effective coronial system. It helps inform the process at all stages. Properly directed and managed researchers can use the information system and incoming cases to help identify trends at an early stage, assist in providing focus for the Coroner's investigation in important areas for community benefit in health and safety, inform developing investigations with health, safety and preventative information and assist in educating the research and general community. In the recent past the State Coroner's Office had the benefit of three Grade 3 Researchers. One was funded by the Department of Justice (suicide researcher), one was funded by WorkSafe and the other, a general injury researcher, was funded by the Department of Human Services. Currently, the suicide researcher's position is vacant, the work-related death researcher's position has been subsumed in the new "Coroner's Work-Related Death Investigation and Resource Unit" and the general injury researcher's position has expired. Research is also a component in the Clinical Liaison Service operation but currently there is no funded researcher's position.

There was no overall research management or support structure and hence the research unit had its limits. A sample of reports by these researchers is included in Appendix A of this submission. A number of these research projects have been used by

---

governments, industry and the community to inform standards, practices and procedures.

The State Coroner has also established advisory groups on transport safety, tree felling safety and health and medical issues. These groups meet regularly at the State Coroner's Office and are active in health and safety issues in their respective areas.

The Transport Industry Safety Group (TISG), is a co-operative venture between many government agencies and the industry. It was established, following a coronial inquiry and recommendations, nine years ago. The TISG was referred to in the "Occupational Health and Safety Act Review". The Fourth Edition of the "Transport Industry Safety Guide" is an example of the work of the TISG that was included in the Appendices to that report. Chris Maxwell Q.C. (now President of the Court of Appeal) said of the TISG, under the sub-heading "culture of engagement" (paras. 1047-1050):

"This Group was established in 1997 to develop and facilitate an industry approach to occupational health and safety, following coronial inquests into fatalities in the transport industry. The group consists of representatives of the Transport Workers Union (Victorian Branch), the Victorian Road Transport Association, the Bus Association of Victoria, VicRoads, Victoria Police and the Authority (WorkCover).

It was evident from my meeting with the Group, and from its publications, that there is a high level of commitment and cooperation between the stakeholders in relation to health and safety for all persons who are involved in - or affected by - the transport industry. One such publication was the Transport Industry Guide to meeting the OHS Duty of Care...."

The Counselling and Support Service is also available at the Coronial Services Centre, to help families to deal with a sudden and traumatic death of a family member that has been reported to the coroner. This service is not limited to families but may extend to witnesses and others affected by the coronial process. A description of this service is included in Chapter 3 of this submission.

---

Chapter 1
Preliminary

This Chapter addresses issues relating to:

- The Purpose of the Act,
- Definitions used in the Act, and
- The effect of common law on the operation of the Act.

The Purpose of the Act

Section 1 of the Act provides:

"The purpose of this Act is to--

(a) establish the office of State Coroner;

(b) require the reporting of certain deaths;

(c) set out the procedures for investigations and inquests by coroners into deaths and fires; and

(d) establish the Victorian Institute of Forensic Medicine."

The Terms of Reference of the Inquiry require the Committee to consider whether the Act provides an appropriate legislative framework for the independent investigation of deaths and fires in Victoria.

Under the rules of statutory interpretation, the Purposes of the Act are a determining factor in defining:

1. The relationship between the office or position of the State Coroner and other sections of the administration, and

2. The power of the State Coroner to enforce reporting of certain deaths, investigating deaths and holding inquests.

Further, exclusion of issues from the purposes of the Act can be interpreted to mean they are not core business for the State Coroner’s Office or that they are subordinate to the issues that are included.

For example, in the Discussion Paper, the Committee has sought specific advice about whether the modern coronial system should continue to investigate non-fatal fires\textsuperscript{29}, whether the scope of the coroner’s power to investigate should appropriately include the power to investigate disasters\textsuperscript{30}, whether the public safety and preventative role of the Coroner should be a specific function of the Act\textsuperscript{31} and whether accommodating the needs of families should be a specific function of the Act.\textsuperscript{32} Inasmuch as


they relate to the Purposes of the Act, these questions will be dealt with in this Chapter.

The State Coroner's Office is of the view that independence of the State Coroner and other coroners requires both protection of the office from interference by the Crown and the State administration and protection of the State Coroner's personal position from influence by direct or indirect threats or promises. Issues of personal independence will be discussed in Chapter 2 of this submission. The independence of the office of the State Coroner will be discussed here.

Part One of the Act determines that the office of State Coroner is not independent of the Crown. Under the current legislation, the functions of the State Coroner are administrative rather than judicial functions\(^{33}\) and, in performing these functions, the State Coroner is fully accountable to the Crown as exemplified by Cabinet and, through them, the Executive Council. The independence of the State Coroner from the executive or administrative arms of Government remains only to the degree that the Attorney General, as a member of Executive Council, is independent of his Department and other Ministers in Cabinet and the Purposes of the Act indicate otherwise.

This Chapter will examine the history of the office or position of coroners in relation to the Crown, the Executive and the Courts and the provisions made elsewhere which influence whether coronial work is a judicial or administrative function. In order to clarify the independence of the State Coroner, the State Coroner's Office will recommend that the Act be amended so that:

**Section 1(a) either:**

- Establishes a Coroners Court of Victoria, or
- Establishes the independent office of the State Coroner, and/or

**Section 1(c):**

- sets out procedures for independent investigations and inquests by coroners into deaths and fires.

In this submission, the State Coroner's Office will also recommend that:

- Non-fatal fires remain within the coronial jurisdiction,
- Prevention and safety-related activities are a core function of the coronial jurisdiction and included in section 1 of the Act,
- Provision of support services for families and others affected by the coronial process is recognised as a core function of the coronial jurisdiction and included in section 1 of the Act.

---

\(^{33}\) Annetts v McCann [1990] HCA 57.
Further, this Chapter will consider the Committee’s questions about definitions as well as other definitions that may be required to implement recommended changes in the legislation.

Finally this Chapter will consider the section 4 provision which seeks to exclude the common law from the coronial jurisdiction. In particular, it will acknowledge the continuing influence of natural justice and fundamental rights including the right to silence and recommend inclusion of provisions which are intended to give coroners the power to compel important witnesses and protect them from use of their evidence against them in other forums.

The Office of State Coroner

The role of the coroner in reporting and investigating unnatural and violent death for the Crown has a long history. Some historians can trace the coroners’ origins back to the time of King Alfred the Great who ruled from AD 87134 and, by 1176, there is documentary support for the specialised work of the coroner:

“The coroner service is one of the oldest public services in existence with the earliest references going back to the twelfth century.”35

Under Henry II and the first part of the reign of Richard I, the local sheriff or 'Kings law officer' performed the role of recording the "Pleas of the Crown". Goods and property of a person responsible for an unnatural or violent death were forfeited to the Crown. As well, a rigid procedure applied to every unexpected death and any deviation from the rules was heavily fined. The rules were so complex that most cases showed some slip-up, with consequent financial penalty payable to the Crown. These cases were two of many Pleas of the Crown determined by itinerant justices appointed by the King.

Between hearings by the itinerant justices, the sheriff acted on behalf of the Crown to ensure that the cases were investigated and the money was collected. He was informed of the death, viewed the body and identified those responsible for presentation before the Court. This function - “keeping the pleas of the Crown”-evolved into the title of coroner.36

When Richard I found that the sheriffs were not always formally recording reportable deaths and the property of perpetrators and other offenders against procedural requirements frequently found its way into the sheriffs' own pockets, he determined that coroners should be elected by the Freemen of the county from among nobility and landed gentry who were wealthy enough to assure some degree of honesty. Since no salary or compensation was allowed, the office was practically limited to persons of great wealth.

34 Second Reading Speech, Coroners Bill 2003, Hansard, NSW Parliament, 29/10/03.
36 The Latin was “custos plactorum coronas” from which the word ‘coroner’ is derived.” Knight CBE, Prof. B, ‘History of the Medieval English Coroner’, p.3
In September 1194, the itinerant justices on circuit in the County of Kent in England determined a set of rules to implement the King's decision, including Article 20 of the “Articles of Eyre” which first recorded the appointment of coroners:

“In Every County Of The King’s Realm Shall Be Elected Three Knights And One Clerk, To Keep The Pleas Of The Crown.”

Although Wales inherited the English concept of coroners after the Edwardian Conquest of 1282 and, in the early years both coroners and sheriffs sometimes also determined fines and forfeiture actions, Chapter 24 of the Magna Carta in 1297 expressly forbade this practice and the coronial role reverted to its administrative rather than a judicial function. The requirement for coroners to be Knights of the Realm was removed during the early 14th Century, but they still needed to own local property to seek office.

Coroners’ appointment by election, their status in the local community and their relationship to the Crown continued to evolve into a common law office of great power and authority as extra fines and forfeiture of objects which caused the death were imposed in all cases of sudden and unexpected death. Coroners were responsible for determining and enforcing these actions and were open to corruption on both counts. In particular, the coroner was personally responsible for making these determinations: for example, he decided the cause of death by looking at the body to detect any sign of violence and the number and type of wounds present. Until 1836, there was no medical involvement in this work and, in England, the coroner’s obligation to inspect the body continued right up until 1980. Further, the forfeiture powers affected everyone in the community, whether or not the death was intentional and whether or not the person causing the death was directly involved. For example, forfeiture of the tool causing death could have been vital to a family's living. At the other end of the scale, steam locomotives and even a steamship were forfeited to the Crown. Consequently, during the 16th and 17th Centuries, coroners performed a thankless job on behalf of the Crown and enjoyed a poor reputation in society.

In 1846, legislation was passed in England and Wales to create a statutory position of coroner. It provided for appointment of lawyers and doctors as coroners by the English County or City Councils with the approval of the Secretary of State. Coroners in the United Kingdom are judicial officers appointed by the Lord Chancellor, even though they are not always lawyers. Different legislation followed in Northern Ireland. In Northern Ireland, coroners are independent judicial officers appointed by the Lord Chancellor from the Bar of Northern Ireland or registered as solicitors. There is no office of coroner in Scotland. Instead, the local procurator fiscal inquires into sudden or suspicious deaths.

There have been two recent major inquiries into the coronial service in the United Kingdom. One was undertaken by Dame Janet Smith into issues arising out of the conviction of Dr Harold Shipman for the murder of some
of his patients in January 2000. The other was the Home Office’s *Fundamental Review of Death Certification and Investigation in England, Wales and Northern Ireland* chaired by Tom Luce and was published on 3 June 2003. A medical representative from Dame Janet’s inquiry team and, separately, Mr Luce with three members of his Review Committee visited the Victorian system in the course of their inquiries. The Luce Committee representatives spent four days examining the whole Victorian coronial system at the end of their inquiry. In their recommendations, both Dame Janet and Luce adopted many of the practices adopted by the Victorian State Coroner under the auspices of the *Coroners Act* 1985. Both advocated a continuing, independent, legally-trained, inquisitorial jurisdiction within the existing court structure of the United Kingdom supported by expert medical and pathological advice.

On 11 March 2004, the Home Office published a *Position Paper* on reforming the coroner system, making a kind of synthesis of the *Luce* and *Shipman* Reports. These reports and *Modernising the Coroners Service-the Way Forward* from Northern Ireland can be accessed electronically using the hyperlinks. The Home Office Position Paper signals there will be about 40-60 full-time coroners in the United Kingdom, all legally qualified, supported by deputies, each advised by one or two medical examiners, sitting in a single national jurisdiction, and presided over by a Chief Coroner, who will be appointed at the level of a Circuit Judge.

The Position Paper did not cover Northern Ireland specifically so the Northern Ireland Court Service has undertaken a consultative process with a view to implementing improvements under the current *Coroners Act (Northern Ireland)* 1959 through administrative re-design. Their report was published on 1 April 2005. The Northern Ireland report indicates that they intend establishing a single coroners’ district for Northern Ireland with all coroners based in Belfast. This will commence in September 2005. Further, in Northern Ireland, the coroners’ service will become fully integrated into the mainstream judiciary. This will be achieved by appointing a High Court judge with coroner’s powers to oversee the coronial service and coroners’ investigations. In Northern Ireland, they expect new protocols and memoranda of understanding for death certification and investigation that are being developed cooperatively between the coroners and police, pathology, and children’s services to be operating by October 2005. Although the Northern Ireland report proposes that the Northern Ireland Coroners Service should be represented on the national Coronial Council, the possibility of establishing a Coronial Council for Northern Ireland will also be kept under review.

---

The Position Paper also indicates that the Home Office intends to ensure verification of the fact of all deaths, certification of the cause of death by a doctor, scrutiny of all such certificates by a medical examiner based in the coroner's office, and referral to the coroner of all deaths which cannot be certified or which are unnatural and require fuller conclusions from investigations and inquests, with a stronger bias towards narrative and preventive findings. The so-called medical examiners will each have a team of up to two more medical staff to provide a second opinion about diagnosis of cause of death and advise whether cases should be subject of further investigation. They also intend to establish a representative Coronial Council for England and Wales with members from Northern Ireland to help take forward improvements that can be made without new legislation. The Coronial Council will have no direct relationship with the Chief Coroner but will provide advice about administrative arrangements through his or her Management Board. The timescale for implementation of these reforms is unclear, as they depend in large part on the enactment of primary legislation, and the Position Paper states that this depends on the Parliamentary timetable. The role of the coroner in modern society is now being debated more than it ever has in its 800 year history. In the context of our common law system of justice and the role of the courts, the relevance of the coroner's inquisitorial process is now being re-considered. The current review forms part of that necessary and important debate. It is happening in a number of common law jurisdictions from the old world to the new. As the Fundamental Review said, after visiting Canada, Australia, New Zealand, Scotland and Ireland:

"Whilst none of the systems we examined could or should be transplanted here in their entirety, this international dimension was a valuable aid to our own thinking. It is plain that more attention has been paid to developing these systems in the New World than so far in the Old."41

This review by the Law Reform Committee of the Parliament of Victoria will form part of that "attention" to "developing" the coronial system in this State to help ensure that we continually review and improve our processes, ultimately for the benefit of the community.

The United States inherited the British legal system during the period when the reputation of coroners was low. Although, the Chief Justice was appointed with other legal appointees such as the attorney for the State and the coroner under the Constitution of the State of Georgia in 1777, the coroners in some other American counties sat with a doctor to overcome the English coroners' difficulty with determining medical causes of death in the absence of medical advice. During the 19th Century, medical examiner systems gradually evolved on an ad hoc basis in some counties in the United States to virtually replace elected or appointed coroner systems. For example, in 1866, a doctor was appointed coroner in Baltimore. In 1877, medical examiners replaced coroners in Massachusetts. Now, medical examiner, mixed medical examiner and coroner and coroner systems and sub-categories or combinations of these

three systems are all operating in different counties in the United States and provinces in Canada. Further, in some counties, the coroner is the Chief of Police, the sheriff or a mortician or an elected official and not necessarily a lawyer. Some Canadian provinces such as Saskatchewan have retained the coronial system but coroners can be either medically or legally qualified.

This professional shift to medical responsibility for investigating death in the United States seems to have slowed in recent years, with medical examiner systems now serving 30% of counties and about 48% of the American population. A major problem common to all medical examiner systems is financial resources - proper medico-legal death investigation is expensive. The limited compensation available makes it difficult to attract and hold medical specialists with legal qualifications or interests whose financial potential in private fee-for-service practice is almost limitless. The other disciplines necessary to the proper investigation of death are also costly, and the office, if honestly directed, produces no revenue for the community. Some commentators suggest that this is because the medical examiner system is expensive and funded through the local government. Further, there are too few forensic pathologists to do all the work required to properly investigate issues wider that the medical cause of death determined at autopsy and they are not usually qualified to address wider public safety and prevention issues. Many of the deaths examined by coroners involve facts and issues far wider and more complex than the medical cause of death.

Australia

In Australia, English common law relating to coronial matters was incorporated into the laws of New South Wales following the First Settlement in 1788. At common law, the Chief Justice of the Supreme Court or his delegate conducted inquests. Legislation creating the paid statutory office of coroner was passed in New South Wales in 1861. Other States followed and developed their legislation independently. Apart from providing for investigation of death, the Australian States' coronial legislation remain s inconsistent in the way different States' Acts provide for delivery of this service to the community. This means that, although recent establishment of the Council of Heads of Australian Coronial Jurisdictions has addressed some coordination difficulties, case law from other States must be interpreted conservatively with consequent loss of learning and National coordination of fundamental service delivery issues, such as consistent development of legislation, remains illusory.

43 Adam, Betty Ann, Justice system on trial: lawyer Impartial body may help prevent wrongful convictions, Star Phoenix, Saskatoon, 28 January 2005.
46 Coroners Act 1861 (NSW).
Victoria

In Victoria, the *Coroners Statute* 1865 provided for appointment of coroners to investigate death in specified districts. At the same time as it established the County Court, the Victorian Parliament passed the *Coroners Act* 1890 which repealed the *Coroners Statute* 1865 and established the statutory role of coroners and deputy coroners in Victoria. Coroners enjoyed all the power, status and jurisdiction attaching to the office in England. They were judges of record and could commit for contempt. In practice, coroners were all magistrates who provided a coronial service as part of their duties in the regional magistrates’ courts. There was little consistency in and no provision for coordination of performance of their coronial functions.

In 1978, J.G. Norris QC was asked by the then Attorney-General to review the operation of the *Coroners Act* 1958. His recommendations led to the introduction of a new Coroners Act in 1985 which enshrined the inquisitorial jurisdiction of the coroner, abolished, as far as legislatively possible, the common law rules affecting the coronial jurisdiction and created the Institute of Forensic Medicine (the "Institute") as a statutory body to provide multidisciplinary support for and subject to direction of the State Coroner.

The new Act addressed concerns amongst lawyers and pathologists that the powers and duties of coroners should be clearly defined in statute in preference to the then current mix of common law and statute. For example, the circumstances in which a death should be reported were not stated in the *Coroners Act* 1890. The *Coroners Act* 1985 also introduced a state coronial system to provide central co-ordination and regulation of the services’ functions. The 1985 Second Reading Speech stated that one of the principal duties of the State Coroner would be to:

> “ensure that there is a coronial system in place of the existing patchwork quilt.”

The 1985 legislation, therefore, set the foundations for the development of the current coroners' role in Victoria. In summary, the major features of the legislation were:

- Establishing a separate administrative rather than judicial coronial jurisdiction;
- Appointment of a State Coroner to oversee a centralised coronial system;
- Specification of the powers and duties of coroners (including the removal of the power to commit for trial and the question of guilt from the coroner’s jurisdiction);
- Listing of categories of reportable deaths;
- Establishing procedures for the holding of inquests;

---

48 s. 3 *Coroners Act* 1890.
• Creating the Institute to provide high quality pathology support to coroners.

These changes were associated with building of the Coronial Services Centre in Southbank to enable cooperation on site between the coroners and the medical and scientific professions involved in investigation of the cause of death and the surrounding circumstances.

Despite the opportunity offered by a complete redraft of the Coroners Act, His Honour failed to recommend the wholesale shift of responsibility for death investigations to the medical examiner systems which have been adopted by some counties in the United States and Canada over the last 100 years.

Amendments of the Victorian Act in 1995, 1999 and 2003 introduced a number of crucial changes in the way the coronial service operates. For example, the Coroners (Amendment) Act 1999 removed the fact-finding role in inquests from juries. This change brought Victoria in line with other States (except NSW) and was:

“a most important shift toward ‘expert’ decision-making in coroners’ courts and removal of the role of the ordinary person from the process.”

Also, the 1999 amendments removed the requirement for the coroner to find contribution because the community tended to view a finding of "contribution" carried with it a connotation of blame. By way of example, a coroner would have to find that a train driver contributed to a death on the train tracks, even if he or she had no opportunity to avoid impact. No matter how the coroner sought to explain that the finding was about the legal definition of the causal chain, the finding of "contribution" was likely to cause confusion.

Further, the reviewable death legislation was implemented in 2004, following a review that found that, while the standard official processes were followed in the case involving the deaths of four children from the same family that prompted the review, there were no systematic means of:

“identifying cases of multiple child deaths and the existence of living siblings; ensuring early assessment of the family’s health needs in multiple child death cases; and triggering a multidisciplinary assessment of the needs of surviving siblings or risks to any prospective children.”

These new provisions require the State Coroner to investigate and report on the circumstances of deaths involving two or more children in a family. Protocols are being developed for the investigation of these cases.

The community and the Government perceive that the State Coroner’s Office has the status of a court, but coronial independence from the Crown and the administration remains a live issue in Victoria. It is

52 e.g. “New Directions for the Victorian Justice System 2004-2014” 25 May 2004; Department of Justice Strategic Priorities 2005, Corporate Planning and Special projects, Department of Justice.
perhaps best exemplified in the New Zealand case of Mr Justice Mahon who was appointed as a Royal Commission\(^{53}\) to investigate the Mount Erebus disaster in which an Air New Zealand plane crashed killing 257 New Zealand passengers and crew.\(^{54}\) An ABC documentary on this case underlines the way in which the Prime Minister and the Chairman of the Air New Zealand Board influenced the preliminary Board of Inquiry and, then, tried to influence the Royal Commission. In the end, although the Royal Commission identified the cause of the crash and made recommendations for preventing further similar crashes, the matter was heard by the Privy Council, the Royal Commissioner was found not to have provided natural justice to the airline and Justice Mahon was forced to resign his position on the High Court in New Zealand.

Since the Victorian legislation was implemented in 1986, coronial legislation in the ACT, South Australia and Western Australia has established Coroners Courts rather than coronial systems or services and coroners are judicial rather than administrative officers. In Tasmania, the Coroners Court is established as division of the Magistrates’ Court.\(^{55}\) They differ from the Victorian, New South Wales and Northern Territory situations in continuing to ensure that coroners have judicial rather than administrative status with associated independence from the Crown and from the administration. In this way, they further secure the independence of the office of the State Coroner.

Further, in Victoria, the coronial system is administered through the Magistrates’ Court. Funding is provided through the Magistrates’ Court budget and all magistrates are appointed as coroners even when they do not routinely perform this role. Appointment of full-time coroners occurs in consultation with the Chief Magistrate although, in performing their coronial role, the magistrates are directed by the State Coroner. State Coroner's Office staff are almost all appointed on a rotating basis from within the Magistrates’ Court with no jurisdiction-related training. Appointments to specialist research and management or investigation positions under the auspices of the State Coroner are restricted by the structure of employment conditions that applies in the Magistrates’ Court. Generally, it is necessary to seek support from other government agencies for this valuable aspect of our work. By way of example, agencies such as the Department of Human Services and WorkCover have and are supporting some aspects of the coronial system.

The State Coroner's Office is not seeking operational separation from the Magistrates’ Court. However, the State Coroner's Office is of the view that creation of a statutory Coroners Court of Victoria with associated appointments of coroners and administrative staff would help to achieve:

- Real independence of the office of State Coroner,

---

\(^{53}\) In the same way as coroners, Royal Commissions are acting administratively even when they are undertaken by a judge: *Sorby v. The Commonwealth* [1983] HCA 10; (1983) 152 CLR 281.

\(^{54}\) *Mahon v Air New Zealand* [1984] AC 808.

\(^{55}\) s. 4 *Coroners Act* 1997 (ACT); s 3 *Coroners Act* 2003 (SA); Long title *Coroners Act* 1997 (Tas); *Coroners Act* 1996 (WA).
- Consistency with recent interstate legislation and proposals in the United Kingdom,
- Acknowledgement of the specialist nature of coronial work, and
- Reality in the common misconception that the coronial system is already a court.

The State Coroner's Office is aware that this recommendation may not be palatable because it reverses the position adopted by the Parliament in 1985. Therefore, the State Coroner's Office is of the view that, in the alternative and as a matter of clarification only, the Purposes of the Act should be amended to include the word 'independent' in section 1(a) and/or 1(c). These words have not been used in the purposes of coroners' legislation in New South Wales and the Northern Territory where administrative coronial systems have also continued to operate.

**Non-fatal Fires**

Coroners' authority to investigate non-fatal fires was established during the eighteenth century when legislation was passed in England vesting coroners with a limited power to conduct inquiries into non-fatal fires. The City of London Records Office holds records of non-fatal fire inquests dating from 1888.

In parallel with these changes in England, the *Coroners Act* 1890 in Victoria required coroners to:

"... inquire into the cause and origin of any fire whereby any building ship of merchandise or any stack of corn pulse or hay or any growing crop within such district shall be destroyed or damaged....

Notwithstanding anything hereinbefore contained no coroner or deputy coroner shall have jurisdiction (unless thereto authorized in writing by the Minister in whose department this Act is administered) to inquire into the cause and origin of any fire whereby any property shall have been destroyed or damaged until some person shall in respect of such inquisition pay the sum of five pounds and five shillings to the coroner, or to some receiver of revenue, and in the latter case produce to the coroner a receipt for the said sum."56

Coroners' discretion to investigate non-fatal fires has been perpetuated in the coroners' legislation in the ACT, New South Wales and Tasmania.57 It has been repealed in more recent legislation in Western Australia, the Northern Territory and South Australia.

In 2003, in response to submissions relating to bush fires made to a broad-ranging review of their Act, the New South Wales Parliament extended their coroners' fire jurisdiction to allow broader investigation into fires if requested by the Attorney General, the State Coroner, the Commissioner of Rural Fire Service or the New South Wales Fire Brigades. This amendment was intended to expedite investigation of otherwise authorised non-fatal fires to cause and origin of the fire so that any recommendations can be implemented before the next bushfire season:

56 ss 4 & 5 *Coroners Act* 1890.

57 s 18 *Coroners Act* 1997 (ACT), ss 15, 15A & 15B *Coroners Act* 1997 (NSW), ss 40 & 43 *Coroners Act* 1995(Tas.).
"...the government is of the view that delays in holding coronial fire inquiries could best be avoided by clarifying the scope of the inquiry to cause and origin of the fire rather than the broader and less easily defined term, "circumstances"."\(^{58}\)

Fire investigation requires sophisticated professional expertise. In Victoria, fires are routinely investigated by the Metropolitan Fire Service, the Country Fire Authority, Parks Victoria, the Victorian Forensic Science Centre and/or the Victoria Police Arson Squad as well as by the Office of Gas Safety or WorkSafe. All these agencies co-operatively investigate appropriate fires under the State's "Fire Investigation Policy and Procedures".\(^{59}\) Private fire investigators employed by insurers and property owners also investigate fire.

When requested, the State-based agencies investigate fires on behalf of the State Coroner. Further, the Metropolitan Fire Service and the Country Fire Authority can request coronial involvement in fire investigations. However, there is no independent coordinating body with power and authority to investigate and promulgate lessons from serious fires about causation, prevention and public safety, particularly the safety of fire fighters in risky situations such as bush fires.

Therefore, in order to continue the State Coroner’s role in public safety and prevention in relation to non-fatal fires and to remain consistent with recent interstate coronial legislation, the State Coroners Office makes no recommendation with respect to the removal of the State Coroner's fire jurisdiction in section 1(c) of the Act. However, there are areas where the legislation could be improved and clarified. These will be discussed in Chapter 6 of this submission.

**The Coroner's Public Safety and Preventative Role**

Although it was not routinely specified in his role, the coroner has played an actively preventative role since King Richard I appointed high status coroners to record and investigate unnatural and violent death. From its inception, this authority coupled with the knowledge obtained from their investigations carried with it the opportunity to impose orders that would improve the safety of local people subject to similar risks. For example, on 22 May 1316, following an inquest into the death of Roger B when a stone from a quarry fell on his head, the coroner ordered the quarry to be enclosed.

Similarly, on 25 January 1788, William Deverill was found to have fallen from a very narrow foot bridge call Black-Avon Bridge and drowned. "...by reason of many past accidents as the present and to prevent future ones, it was judged highly necessary to adjourn until after a convention by vestry of the chief inhabitants of Chippenham, the result whereof is to widen and strengthen the bridge and render it safer in time of floods."

As well, in 1821, a coronial jury determined that a man "suffocated in a certain pond by a certain gas water which is thrown into the pond by a

---


"certain gas company". They recommended that the Parish of St Matthew Bethnal Green take proper measures ‘to remedy the said evil’.

To some degree, this preventative role of coroners was recognised in the Coroners Act 1985. Section 19(2) of the Act provides coroners with authority to comment on any matter connected with the death including public health or safety or the administration of justice. Further, section 21 of the Act provides coroners with jurisdiction to report to the Attorney-General on a death which the coroner investigated or make recommendations to any Minister or public statutory authority on any matter connected with a death which the coroner investigated, including public health or safety or the administration of justice.

The importance of coroners’ public safety and prevention role is stressed by Kevin Waller, who asserts that:

“the modern coroner is part of the Australian magistracy, performing a highly specialised function which is of great benefit to the community in general... they are keeping the public much better informed of the circumstances surrounding important and controversial deaths and fires, and ... are able to make useful suggestions as to how such events may be curtailed.”60

Applying similar provisions, the New Zealand High Court said:

"Although the role of the coroner in making comments and recommendations was limited by the purposes of an (investigation), it was an inquisitorial process, and the Act did not confine the coroner to comments only on the same causative elements or circumstances as those in which the particular death occurred. The provision allowed for comment on all the implications of circumstances similar to those surrounding the death. The public interest in preventing further loss of life required a broader interpretation of the wording ... which empowers the coroner to comment on and make recommendations as to the manner in which persons should act in circumstances similar to those in which the death occurred, provided the comments were justified by an objective assessment of the evidence in the case. If comments were restricted to matters which exactly mirrored the circumstances of the case under consideration, that would hinder the useful public voice of the coroner in commenting on matters of public interest."61

However, in 1989, the Supreme Court in Victoria restricted coroners' capacity to perform their preventative role:

"The power to comment arises as a consequence of the obligation to make findings and is not free ranging. The State Coroner may not enquire for the sole or dominant reason of making comment or recommendation."62

Further, in 1994 Mr Justice Harper said:

---

"...the effect of this provision is to forbid the coroner from commenting on any matter unconnected with the death."63

These decisions limited the scope of Victorian coroners' investigations and their capacity to exercise their public safety and prevention roles. This limitation was also contrary to the recommendations of the 1991 National Report of the Royal Commission into Aboriginal Deaths in Custody (RCADIC) which specifically referred to the need to ensure that appropriate recommendations were made by coroners to relevant authorities in order to pave the way for remedial action.64 As well, in 1995, a Victorian case study of Deaths in Custody had highlighted the importance of the ability of the Coroner to make recommendations that could lead to the prevention of deaths in custody.65

In 1999, some of this restriction was clawed back by an amendment to the Act which was intended to enable the coroner to send copies of his or her findings to 'any Minister or public statutory authority". This amendment was not only consistent with the RCADIC recommendations but enhanced the role of coroner "in preventing avoidable deaths".66 Further, in June 2004, the Supreme Court opened the door to some collateral coronial investigations when Justice Williams allowed the coroner to seize medical records for patients who were treated by the same doctor and had similar diagnoses to the deceased to allow wider assessment of the doctor's prescribing practices:

" I am satisfied that it would have been reasonable for the (coroner) to have held the belief that the extra records might contain material relevant to possible findings he might make under s 19(1)(b) and (c), in particular, and that it was necessary for his investigation to obtain them under s 26(3)."67

Last year, the Attorney General insisted that:

"Unlike other judicial officers, the State Coroner's role goes beyond making findings on the relevant law and facts of the case to include making recommendations that would prevent the re-occurrence of similar deaths or accidents in the future. This role is an important and valuable one for improving the safety of the community."68

In order to confidently achieve this public safety and prevention role, the State Coroner's Office is of the view that section 1 of the Coroners Act 1985 requires amendment to ensure that there is no further dispute about coroners' jurisdiction to perform their important public safety and prevention role. In Queensland, this is achieved by placing the preventative role in the purposes of the Coroners Act 2003:

"The object of this Act is to--

"..."
(d) help to prevent deaths from similar causes happening in the future by allowing coroners at inquests to comment on matters connected with deaths, including matters related to--

(i) public health or safety; or

(ii) the administration of justice.\(^\text{69}\)

Further, the State Coroner's Office needs to have clear authority to collect and analyse the information it collects in its investigations including maintaining the current National Coronial Information Service database and undertaking or hosting research projects focussed on particular public safety and prevention issues. In Queensland, there is legislative provision for providing and accessing data from the National data bases such as the National Coronial Information System described in Chapter 5.\(^\text{70}\) To effectively acquire, analyse and use information that can be gained during and after a coronial inquiry for community benefit and education, the research capacity of the coroner needs to be supported, managed and strengthened.

The State Coroner’s Office is of the view that, with amendment to generalise from the inquest only situation and to enable data collection and analysis, the Queensland form of words is of assistance in ensuring that the coroners' safety and prevention role is integrated into the purposes of the coronial jurisdiction. In addition, the data collection process, that is the National Coroners' Information System or its equivalent, needs to be further protected in the legislation.

**Support for Families and Other People**

There will always be a tension between the coronial process required for proper investigations to be performed and its intrusion on grief and mourning for loved ones who have died.

“The bereaved are precipitated into a devastating situation and are having to deal with agencies and procedures unknown to them and from which they feel totally excluded.”\(^\text{71}\)

The Terms of Reference of the Inquiry specifically seek recommendations from the Committee about whether the Act provides an appropriate legislative framework for the provision of support for families, friends and others associated with a deceased person who is the subject of a coronial inquiry.

Further, in its Discussion Paper, the Committee has asked:

- 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?

\(^{69}\text{s. 3 Coroners Act 2003 (Qld).}\)

\(^{70}\text{S. 93 Coroners Act 2003 (Q’ld).}\)

• Do you think the Coroners Act is able to accommodate those needs? Are there any resource issues to consider?\textsuperscript{72}

• As well, the Committee has asked whether family members have a right to be informed of the progress of the investigation, whether the term ‘family member’ should be defined in the Act, who should inform the family member and are there any resource issues to consider in these questions?\textsuperscript{73}

All these questions will be dealt with later in this submission.

The State Coroner’s Office is of the view that it has a duty to minimise the effect of the coronial investigation on the grieving process and on everyone who is involved in the coronial investigation. This duty increases as time passes and in cases involving formal hearings. Further, the complications that arise when the interaction between family members and the coronial process is not managed sensitively result in extra work and can interfere with proper investigations, refusal of organ donations and occupational health and safety issues for the people who work in the coronial system.

The Northern Ireland Report goes further in saying:

“Providing a service to families who have been bereaved is one of the core functions of the Coroners Service.”\textsuperscript{74}

The State Coroner’s Office is also aware of the tensions in providing support in the context of a judicial investigatory process and the need to ensure that there is a balance. Luce highlighted the issue in the Fundamental Review:

“We have also been conscious that the coroner is charged with fulfilling a difficult role, where there can be competition between the two objectives of providing a bereaved family with sympathy in their loss and the need to undertake an impartial judicial inquiry. Decisions about how to proceed often need to be made quickly and this is not easy when families are experiencing a great weight of feeling and distress.”\textsuperscript{75}

In this context, Luce noted that sometimes there are tensions within a particular family about the circumstances of a death or, alternatively, to quote a London coroner, “those cases involving more than one death involve families with different needs”. Also importantly, there are:

“frequently other participants than the family with an equal right to fair and objective treatment - doctors and nurses in health care settings, prison staff, and the drivers of trains used as a means of suicide...”\textsuperscript{76}

\textsuperscript{74} Northern Ireland Court Service, “Modernising the Coroners Service in Northern Ireland: The Way Forward”, 1 April 2005.
Although coroners’ websites in New South Wales, South Australia and Tasmania and Western Australia refer to the availability of grief counselling services, Western Australia is the only Australian State to include provision for support services in its coronial legislation.\(^\text{77}\)

Similarly, in Melbourne, although there is no provision in the Act to indicate who has responsibility for providing support services to families and others, the Counselling and Support Service is available at the Coronal Services Centre, to help the bereaved to cope with a sudden and traumatic death that has been reported to the coroner. On 1 March 2004, a pilot program was launched which requires counsellors to make contact with and offer professional support to almost all families of reportable deaths that occur in Melbourne. On-going support by the service is not limited to families but may extend to witnesses and others affected by the coronial process. Although it is envisaged that the program will remain a key strategy of the State Coroner’s Office in ensuring an accessible, responsive, and sensitive court service for the community, there is no formal or legislative requirement for the program to operate and it has not been subject to independent review.

However, the Family Contact Program is not usually available in regional areas. In the future, it is important for a modern coronial service to have a short term counselling, support and, where appropriate, referral service that is available throughout regional Victoria. An effective short term counselling and support service attached to the State Coroner’s Office is vital when a major disaster or terrorism event occurs. We have had recent experience of the usefulness of a coronial counselling and support service (Bali and the Boxing Day Tsunami). A description of the current service is included in Chapter 3 of this submission. Specially designed information packages are also helpful.

The State Coroner’s Office is of the view that, as well as responding to expected changes in the frequency, geography and cultural diversity of the dying and the bereaved, funding of its services should take into account the influence that death has on everyone associated with it and the way in which adequate services can ameliorate the inevitable intervention of coronial processes on their grief and pain. While the specific nature of the service should not be confined by legislation, it is appropriate for the bereavement support program to be properly acknowledged in the Act as one of its primary functions. This will reassure those most affected by the coronial process, assist with management of the investigation process and ensure on-going funding.

\(^\text{77}\) s. 20 Coroners Act 1996 (WA).
For these reasons, the State Coroners Office recommends:

RECOMMENDATION 1.1a

That the Parliament of Victoria amend section 1 of the Coroners Act 1985 to include:

The purpose of this Act is to--

(a) establish a Coroners Court in Victoria;
(b) require the reporting of certain deaths;
(c) set out the procedures for investigations and inquests by coroners into deaths and fires;
(d) help to prevent deaths or fires from similar causes happening in the future by collecting and analysing data and enabling coroners to comment and make recommendations about certain matters connected with deaths or fires, including matters related to—
   (i) public health or safety; or
   (ii) the administration of justice;
(e) provide support for families, friends and others associated with a death which is the subject of a coronial investigation;
(f) establish the Victorian Institute of Forensic Medicine.

Alternatively, the State Coroner's Office recommends:

RECOMMENDATION 1.1b

That the Parliament of Victoria amend section 1 of the Coroners Act 1985 to include:

The purpose of this Act is to--

(a) establish the independent office of State Coroner;
(b) require the reporting of certain deaths;
(c) set out the procedures for independent investigations and inquests by coroners into deaths and fires;
(d) help to prevent deaths or fires from similar causes happening in the future by collecting and analysing data and enabling coroners to comment and make recommendations about certain matters connected with deaths or fires, including matters related to—
   (i) public health or safety; or
   (ii) the administration of justice;
(e) provide support for families, friends and others associated with a death which is the subject of a coronial investigation;
(f) establish the Victorian Institute of Forensic Medicine.
Definitions used in the Act

Section 3 of the Act provides the definitions which limit the operation or interpret the meaning of the Act. In the Discussion Paper, the Committee has sought specific advice about the definitions of:

- Person held in care and in custody;78 and
- Reportable death.79

Further, the Committee seeks advice about the definition of “disaster.”80

The State Coroner has considered all the current and some other proposed definitions in section 3 of the Act. Those requiring commentary have been presented in bold type in this list and these are discussed below. The State Coroner’s Office is of the view that the definitions that have not been highlighted in this list do not require amendment.

Section 3 of the Act provides:

“In this Act—

“anaesthetic” The State Coroner’s Office is of the view that this word requires formal definition.

“autopsy” The State Coroner’s Office is of the view that this word requires formal definition.

“child” means a person under the age of 18 years of age;

“coroner” includes the State Coroner and the Deputy State Coroner;

“Council” means the Council of the Institute;

“death” includes suspected death; The State Coroner’s Office is of the view that this definition requires further precision.

“Director” means the Director of the Institute and includes a person appointed to act as Director;

“doctor” means a registered medical practitioner within the meaning of the Medical Practice Act 1994;

“domestic partner” of a person means an adult person, to whom the person is not married but with whom the person is in a relationship as a couple where one or each of them provides personal or financial commitment and support of a domestic nature for the material benefit of the other, irrespective of their genders and whether or not they are living under the same roof, but does not include a person who provides domestic support and personal care to the person--

(a) for fee or reward; or

(b) on behalf of another person or an organisation (including a government or government agency, a body corporate or a charitable or benevolent organisation);

The State Coroner’s office is of the view that this definition will become redundant of the Committee adopts the recommended definition of senior next of kin.

“government body” means—

(a) a department within the meaning of the Public Sector Management and Employment Act 1998 or an office specified in section 16(1) of that Act;

(b) a public statutory authority; or

(c) a State owned enterprise within the meaning of the State Owned Enterprises Act 1992; or

(d) a corporation which is substantially owned or effectively controlled by the state; or

(e) any other body whether incorporated or not incorporated which is supported directly or indirectly by government funds;

“Institute” means the Victorian Institute of Forensic Medicine;

“investigation” includes an inquest;

“legal practitioner” has the same meaning as in the Legal Practice Act 1996, but does not include an incorporated practitioner;

“parent” in relation to a child includes—

(a) a step-parent;

(b) an adoptive parent;

(c) a foster parent;

(d) a guardian;

(e) a person who has custody or daily care and control;

(f) a person who has all the duties, powers, responsibilities and authority (whether conferred by a court or otherwise) which, by law, parents have in relation to children;

“natural causes death” The State Coroners Office is of the view that these words require formal definition.

“pathologist” means a doctor with a qualification in pathology recognized by the National Specialist Qualification Advisory Committee of Australia;

“person held in care” means:

(a) a person under the control, care or custody of the Secretary of 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;

The State Coroner’s Office is of the view that that, as indicated by the bold type, this definition requires further consideration and other categories should be inserted.

“prescribed” means prescribed by the regulations;
“preventable death” The State Coroner’s Office is of the view that these words require formal definition.

“public statutory authority” means any public body constituted or established for a public purpose by or under an Act;

“reportable 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 person who ordinarily resided in Victoria at the time of death; or
(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
(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
(iia) 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
(iib) 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;

The State Coroner’s Office is of the view that that, as indicated by bold type, this definition requires further consideration and other categories should be inserted.

“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;

"senior next of kin" the State Coroner’s Office is of the view that this definition should be moved to section 3 of the Act and amended.
“sibling” in relation to a child includes a half-brother, half-sister, adoptive brother, adoptive sister, step-brother or step-sister of the child;

“spouse” of a person means a person to whom that person is married;

“tissue” has the same meaning as in the Human Tissue Act 1982. 81

This submission will now discuss the definitions indicated in bold above.

Anaesthetic

In the Discussion paper, the Committee seeks advice in relation to deaths involving anaesthetics. 82 In part this issue is addressed by introducing a definition of ‘natural causes death’ as indicated below. As relevant to these and other issues related to doctors understanding of reportable death, the Form used by doctors to complete their medical deposition for the coroner asks the following questions in tick box form 83:

<table>
<thead>
<tr>
<th>Reason for reporting death to the coroner</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unexpected</td>
</tr>
<tr>
<td>As a result of anaesthetic</td>
</tr>
<tr>
<td>During anaesthetic</td>
</tr>
</tbody>
</table>

Was this death expected as a consequence of this illness or injury? (yes/no)

Opinion as to cause of death?

Type of procedures performed during this admission (please specify)?

- Surgical procedures?
- Medical procedures?
- Diagnostic procedures?
- Other?

Type of anaesthesia administered for the above procedures?

- General?
- Local?
- Spinal/epidural?
- Sedation?
- Regional?
- Other?

Therefore, in completing the Medical Deposition, doctors determining whether or not to report a death in which the deceased is subject to anaesthesia should be under no misapprehension about the wide definition of anaesthesia. This may cause some problems for medical

---

81 s. 3(1) of the Human Tissue Act 1982 provides:
“Tissue’ includes an organ, or part, of a human body or a substance extracted from, or from a part of, the human body.”


83 Taken from Death Report to Coroner-Medical Practitioners Deposition form.
officers, particularly general practitioners, who are unaware that the patient is subject to local anaesthesia or sedation.

Further, a death associated with but not necessarily caused by anaesthesia is reportable if the cause of death is not a natural causes death and/or it is unexpected. Therefore, all deaths in which this question is answered in the negative or the cause of death is not a natural causes death are also reportable deaths.

In South Australia, anaesthetic is defined:

"anaesthetic" means a local or general anaesthetic, and includes the administration of a sedative or analgesic.84

The State Coroners Office is of the view that this definition is too unspecific and does not provide for developments in anaesthetic techniques. Instead, it recommends:

RECOMMENDATION 1.2

That Parliament amend section 3 of the Coroners Act 1985 to include the following definition:

“anaesthetic” includes general anaesthetic, local anaesthetic, spinal or epidural anaesthetic, sedation, regional anaesthetic or any other procedure or administration of an anaesthetic agent which causes partial or complete loss of sensation for the purposes of medical treatment.

Autopsy

In the context of family members and others making applications for or against autopsies being performed under sections 28 or 29 of the Act, there is sometimes dispute about whether an ‘autopsy’ includes a pathologist’s external inspection of the intact body and/or taking of body fluid samples for toxicological analysis. In practice, the ‘autopsy’ is presumed to be limited to internal examination.

A medical dictionary defines ‘autopsy’ as:

“Examination of a body after death. An autopsy, a legal and medical procedure also called a post-mortem examination, is performed by a medical examiner or by a pathologist to establish a cause of death or to detect the presence or absence of disease or injury.”85

Further, the Human Tissue Act 1982 uses ‘post-mortem examination’ in apparently the same context as the Coroners Act 1985 uses autopsy. For example, s 29(4) provides:

“A coroner may give a direction, either before or after the death of a person to whom this section applies, that his consent to a post-mortem examination of the body of the person is not required and, in that event sub-sections (2)

84 s. 3 Coroners Act 2003 (SA).
and (3) do not apply to or in relation to a post-mortem examination of the body of the deceased person.”

Therefore, it seems appropriate to interpret ‘autopsy’ and ‘post-mortem examination’ synonymously.

In Queensland, ‘autopsy’ is widely defined as:

“The autopsy may consist of—
(a) for a body that has been cremated—an examination of the cremated remains of the body; or
(b) for a body that has not been cremated—
(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.”

There, coroners must order an autopsy as part of an investigation and specify the type of autopsy, within this range, that they require. Separate arrangements are provided for taking of body samples for toxicological analysis when an autopsy is ordered but none apply if no autopsy is ordered. The State Coroner’s Office of the view that this system is unnecessarily complicated and does not allow for the requirement to perform a preliminary external examination in order to decide what sort of autopsy to perform.

For the purposes of clarifying this matter and reducing family stress, the State Coroner’s Office recommends:

RECOMMENDATION 1.3

That Parliament amend section 3 of the Coroners Act 1985 to include the following definition:

“autopsy” does not include external inspection of the body or taking of body fluids for toxicological analysis.

Death

Despite its crucial relationship to the coroners' jurisdiction, death is not defined in the Act. In the absence of a body, case law has determined that, if a person has not been heard of for seven years, there is a presumption of law that he is dead. However, at what time within that period he died is not a matter of presumption but of evidence and the onus of proving that the death took place at any particular time within the seven years lies with the person who claims a right to the establishment of that fact.

In the coroners' arena, death "includes suspected death" and, as such, a coroner can determine the fact of death even without a body and not subject to time restraints. This determination will depend on a variety of

---

86  s. 19(2) Coroners Act 2003 (Qld.)
87  ss. 19(1) & (3) Coroners Act 2003 (Qld.)
88  ss. 23 & 24 Coroners Act 2003 (Qld.)
89  Axon v Axon [1937] HCA 80; (1937) 59 CLR 395 per Dixon J.
facts ascertained during the investigation and inquest (an inquest is mandatory in suspected death cases).

It is noted that section 4 of the Births Death & Marriages Registration Act 1996 provides:

"death" does not include a still-birth."

'Still birth' is defined as:

"...a child of at least 20 weeks gestation or, if it cannot be reliably established whether the period of gestation is more or less than 20 weeks, with a body mass of at least 400 grams at birth, that exhibits no sign of respiration or heartbeat, or other sign of life, after birth."

The State Coroner's Office is of the view that exclusion of still birth should also be addressed in the definition section of the Act.

The State Coroner's Office recommends:

RECOMMENDATION 1.4
That Parliament amend the definition of death in section 3 of the Coroners Act 1985 to:

"death" includes suspected death and excludes still birth.

Disaster and terrorism events

The Committee has asked two questions in relation to disasters:

- 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?

- What kinds of events do you think should be included in the definition of disaster?90

In Victoria, a disaster is already defined by declaration by the Premier acting on advice of the Coordinator in Chief of Emergency Management who is usually the Chief Commissioner of Police:

"If there is an emergency which the Premier of Victoria after considering the advice of the Co-ordinator in Chief and the State Co-ordinator is satisfied constitutes or is likely to constitute a significant and widespread danger to life or property in Victoria, the Premier may declare a state of disaster to exist in the whole or in any part or parts of Victoria."91

Victoria Police is the lead response agency when a disaster or terrorist act occurs in Victoria.92 The Emergency Services Commissioner, within the meaning of the Emergency Management Act 1986, has the power to establish and monitor standards for the prevention and management of emergencies to be adopted by all emergency services agencies. Further, the Minister for Police and Emergency Services has appointed the

---

91 s. 23 Emergency Management Act 1986.
Secretary of the Department of Human Services as the State Emergency Recovery Co-ordinator.

Appropriately, the coroners role in a disaster is limited to informing the State Coroner at the beginning of the response process and determining the statutory functions under section 19 of the Act that finalise the process. In particular, the State Coroner is a member of the State Emergency Response Planning Committee.\textsuperscript{93} The State Coroner and the State Coroner's Office was consulted in relation to the development of the Victorian Emergency Training and Development Strategy.\textsuperscript{94} Further, the role of the State Coroner's Office in identification of victims is identified in the Emergency Management Manual Victoria\textsuperscript{95} and the Victorian Victim Disaster Identification Manual requires the Reconciliation Centre for Disaster Victim Identification (DVI) to be established in the court foyer area of the Coronial Services Centre. The State Coroner sits on the Disaster Victim Identification Board. The Victorian Victim Disaster Identification Manual also recognises that the State Coroner retains his or her statutory authority to investigate deaths and fires that contribute to a disaster and to direct that more than one death or more than one fire or both a death or deaths and a fire or fires be investigated at one inquest.\textsuperscript{96}

Further, the role of the State Coroner's Office in identification of victims is identified in the Emergency Management Manual Victoria.\textsuperscript{97} The Victorian Victim Disaster Identification Manual requires the Reconciliation Centre for Disaster Victim Identification (DVI) to be established in the court foyer area of the Coronial Services Centre and the State Coroner sits on the Disaster Victim Identification Board. The Victorian Victim Disaster Identification Manual also recognises that the State Coroner retains his or her statutory authority to investigate deaths and fires that contribute to a disaster and to direct that more than one death or more than one fire or both a death or deaths and a fire or fires be investigated at one inquest.\textsuperscript{98}

Increasingly, coroners in Australia are investigating disasters on behalf of their respective communities. Examples are the Westralia explosion and fire, the Canberra Hospital implosion, the Linton wildfire, the recent fires in South Australia, the Sydney-Hobart yacht race and Canberra bushfire.

Therefore, the State Coroner already has jurisdiction to investigate and make recommendations in relation to fire disasters or disasters that involve death that occur in Victoria. This power was exercised in relation to the Linton Wildfires in 1998\textsuperscript{99} the Longford disaster in 1998\textsuperscript{100} and the Westgate Bridge disaster in 1973.\textsuperscript{101}

\textsuperscript{98} s. 43 Coroner\textsuperscript{es} Act 1985.
\textsuperscript{100} Investigation into the deaths of Peter Wilson and John Lowery, 15 November 2002.
\textsuperscript{101} Investigation into the deaths of 12 April 1973.
Coroners in the ACT and the Northern Territory have specific jurisdiction to investigate disasters. Their Coroners Acts define disaster in essentially the same way as a disaster is defined in the Emergency Management Act 1986 in Victoria:

""disaster" means 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."

In Tasmania, the Coroners Act 1997 provides for investigation of explosions. Explosions are undefined. There is no suggestion in these other States that the disaster or explosion jurisdiction provides coroners with power to investigate disasters other than those involving multiple deaths and injuries and/or fires or risks of these occurring.

In deaths that arise from interstate or overseas disasters, the South Australian Coronial Service does not have jurisdiction to investigate deaths which occurred outside the State except when it involves:

"A death...
 a) a cause of which occurred, or possibly occurred, in the State; or
 b) where, at the time of death, the person was ordinarily a resident in the State; or
 c) in the case of a death on an aircraft or vessel—where the flight or voyage was to a place of disembarkation in the State."

Similarly, the Queensland Coronial Service does not have jurisdiction to investigate deaths which occurred in other States:

"... unless directed to do so by the Minister, if--
(a) the death happened in another State and has been reported to a non-Queensland coroner; or
(b) the death happened outside Australia."

However, the Coroners Act 1985 already provides the State Coroner in Victoria with sufficient jurisdiction to fulfil a primary role in any cooperative arrangement required to respond to incidents outside Victoria such as the Bali tragedy and the South East Asia Tsunami and to prepare for the risks associated with the 2006 Commonwealth Games in Victoria. To this end and to generally improve management of these events, Victoria has recently established the position of Disaster Co-ordinator in the State Coroner's Office.

Section 25 of the Act provides the State Coroner with power to assist coroners in other states or territories of Australia. Further, Schedule 1 of the Crimes at Sea Act 1999 articulates a cooperative scheme that has been agreed by the Commonwealth and the States to apply the criminal law (including coronial inquiries) of the States extraterritorially in the areas

---

102  s. 19 Coroners Act 1997 (ACT), s. 28 Coroners Act (NT).
103  s. 3 Coroners Act 2003 (SA).
104  s. 12 Coroners Act 2003 (Qld).
adjacent to the coast of Australia. Under the scheme, the criminal law of each State applies in the area adjacent to the State—

(a) for a distance of 12 nautical miles from the baseline for the State—by force of the law of the State; and
(b) beyond 12 nautical miles up to a distance of 200 nautical miles from the baseline for the State or the outer limit of the continental shelf (whichever is the greater distance)—by force of the law of the Commonwealth.

The State Coroner and Deputy State Coroner are also appointed as coroners in Tasmania.

Further negotiations are proceeding between the Council of Heads of Australian Coronial Jurisdictions and Emergency Management Australia (Commonwealth Attorney General's Office) with a view to providing a more cooperative interstate framework when a major disaster or terrorism event occurs. This applies where the incident occurs either overseas or locally affecting the whole Australian community and/or straddling a number of jurisdictions. The State Coroner is using his jurisdiction under section 25 of the Act to play an active part in these negotiations. Work in this area will require further amendment to the Act (as well as other Coroners' legislation throughout Australia) to provide an improved framework to deal with major disasters.¹⁰⁵ A Memorandum of Understanding is now being developed together with a system of Coronial Liaison Officers.

Therefore, subject to the above proviso, the State Coroner’s Office is of the view that there is no reason for the Coroners Act 1985 to provide the State Coroner with specific jurisdiction to investigate disasters or terrorism events.

**Domestic partner**

To maintain consistency in the proposed amendment to the definition of "senior next of kin", the State Coroner's Office is of the view that this definition should be revoked.

Therefore, the State Coroner's Office recommends:

**RECOMMENDATION 1.5**

That the Parliament revoke the definition of "domestic partner" in section 3 of the Coroners Act 1985.

**Family member**

In its Discussion Paper, the Committee has sought advice about whether family member should be defined in the Act.¹⁰⁶ The State Coroners Office

---

¹⁰⁵ Council of Heads of Coronial Jurisdiction "Disaster Management and Disaster Victim Identification" document (5th November 2002), immediately following Bali. And also see Latrobe University "Options Paper" on the "Australian coronial jurisdiction in national and international disasters." (by the National Centre for Public Health Law for the Heads of Coronial Jurisdictions).

is aware of the major demographic changes in family structures that are occurring in the community and the culturally diverse nature of families in Victoria. Further, issues that arise from the definition of senior next of kin in section 29 of the Act will be discussed later in this submission.

Without in any way inferring that family and friends are unimportant in the coronial process, the State Coroner’s Office is of the view that it is inappropriate to define a family member in the Act with a view to then requiring certain information to be provided to that person or for that person to be otherwise involved in the coronial process. Rather, families can be better served by provision of professional short term counselling and support services throughout the process by the Counselling and Support Service for everyone who is affected by the death.

The State Coroner's Office is of the view that if the Committee decides it should be legislatively required to provide information to family members, then that requirement should be directed to providing the information to the "senior-next-of-kin".

Inquest

Practice has determined that inquest means a formal hearing. Further, Justice Ashley has recently perpetuated this definition:

“An inquest is not a proceeding inter partes. It is part of an investigative process which is concerned, inter alia, to set the public mind at rest where there are unanswered questions about a reportable death....

The Act draws a clear distinction between the investigation of ‘reportable deaths’ and the holding of inquests. That is so despite the definition of ‘investigation’ in s 3, explicable in that an inquest may be part of the investigative process.” 107

However, the current definition of ‘inquest’ in the Act perpetuates the historical presumption that coronial investigations in a case are constituted by the inquest or, taken together with the definition of ‘investigation’ and sections 4 & 44, the entire investigation including the formal hearing could be called an ‘inquest’. Further, these expectations can be perpetuated in the Victorian community by American television drama which frequently emphasises the role of formal hearings in their investigations.

In 2003/4 (2002/3), 284 (247) inquests were held and 3828 (3813) findings were handed down without inquest. These were distributed between Melbourne and country courts as indicated in Figure 5.

In reality, more than 90% of coronial investigations in Victoria are determined without inquests. For example, in 2003/4 (2002-3), there were 4498 (4219) deaths reported to the State Coroner, 284 (247) inquests were held and 3828 (3813) findings were handed down without inquest. These were distributed between Melbourne and country courts as indicated above.

Therefore, without more, the current definition of inquest can be somewhat misleading.

For these reasons, State Coroner's Office is of the view that the definition of inquest should be amended to more precisely define its intended meaning.

The State Coroner's Office recommends:

RECOMMENDATION 1.6

That the Parliament amend the definition of inquest in the Coroners Act 1985 to read:

“Inquest” means a formal hearing which may be part of the coronial investigation process.

Natural causes death

Section 37(1) of the Births Deaths and Marriages Act 1996 requires doctors to register a death with the Registrar of Births Deaths and Marriages unless it is reportable to the coroner. Although it is intended that all deaths other than those which result from so-called natural causes' are reportable, 'natural causes death' is undefined in the Act and is therefore determined by exclusion from the definition of 'reportable death'. The definition of 'reportable death' in the Act is a list of specific causes of death. This list of 'reportable deaths' is not always interpreted to include
deaths which are considered by the State Coroner and/or the Registrar of Births Deaths and Marriages to be reportable, for example deaths due to industrial disease, some deaths from hospital adverse events and deaths from otherwise natural causes such as asthma which could have been prevented by different treatment or emergency responses.

In some situations, this interpretation is further complicated by case law which has determined that an otherwise ‘natural causes death’ does not become unnatural simply because of the circumstances surrounding it:

"In the present case no one disputes the pathologist’s assessment of the cause of death in the post-mortem report if only the medical aspect is considered. It follows that, as none of the other alternatives .... is remotely relevant, the only basis on which an inquest could be held would be if it can be said that, because of the late arrival of the ambulance, there is reasonable cause to suspect that Miss Thomas died an unnatural death. That is therefore the question we have to consider......

I do not know what the cause of (ambulance) delay was. But in each of these scenarios common sense indicates that what caused the patient’s death was, on Lord Salmon’s... in Alphacell Ltd v Woodward [1972] All ER 475 at 490, [1972] AC 824 at 847, the asthmatic attack not the congestion of the traffic, the bursting of the water main, the malfunction of the computer or the inefficiency of the ambulance service. But the asthmatic attack is a natural cause of death, and the death is not, in my judgment, turned into an unnatural death by any of the facts suggested in any of the alternative scenarios.....

The coroner was not excluding the other evidence: he was saying that, even when all the other evidence is taken into account, the cause of death was still the asthmatic attack and the death was not an unnatural death. That is also my view, for the reasons I have endeavoured to give."108

Further, Courts have determined that death resulting from withdrawal of life support is a 'natural causes death' if supported by proper consultation:

‘the object of medical treatment and care was to benefit the patient, but since a large body of informed and responsible medical opinion was of the view that existence in the persistent vegetative state was not a benefit to the patient, the principle of the sanctity of life, which was not absolute, was not violated by ceasing to give medical treatment and care involving invasive manipulation of the patient's body, to which he had not consented and which conferred no benefit upon him.'109

In these examples that have been determined in the higher courts, it can be difficult for doctors, police and the public to decide whether or not a death is reportable to the coroner. Further, unless the definition of reportable death is read widely, ambulance or medical responses to, say, an asthma attack may be excluded from coronial investigation despite their possible contribution to the cause of death and/or their potential to provide information to the coroner that will improve the safety of Victorians. In deciding whether a death is a ‘reportable death’ in these cases, a doctor may also have to make a preliminary determination about

whether or not the patient provided him or her with informed consent for the actions which caused the death.

In order to clarify these issues, the State Coroner's Office is of the view that the Act should be amended to include a definition of 'natural causes death' in combination with amendment to the definition of 'reportable death'. These amendments should reverse the current presumption that deaths are not reportable unless they fit into the criteria defined in reportable death. Rather, all deaths should be reportable unless they fit into the criteria defined by this new definition of 'natural causes death'. This change in definition will increase the number of reportable deaths in Victoria and will have resource implications for the State Coroner's Office.

Even then, the definition of reportable death should continue to include a number of at risk categories of patient whose deaths are reportable, whether or not they are due to natural causes so defined. These patients are further defined in the definitions of 'reportable death' and 'person held in care'. Under section 17 of the Act, a coroner must always hold an inquest in matters where the deceased was 'in care' at the time of death or meets a number of other criteria. The State Coroner's Office is of the view that this requirement should not apply for people who died of natural causes. Although this issue will be discussed in Chapter 7, this proposed definition of 'natural causes death' is intended to apply to exclude these patients from mandatory inquests and claw back some of the resource implications associated with widening the definition of reportable death.

The State Coroner's Office recommends:

**RECOMMENDATION 1.7**

That Parliament amend section 3 of the *Coroners Act 1985* to include the following definition:

"natural causes death" occurs as the result of organ failure which is not caused or exacerbated by any outside influence such as violence, accident or injury (whether it appears to have resulted directly or indirectly), dental or medical intervention, medication, other drugs, poisons or toxins.

**Person held in care**

The definition of a 'person held in care' must be considered in the context of both the mandatory reporting provisions of section 13 of the Act and the mandatory inquest provisions of section 17(1) of the Act. The State Coroner's Office is of the view that all deaths of persons held in care, should be reportable deaths. However, this submission will address issues relating to mandatory inquests for these deaths in its commentary on section 17 of the Act.

This section will consider each of the categories of 'persons held in care' specified in the Act. It will then discuss whether other categories of vulnerable people should be included in this definition.
**A person under the control, care or custody of the Secretary of the Department of Human Services**

In the Discussion Paper, the Committee has sought specific advice about whether the current definitions in the Act of ‘persons held in care’ as categories of deaths reportable to the coroner are adequate or should the categories be extended in any way—for example, to include deaths of other vulnerable persons?¹¹⁰

Children and young people who are subject to the custody to the Secretary of the Department of Human Services are covered by this definition.¹¹¹ Similarly, young people detained in a remand centre, youth residential centre or youth training centre are ‘persons held in care’.¹¹²

However, even if children are placed in the care of the Secretary of Human Services on guardianship orders, they are not necessarily defined as ‘persons in care’ for the purposes of the Act because the Secretary does not have the right to have the daily care and control of the child or the right and responsibility to make decisions concerning the daily care and control of the child.¹¹³ Further, children who are placed in the care of foster carers by order of the Children’s Court are not defined as persons held in care unless the placement is delegated by the Secretary of the Department of Human Services.

It is inconsistent that children on guardianship to the Secretary orders and in foster care are not defined as persons held in care and, if they are not otherwise reportable to the State Coroner, may be unreportable deaths whereas children in the custody of the Secretary are defined as persons held in care and their deaths are always reportable and always require an inquest. This could include, for example, deaths from asthma or other respiratory disease. Further, failure to report these deaths on otherwise legitimate grounds could influence the operation of the reviewable death procedures.

The Luce report went further to include all child deaths that occur in children’s health services and child protection agencies¹¹⁴:

> “In some coroner districts there are standing protocols between the coroner and the various children’s services and the child protection agencies setting out how the children’s agencies should be involved in death investigation and how the coroner and his staff should work with them…. There should be such protocols in all areas taking into account the characteristics of the areas and the configuration of the relevant children’s health services and the child protection networks.”

The resource implications of imposing mandatory reporting of all child deaths in health services as well as child protection agencies would be significant. However, the State Coroners Office is still of the view that, in the case of child deaths, a ‘person held in care’ should include a child in

¹¹¹  ss. 5 & 123 Children and Young Persons Act 1986.
¹¹²  s. 252 Children and Young Persons Act 1986.
¹¹³  ss. 4 & 123 Children and Young Persons Act 1986.
the custody or guardianship of or held in detention by the Secretary of the Department of Human Services under the Children and Young Persons Act 1986 or otherwise in care under orders of the Children's Court.

A person in the legal custody of the Secretary to the Department of Justice or the Chief Commissioner of Police, or in the custody of a member of the police force or in the custody of a protective services officer appointed under the Police Regulation Act 1958

In the Discussion Paper, the Committee has sought specific advice about whether the current definitions in the Act of 'deaths in custody' as categories of deaths reportable to the coroner are adequate or should the categories be extended in any way-for example, to include deaths of other vulnerable persons?115

People who are subject to legal custody of police or the Department of Justice include offenders who are under arrest, detained in police watch houses, or serving sentences in adult prisons. Coroners have also determined that this category includes offenders involved in police pursuits in acknowledgement of their practical arrest. Some of these persons are young people who would not otherwise be subject to the adult detention system. The State Coroner's Office is of the view that inclusion of all these categories in the definition of 'persons held in care' is uncontroversial.

However, there had also been research published, which was quoted by the shadow Attorney-General during the 1999 debate, showing that “the number of deaths in the supervision population is at least...6.4 times greater than one would expect...in the general community and the “…death rates of people undergoing community based orders…are higher than one would expect for offenders in prison.”116

Since 1986, sentencing options involving close supervision by Community Corrections Victoria have widened from parole orders, which are subject to supervision by Community Corrections Officers on behalf of the Adult Parole Board, to include Drug Court Orders, which are subject to the direction of the Magistrates' Court, and Intensive Corrections Orders, Combined Custody and Treatment Orders. All these sentences or orders are regarded as potential or alternatives to actual prison sentences but they are served in the community.

In most cases, these orders require offenders to serve part of their sentence in prison and then report frequently to Community Corrections. In all cases, breach of conditions of the order requires mandatory restoration of the prison sentence. People on these orders can be interpreted as being persons 'held in the care', if not legal custody of, the Department of Justice. There is also current discussion about the use of suspended sentences.117 Changes in this provision of the Sentencing Act 1991 will influence the numbers and types of people who are held in the legal custody of the police or the Department of Justice.

This section of the definition of ‘persons held in care’ causes difficulty in the State Coroner's Office with respect to the definition of reportable death and determination of whether the investigations into their deaths are subject to mandatory inquests. On one hand, the degree of control and care exercisable by Community Corrections Officers is limited when prisoners are released into the community. On the other hand, it is clear that the people on these orders are vulnerable and the Office of Community Corrections admits is owes a duty of care to these clients.

The State Coroner's Office is of the view that deaths of persons held in detention centres under Commonwealth legislation should also be reportable deaths.

On balance, the State Coroner's Office is of the view that deaths involving people who are under arrest or on remand in custody or serving current prison sentences or held in detention centres should be classified as 'persons held in care'. However, deaths of those on orders requiring intensive intervention by the Office of Community Corrections should remain reportable to the State Coroner but should not necessarily be included in the definition of 'persons held in care'.

A patient in an approved mental health service within the meaning of the Mental Health Act 1986;

The category of deaths encompassed by this provision is limited by two further definitions that apply to its interpretation:

- ‘patient’ means a forensic patient, an involuntary patient, or a security patient;
- ‘approved mental health service’ means premises or a service proclaimed to be an approved mental health service under s 94, including the Victorian Institute of Forensic Mental Health, or declared to be an approved mental health service under s 94A of the Mental Health Act 1986.

Further, case law has determined that it is admission to an approved mental health service that characterises a person as an involuntary patient.118

This Supreme Court interpretation conflicts with the reality that Community Treatment Orders are now the primary way in which people are provided with involuntary psychiatric treatment in Victoria. These orders permit involuntary treatment of some people with mental illness while they live in the community. As such, they are a less restrictive option than inpatient treatment. The change over the past decade from institutional treatment and care to a primary focus on community-based treatment has been guided by the national mental health strategy.119

---

119 Bronwyn Pike, Mental Health (Amendment) Bill, Second Reading Speech, Hansard 18 September 2003, p 577
Community Treatment Order the person subject to the order is deemed to be an involuntary patient while subject to the order.\textsuperscript{120}

In practice, the State Coroner’s Office is of the view that involuntary patients in approved mental health services and persons subject to Community Treatment Orders are 'persons held in care'. However, psychiatric patients who are not subject to orders under the \textit{Mental Health Act} 1986 are not considered to be 'persons held in care'. Approved mental health services are almost all public psychiatric facilities. Therefore, under the current definitions, it seems to be the involuntariness of treatment and the availability of medical insurance that determines whether or not a person fits into the 'person held in care' categories.

On one hand, the State Coroner’s Office is not certain that this is the intention of Parliament in imposing the definition or that this definition accurately recognises the vulnerability of some psychiatric patients treated voluntarily in private facilities. On the other hand, the State Coroner's Office is concerned about opening the flood gates if a wider definition of 'person held in care' is imposed on psychiatric patient deaths.

On balance, the State Coroner’s Office is of the view that all psychiatric patients who die when they are in hospital should be classified as 'persons held in care.' However, voluntary psychiatric out-patients should not be classified as in care. It should be noted that they may be still subject to a coronial investigation if the death is a "reportable death."

\textbf{Other categories of persons held in care}

In considering whether other groups of vulnerable people should be defined as persons held in care, the State Coroners Office adopts the Queensland legislation which includes people with a disability living in an accredited residential service as persons held in care. This recognises the particular vulnerability of this group of people.

The State Coroner’s Office recommends:

\textbf{RECOMMENDATION 1.8}

That the Parliament amend the definition of 'person held in care' in the \textit{Coroners Act} 1985 to read:

“person held in care” means:

(a) A child in the custody of or guardianship of or held in detention by the Secretary of the Department of Human Services under the \textit{Children and Young Persons Act} 1986 or placed in care under an order of the Childrens Court; 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

\textsuperscript{120} Wilson \textit{v Mental Health Review Board} [2000] VSC 404.
(iii) in the custody of a protective services officer appointed under the Police Regulation Act 1958; or
(iv) held in a detention centre under Commonwealth legislation;

(b) a patient in an assessment or treatment centre under the Alcoholics and Drug-dependent Persons Act 1968; or

(c) a person undergoing treatment for a psychiatric disorder as an inpatient in an approved mental health service or a hospital as defined under the registered private hospital; or

(d) a person with a disability defined under section 3 of the Disability Services Act 1992, who--

(i) was living in a residential care service or a supported residential service as defined under section 3 of the Health Services Act 1988; or
(ii) was receiving residential services operated, or wholly or partly funded, by the Department of Human Services.

Preventable Death
The State Coroner’s Office has recommended that the Purposes of the Act should be amended to include jurisdiction for the State Coroner to:

"help to prevent deaths or fires from similar causes happening in the future by collecting and analysing data and enabling coroners to comment and make recommendations about certain matters connected with deaths or fires, including matters related to—

(i) public health or safety; or
(ii) the administration of justice."

If this recommendation is accepted by the Committee, there will be a consequential discretion to define deaths that are subject to this jurisdiction. Therefore, the State Coroner’s Office recommends:

RECOMMENDATION 1.9

That the Parliament amend section 3 of the Coroners Act 1985 to include the following definition:

“preventable death” means a death that would not have occurred but for identified system failures.

Reportable Death
The current definition of reportable death is intended to include every death other than a death certified to be a 'natural causes death' by a doctor who was responsible for a person’s medical care immediately before death, or who examines the body of a deceased person after death or a still born child.121

Section 15(1) of the Act grants jurisdiction to a coroner to investigate a death if it appears to the coroner that the death is or may be a reportable

---

121 s. 34 Births Death & Marriages Registration Act 1996.
death. To put that proposition in another way: once a coroner is satisfied that a death is or may be a reportable death, then that death becomes one which that coroner must continue to investigate.\footnote{Clancy v West 17/8/94 (SCVic) 9649/1993 (Harper J), approved by the Full Court in Clancy v West [1996] 2VR 647.}

In the absence of a definition of natural causes death, the State Coroner's Office is of the view that the current definition of reportable death is circular and can lead to misunderstanding and misinterpretation.

In the Discussion Paper, the Committee has sought specific advice about the definition of reportable death.\footnote{Questions 1, 2, 3 & 4 Coroners Act 1985 Discussion Paper, Victorian Parliament Law Reform Committee, 2005.} They have included questions about whether doctors understand what is meant by a reportable death, whether Guidelines would assist them, whether the category should by revised and whether this revision should include any particular disease categories. The Committee is also concerned about under-reporting of deaths involving medical treatment and deaths involving or associated with anaesthetics.

The State Coroner's Office is of the view that some of these questions can be addressed by introducing new definitions of 'anaesthetic', 'death' and 'natural cause death' as indicated earlier in this submission combined with amendment of this definition of 'reportable death' to reverse the decision process relating to natural causes death. In other words, any death that is not within the definition of a natural causes death is a reportable death.

The general definition of reportable death differs across jurisdictions in Australia.\footnote{s. 3 Coroners Act 1985 (Vic.); s. 13 Coroners Act 1997 (ACT); ss. 13, 13A, 13 AB, 13B & 13C Coroners Act 1980 (NSW); s. 12 Coroners Act (NT); s. 8 Coroners Act 2003 (Q'ld.); s. 3 Coroners Act 2003 (SA); s. 3 Coroners Act 1995 (Tas.); s. 3 Coroners Act 1996 (WA).} A 2003 review of Australian Coronial Process in relation to the health care sector has also recommended a uniform national definition of what constitutes a reportable death, particularly as it relates to deaths that occur in the healthcare setting.\footnote{Recommendation 9, J.E. Ibrahim, N. McMillan, C. Grech, L. Bugeja and D. Ranson, "The Role of the Coronial Process in Initiatives for Improving Patient Safety and Quality in Health Care", Draft Final Report of a Consultancy into the Coronial Death Investigation Process in Australia: Its Role in Reviewing Safety and Quality in Healthcare Provision, May 2003.}

With this philosophy in mind, the State Coroner’s Office has considered the current definition of reportable death. It is of the view that the definition should adopt a definition that relies more on correct diagnosis of ‘natural causes death’ and requires reporting of everything else. Further, some other institutional deaths which may also be natural causes deaths, including deaths of persons held in care and anaesthetic deaths, should remain reportable deaths but, wherever possible, their definition should align themselves with those adopted by other Australian coronial jurisdictions.

To make clear what amendments are proposed by the State Coroner’s Office, the subsections of the current definition denoted in bold above
should be considered by the Committee. These bold subsections will be considered individually and other recommended subsections will then be considered.

**A death that appears to have been unexpected, unnatural or violent or to have resulted, directly or indirectly, from accident or injury**

As well as including violent death, this section is interpreted to include all unexpected deaths arising in the course of medical treatment. It is identified in the Medical Deposition from the question: Was this death expected as a consequence of this illness or injury? (see the Form above).

However, the State Coroner's Office is of the view that many failures to report reportable deaths may arise from some doctors’ narrow interpretation of this category of reportable death. Some of their misunderstandings are answered by the new definition of 'natural causes death'. However, as a matter of clarity and to recognise the frequency with which medical mistakes occur, examples of reportable medical deaths should continue to be included as examples in the definition of 'reportable death'.

Further, the Queensland *Coroners Act* 2003 provides for reporting if the death was a violent or otherwise unnatural death or the death happened in suspicious circumstances. It separately provides for reporting of deaths "not reasonably expected to be the outcome of a health procedure. "Health procedure" is defined in Schedule 2 of the Queensland *Coroners Act* 2003 as:

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

In relation to medical deaths, the South Australian legislation provides for reporting of all deaths that occur in hospitals and within 24 hours of discharge other than those specified in regulations:

(d) that occurs during or as a result, or within 24 hours, of--

(i) the carrying out of a surgical procedure or an invasive medical or diagnostic procedure; or

(ii) the administration of an anaesthetic for the purposes of carrying out such a procedure,

not being a procedure specified by the regulations to be a procedure to which this paragraph does not apply;

(e) that occurs at a place other than a hospital but within 24 hours of--

(i) the person having been discharged from a hospital after being an inpatient of the hospital; or

(ii) the person having sought emergency treatment at a hospital;"
While the State Coroner’s Office is of the view that it has an important role to play in its independent examination of medical deaths because of current hospital funding which is intended to minimise bed occupancy and prefers the South Australian concept, expanding the scope of the definition of reportable death to the degree adopted in South Australia will require huge resources. Therefore, from a practical point of view, it recommends the Committee adopt the Queensland examples of medical death rather than the South Australian model.

**Death that occurs during an anaesthetic**

The new definition of 'anaesthetic' should improve understanding of the need to report these deaths.

**Death that occurs as a result of an anaesthetic and is not due to natural causes**

Introduction of the new definition of 'natural causes death' should help to define this category of reportable deaths for reporting doctors.

**Death of a person who immediately before death was a person held in care**

This provision recognises the particular vulnerability of people defined as persons held in care. However, sometimes their deaths arise because there has been insufficient preparation made for their release from care or the cancellation of their supervision on, say, parole or a Community Treatment Order occurs because they fail to comply with the order. For some of these clients, this release will be associated with increased vulnerability.

**Death of a person under the control or care of the Secretary to the Department of Justice or a member of the police force**

Having regard to the proposed definition of 'person held in care' and the issues raised above in relation to people on orders requiring close supervision by Community Corrections Victoria including parole orders, Drug Court Orders, Intensive Corrections Orders, and Combined Custody and Treatment Orders, the State Coroners Office is of the view that this category of reportable deaths should be expanded to include people subject to orders requiring intensive supervision by a Community Corrections Officer who are not a person held in care. It is not intended that deaths involving persons on Community Based Orders or bail should be reportable unless other reportable issues are involved.

**Death 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**

S 3(1)iaa was introduced by the Mental Health (Amendment) Act 2003 that came into operation on 22 October 2003. The Second Reading Speech indicated:

> 'The Coroners Act requires that 'reportable deaths’ be reported to a coroner or the officer in charge of a police station. The death of a person receiving treatment or care for a mental disorder from a psychiatric service that is also a
‘reportable death’ must also be reported to the chief psychiatrist. These provisions ensure there is independent review of the circumstances surrounding a reportable death.

It has been unclear whether the death of a person subject to a community treatment order or a restricted community treatment order is a ‘reportable death’. The bill amends the Coroners Act to clarify that the death of such a person is a reportable death for the purposes of that Act."128 However, the State Coroner’s Office treats people who are on Community Treatment Orders as persons held in care who are therefore subject to mandatory inquests under section 17(1) of the Act. The recommended amendments to that definition reflect this practice and the definition of reportable deaths includes persons held in care immediately before death. Therefore, if the Committee recommends that the proposed amendments to the definition of ‘persons held in care’ are appropriate, there is no need for this category of deaths to remain specified in the ‘reportable death’ group.

Other categories of reportable death

The State Coroner’s Office adopts the South Australian inclusion of deaths of people under guardianship orders129 as reportable deaths rather than 'persons held in care'.130

Aged care deaths

It should be noted that the numbers of deaths as a proportion of the population in their age category can be expected to increase as the population ages and deaths due to falls and other age-related conditions increase.131 Many of these people will die in aged care facilities where their vulnerability can lead to preventable but otherwise natural deaths associated with, for example, falls or medication errors. Deaths that occur under these circumstances are known to be under-reported to the State Coroner (see Chapter 4).

However, most of the issues that are likely to exacerbate death in the aged population are already reported under other categories of reportable death recommended in this submission.

Occupational disease

The Home Office Position paper has adopted the list of categories of reportable death recommended in the Fundamental Review.132 In general these are consistent with those recommended in this submission. However, they also include any death in which occupational disease may have played a part.

The State Coroner’s Office is of the view that it would be appropriate for the Committee to recommend that Parliament prescribe deaths from

---

128 Bronwyn Pike, Mental Health (Amendment) Bill, Second Reading Speech, Hansard 18 September 2003, p 578.
129 s. 22 Guardianship & Administration Act 1986.
130 s. 3 Coroners Act 2003 (SA).
specific occupational diseases under the regulations to the Act. More particularly, the State Coroner is currently establishing a Work-related Death Investigation and Resource Unit which is being managed by the Institute and funded by the Department of Justice using resources provided by the Victorian Workcover Authority.\textsuperscript{133} This Unit will assist in providing advice to the State Coroner about the classes of occupational diseases that should be prescribed and help monitor any new occupational disease categories that also need to be reported. Otherwise, the resources involved in the reporting and investigation of all occupational disease deaths would be considerable.

There have been estimates of a minimum of 800 deaths per year in Victoria from occupational disease. Accordingly, the resources of the State Coroner's Office could be directed to targeting certain areas, undertaking detailed investigations with a view to understanding the future health and safety implications. The recommendation (found later in this report) for State Coroner's own initiative and limited investigations may also help ensure that occupational diseases that need to be investigated are addressed.

\textit{Reviewable deaths}

The reviewable death legislation was implemented in 2004, following a review that found that, while the standard official processes were followed in the case involving the deaths of four children from the same family that prompted the review, there were no systematic means of:

\begin{quote}
“identifying cases of multiple child deaths and the existence of living siblings; ensuring early assessment of the family’s health needs in multiple child death cases; and triggering a multidisciplinary assessment of the needs of surviving siblings or risks to any prospective children.”\textsuperscript{134}
\end{quote}

These new provisions require the State Coroner to investigate and report on the circumstances of deaths involving two or more children in a family.

Accordingly, the State Coroner's Office recommends:

\textbf{RECOMMENDATION 1.10}

That the Parliament amend the definition of ‘reportable death’ in section 3 of the Coroners Act 1985 to read “reportable death” means any death -

(a) where the body is in Victoria; or

(b) that occurred in Victoria; or

(c) the cause of which occurred in Victoria; or

\textsuperscript{133} Victorian Workcover Authority, Press Release, “World First: Coroners Work-Related Deaths Investigation and Resource Unit”, 25 October 2004. There is a detailed submission to the Attorney General and Minister for Workcover on the establishment of this Unit.

\textsuperscript{134} Rob Hulls, Second Reading Speech, Death Notification Legislation (Amendment) Bill, Parliament of Victoria, 6 May 2004, p 1052.
(d) of a person who ordinarily resided in Victoria at the time of death; or

(e) that is not a 'natural causes death', including a death

   (ea) that appears to have been unexpected, unnatural or violent or to have resulted, directly or indirectly, from accident or injury; or
   (eb) that occurs during an anaesthetic; or
   (ec) that occurs as a result of an anaesthetic and is not a natural causes death; or
   (ed) that was not reasonably expected to be the outcome of a health procedure; or
   (ee) that occurs in prescribed circumstances; or

(f) of a person who immediately before death was a person held in care; or

(g) of a person who is protected under the Guardianship and Administration Act 1986; or

(h) of a person under the control or care of the Secretary to the Department of Justice or a member of the police force or subject to orders requiring intensive supervision by a Community Corrections Officer but was not a person held in care; or

(i) 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;

Senior next of kin

'Senior next of kin' is defined and used in section 29 of the Act to provide authority for making an application that no autopsy be performed and 'senior available next of kin' in the Human Tissue Act 1982 to provide authority for giving consent for performing an autopsy in a hospital or taking of tissue for donation or research. This submission will also recommend that the senior next of kin have other rights and responsibilities not necessarily available to other family members.

Therefore, the State Coroner's Office is of the view that the definition of senior next of kin should be included in the definitions section of the Act.

Further, family structures have changed substantially since 1985 and the State Coroner's Office experience is that the person who meets the
current criteria of senior next of kin is often not the most appropriate person to be making decisions about the body of the deceased.

For example, in circumstances where the deceased has been separated from his or her spouse for a long time but has not divorced, the senior next of kin under the current definition remains the spouse even when there are adult children or a new partner available who have a close relationship with the deceased. As well, section 5 of the Marriage Act 1961 (Cth) has been amended to provide:

"'marriage’ means the union of a man and a woman to the exclusion of all others, voluntarily entered into for life.”

At the other end of the scale, some people are able to claim the status of senior next of kin when they have been living in a domestic relationship for, say a month, to the exclusion of other close family members. The State Coroner's Office is also sensitive to the collective decision-making processes adopted by some cultures in determining appropriate responses to death of family members.

In Western Australia, the senior next of kin is defined as:

"senior next of kin” in relation to the deceased person means the first person who is available from the following persons in the order of priority listed —

(a) a person who, immediately before death, was living with the person and was either —

(i) legally married to the person; or
(ii) of or over the age of 18 years and in a marriage-like relationship (whether the persons are different sexes or the same sex) with the person;

(b) a person who, immediately before death, was legally married to the person;

(c) a son or daughter, who is of or over the age of 18 years, of the person;

(d) a parent of the person;

(e) a brother or sister, who is of or over the age of 18 years, of the person;

(f) an executor named in the will of the person or a person who, immediately before the death, was a personal representative of the person; or

(g) any person nominated by the person to be contacted in an emergency."

The State Coroner's Office is of the view that this definition more accurately reflects most current relationships.

For these reasons, the State Coroner's Office recommends:

RECOMMENDATION 1.11

That the Parliament insert a new definition of 'senior next of kin' in section 3 of the Coroners Act 1985 which reads:

"senior next of kin” in relation to the deceased person means the first person who is available from the following persons in the order of priority listed —

(a) a person who, immediately before death, was living with the person and was either —
(i) legally married to the person; or 
(ii) of or over the age of 18 years and in a marriage-like relationship (whether the persons are different sexes or the same sex) with the person;

(b) a person who, immediately before death, was legally married to the person;

(c) a son or daughter, who is of or over the age of 18 years, of the person;

(d) a parent of the person;

(e) a brother or sister, who is of or over the age of 18 years, of the person;

(f) an executor named in the will of the person or a person who, immediately before the death, was a personal representative of the person; or

(g) any person nominated by the person to be contacted in an emergency.

The effect of common law on the operation of the Act

Section 4 of the Act provides:

“A rule of the common law that, immediately before the commencement of this section, conferred a power or imposed a duty on a coroner or a coroner’s court ceases to have effect.”

Historically, the common law role of coroner evolved into a statutory position under the Coroners Act 1890 with authority to investigate unnatural and violent deaths and some fires.

However, despite removal of the common law and coroners performing an administrative rather than a judicial role, coroners have a duty to act judicially and to comply with the rules of natural justice. In particular, coroners are required to:

1. Provide interested parties against whom an adverse finding is to be made the opportunity to respond or explain;

2. Before making a finding that a professional person contributed to the cause of death of another within the course of his or her professional duties, there must exist a comfortable satisfaction that there has been a departure from normal standards (negligence) which contributed to the death.

3. The privilege against self-incrimination applies to coronial investigations including inquests. It underlies the current practice

---

137 Annetts v McCann [1990] HCA 57. See also Barci v Heffey 1/2/1995 (SCVic) 4306/95 (Beach J); Mahon v Air New Zealand [1984] AC 808; Moore v Guardianship & Administration Board [1990] VR 902.
138 Secretary to the Department of Health and Community Services v Gurvich [1995] 2VR 69 applying Dixon J in Briginshaw v Briginshaw [1938] HCA 34; (1938) 60 CLR 336; Anderson v Blashki [1935] 2 VR 89.
139 Re O’Callaghan (1899) 24 VLR 957. See s 29 of the Evidence Act 1958.
of delaying listing of cases attracting allegations of murder, manslaughter and culpable driving until after they have been finalised in the higher courts.\textsuperscript{140}

Although coroners may have some limited power to draw an adverse inference when a witness invokes the privilege against self-incrimination to refuse to cooperate with a coronial investigation, this must be expressed in the coroner's finding:

"... I am not satisfied that this reference signified that the plaintiff's failure to give evidence created an adverse inference which the coroner then took into account. I would have expected the coroner to have said so expressly if this had been so. This makes it unnecessary to decide what use can be made of the failure of a person against whom allegations are directed to give evidence. There must obviously be strict limits on the inferences possible in such circumstances. Given the nature of the allegations, it would be proper to apply by analogy the rules in a criminal proceeding and I do not propose in any event to draw an adverse inference against the plaintiff in the circumstances of this case from her failure to give evidence. But I am not to be taken as expressing any view that failure to answer questions in routine investigations of fatal accidents for example should not be able to be used within strict limits as part of the evidentiary material on a coroner's investigation. Much less am I casting any doubt on the ambit of the powers conferred on the coroner by the \textit{Coroners' Act}.\textsuperscript{141}

The Committee is considering whether a change to the law limiting a person's right to claim privilege against self-incrimination at coronial inquests is justified.\textsuperscript{142}

In Victoria, the scope of the effect of this privilege has widened as the Parliament has created at least 47 indictable offences as well as those included in amendments to the \textit{Crimes Act} 1958. A list of this legislation is included in Appendix B of this submission. It seems from the chronological order of the legislation in which indictable offences have been created, that in the 1950s indictable offences were created by Acts (other than the \textit{Crimes Act} 1958) to cover very specific crimes relating to such things as forests, mines and cemeteries. In the 1960s and 1970s, legislators further expanded the definition of indictable offence in only five instances.

However, in the 1980's and 1990's the number of indictable offences increased dramatically, with new indictable offences being created in 22 different Acts of Parliament. This trend may be explained by the subject matter of the Acts: workplace safety, technological advances, and privatisation of services. Significant events such as the Longford explosion also seem to account for the creation of some of these new offences.

Despite section 57(3) of the Act which provides that, except as provided under s 55AB of the \textit{Evidence Act} 1958, a record of the inquest is not evidence in any court of any fact asserted in it, the apparently unintended

\textsuperscript{140} \textit{R v Coroner; Ex parte Alexander} [1980] VR 731.
\textsuperscript{141} Gobbo J in \textit{Anderson v Blashki} [1993] 2 VR 89.
effect of creating these new indictable offences has been that a number of important witnesses are excused from giving evidence in inquests. For example, in some cases, police witnesses in police pursuit related deaths or police shooting deaths have invoked the privilege associated with offences as work colleagues or supervisors under sections 21 and 25 combined with section 47 of the Occupational Health and Safety Act 1985 to avoid giving evidence in inquests. This failure, combined with the influence of legal advice and insurance requirements on statements made by professionals who witness fatal incidents, can severely limit coroners' capacity to accurately determine the circumstances surrounding a death or make appropriate recommendations.

Counsel opinion on this matter was considered by the Fundamental Review of Death Certification and Coroner Services in England. They were of the view that protection was required to ensure full and frank disclosure by witnesses and considered seven options for its implementation:

- Complete Embargo
- No Embargo
- Limited Embargo within Coroner’s Discretion
- Undertakings-The civil litigation model
- Compulsory Disclosure in Confidence
- Undertakings-the Bloody Sunday Model
- Compulsory Disclosure Under Limited Embargo.

In the Fundamental Review, Tom Luce recommended:

"The present right to refuse to answer questions at an inquest which might lead to self-incrimination should be replaced by a procedure requiring all questions to be answered in return for an undertaking that the testimony will not be used against the witness in any criminal trial."144

The coroners' legislation in all States and Territories except the ACT and Victoria has been amended to provide a specific statutory privilege against self incrimination in inquests or to restrict the admissibility of self incriminating oral evidence given at an inquest in any other court proceedings. The South Australian Act also provides protection against compellability of production of incriminatory documents or records.

In Victoria, sections 184 and 184 of the Crimes Act 1958 already provide for compellability of witnesses in offences involving receipt or solicitation of secret commissions and their protection from use of the evidence against them. In these cases, the court must issue a certificate:

"When a person has received a certificate as aforesaid and any criminal proceeding is at any time instituted against him in respect of the offence which was in question in the proceeding in which the said person was called as a witness the court having cognizance of the case shall on proof of the certificate..."146

87
and of the identity of the offence in question in the two cases stay the proceedings.”

In New South Wales, the coroner can compel witnesses to answer questions but he or she required to issue a certificate to protect them from use of incriminatory evidence. This seems unnecessary. Rather, it is submitted that it would be less cumbersome to provide general protection of witnesses against use of their oral evidence against them in other forums as provided in the Queensland legislation.

Further, last year the State Coroner made recommendations about the need to amend the Coroners Act 1985 so that essential witnesses can be required to give evidence. In that finding, the State Coroner recommended that consideration be given to adopting a provision similar to that provided by the New South Wales Act. More recently, in a police shooting investigation, the coroner adopted the State Coroner’s recommendation that the Act be amended to protect witnesses who give evidence which may be incriminating including use of information derived from that evidence.

Therefore, the State Coroner's Office recommends:

RECOMMENDATION 1.12a

That the Coroners Act 1985 be amended to include a new section:

"Incriminating evidence

(1) This section applies if a witness refuses to give oral evidence at an inquest because the evidence would tend to incriminate the person.

(2) The coroner may require the witness to give evidence that would tend to incriminate the witness if the coroner is satisfied that it is in the public interest for the witness to do so.

(3) The evidence is not admissible against the witness in any other proceeding, other than a proceeding for perjury.

(4) Derivative evidence is not admissible against the witness in a criminal proceeding.

(5) In this section--
‘derivative evidence’ means any information, document or other evidence obtained as a direct or indirect result of the evidence given by the witness; and
‘proceeding for perjury’ means a criminal proceeding in which the false or misleading nature of the evidence is in question."

If the State Government is not inclined to provide general protection for witnesses in coronial investigations who might incriminate themselves under legislation which was not intended to provide them with protection

---

147 s. 33AA Coroners Act 1980 (NSW),
148 s. 39 Coroners Act 2003 (Qld),
149 Case Nos 1821/02, 1822/02 & 1823/02, Findings in the Investigation into the Deaths of Simon James Lovitt, Shaun Ryan Law and Cao Tri Vo, 4 February 2004.
150 Case No 434/04 Investigation into the Death of Peter Arthur Hubbard, 15 July 2005.
against compellability, the legislation which includes new indictable offences should be reviewed with a view to including a provision in each relevant section which provides that evidence provided in a coronial investigation is inadmissable for the purpose of proving the indictable offence.

In the alternative, the State Coroner's Office recommends:

**RECOMMENDATION 1.12b**

That the Parliament review legislation which provides for indictable offences, including the *Occupational Health and Safety Act 2004*, and where relevant, include provision that evidence provided to and derivative evidence arising out of a coronial investigation is not admissible in proving the offence in another jurisdiction.
Chapter 2
Coroners

...Coroners fulfil an important public function. It is of an investigative nature, quite unlike that which a court undertakes in the ordinary course of things. Coroners do not adjudicate upon proceedings inter partes. Any findings which they make do not determine legal rights. The purpose of a coroner's investigation is to determine what happened.151

In Victoria, the functions and powers of coroners arise from the Coroners Act 1985, the Registration of Births Deaths and Marriages Act 1996, the Cemeteries and Crematoria Act 2003 and the Human Tissue Act 1982. Other legislation influencing their work includes Other Victorian legislation that influences the operation of the State Coroners Office includes the Mental Health Act 1986, the Children and Young Persons Act 1986, the Police Regulation Act 1986, the Road Safety Act 1986, the Public Prosecutions Act 1994, the Crimes Act 1958, the Metropolitan Fire Brigades Act 1958, the Country Fire Authority Act 1958, the Evidence Act 1958, the Wrongs Act 1958, the Crimes at Sea Act 1999, the Emergency Management Act 1986, the Guardianship and Administration Act 1986, the Medical Treatment Act 1988 and the Terrorism (Community Protection) Act 2003. Magistrates also have the authority to waive government fees and charges in relation to burials pursuant to section 52 of the Cemeteries Act 1958.152

Part 2 of the Act provides for the appointment and functions of the State Coroner and Deputy State Coroner and for the appointment of other coroners. Sections 10 and 10A of the Act address the delegation powers of the State Coroner and coroners.

As well as their administrative roles, the State Coroner and the Deputy State Coroner are required to fulfil the functions of full-time coroners. Together with three other full-time coroners, they are housed in the purpose built Coronial Services Centre in Southbank in Melbourne (opened in 1988) which is the home of the State Coroner’s Office and the Victorian Institute of Forensic Medicine. In 2003/4, these five full-time coroners determined 1300 cases, including 120 or 88% inquests and 1181 or 76% of chambers findings in Victoria.

The State Coroner and Deputy State Coroner

The Law Reform Committee has indicated that it is considering whether the practice of appointing a State Coroner for a fixed term of three years has the potential to compromise the independence of the position and whether the Coroners Act 1985 should be changed so that the State Coroner is appointed for a defined period? If so, how long should the appointment be for?153

---

152 The Health Legislation (Miscellaneous Amendments) Bill 2005 will extend this authority to coroners.
The current State Coroner, Graeme Johnstone, is a magistrate currently appointed on a renewable three year appointment. He has been in the position for over ten years. His current term expires in November 2005 and, for that reason, he has determined not to contribute to this section of the State Coroner’s Office submission.

The current Deputy State Coroner, Iain West, is a magistrate appointed until he reaches the retiring age of a magistrate. The Deputy State Coroner has been in the position for 12 years.

These terms of appointment of the current State Coroner and the Deputy State Coroner are enforceable on the basis of reasonable expectation and, without good reason, should not be disturbed. 154

Section 6 of the Act provides:

(1) The Governor in Council may appoint a judge of the County Court, a magistrate or a barrister and solicitor as the State Coroner or as the Deputy State Coroner.

(2) Appointment as the State Coroner or the Deputy State Coroner does not affect--

(a) the tenure of office of a judge or a magistrate; or

(b) any right or privilege of the holder of an office of judge.

(3) Service by a judge as the State Coroner or the Deputy State Coroner shall be taken to be service as a judge of the County Court.

(4) The Deputy State Coroner is to act as State Coroner when the State Coroner is absent from duty or the office of State Coroner is vacant and when acting has all the powers and duties of the State Coroner.

In determining whether the Coroners Act 1985 should be amended to specify the terms of appointment of the State Coroner and Deputy State Coroner when these vacancies arise, the State Coroner’s Office is of the view that the Committee should consider a number of factors as well as the requirement for the State Coroner to be independent of influence from Crown, the administration and other non-government institutions. These include:

1. The increasing responsibility of the role,

2. The status of the State Coroner in the community, and

3. The type of work required to adequately perform the role.

The increasing responsibility of the role

In the time since the Coroners Act 1985 was implemented, the number of reportable deaths has increased by 172%. Further, the jurisdiction has become more complex with previously unimportant issues arising such as the high number of police shootings (which resulted in a special investigation by the then State Coroner Hallenstein) and deaths in custody during the late 1980s and early 1990s, the increase in number and range

154 See also, Rob Hulls, Second Reading Speech, Courts Legislation (Amendment) Bill Parliament of Victoria, Hansard, p. 1310, 1 May 2003, with respect to existing appointments of Deputy Chief Magistrates.
of reported work-related deaths which now include, on one hand, falls and
other physical injuries in the workplace to, at the other extreme, asbestos
related deaths, the current series of gangland killings, increased
awareness of the number of preventable deaths occurring in health care
facilities, and the aging of the Victorian community leading to preventable
deaths from age-related factors such as fractured necks of femur
frequently associated with falls in the elderly.

Therefore, the State Coroner’s Office is of the view that the State Coroner
and the Deputy State Coroner should be appointed in a manner that
recognises the increasingly complex nature of the role the office plays in
the community.

The status of the State Coroner in the community

Even though the coronial service is not a court, the State Coroner enjoys
recognition in the community as Head of an important jurisdiction. In
recognition of this status and independence, the community has placed
control of the body in reportable or reviewable deaths, in the hands of the
State Coroner until he authorises its release for disposal. If the
Committee and the Parliament accept the State Coroner’s Office
recommendations that the coronial service be established as a court, this
authority will be further enhanced.

Therefore, the State Coroner’s Office is of the view that the State Coroner
and the Deputy State Coroner should be appointed in a manner that is
consistent with other similar heads of jurisdiction.

However, there is no consistency between jurisdictions in the statutory
arrangements for appointments of State Coroners and Deputy State
Coronors in other Australian States:

- The ACT Coroners Act 1997 and the Tasmanian Coroners Act
  1995 declare the Chief Magistrate has the powers of the Chief
  Coroner.\textsuperscript{156}
- The State Coroner in New South Wales must be a Magistrate
  appointed for five years renewable.\textsuperscript{157}
- The Coroners Act 2003 (Q’ld) provides for appointment of a
  magistrate as the State Coroner for a five-year period renewable
  once.\textsuperscript{158}
- The Coroners Act in the Northern Territory provides for
  appointment of a magistrate as Territory Coroner without providing
  for a term of appointment.\textsuperscript{159}
- In South Australia, the State Coroner is a magistrate appointed for
  seven years and eligible for re-appointment.\textsuperscript{160}

\textsuperscript{155} s 24 Coroners Act 1985.
\textsuperscript{156} s 6 Coroners Act 1997 (ACT); s. 7 Coroners Act 1995 (Tas).
\textsuperscript{157} s. 4A Coroners Act 1980 (NSW).
\textsuperscript{158} s 70 Coroners Act 2003(Q’ld).
\textsuperscript{159} s 4 Coroners Act (NT).
\textsuperscript{160} s. 4 Coroners Act 2003 (SA).
• Similarly, in Western Australia, the State Coroner is a magistrate appointed on the same terms as the Chief Stipendiary Magistrate.\(^{161}\)

There is also little consistency in the conditions of appointment of Deputy State Coroners across Australia:

• The Tasmanian *Coroners Act* 1995 does not provide for appointment of a Deputy Chief Coroner.

• Section 8 of the ACT *Coroners Act* 1997 provides for appointment of a Deputy Coroner without specifying his or her qualifications or term of appointment.

• The New South Wales *Coroners Act* 1980 provides for appointment of up to three Deputy State Coroners. If more than one Deputy State Coroner is appointed, one is to be appointed as Senior Deputy State Coroner.\(^{162}\)

• In Queensland, the Deputy State Coroner is a magistrate appointed for a renewable once only term of five years.\(^{163}\) In South Australia, all magistrates are appointed Deputy State Coroners.\(^{164}\)

• In Western Australia, the Deputy State Coroner is appointed on the advice of the State Coroner for a period specified in the terms of appointment.\(^{165}\)

The Luce Report in the United Kingdom has recommended that their coronial system should be headed by two Chief Coroners, one in England and Wales and one in Northern Ireland. The Chief Coroners will be or have an appointment equivalent to a Circuit Judge.

In Victoria, the Chief Magistrate has an appointment equivalent to a County Court judge including unlimited tenure.\(^{166}\) However, a Deputy Chief Magistrate appointed after amendment of the *Magistrates Court Act* 1989 in 2003\(^{167}\) holds a renewable appointment for five years after which he or she may revert to a magistrates' position.\(^{168}\) The President of the Children’s Court is a County Court judge on a renewable five-year appointment to the Children’s Court.\(^{169}\) The State Ombudsman holds office for a term of 10 years and is not eligible to be re-appointed.\(^{170}\)

The State Coroner’s Office is of the view that the current criteria for selection of the State Coroner and the Deputy State Coroner provide a range of seniorities and status consistent with the range that is specified in individual jurisdictions elsewhere and the status of the position in the Victorian community. However, in some ways, the appropriate terms of

---

\(^{161}\) s. 6 *Coroners Act* 1996 (WA).
\(^{162}\) s. 4A *Coroners Act* 1980 (NSW).
\(^{163}\) s. 78 *Coroners Act* 2003 (Q’ld).
\(^{164}\) s. 5 *Coroners Act* 2003 (SA).
\(^{165}\) s. 7 *Coroners Act* 1996 (WA).
\(^{166}\) s. 10A *Magistrates’ Court Act* 1989.
\(^{168}\) s. 7(2A) *Magistrates’ Court Act* 1989.
\(^{169}\) s.12(2) *Childrens and Young Persons Act* 1989.
\(^{170}\) s. 3 *Ombudsman Act* 1973.
appointment depend on the previous status of the appointment. For example, if a State Coroner or Deputy State Coroner is appointed from the magistracy or the County Court, they have a secure position but the pay will decrease if they return. Of course, many State Coroners see no future in returning to the Magistrates’ bench. On the other hand, if they are appointed from the practising legal profession their security and consequent independence may be threatened if the appointment is limited.\textsuperscript{171}

**The State Coroner’s workload**

In 1984, the Second Reading Speech for the Coroners Bill stated:

> At present, regional magistrates sit as coroners as required. There is no central coordination or regulation of the performance of these functions. It will be one of the principal responsibilities of the State Coroner to ensure that there is a coronial system in place of the existing patchwork quilt.\textsuperscript{172}

Further, section 7 of the *Coroners Act 1985* specifies the role of the State Coroner is:

(a) to ensure that a State coronial system is administered and operated efficiently;
(b) to oversee and co-ordinate coronial services;
(c) to ensure that all reportable deaths reported to a coroner are investigated;
(c) to ensure that all reviewable deaths reported to the State Coroner are investigated;
(d) to ensure that an inquest is held whenever it is desirable to do so;
(e) to issue guidelines to coroners to help them carry out their duties;
(f) such other functions as are conferred or imposed on the State Coroner under this Act.

These statutory functions include:

- Directing other coroners;\textsuperscript{173}
- Directing the Institute of Forensic Medicine\textsuperscript{174}
- Assisting interstate coroners;\textsuperscript{175}
- Ordering exhumations;\textsuperscript{176}
- Directing multiple investigations;\textsuperscript{177}
- Performing the roles of a coroner.\textsuperscript{178}

In short, today’s State Coroner has a very wide range of duties involving investigatory, administrative, judicial, preventative and educational functions.\textsuperscript{179} Performance of all these functions is onerous and requires multi-disciplinary skills. Failure to perform these supervisory and quality

\textsuperscript{171} e.g. Rule 92A Victorian Bar Practice Rules 14 July 2005.
\textsuperscript{173} ss 13, 33, 59A(2) Coroners Act 1958.
\textsuperscript{174} s 66(1) Coroners Act 1958.
\textsuperscript{175} s 25(1) Coroners Act 1985.
\textsuperscript{176} s 30(1) Coroners Act 1985.
\textsuperscript{177} s 43 Coroners Act 1985.
\textsuperscript{178} s 3 Coroners Act 1985.
\textsuperscript{179} Report of the Working Group on the Review of the Coroner Service in Ireland 200, p.2
assurance roles could result in accepting some public responsibility for situations such as the Bundaberg case in Queensland, the King Edward Memorial case in Perth, the Bristol Royal Infirmary and the Shipman cases in the United Kingdom.

The international nature of terrorism and the State Coroner's increasing role in major disasters, resultant work with Federal Government Departments, defence forces and security agencies put added pressure on the role. Also, there are the increasing demands of the interface with interstate and overseas colleagues and other professionals.

The State Coroner's Office is of the view that the work of the State Coroner has expanded and become sufficiently diverse to justify provision in the Coroners Act 1985 for the appointment of an Acting State Coroner. There is no provision in the Act for appointment to Acting State Coroner or Acting Deputy State Coroner's positions if the State Coroner and/or the Deputy State Coroner are unavailable or unable to perform their roles. This creates the risk of a hiatus in management and responsibility which can occur if, say, the State Coroner is on leave and the Deputy State Coroner becomes ill. The New South Wales Coroners Act 1980 provides for appointment of up to three Deputy State Coroners. If more than one Deputy State Coroner is appointed, one is to be appointed as Senior Deputy State Coroner.¹⁸⁰ In Queensland, section 81 of the Coroners Act 2003 provides for the State Coroner to appoint an Acting Deputy State Coroner in consultation with the Chief Magistrate for a renewable term of up to six months.

The State Coroner's Office is of the view that it is appropriate for the Act to be amended to enable appointment of an Acting State Coroner when the State Coroner and the Deputy State Coroner are absent from duty.

Despite the security offered by continuing judicial or magistrates' appointments, there is consensus in the State Coroner's Office that the terms of new appointments as State Coroner and Deputy State Coroner should be:

1. For at least ten years in order to ensure continuity and stability and prevent loss of knowledge and experience;
2. Fixed term appointments to prevent uncertainty in the period running up to expiry of the term or, if the Government is inclined to continue its history of renewable appointments, the timing and process for making that decision should be stipulated;
3. Overlap by, say, six months, with the new appointment to enable transfer of information and expertise;
4. Staggered with appointment of the Deputy State Coroner so that a vacuum is not created.

Therefore, the State Coroner's Office recommends:

¹⁸⁰ s. 4A Coroners Act 1980 (NSW).
RECOMMENDATION 2.1

That the Parliament amend section 6(1) of the Coroners Act 1985 to read:

The Governor in Council may appoint a judge of the County Court, a magistrate or a barrister and solicitor as the State Coroner or as the Deputy State Coroner for ten years from the date of appointment.

Consequential amendments will be required elsewhere in the legislation including sections 6(2), 6(3), 6(4).

Further, the State Coroner’s Office recommends:

RECOMMENDATION 2.2

That Parliament amend the Coroners Act 1985 to enable appointment of an Acting State Coroner when the State Coroner and the Deputy State Coroner are absent from duty.

The State Coroner's Office is also of the view that, in recognition of the role’s independence from Government and in accordance with Recommendation 17 of the Royal Commission into Aboriginal Deaths in Custody, the State Coroner should be required to report annually to Parliament with special reference to the public safety and prevention activities of the office including the recommendations made by coroners in Victoria and the responses to these recommendations.

RECOMMENDATION 2.3

That the Parliament amend section 7 of the Coroners Act 1985 to read:

The functions of the State Coroner are as follows:

(a) to ensure that a State coronial system is administered and operated efficiently;
(b) to oversee and co-ordinate coronial services;
(c) to ensure that all reportable deaths reported to a coroner are investigated;
(ca) to ensure that all reviewable deaths reported to the State Coroner are investigated;
(d) to ensure that an inquest is held whenever it is desirable to do so;
(e) to issue guidelines to coroners to help them carry out their duties;
(f) to report annually to Parliament; and
(g) such other functions as are conferred or imposed on the State Coroner under this Act.
Coroners

Lord Lane’s description of the coroner’s role remains relevant in Victoria today:

“A coroner’s task ... is a formidable one, and no one would dispute that; that is quite apart from the difficulties which inevitably arise when feelings are running high and the spectators are emotionally involved and vocal. Once again it should not be forgotten that an inquest is a fact-finding investigation and not a method of apportioning guilt. The procedure and rules of evidence which are suitable for one are unsuitable for the other. In an inquest it should never be forgotten that there are no parties, there is no indictment, there is no defence, there is no trial, simply an attempt to establish facts. It is an inquisitorial process, a process of investigation, quite unlike a trial where the prosecutor accuses and the accused defends, the judge holding the balance or the ring, whichever metaphor one chooses to use.....”181

The Committee has sought particular advice in relation to training of newly appointed coroners. 182

Coroners’ primary function is to direct the investigation into and make findings concerning the facts which are relevant to their statutory duty under section 19 of the Coroners Act 1985. Their secondary but increasingly important role is to comment on any matter connected with these deaths or fires including public health or safety or the administration of justice. This means that the current statutory role of the coroner is different from that of any other judicial or administrative officer:

1. The coroners' jurisdiction is mandatory. The Coroners Act 1985 requires a coroner to investigate all reportable deaths and some fires unless an investigation is held in another State or Territory or the death occurred outside Australia. In these circumstances, coroners retain a discretion with respect to their investigation and the decision is usually taken following discussion with coroners in the other jurisdictions involved. Reportable deaths frequently occur unexpectedly, from violence or other preventable causes or when the deceased is in care of the State. The coroner has legal control of the body in all reportable deaths until he or she authorises its release and issues an interim death certificate. An inquest is also a component of the investigation process for some reportable deaths. It is mandatory in some cases such as deaths in custody and care. Otherwise, the holding of an inquest is discretionary.

2. The coroner’s function is investigative and inquisitorial rather than adjudicative and adversarial. Coroners are required to investigate matters in their jurisdiction and, in the case of a death, determine the identity of the deceased, how the death occurred, the cause of death and the particulars needed to register the death. In matters involving fires, the coroner must find, if possible, the cause and origin of the fire, the circumstances in which the fire occurred, and the identity of any...


person who contributed to the cause of the fire. Coroners must not include in a finding or comment any statement that a person is or may be guilty of an offence. It follows that statements are sought and witnesses at an inquest are called by the coroner not, as in other jurisdictions, by the parties.

3. Coroners are appointed by the Governor in Council and their selection criteria are wider than those for other judicial officers. Magistrates, acting magistrates and barristers and solicitors may be appointed as coroners. Currently, all magistrates and acting magistrates are also appointed as coroners. There is one coroner without a concurrent magistrate or acting magistrate’s appointment.

Under the Act, coroners have a wide-ranging discretion to comment on any matter directly connected with the death or fire they are investigating including public health or safety or the administration of justice. Coroners may report to the Attorney-General on a death or fire which the coroner investigated or make recommendations to any Minister or statutory body on any matter connected with or similar to the death and must report to the Director of Public Prosecutions if they believe that an indictable offence has been committed in connection with the death or fire. However, as described earlier in this submission, this discretion to investigate the circumstances surrounding a death is limited by case law that limits coronial investigations to matters required to perform the coroners’ core functions as specified in section 19 of the Act.

As well, the Human Tissue Act 1982 provides coroners with jurisdiction to determine matters relating to the removal of tissue from the body in cases of reportable death.183

The State Coroner's Office is of the view that coronial work is a specialist jurisdiction requiring more intensive training than is currently available. Most of coroners’ training is obtained from experience. In addition, all current full-time coroners have recently undertaken a two day national training program. When they require assistance, all have access to the more experienced full-time coroners, as well as the forensic pathologists, the State Coroner’s Assistants Unit of Victoria Police and members of the State Coroner’s Advisory Committees. Some of the full-time coroners have also attended the first national training program which took place two years ago. Professional development also occurs during the annual Australasian Coroners’ Society Conference when State and Territory coroners, other professionals and agency representatives congregate to discuss common issues. Other training programs are scheduled for full-time coroners and staff dealing with counter-terrorism issues. As well, all Victorian coroners have access to the State Coroner's Practice Manual which is available in hard copy, on CD-ROM and on the JOIN website.

In regional areas, magistrates perform coronial work as well as their usual day-to-day magistrates' work. They have access to the State Coroner's Practice Manual and some of them have undertaken the National Coronal Training Program but this is not a prerequisite for performing the work. In

183 ss. 27, 29, 30, 31, 33 & 34 Human Tissue Act 1982.
addition, the State Coroner regularly attends the annual Country Magistrates Conference to advise on coronial issues.

Further, with respect to the recommendations of the Royal Commission into Aboriginal Deaths in Custody, all magistrates and coroners have the opportunity to attend the JOIN Aboriginal Awareness programs but this is also not a pre-requisite for performance of their functions. However, in the course of their work, full-time coroners who are required to investigate most deaths in care quickly become aware of the recommendations of RCADIC with respect to prevention of deaths in custody.

The State Coroner’s Office is of the view that, as the sophistication of the coronial jurisdiction grows, it is becoming increasingly difficult for magistrates who have not worked regularly as coroners or have not had specific training in relation to coronial work to perform some of the specialist coronial functions. While recognising the value of professional development and training, that of itself is not the sole answer, as it takes many years to develop the necessary experience and understanding of the coronial jurisdiction.

This issue was raised by the review of the role of the coronial process in initiatives for improving patient safety and quality in health care which recommended that all State and Territory jurisdictions establish a small group of coroners to specialize in managing the investigation of deaths in healthcare settings. It will become even more complicated if the Parliament accepts the recommendations in this submission which require coroner’s to consider the public health and safety issues in their jurisdiction and properly support families in the coronial process.

Therefore, the State Coroner’s Office recommends:

**RECOMMENDATION 2.3**

That coroners are supported by appropriate, specialist professional development courses and training programs.

**Delegations**

Sections 10A and 15(4) of the Coroners Act 1985 provide for the State Coroner to, by instrument, delegate to a coroner any power or duty of the State Coroner under the Coroners Act 1985 or, by implication, any other legislation other than a prescribed power or duty or this power of delegation. There are no powers or duties prescribed under the Coroners’ Regulations 1996.

However, the State Coroner has not formally devolved in this way any of his specific powers or duties to coroners other than to the Deputy State Coroner as provided in section 6 of the Coroners Act 1985. Therefore, the

---

State Coroner retains sole authority and responsibility to manage investigations into reviewable deaths, oversee and coordinate coronial services, ensure the coronial system is operated and administered efficiently, ensure all reportable deaths are reported to the coroner, ensure inquests are held when it is necessary to do so. Further, he has not designated a specific coroner to investigate deaths in custody in accordance with Recommendations 7 and 9 of the Royal Commission into Aboriginal Deaths in Custody. However, traditionally, most deaths in custody are investigated by the full-time coroners.

The State Coroner’s Office is of the view that there is no need to change the State Coroner's power of delegation to coroners.

Coroners' powers of delegation to clerks allow nearly all of the practical responsibilities of coroners to be delegated to coroners' clerks and registrars except those required under section 17 of the Act, that is holding inquests and preparing findings. Applications for retention of a body or tissue under section 33 of the Human Tissue Act 1982 require written confirmation of oral authorisation by a coroner.

There are no other relevant delegations or prescribed powers.

In practice, acting on advice from the forensic pathologists, coroners' clerks and Deputy Registrars in the Initial Investigations Office provide the administrative back up and order autopsies unless the family indicates they intend to object. This process is currently under review. Further, clerks in the Main Office ensure that coroners' reporting obligations to the Registrar of Births Deaths and Marriages are met. Coroners' clerks also draft Chambers Findings for consideration by coroners.

Coroners continue to make all decisions in relation to applications under sections 28 or 29 of the Coroners Act 1985 and other applications, decisions about retention of tissue for donation or research, issue of coroners authorities to enter properties and/or seize documents and other evidence, decisions about whether or not to hold an inquest in discretionary cases, final determination of Chambers Findings, how an inquest will proceed and findings arising from Chambers determinations and investigations involving inquest.

The State Coroner's Office is of the view that there is no need to extend these delegations.

---

Chapter 3
Coroners Clerks

Section 12 of the Act provides:

(1) A coroner's clerk may--

(a) on behalf of a coroner, receive information about a death or fire which a coroner is investigating otherwise than at an inquest; and

(b) administer an oath in relation to a death or fire which a coroner is investigating otherwise than at an inquest; and

(c) issue a summons requiring a witness to attend an inquest to give oral evidence or to produce documents.

(2) An affidavit relating to an investigation by a coroner may be sworn before a coroner's clerk.

Further, the coroners' clerks are required to perform the work formally delegated to them by the State Coroner in his role of coroner under section 6 of the Act (see Appendix C).

These statutory roles and delegations are similar to those provided in sections 8 and 10 of the Coroners Act (NT) and sections 10 and 13 of the Coroners Act 1996 (WA). Coroners' legislation in other States in Australia does not specify the role of coroners' clerks. Section 86 of the Coroners Act 2003 (Q'ld) provides more specific powers of delegation by coroners to coroners' registrars and deputy registrars. In particular, although the Queensland State Coroner has wide powers of delegation to the registrar, he cannot delegate his power to a deputy registrar unless the deputy registrar is appropriately qualified which specifically includes having the qualifications, experience or standing appropriate to exercise the power.

In Victoria, the State Coroner's Office is administered by a Grade 6 Principal Registrar, Rick Roberts. The Principal Registrar reports to the State Coroner for coronial issues and the Chief Executive Officer of the Magistrates' Court for administrative matters. Working with him at the Coronial Services Centre, there are 19 coroners' clerks including one part-time Grade 5 DVI/Security Manager, a Grade 4 Deputy Registrar, 12 Grade 3 coroners' clerks who are all also Deputy Registrars, and five Grade 2 coroners' clerks. Ten coroners' clerks are permanently employed at the Coronial Services Centre. Three of these are only employed under the Public Sector Management Act 1998. The others are part of the Magistrates' Court structure on, usually, a two year rotational posting. In regional Victoria, the Magistrates' Court clerks perform the role of coroners' clerks. As well, the Principal Registrar is responsible for managing the Counselling and Support Program and two research officers: one funded by the Department of Justice to research suicides and the other funded by Workcover Victoria to research work-related deaths.\footnote{The suicide research position is currently vacant. The workplace death position has been subsumed into the new Workplace Death Investigation Unit.}
The Counselling and Support Program is funded under the same categories as the coroners' clerks. At a practical level and from the resources point of view, all the services required to implement this commitment are currently delivered by the coroners' clerks and the Counselling and Support Service based in the Coronial Services Centre in Melbourne as indicated below. They are not always provided in regional areas. Further, in some regions, coroner's clerks have little training in how to perform their role in the coronial jurisdiction.

The State Coroner's Office is of the view that the two year rotational posting of coroners' clerks to the State Coroner's Office from the Magistrates' Court needs review because they are just beginning to gain experience when it is time for transfer to another area in the Magistrates' Court system.

The effects of trauma, grief, and upheaval experienced by relatives and friends of people who die suddenly and unexpectedly, can have implications for the physical, emotional, and social health and wellbeing. The ensuing stress can have lasting effects upon motivation, eating and sleeping patterns, personal relationships, and negative feelings about themselves.

Clinical and anecdotal evidence indicates that at the time of a sudden death a person's sense of security and safety has been violated. The resulting distress and anxiety can overload a persons; mind leaving them in a state of extreme vulnerability. Experience in working with families following trauma or crisis has shown that- providing affected people with information comfort, support, information, practical assistance, listening and helping clarify experience are pivotal in assisting them to restore confidence so that they can begin their own recovery.

Therefore, the State Coroner's Office is of the view that families and others involved in a recent death should be provided with as much information as possible about the way the coronial process will affect them in a responsive, timely and culturally appropriate manner. Families and others affected by the coronial process can also be provided with information by a range of other methods, for example: the State Coroner's website, a publication called "The Coroner's Process", pamphlets on suicide and counselling and support. Some of these areas need further and ongoing development.

For the sake of simplicity, coroners' clerks' involvement in the coroners' investigation process can be divided into the Case Initiation and Processing phase, the Counselling and Support Program, the Case Investigation phase and the Case Determination and Finalisation phase. Using these headings, this Chapter will provide more detail about the work undertaken by the coroners' clerks as outlined from the coroners' perspective in the Background section at the front of this submission.

---

Case Initiation and Processing

The Committee has sought advice about the following issues that relate to initial contact between the State Coroner's Office and the members of the community most affected by coronial investigation of a recent death:

- Should the Act give family members the right to be informed or to be kept informed of certain events?\(^{188}\)
- Touching, viewing and other cultural issues relating to the body and the scene of death, \(^{189}\)
- 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?\(^{190}\)
- Should the Act require coroners to inform the senior next of kin when a tissue or body part has been retained after the autopsy?\(^{191}\)
- 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?\(^{192}\)
- Should the Act require the State Coroner’s Office to inform family members about the availability of the free counselling service?\(^{193}\)

All case initiation and processing in Victoria, is performed by the coroners' clerks in the Initial Investigations Office which is managed by the Grade 4 Deputy Registrar. Some coroners' clerks always work in the Initial Investigations Office. Others are rotated between the Initial Investigations Office and the Main Office. In the Initial Investigations Office, they work three shifts to ensure 24-hour coverage. The Initial Investigations Office staff are effectively the eyes, ears and hands of the State Coroner during the initiation phase of a reported death and their work is crucial to the proper achievement of the State Coroner’s role. In Melbourne, about 40% of bodies are released for burial or cremation within 72 working hours of admission (Fig. 6).\(^{194}\)

---


\(^{194}\) q1 is Jan-Mar; q2 is Apr-Jun, q3 is Jul-Sep, and q4 is Oct-Dec.
The decisions coroner's clerks in the Initial Investigations Office have to make to achieve this release are summarised in the flow chart below (Fig. 7).

The work required to achieve these outcomes includes, for example:

- Answering the phones on a 24-hour, seven day a week basis,
- Providing advice to medical practitioners, funeral directors and police about whether or not a death is reportable to the State Coroner and other questions that they ask, for example, whether they can perform an autopsy in the hospital,
- Taking and recording all reports of death and serious fires to the State Coroner,
- Entering all available information on the State Coroner’s Case Management System,
- Liaising with regional police with respect to their faxing copies of their reports to the Initial Investigations Office and to their regional Magistrates’ Court unless the death is a Reviewable Death, homicide, SIDS death, industrial death, multiple death, or case of high public interest. These cases are investigated from Melbourne.
- Contacting the regional Magistrates’ Courts next day to ensure they are aware of deaths in their region and have made arrangements for autopsies and identification,
- Advising family members and others seeking information about the coronial process and the status of their loved one, including the likelihood that an autopsy will be performed and their right to object,
- Maintaining appropriate confidentiality and privacy of family members and the deceased;
- Re-allocating regional cases to the local coronial systems,
- Liaising with senior next of kin, coroners, the Family Contact program and forensic pathologists from the Institute in relation to issue of death certificates, determination of medical cause of death by way of inspections and report, applications under sections 28 and 29 of the Act, and ordering of autopsies,
- Liaising with coroners, mortuary staff and forensic pathologists from the Institute in relation to performance of autopsies and reception and release of bodies,
- Ensuring that the medical cause of death determined by the forensic pathologist is accurately recorded in the Case Management System,
- Authorising and arranging release of bodies to funeral directors or families for cremation or burial,
- Checking the identity of bodies received and released to funeral directors or families against physical descriptions and tags,
- Managing applications for no autopsy to be held or seeking autopsy,
- Alerting the State Coroner or Deputy State Coroner on duty when incidents involving multiple deaths, work-related fatalities, serious fires, high profile incidents arise such as police shootings or deaths in custody,
- Calling out the duty pathologist when requested by the Victoria Police Homicide Squad or the State or Deputy State Coroner,
- Arranging police attendance at scenes and co-ordinating the services of the government contractors for the removal of deceased persons from death scenes,
- Obtaining medical records and files from hospitals and medical practitioners,
- Checking all bodies are monitored by the Institute twice a day to make sure there are no hold ups and ensuring bodies are released from the mortuary as quickly as possible,
- Managing family disputes about disposal of the body,
- Processing deaths reported by the Registrar of Births Deaths and Marriages, and
- Drafting chambers findings when they have time.

The Deputy Registrars also provide a 24 hour service for the Magistrates' Court in relation to issue of warrants and interim intervention orders under the Crimes (Family Violence) Act 1987.195

As well, during the day, the coroners’ clerks in the Initial Investigations Office support family members and others who come to the Coronial Services Centre to identify the deceased person. This includes checking that bodies are suitable for visual identification and that the correct body is presented for identification. If they are unsuitable, special arrangements have to be made for alternative identification. When family members are particularly distraught or there is some other complicating factor such as potential criminal involvement or a decision about tissue donation associated with the identification process, the Counselling and Support Service will assist them in this role.

---

195 In 2004/5, Deputy Registrars working afternoon or night shift at the Coronial Services Centre issued 2251 warrants (up 16% on last year) and 4677 Interim Intervention Orders (up 66% on last year).
The Initial Investigations Office staff also accommodate cultural rites such as viewing, touching or sitting with the body when requested to do so by family members or through the Counselling and Support staff if these requests are appropriate in all the circumstances. When there is any doubt, these issues are discussed with a coroner. As one of the Deputy Registrars said recently to a family member requesting the right to perform cultural rites:

“One of the real difficulties for our office is cultural needs. Often we do not know what is required because we won't know the deceased's cultural background. When we find out and are advised, we will act accordingly....”

The State Coroner, the Deputy State Coroner and the Principal Registrar are always on call to make decisions or give advice when the coroner's clerk is acting on their delegation and they are unsure about what to do.

At the Coronial Services Centre each weekday morning, the coroners’ clerks on duty meet with the Counselling and Support staff and the counsellors from the Donor Tissue Bank to review the deaths reported to them over the last 24 hours. At this meeting, information is shared about families and other issues that have arisen so that everyone involved can be appropriately followed up and informed of their rights under sections 28 or 29 of the Act. However, as previously observed, this family contact and information process does not occur in regional Victoria.

When these processes are complete and the body has been released, responsibility for managing the investigation, determination and finalisation of the case shifts to the Main Office.

This job description and operational flow chart of the work of the Initial Investigations Office indicates that, in Melbourne, many of the Committee's concerns about provision of information and appropriate services to families and others immediately following the death of their loved one are being addressed in a timely manner. However, in regional areas, these services are more disparate and are routinely provided by the Initial Investigations Office staff in Melbourne or by the Magistrates' Court clerks operating as coroners' clerks.

There are, of course, some limits to the capacity of the State Coroner's Office to meet all the needs of families, for example when the death is a homicide and touching may involve contamination of evidence. Therefore, the State Coroner's Office is of the view that these services should not be prescribed as rights in the Act but, rather they should be included in the State Coroner's Office charter and remain open to individual interpretation on a case-by-case basis.

Counselling and Support Service contacts with families or other interested parties

The Counselling and Support Service attached to the State Coroner's Office also makes contact with all families on the day of admission to inform them of the coronial process including any particular issues that may arise in their situation, their rights to seek or object to autopsy and the availability of support services and short-term counselling. Other issues that may be raised include availability of the autopsy report and the
requirement to make a statement for investigators on behalf of the coroner. The Counselling and Support Service also maintains contact with families and interested parties throughout the process and provides a telephone response service. As well, they inform families and others about the Inquest Preparation seminar that they run every three months for interested parties in cases likely to proceed by way of inquest.

Investigators from the Victoria Police, the State Coroner’s Assistants Unit, the Clinical Liaison Service or forensic pathologists from the Institute may also make contact with families in the course of the coroners’ investigation into the death. Sometimes, they will also respond to a request made through the Counselling and Support Service to provide further explanation to family members and other interested parties.

In particular, there are two Grade 3 and one Grade 2 counsellors working for the Counselling and Support Service which is part of the State Coroner’s Office in Melbourne. Together with the Transplant and Family Liaison Coordinators from the Donor Tissue Bank which is run by the Institute, the service is called the Family Contact Program.

The Family Contact Program is an initiative of the State Coroner’s Office supported by the Victorian Institute of Forensic Medicine (incorporating Donor Tissue Bank). The program aims to strengthen the links between staff of the Coronial Service Centre and streamline communication with families, to achieve better service delivery outcomes for the community as a recognised avenue for continuous improvement. It was identified as a key strategy within the Strategic Business Plan of the State Coroner’s Office for the period 1 July 2004 - 30 June 2007 and is aligned with the broader direction of the Justice Statement and the Justice Portfolio three year strategy.

All cases reported to the State Coroner through the Initial Investigations Office in the previous 24 hours or over the weekend are reviewed each weekday morning with the Family Contact Program. Contact with a family in the Melbourne metropolitan area is initiated, usually within a 24 hour period. In recognition of the sensitive and distressing nature of the information being provided to bereaved families at a time of extreme vulnerability, the staff of the Counselling and Support Service (State Coroner’s Office) and the Transplant and Family Liaison Coordinators (Donor Tissue Bank) have been identified as being best placed to initiate this contact.

The support provided by the Counselling and Support Service aims to ensure family members and others understand their rights with respect to the State Coroner’s control of the body and coronial processes and ameliorate some of the impacts of death and the coronial process on the bereaved, based on principals of crisis intervention (ie. appropriate early intervention can significantly minimise the effects of loss and grief). Preventative approaches then focus on identifying and reducing risk factors and increasing protective factors, in order to decrease the likelihood of adverse psychological outcomes.
Although every effort is made to speak with the senior next of kin, the contact process recognises that this may sometimes not be possible. If speaking with a person other than the senior next of kin, the relationship of this person to the senior next of kin is noted. Only a senior next of kin can object to an autopsy.

The current definition of senior next of kin can create dissent among family members in situations involving non-nuclear families and difficulties for the counselling and support staff. Some of these issues will be addressed if the definition is changed as recommended in Chapter 1 of this submission.

In general terms, the program aims to:

- systematically provide consistent, clear, and reliable information in a timely manner
- provide a central point of communication with a coronial services centre staff member for families in order to facilitate easier access to the court system
- provide information to families regarding their legal rights and opportunities for objecting to autopsy
- avoid repetition and duplication of information thereby reducing unnecessary distress to families
- provide information regarding support services.

In addition, the program was designed to be a comprehensive Statewide strategy and approach but this has not been possible to date given the complex nature of this task. The case management information technology facilities do not allow communication across the State to track case progress. The significant time and resources required to broaden the program to include rural regions will be reduced when the new computer system is installed soon. Implementation of the Family Contact Program is now being trialled in Moe.

In order to ensure consistency of information being provided, all staff involved in the program have been trained and have access to a ‘Practice Instruction’ folder. The main points of discussion have been categorised with discussion guidelines throughout to ensure the family understand what is being discussed. A copy of the Practice Instruction is included as Appendix D.

In the period, January 2004 to June 2005, the Counselling and Support Service in the State Coroner's Office contacted 1759 families in the two days after the death of a family member was reported to the State Coroner. They also conducted:

- 555 face-to-face counselling sessions with family members, usually about five but up to 20 people per session,
- 455 telephone counselling sessions,
- Assisted with 22 identifications,
• Sent out 870 Suicide Bereavement Information kits,
• Conducted six Inquest information Nights with a total of 130 attendees, and
• Answered 276 professional queries.

Following the commencement of the reporting of all asbestos-related deaths, a program was developed in April 2005 to assist families in understanding the role of the State Coroner in investigating these deaths. Details of asbestos-related deaths are obtained via the computer system on a daily basis. The counsellors then locate details for the senior next of kin family member affected by the death. A register is maintained of all contacts made with families. The service then sends a letter to families/affected individuals with an Asbestos-related Deaths Information brochure.

Anecdotally, feedback from families has been extremely positive. Of note, is feedback in relation to their appreciation for the information being provided early, at a time of confusion regarding the coroner's involvement and of being unclear as to "what happens now".

Families have also expressed their appreciation for being advised of their rights to object to autopsy, the option assisting them in regaining a sense of control of their situation and their connection with their loved one.

One of the issues this program was designed to address was that of complaints from family members that autopsies were being performed without their consent. Whilst in the past, statistics on these complaints were not formally recorded, these complaints were increasing and appeared to reflect the changing attitudes of the community in regard to their rights. Since the pilot program was introduced the number of objections to autopsy have increased which seems to indicate that when informed, some families will exercise this right. Moreover, in the twelve-month period following the implementation of the program, only one complaint has been received in relation to this issue.

**Case Investigation phase**

The Committee is seeking advice in relation to a number of further questions that relate to the statutory or delegated work of the coroners' clerks during the Case Investigation phase of the coroner's investigation. These questions include:

• Should the Act give family members a right to be informed of progress of the investigation? Who should be required to inform the family? Should anyone be responsible for ensuring this occurs?\(^{196}\)

• Should the Act include requirements about notification of immediate family about the time and place of an inquest and should the Act make special reference to RCADC on this matter?\(^{197}\)


In Melbourne, the Main Office coroners' clerks are responsible for managing the investigation, determination and finalisation phases of the coronial system. In regional offices, the coroners' clerk attached to the regional Magistrates' Court performs this role.

There are seven coroner's clerks at the Coronial Services Centre providing the administrative services required to perform these tasks. To help understand the process, a flow chart of the State Coroner's Investigation Process in the Main Office is provided on the next page (Fig. 8).

In the investigation phase, the Main Office coroners' clerks' tasks include:

- Answering the phones,
- Writing letters to interested parties and responding to correspondence on behalf of coroners,
- Routine notification of the Registrar of Births Deaths and Marriages of the cause of death of Melbourne and regional cases so that a Death Certificate can be issued,
- Preliminary determination of whether case is a reportable death,
- Providing interested parties with a copy of the autopsy report and/or the coroner's brief of evidence. This is usually accompanied by a letter alerting the recipient of the contents of the documents and advising them to seek professional support when reading them,
- Allocation of files to the Victoria Police Coroner's Assistants Unit or the Clinical Liaison Service for further investigation,
- Maintaining continuity of the files,
- Liaising with investigators, particularly police investigating on behalf of the coroner, in order to obtain statements and other evidence required in the investigation,
- Organising independent expert witnesses when coroners seek their review of a file and/or their expert advice,
- Submitting files to the full-time coroners for decision about whether or not the investigation is complete and whether or not it should proceed to inquest,
- Drafting chambers findings for review by a coroner,
- Listing cases for inquest,
- Assisting the coroner with the management of the inquest hearing, including controlling exhibits, recording the proceedings, swearing in witnesses,
- Finalising Melbourne and regional files ready for archiving. State Coroners' files are permanent records. They become public documents on completion of the file and are archived at the Public Records Office.
As they become experienced, some coroners' clerks accept responsibility for specialist files, for example, homicides are coordinated by one clerk and hospital deaths are usually coordinated by another.

When the coroners' clerks in the Main Office are of the view that a file is ready to be determined, the file is submitted to a coroner. After reviewing the file, the coroner may decide that the matter is ready for completion as a chambers finding or to proceed to listing for an inquest. However, when they review the file, coroners frequently seek further investigation or clarification of issues in the file or decide that an expert opinion is required. This means that, for the coroners' clerks, there is usually an overlap between the investigation phase and the determination and finalisation phases of the coronial process.

**Fig. 8 Flow Chart of State Coroner's Process in Main Office**

In regional areas, all these decisions are taken by the coroner's clerk in the Magistrates' Court.

**Case Determination and Finalisation phase**

When a coroner has decided that a matter will be determined as a chambers finding, the Main Office coroners' clerks notify interested parties including families of the decision to proceed without inquest. If the State Coroner does not receive a request to hold an inquest within 21 days of sending out this notice, the chambers finding is finalised, the file is completed and all interested parties are provided with a copy of the finding.
If the coroner determines that further investigation of the case requires an inquest or if the matter is subject to the mandatory inquest provisions of the Act, he or she will also decide which witnesses need to be called to give oral evidence. Sometimes, a mention hearing is required to help the coroner determine the parameters of the inquest. The listing clerk will then notify all interested parties of the date and time of the inquest and issue appropriate summons to appear and, sometimes, bring documentation.

Further, at the inquest, a Main Office coroners’ clerk assists the coroner in the hearing and manages the tape recording and other procedural issues required under the Evidence Act 1958 and the Coroners Act 1985.

After the inquest is completed and the coroner has prepared a finding in the matter, the case is determined by handing down the finding in court and the coroners’ clerks distribute copies to all interested parties. Also, if the coroner directs, the finding will be sent to the Attorney General, Ministers of the Crown, government agencies, industry and community groups.

The State Coroner’s Office is of the view that the Main Office procedures ensure that family members and others affected by the death are informed of the progress of the investigation, coroners’ decisions to proceed by way of chambers findings and the dates and time of an inquest. Further, the State Coroner's Office does not believe there is a need to amend the Act to ensure they are provided with as much information as possible about the way the coronial process will affect them in a responsive, timely and culturally appropriate manner. However, there still is potential for improvement in available documentary information and website activity in this area.

Therefore, in general terms, the State Coroner's Office is of the view that families and other interested parties are already informed of progress and have access to information when they need it. The information that is provided to families and interested parties is similar to that required to be provided to the next of kin under section 20 of the Coroners Act 1996 (WA). With respect to counselling, section 16 of the Coroners Act 1996 (WA) also provides:

16. Counselling

(1) The State Coroner is to ensure that a counselling service is attached to the court.
(2) Any person coming into contact with the coronial system may seek the assistance of the counselling service of the court and, as far as practicable, that service is to be made available to them.

The State Coroner's Office is of the view that provision of support services for families and others affected by the coronial process should be recognised as a core function of the coronial jurisdiction and included in Section 1 of the Act. The Counselling and Support Service is an essential element in the capacity of the State Coroner's Office to ensure that families and others involved in a recent death should be provided with as much information as possible about the way the coronial process will affect them in a responsive, timely and culturally appropriate manner.
However, although the State Coroner's Office is of the view that a short-term counselling and support service should be available to all Victorians, the individual nature of the needs of family members and others effected by a death lead to the view that the particulars of the service should not be mandated in legislation other than as a Purpose of the office of the State Coroner as recommended in Chapter 1 of this submission.

On that basis, the State Coroner's Office recommends that:

**RECOMMENDATION 3.1**

The Government of Victoria continue to support the operation of the a short term counselling and support program including its implementation across Victoria.
Chapter 4  
Reporting of Deaths

Over 86% of deaths in Victoria are natural, uncontroversial and unpreventable. They are not reported or reportable to the State Coroner. Families deal with their grief and dispose of the body in the way that is most culturally and personally appropriate for them. In many cases, their loved one will have advised them about the way in which he or she prefers to be farewelled or included instructions in their wills.

*Fig. 9 Deaths Reported in Victoria*

Any involvement of the State Coroner's Office interferes with performance or these deeply held rituals and interrupts the grieving process. Therefore, the Act and the State Coroner's Office always function within a tension created, on one hand, by families' usual preference to perform its rituals privately and quickly against, on the other hand, the community's understanding that death that occurs under controversial circumstances should be investigated and that preventable deaths should not happen again. This takes time and intrudes into the lives of families and others affected by the death.

The first key to managing of this tension on a case by case basis lies with the definitions of natural causes death and reportable death. The State Coroner's Office has made recommendations in relation to both these definitions already in this submission.
The second key to resolution of this tension is to ensure that deaths that the community deems reportable to the State Coroner are reported but deaths where the community believes coronial intervention is not justified should not be reported and their disposal should remain in the families' control. This second arm of the issue surrounding reporting of deaths will be discussed in this Chapter.

In particular, the State Coroner's office is of the view that the system needs to effectively identify those cases requiring investigation and target resources accordingly.\(^{198}\)

Sections 13, 13A and 14 of the Act require members of the public, police officers and doctors to report reportable and reviewable deaths to the State Coroner and provide any information they have about the death. Other States have similar obligations to report deaths to the coroner or police officer if they are believed to be reportable.\(^{199}\)

In particular, section 13(3) provides an offence for breach of the following:

(3) A doctor who is present at or after the death of a person must report the death as soon as possible to a coroner if--

(a) the death is a reportable death; or

(b) the doctor does not view the body; or

(c) the doctor is unable to determine the cause of death; or

(d) no doctor attended the person within 14 days before the death and the doctor who is present is unable to determine the cause of death from the deceased's immediate medical history.

Further, subsection 13(5) provides:

(5) 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.

However, a snapshot of 356 deaths reported directly to the State Coroner in April 2005 indicates that about 58% of these deaths were first reported by Victoria Police members in metropolitan Melbourne and 85% in regional Victoria (Fig. 10). Hospital doctors first reported nearly all the rest of the deaths reported directly to the coroner.
In New South Wales, Northern Territory and Western Australia, the Coroners Acts specifically require doctors to report reportable deaths to the State Coroner.\textsuperscript{200} In the Northern Territory, Tasmania and Western Australia, deaths in care or custody must also be reported by the custodian at the time of the death.\textsuperscript{201} In Northern Ireland, reporting of reportable deaths is being achieved without legislative amendment by establishing formal protocols between the Chief Coroner and police, children's services and other relevant agencies.\textsuperscript{202}

The Committee has sought advice on the following relevant issues:

- In your experience, do doctors have a good understanding of what is meant by a reportable death in the category of unexpected, unnatural, violent and accidental deaths?

- 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?

\textsuperscript{200} s. 12B Coroners Act 1980\(\text{(NSW)}\), s. 12(3) Coroners Act \(\text{(NT)}\), s. 17(3) Coroners Act 1996 \(\text{(WA)}\).

\textsuperscript{201} s. 12(4) Coroners Act \(\text{(NT)}\), s. 19(4) Coroners Act 1995\(\text{(Tas)}\), s. 17(5) Coroners Act 1996 \(\text{(WA)}\).

• 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 like in the ACT or Queensland?

• Is there currently 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?

• How often are deaths reported to the coroner by the general community?

• Is the general community aware of their obligation to report notifiable deaths to the coroner?

• If not, who should be responsible for raising awareness? Should this be a function of the State Coroner? What strategies could be used?

• Should the Act impose a penalty on police officers who fail to report to a coroner information relevant to an investigation?

• Should there be a legal requirement as part of the death certification process that a doctor some other person be required to physically view all bodies?

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

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

• Should the Act or Coroner's guidelines be more specific as to the degree of certainty required for diagnosis?

• Do the current Institute guidelines provide for an appropriate degree of certainty on diagnosis?203

Further questions about the definitions of anaesthetic deaths and persons held in care have been dealt with in Chapter 1.

**Reporting of Deaths to the State Coroner**

Under the current system in Victoria, whether a death is reportable to the State Coroner depends on the diagnosis provided by a doctor immediately after death on the basis of external examination of the body and awareness of the deceased's medical history. The State Coroner requires doctors who have not seen the body and treated them in the last three weeks and/or had access to their medical files to report the death. Sometimes doctors are required to go to the funeral director's office to view the body when they intend to certify the death after the body has been removed.

---

Even as the number of reportable deaths has risen, the number of deaths reported to the coroner that are determined to be natural causes deaths and, therefore, are not reportable deaths has remained stable over the last five years (Fig. 11).

**Fig. 11 Natural Causes Deaths Reported to the Coroner**

The State Coroner's Office does not have any view about whether this requirement to view the body should be legislative or remain a State Coroner's requirement for determination of cause of death and the consequent duty to report to the State Coroner is communicated to doctors through the Guidelines disseminated by the Institute and the Medical Board.

Further, at this initial gate-keeping stage of a coroner's investigation, diagnosis of medical cause of death is based on the circumstances of the death as known at the time of the diagnosis, observation of the body and knowledge or records of the patient's recent medical history. At best, it is determined by the reporting doctor's assessment of the likely cause of death. The State Coroner's Office is of the view that, at this early but crucial stage, it is unlikely that duplicate assessments of cause of death without more or more reliable background information will improve the accuracy of diagnoses except where diagnoses are deliberately misreported or result from doctors' clinical inexperience.

The Registrar also routinely reviews all deaths reported to her by doctors. Those that appear, on the basis of the Medical Deposition, to be reportable deaths are referred to the State Coroner as reported deaths and their files are reviewed by pathologists in the Institute. In cases where a forensic pathologist determines that the death was not a natural causes death, the State Coroner commences a coronial investigation.

The State Coroner's Office, the Institute and the Registrar of Births Deaths and Marriages have been working together for about two years on
improving the reporting of deaths to the State Coroner. The Registrar’s Office has been looking at technology surveillance to help identify unusual patterns in deaths to help identify cases like Shipman.

In a recent email to the State Coroner, the Registrar of Births Deaths and Marriages said:

"The Registry of Births, Deaths and Marriages' current computer system has the capacity and some capability currently to meet some of the weaknesses identified in the Shipman Inquiry. It can be developed to create an expert system to identify suspicious registrations. It can be further adapted to interrogate imputed data to detect anomalous/inconsistent information and, if connected system to system, has the ability to check a deceased person’s health history, e.g. was a person who died of cancer receiving treatment from a specialist. This last part would require some external information exchange and analysis with external organisation like the Health Insurance Commission.... A significant improvement can be achieved with a minimum of investment compared with the UK model. The system development would provide ongoing advice about anomalous death registration patterns. Comparisons can be based on death rate per doctor (taking into account activity levels) and death rate per geographic area."

The Registrar considers that the Registry of Births, Deaths and Marriages is able to perform:

"... random and/or defined audits to show unusual patterns in certification of deaths, e.g. a doctor signing more medical certificates of cause of death than would be expected or recording the same cause of death for a number of patients. It is also able to confirm that doctors are registered with the Medical Practitioners' Board and are currently practising."

The Registrar also noted that these suggested processes "together with stronger working relationships with the State Coroner's Office and Institute would see some of the current risks mitigated." She said that of "practical importance is the area of communication and education in the completion of the medical certificate of cause of death to ensure that the requirements are clearly and adequately conveyed to doctors."

This current sifting and surveillance process closely resembles that recommended for reported deaths in the Luce report but, in Victoria, the medical assessor would be based at the Registrar of Births, Deaths and Marriages' Office rather than with the State Coroner.

The frequency of failure to report reportable deaths to the State Coroner identified by the Registrar of Births Deaths and Marriages has escalated since 2002 to 99 per 1000 reportable deaths in 2004 (Fig. 12).

The increase in the numbers of unreported deaths in 2003 and 2004 may be partly explained by three State Coroner’s determinations. Two of these determinations were intended to widen the practical interpretation of reportable death (these deaths always were reportable):

1. In early 2003, the State Coroner, the Institute and the Registrar of Births, Deaths and Marriages began to develop an improved working relationship in order to help identify and address under-reporting.
2. In November 2003, the State Coroner determined that deaths associated with falls were reportable deaths even if the medical cause of death was a natural causes death. The decision was accompanied by introduction of a Falls Investigation Standard that is described in the next Chapter and included in the Appendices. It was accompanied by letters to all the medical colleges and hospitals. This State Coroner's Direction increased the number of otherwise natural causes deaths because, in many fall associated deaths, the immediate cause of death is pneumonia.

*Fig. 12 Frequency of Failure to report Reportable Deaths*

3. On 11 May 2004, the State Coroner informed all medical colleges that deaths associated with asbestos were reportable deaths and all bodies where the medical cause of death was associated with exposure to asbestos were to be reviewed by forensic pathologists at the Coronial Services Centre. This increased the number of otherwise natural causes deaths and the number of bodies received at the Coronial Services Centre. However, in May 2005, a new protocol was introduced which maintained the reportable nature of asbestos deaths but removed the requirement for bodies of asbestos victims to come to the Coronial Services Centre mortuary if specific information was provided to the Initial Investigations Office. This Protocol is included in Appendix C. It will not reduce the number of unreported reportable deaths but it does
remove some of the family anxiety associated with the body being taken away from their region and associated delays and costs related to release and transport of bodies for cremation or burial.

The State Coroner’s Office has no explanation for the increasing frequency of failure to report deaths that began in 2002. The State Coroner’s Office has analysed all 69 cases reported to the State Coroner by the Registrar of Births Deaths and Marriages during April, May and June 2005. This snapshot indicates that the source of unreported reportable deaths was distributed as shown in Figure 13.

This distribution of unreported reportable deaths indicates that regional deaths are over-represented in failure to report reportable deaths. Further, hospitals and nursing homes are the most usual source of unreported reportable deaths but these sources are evenly distributed between metropolitan Melbourne and Regional Victoria. Deaths associated with falls were the most frequent unreported reportable deaths in this snapshot.

These data suggest that doctors in hospitals and nursing homes are still not always aware of their statutory duty to report fall-related deaths to the State Coroner. The precise reasons for this failure to comply with their obligations are not clear. However, anecdotal information suggests that there is a degree of ignorance of the reporting criteria, particularly as it relates to falls, which is not addressed in Grand Rounds or at medical school.

Further, doctors from regional areas who know about these reporting criteria say they have been inclined to avoid mentioning them as secondary issues in what otherwise fits the proper description of a natural causes death. Some general practitioners in regional areas who know their patients on a more personal level say that they are loathe to take the step of reporting a death that they know may involve police investigation, autopsies including transfer of bodies out of the region, and delays including potential inquests.

The State Coroner's Office is of the view the changes in the definition of 'reportable death' recommended in this submission should overcome some of the current barriers to doctors’ awareness of the obligation to report reportable deaths to the State Coroner because they change the emphasis of the doctor’s decision: report unless it is a natural causes death rather than report if it is not a natural causes death. Further, they extend doctors’ current practices and forms rather than introduce a new system which will require careful implementation. These changes in definition of 'reportable death' will also increase the number of reportable deaths to a level where coronial involvement is expected and managed rather than avoided wherever possible.

The under-reporting issue would be overcome altogether if the recommendations of the Shipman Inquiry were implemented requiring all deaths to be reported to the State Coroner and requiring the coroner to make the decision about which ones required further investigation. This would also assist in determining the reliability of the diagnosis of medical
cause of death. However, the State Coroner's Office is of the view that the Shipman solution is impracticable, resource intensive and, in the context of regional Victoria, disrespectful of the needs of families who prefer quick turnaround of a body and it to stay as near as possible to home. In this respect, the Luce report and the Home Office Position Paper agree.

**Fig. 13 Characteristics of Unreported Reportable Deaths**

Rather, the State Coroner's Office is of the view that on-going assessment of deaths reported to the Registrar of Births Deaths and Marriages and a major publicity campaign through the medical colleges, medical schools, hospitals, nursing homes and public media should be implemented in an attempt to increase doctors’ reporting of reportable deaths.

The current sifting and surveillance process undertaken by the Registrar of Births, Deaths and Marriages, the State Coroner's Office and the Institute closely resembles that recommended for reported deaths in the Luce report although there is no medical assessor or expert currently based at the office of the Registrar of Births Deaths and Marriages.

However, in the absence of an autopsy, the definition of medical cause of death and consequential requirement to report will always rely on the diagnosis by the doctor who views the body. The need for some degree of certainty in a diagnosis that will not be tested creates an on-going and unresolvable tension against the needs of the family for their body to be released and the cause of death to be communicated to them. The State Coroner's Office is of the view that a specific degree of certainty required for diagnosis in the Act or in State Coroner's guidelines or a change in the Guidelines issued to the medical profession through the Institute, the Medical Board and others will not advance this issue further.

Introduction of even more general reporting criteria with a second assessment of whether the death is a 'reportable death' occurring at the
forensic pathology level, as mooted by the Position Paper in the United Kingdom\textsuperscript{204}, is a third way of addressing non-compliance. It will provide immediate accountability for doctors who are deliberately falsifying cause of death in order to evade their reporting responsibilities and ensure that autopsies are available in these cases.

However, even under this scheme, the information on which the two doctors determine cause of death prior to autopsy will not usually change from the information currently interpreted by one doctor. Further, it will be resource intensive, there is a dearth of forensic pathologists already, particularly in regional areas (see Chapter 5), it may not sufficiently protect victims from undetected unnatural death and, in many cases, it will require transfer of bodies to Melbourne and back to regional areas for funerals with associated delays in their release to families and resource implications.

In the experience of the State Coroner's Office, this was a major social and cost issue when the State Coroner required bodies to be brought to Melbourne in asbestos deaths. In order to resolve some of the community and family tensions associated with the reporting of this class of death, the State Coroner's Office adopted a new method to deal with these issues. The bodies are not usually brought to Melbourne and the investigation is based on the medical records and information from families and others.

The State Coroner's Office is of the view that sophisticated investigatory technology as well as limited medical support should be located in the Office of the Registrar of Births Deaths and Marriages. Provided there are the appropriate legislative links and protections, there are potential benefits for the community. Working together in a co-operative way will continue to address the under-reporting issue and help to identify unusual trends. Further, the assessment process can be strengthened by regular education campaigns on reporting of deaths, audit process checking on reporting in key institutions like nursing homes and hospitals and statutory provision for the State Coroner to initiate "own initiative" investigations or undertake limited purpose investigations.

For all these reasons, the State Coroner's Office recommends:

**RECOMMENDATION 4.1**

That the State Government commit resources to a major education campaign targeting doctors in hospitals and nursing homes to ensure they understand their obligations in relation to reporting deaths to the State Coroner.

Further, the State Coroner's Office recommends:

**RECOMMENDATION 4.2**

The State Government provide resources for computer surveillance systems and a specialist medical assessment team in the Office of

\textsuperscript{204} "Reforming the Coroner and Death Certification Process A Position Paper", Presented to Parliament by the Secretary of the Home Department by Command of Her Majesty, March 2004, CM 6159.
the Registrar of Births, Deaths and Marriages to identify trends in
deaths that may require investigation and to monitor Death Certificates for deaths that should have been reported to the
coroner.

As well, the State Coroner's Office recommends:

**RECOMMENDATION 4.3**

That the State Government implement an independent audit system
to address and monitor the under-reporting of deaths to the coroner.

Members of the public rarely report deaths to the State Coroner. Further, reports by police frequently duplicate those that have been provided by doctors. In view of the requirement for doctors to certify death and indicate cause of death in cases which are not referred to the State Coroner, it is probably unnecessary for the public to be expected to perform this role. Further, when family and others associated with the death are concerned about whether an accurate cause of death has been reported by the certifying doctor, they can contact the State Coroner, the police or the Health Services Commissioner.

Therefore, the State Coroner's Office is of the view that it is unnecessary for members of the community to be further made aware of their statutory obligation to report reportable deaths.

**Own initiative and limited purpose investigations**

Under the existing Act, the State Coroner only responds to deaths that have been "reported." There is no own initiative investigation process in the Act. The State Coroner's Office is of the view that an own initiative and limited purpose investigation jurisdiction would be another useful tool in implementing its public health and safety role.

The 2003 Fundamental Review recommended:

> The coroner should be given explicit powers to investigate any death on his own initiative whether or not it had been formally reported to him; and to investigate any group of deaths which have already been certified if, in retrospect, there are grounds to think there might have been common factors not previously identified.\(^{205}\)

An own initiative investigatory capacity in the State Coroner combined with the recommended audit process, medical review of deaths by the Registrar of Births, Deaths and Marriages and specific education would provide an added degree of protection and confidence for the public.

With the difficulty of under-reporting of deaths "own initiative, limited purpose investigations" may also provide added confidence to any audit process. In Luce, it was recommended that:

The coroner should be able to require for any specified time that all deaths occurring in particular facilities or locations should be reported to him, even if they would not normally fall within reportable categories.206

"Limited purpose investigations", provided they are supported with appropriate resources, could also be used to audit deaths of potentially vulnerable people, like in nursing homes or particular classes of deaths, such as a specified occupational disease not contained in the prescribed list in the Regulations to the Act.

The State Coroner's Office is of the view that these "limited purpose" investigatory tools should be directed by the State Coroner.

For all these reasons, the State Coroner's Office recommends:

RECOMMENDATION 4.4

That Parliament amend the Coroners Act 1985 to provide for own initiative and limited purpose investigations on direction of the State Coroner.

---

Chapter 5
Investigation of Deaths

The State Coroner has a statutory duty to ensure that all reportable and reviewable deaths reported to him are investigated. Further, section 15(1) of the Act imposes a statutory duty on coroners to investigate reportable deaths and deaths that may be reportable deaths other than reviewable deaths unless they occurred outside Australia or a coronial inquiry is proceeding in another State. The source of power to investigate is associated with the particular death not the individual who has died.

Although they can assist interstate coroners, the South Australian Coronial Service does not have jurisdiction to investigate deaths which occurred in other States except when it involves:

“A death...
(d) a cause of which occurred, or possibly occurred, in the State; or
(e) where, at the time of death, the person was ordinarily a resident in the State; or
(f) in the case of a death on an aircraft or vessel--where the flight or voyage was to a place of disembarkation in the State.”

The Queensland Coronial Service does not have jurisdiction to investigate deaths which occurred in other States:

“...unless directed to do so by the Minister, if--
(a) the death happened in another State and has been reported to a non-Queensland coroner; or
(b) the death happened outside Australia.”

In Victoria, despite a statutory obligation to investigate reportable deaths, the scope of coronial investigations is limited by the purposes provided in section 19(1), (2) and (3) of the Act:

“(1)(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 Death & Marriages Registration Act 1996.

(2) A coroner may comment on any matter connected with the death including public health or safety or the administration of justice.

(3) A coroner must not include in a finding or comment any statement that a person is or may be guilty of an offence”.

In 1989, His Honour Mr Justice Nathan decided:

“... the defendant would have acted beyond power if the extra records could not reasonably be regarded as relevant to the matters about which findings could be made under s 19(1). Further, a belief as to the relevance of their..."
contents to any comment the defendant might make under s 19(2) would not, in isolation, justify him obtaining them....

Accordingly, in all the circumstances, I am satisfied that it would have been reasonable for the defendant to have held the belief that the extra records might contain material relevant to possible findings he might make under s 19(1)(b) and (c), in particular, and that it was necessary for his investigation to obtain them under s 26(3).” 211

In 1999, the obligation on a coroner to make a finding about the identity of a person contributing to the death of another person was also removed to address the following situation:

“A finding that as a matter of fact a person contributed to the death of another person could be understood as a finding that the person is in some way legally responsible for the death. This may lead to such persons suffering from unwarranted feelings of guilt or blame. For instance, the obligation under the act means that if a person commits suicide by leaping in front of a train, a coroner is obliged to find that the train driver contributed to the cause of death, even though there may have been nothing that the train driver could have done to avoid the death.” 212

Coroners are not restricted by common law or the rules of evidence in investigating a death. 213 Rather, subject to the directions of the State Coroner 214 and within the restrictions imposed by natural justice and the requirement to act judicially 215, they can obtain relevant information in any way they think fit.

The State Coroner’s Office is of the view that the provisions of section 19(1) and 19(2) restrict coroners’ ability to perform the core public safety and prevention functions recommended in Chapter 1 and adopted by the Attorney General in his Justice Statement. 216 Rather, a coroner investigating a death should be directed to the need to determine whether or not the death is preventable. Further, if the death is preventable, the coroner should have unfettered discretion to comment and make recommendations to implement changes which are intended to prevent deaths arising from the same sort of incident occurring again.

---

213 ss.7(c), 15(4) & 16 Coroners Act 1985.
214 s. 16 Coroners Act 1985.
Therefore, the State Coroner’s Office recommends:

RECOMMENDATION 5.1

That Parliament amend section 19 of the Coroners Act 1985 to insert a new subsection 19(2A):

“(2A) A coroner may find that the death was a preventable death.”

Section 14 of the Act requires people who report a death to the State Coroner to provide him or her with all relevant information:

“(1) A person who reports a reportable death or a reviewable death must give to the coroner investigating the death any information which may help the investigation.

Penalty: 10 penalty units.

(2) A member of the police force who has information relevant to an investigation relating to a reportable death or a reviewable death must report it to the coroner investigating the death.”

Other States with similar provisions with respect to information include Tasmania and Western Australia.217 Both these statutes include penalties for police as well as other members of the community who fail to provide relevant information to the coroner.

Most professional witnesses who are required to provide statements to the coroner obtain advice from their lawyers and/or their insurance company. The State Coroner's Office has no doubt that, acting on this advice, some witnesses withhold relevant information from their witness statements. The reasons for this withholding of information are complex.

To some degree, this failure to be open and frank with the State Coroner's Office is the consequence of vestigial adversarial practices and fear of the consequences of being found personally to have "contributed" to the death. These are not now part of the coronial investigation system.

In part, withholding of relevant information is a matter of public interest. For example, policy issues arise when deciding whether to enforce this provision in relation to information provided in internal investigations of adverse events in health service facilities. The coroner must balance the likelihood that the information will further his or her capacity to correctly determine cause of death and make useful recommendations to improve safety in the particular investigation against the possibility that health professionals will fail to participate properly in internal reviews because of concerns about personal liability and/or reputation.218

Witholding of relevant information can also be a legitimate exercise of the statutory and common law privilege against self-incrimination as discussed in Chapter 1 of this submission.

217 s. 20 Coroners Act 1995 (Tas), s. 18 Coroners Act 1996 (WA).
Failure to provide coroners with all the relevant information, combined with the resource constraints that restrict all coronial investigations, can influence the legitimacy of coroners’ findings, comments and recommendations. Incongruously, it also influences coroner’s decisions about whether or not to hold an inquest to obtain the information that could have more easily been included in the statements of witnesses in the investigation. Often, if a coroner is satisfied that the information is complete and accurate, a detailed chambers finding will be written dealing with a range of factual complexities and significant public health and safety issues.

The State Coroner’s Office manages this issue as best it can by:

1. Deciding whether to hold an inquest and proceeding with inquests after other legal and internal review issues have been dealt with,
2. Actively promoting its inquisitorial jurisdiction,
3. Relying as much as possible of original documents such as medical files and police running sheets, rather than the retrospective statements of those who contributed to them, and
4. Promoting its interest in systems rather than personal failures and its shared commitment to public safety and prevention.

It is assisted in these tasks, as it relates to hospitals, by the State Coroner’s Clinical Liaison Service.

However, without making specific recommendations on this issue, the State Coroner’s Office is of the view that its potential public safety and prevention role is inhibited by limited Government, institutional and professional commitment to providing support for coronial investigations when they may impinge on liability and/or day-to-day operations. However, the State Coroner’s Office is of the view that multi-disciplinary team based investigation or investigation support systems, like the Clinical Liaison Service or the new State Coroner’s Work-related Death Investigation and Resource Unit, assist investigations when overseen by an individual, full-time coroner.

The current jurisdiction of coroners also reflects 1999 amendments to the Act that provided coroners with authority to make recommendations to other statutory authorities and Ministers. These amendments became especially relevant in the aftermath of a number of deaths in privately run prisons. After investigating these deaths, the coroner was able to make findings and recommendations relating to the management procedures, information transfer systems and placement systems used in prisons and direct them to the appropriate players. As a result of the consequent public pressure and increased scrutiny of the private prisons contracts the Government introduced higher performance measures when renewing two private prison contracts and appointed a new Correctional Services Commissioner. It also introduced new safe design standards for cells.

However, although under the current Act, a coroner has jurisdiction to report his or her findings and recommendations are public documents open to general distribution, there is no obligation to implement or respond
to them. The only incentive or sanction to ensure that recommendations are considered and acted upon is the potential adverse publicity brought about by the Coroner’s increasingly prominent community role, substantial media/public interest and the pressure these bring to bear.

The State Coroner’s Office is of the view that, at a minimum, Government agencies should be required to respond to recommendations made by coroners within six months of delivery of the finding, recommendations or comments. These responses should indicate reception of the recommendations, changes and planned changes made in response to the recommendations and, where the recommendations have been rejected, the reasons for this rejection. In specific cases, the suggested response time may need to be longer, accordingly there may need to be a provision that allows for interim responses. The State Coroner should then be required to include these responses in his annual report to Parliament.

To some degree, the Victoria Police already respond like this in their three monthly report to the State Coroner on their implementation of coroner’s recommendations. This system has been in place for sometime. The Department of Human Services has also recently developed a response system to coroners’ recommendations. On occasions, other government agencies and sectors of the community also respond. This is a very positive result for the agency to whom the recommendations are directed, the community and the coronial system. Often families want to see positive outcomes from the coroner’s inquiry into the death of their family member. Filing the coroner's recommendations away and not considering taking any action as often happened in the past, is no answer.

However, other than to require government agencies to formally respond, the State Coroner’s Office is loathe to recommend that the responses of other organisations in the community be mandated in legislation. To assist in educating the community in the preventative role of the coroner the State Coroner will establish and publicise a formal monitor of the responses to coronial recommendations and include this in his Annual Report. It is considered that this will also help encourage community organisations to address coroners’ recommendations and provide the coroner with information on countermeasures.

RECOMMENDATION 5.2

That Parliament amend the Coroners Act 1985 to require government departments and statutory authorities to respond to coroners' recommendations within six months of delivery of the finding, recommendations and comments.

---

219 See also Recommendation 17 of the Royal Commission into Aboriginal Deaths in Custody.
**State Coroner’s Investigation Tools**

The Committee seeks advice on:

- Whether there are any issues or concerns in relation to the State Coroner’s guidelines and investigation standards?
- In your experience, are all Coroners in Victoria familiar with the standards and guidelines and do they consistently use them when investigating a death?
- Are coroner’s investigations reviewed to assess whether the standards and guidelines are consistently applied?
- Can the public readily access all the State Coroner’s guidelines and investigation standards? Are the current guidelines and investigation standards publicised in any way?
- Are there any other kind of investigations which need investigation standards or guidelines?
- Are there any issues or concerns with the current categories of deaths in which an inquest is mandatory? Should the current categories be expanded?
- Are there any issues or concerns with the current criteria coroners use to determine if a discretionary inquest should be held?
- Are there any issues with the appeal process to the Supreme Court following a coroner’s refusal to hold an inquest? \(^{221}\)

**Investigation Standards**

Under his authority to issue guidelines to coroners to help them carry out their duties, \(^{222}\) the State Coroner has adopted investigation tools which are intended to ensure proper investigation of specific incidents and causes of death. These include:

- Falls Investigation Standard
- Radiology Investigation Standard
- Asbestos-related deaths
- Management of Skeletal Remains
- Heroin-related deaths.

Copies of these investigation tools are included in Appendix C. They are included in the State Coroner’s Practice Manual which is available to all


\(^{222}\) s. 7(e) *Coroners Act 1985*. 
coroners in Victoria. No audit has been undertaken as to application of these tools to coronial investigations.

Coroners’ legislation in Queensland provides specific direction for the issue of investigative guidelines and mandatory compliance with these guidelines except as they conflict with directions of the State Coroner on a case by case basis. 223

However, the State Coroner’s Office is of the view that mandatory compliance with State Coroner’s investigation tools in coronial investigations denies the different circumstances of every death. Rather, the State Coroner’s Investigation Tools provide a guide to investigators and encouragement to those at the sites of frequent relevant deaths to implement prevention and accountability protocols in anticipation of the questions they will be asked if a death occurs.

Inquests

Over 90% of investigations are determined by way of Chambers Findings without inquests (Fig 14). 224

Coroners may also hold an inquest or formal hearing in order to obtain further information as part of their investigation. 225 In most cases, the decision whether or not to hold an inquest is a matter for an individual coroner subject to the State Coroner’s Guidelines on this matter226:

“Section 17(2) is notable in two respects. First, it gives a discretion to hold an inquest in any circumstances in which a coroner having jurisdiction to investigate the death believes it desirable to hold one. This is a valuable statutory option exercisable, no doubt, in the public interest; and it is in contrast to the position obtaining, for example, in England, where a coroner, in general, is obliged to hold an inquest in statutorily stipulated circumstances but has no discretion to hold one if none is mandatory: cf R v Poplar Coroner; Ex parte Thomas [1993] QB 610 at 626. Secondly, s 17(2) plainly gives to a coroner who has jurisdiction to investigate a death a discretion not to hold an inquest if s 17(1) does not apply and the coroner believes it is not desirable to hold one. A more absolute discretion conferred upon a coroner to hold or not to hold an inquest in a case not falling within s 17(1) could scarcely be formulated.”227

Section 17 of the Act specifies the circumstances where a coroner must include an inquest in his or her investigation tools. Until 1986, mandatory inquests were required where a person:

- Was slain
- Drowned
- Died suddenly
- Died whilst a patient in a lunatic asylum/mental hospital

223 s. 14 Coroners Act 2004 (Q’ld).
224 Reported to State Coroner’s Office, from State Coroner’s Office Case Management System.
225 s. 17(2) Coroners Act 1985.
226 These are included in Appendix C of this submission.
• Died whilst in prison
• Was executed (1864 to 1975)
• Was an infant Ward of the State and died under suspicious circumstances (from 1883; regardless of suspicion 1890-1907 only).

Fig. 14 Changes in the Frequency of Chambers Findings

In 1999, coroners’ discretion to conduct an inquest into the death of a person was removed not only when they were in the “care or custody of” but also when they were in the “control of” the Secretary of the Department of Human Services and the Secretary of the Department of Justice. The inclusion of the term control can be interpreted to mean that the definition of “person held in care” includes persons who are held in physical custody and those who have been released on Community Based Orders and Community Treatment Orders.

This amendment came about as a consequence of a number of social issues present at the time. Leading up to the amendments had been the increased number of police shootings and deaths in custody. There had also been research published, which was quoted by the shadow Attorney-General during the 1999 debate, showing that:

“the number of deaths in the supervision population is at least...6.4 times greater than one would expect...in the general community and the “...death rates of people undergoing community based order...are higher than one would expect for offenders in prison.”

Also, in the background was the Government’s policy of de-institutionalisation and reintegration into the community of mental health patients on Community Treatment Orders. Public concern over this policy, particularly the lack of support and resources available to these people to cope in the wider community, their obvious vulnerability and increased risk of death due to a criminal offences or suicide, may have prompted the

Government to make such an amendment as a concession in favour of accountability.

Now, section 17(1) of the Act provides a number of circumstances in which an inquest is mandatory:

“A coroner who has jurisdiction to investigate a death must hold an inquest if the body is in Victoria or it appears to the coroner that the death, or the cause of death, occurred in Victoria and-

(a) the coroner suspects homicide; or
(b) the deceased was immediately before death a person held in care; or
(c) the identity of the deceased is not known; or
(d) the death occurred in prescribed circumstances; or
(e) the Attorney-General directs; or
(f) the State Coroner directs.”

The State Coroner’s Office has taken into account the requirement for mandatory inquests in its recommendations for amendment of the definition of “person held in care” and “reportable death”. It is of the view that this provision is required to ensure protection of vulnerable persons in the community and accountability of the institutions that care for them. However, together with widening the definition of ‘person held in care’ as recommended above, State Coroner’s Office is of the view that the criteria for mandatory inquests should be amended to only require inquests when the cause of death in this group of people is unknown or not a natural causes death.

Therefore, the State Coroner’s Office recommends:

**RECOMMENDATION 5.3**

That the Parliament amend section 17(1) of the *Coroners Act 1985* to read:

“A coroner who has jurisdiction to investigate a death must hold an inquest if the body is in Victoria or it appears to the coroner that the death, or the cause of death, occurred in Victoria and the cause of death is unknown or is not due to natural causes-

(a) the coroner suspects homicide; or
(b) the deceased was immediately before death a person held in care; or
(c) the identity of the deceased is not known; or
(d) the death occurred in prescribed circumstances; or
(e) the Attorney-General directs; or
(f) the State Coroner directs.”

Further, section 17(3) of the Act provides particular circumstances where a coroner may exercise his or her discretion not to hold an inquest in homicide cases that have been determined in the criminal courts. Section
17(3) was introduced to enable finalisation of cases which have been determined elsewhere without inquest where appropriate:

“The State Coroner has requested and the government has agreed to an amendment to give a coroner a discretion to decide whether an inquest should commence or continue after criminal proceedings have been concluded and a person has been either acquitted or found guilty of homicide. The discretion to conduct an inquest will apply in cases of deaths both prior to and after the commencement of this amendment. ....

Clearly, a coroner’s role is different from that of a judge and jury hearing criminal charges. A coroner’s investigation is concerned with public civilian issues while the criminal law judicial process is concerned with determining whether a person is guilty or innocent of a criminal charge. However, there is no purpose in conducting an inquest in cases where all the public issues have been resolved by the criminal law judicial process. In many cases, the circumstances of a death, as much as they can be ascertained, will have been fully determined in the criminal proceedings....

The proposed amendment also has the potential to save costs and in some instances reduce the emotional burden on relatives of the deceased. Just as some relatives of the deceased find that a coronial inquest serves a useful purpose, others find a coronial inquest into the death of a relative a painful and unnecessary process following a criminal trial in which the issues surrounding the death have been thoroughly canvassed and a person has been found guilty or has been acquitted of homicide. Removing the requirement on a coroner to hold an inquest in such circumstances will allow a more reasonable, compassionate approach. It will also allow the resources of the coronial service to be more usefully directed to other inquests.229

The State Coroner’s Office is aware of an inconsistency in this provision in that no provision for the exercise of discretion applies to homicides where the charge is arson causing death.230

Therefore, in order to rectify an apparent inconsistency, the State Coroner’s Office recommends:

**RECOMMENDATION 5.4**

That the Parliament amends section 17(3)(a)(i) of the *Coroners Act 1985* to read:

“(i) the murder, manslaughter, infanticide, child destruction or arson causing death of the deceased;”

Further, section 18 provides for application to hold an inquest as part of the investigation process. Refusal to hold an inquest is subject to direction by the State Coroner and/or review by the Supreme Court. Frequently, family members request an inquest in an attempt to use the coronial system as a further forum for acting out family conflicts and/or their general dissatisfaction with professional care of the deceased that is unrelated to their death.

The family requests are treated seriously but, when the evidence is complete or there is no relationship between their specific complaints and

---

230 s.197A *Crimes Act 1958.*
the death of their family member, the coroner may determine that there is nothing to be gained from an inquest.

The State Coroner’s Office is of the view that, in the absence of mandatory conditions, the decision whether or not to hold an inquest should be a matter for determination by the coroner investigating the death according to the State Coroner’s Guidelines. Review of the decision not to hold an inquest should therefore remain within the coronial system. On this basis, except where matters of law are concerned, the State Coroner’s Office is not appropriate for the Supreme Court to review this decision. Rather the review should lie with the State Coroner or, where the matter involves him, the Deputy State Coroner.

Therefore, the State Coroner’s Office recommends:

RECOMMENDATION 5.5

That section 18(3) of the Coroners Act 1985 be revoked.

Assistance with Investigations

In performing their investigatory role, coroners are routinely assisted in undertaking their investigations by:

- Coroners’ clerks pursuant to s 12 of the Act and State Coroner's Delegations.

- Forensic pathology services provided or arranged by the Victorian Institute of Forensic Medicine.

- As required by section 18A of the Police Regulation Act 1958, coroners are assisted in their investigations by the Victoria Police-State Coroner’s Assistants’ Unit and, through them, other police such as the Homicide Squad and local uniform police whenever a coroner so requests.

- The Clinical Liaison Service also provides expert medical assessment of incidents that occur in hospitals and other health settings.

- The National Coroners’ Information Service can provide statistical information or inform coroners about other relevant findings. A description of their work is included in Appendix D.

- Researchers attached to the Coronial Services have undertaken projects on a number of relevant issues and are available for consultation.

Coroners can also be assisted in their investigations by a range of other relevant agencies or experts such as the Office of Public Prosecutions, Worksafe, Office of the Chief Electrical Inspector, Office of Gas Safety, engineers and medical experts.
The Committee seeks specific advice on the following:

- Should Coroners have the power to require investigating police officers to report directly to Coroners and to issue directions to police officers concerning investigations?
- Are there any kinds of coronial investigations where it is not appropriate for investigations to be undertaken by police officers?
- Do the State Coroner or coroners currently appoint lawyers to assist with investigations? Should this be mandatory for deaths in custody or other kinds of investigations?
- Do coroners use any other kinds of investigators? Should there be provision for appointment of certain kinds of investigators under the Act?
- Do you think the Coroner's current role allows an appropriate level of involvement in improving general patient safety in the Victorian health care system?
- In your experience, are there any obstacles or issues preventing a coroner from fulfilling this role?231

**Coroners clerks**

This work is described in Chapter 3. Provided, their term of secondment from the Magistrates' Court is extended, the State Coroner’s Office makes no recommendations in relation to the investigatory role of coroners’ clerks. However, the State Coroner's Office is of the view that the increasing professional demands on the staff in the State Coroner's Office and consistency with the recommendation that the State Coroner's Office becomes a Court requires that Coroners' Clerks be designated Coroners' Registrars.

**RECOMMENDATION 5.6**

That the Parliament replace the words "Coroners' clerk" with the word "Coroners' Registrar" throughout the Coroners Act 1985 and the Coroners Regulations 1996.

**Victoria Police**

In the ACT, New South Wales and Queensland, police assistance to the coroner is provided on a case by case basis232 or under the statutory obligation in their police legislation, for example:

---


232 s. 63 Coroners Act 1997 (ACT), s. 17C Coroners Act 1980(NSW).
Assisting coroner to investigate a death

(1) It is the duty of police officers to assist coroners in the performance of a function, or exercise of a power, under the Coroners Act 2003, including—

(a) the investigation of deaths; and

(b) the conduct of inquests.

(2) Without limiting subsection (1), it is the duty of police officers to comply with every reasonable and lawful request, or direction, of a coroner.\[233\]

In South Australia, the Act implies that police officers investigate coronial matters.\[234\] In the Northern Territory, police are obliged to cooperate with coronial investigations of deaths in custody.\[235\]

In Victoria, section 18A of the Police Regulation Act 1958 provides:

“18A. Assistance to coroners

The Chief Commissioner of Police shall direct that a sufficient number of members of the police force be present at any place at which an inquest may be held (whether or not an inquest is being held) whenever a coroner so requests.”

Further, the Act provides that deaths may be reported to police station and that any information known to a police officer must be reported to the State Coroner.\[236\]

The coronial system relies heavily on police to undertake investigations for the coroner. They provide this assistance to the State Coroner as members of the State Coroner's Assistants Unit, as attending members at a scene or in consultation with the State Coroner's Assistants Unit or as the Homicide, Arson Squads or Traffic Management specialist units. The State Coroner's Office has no evidence that information is being routinely withheld by police in their investigatory role on the State Coroner's behalf. Therefore, it is of the view that financial penalties for police failure to provide information are unnecessary and could introduce an adversarial component in what is essentially a cooperative relationship.

In general, there is a cooperative working relationship between Victoria Police and the State Coroner's Office and Overall, the quality of investigation briefs prepared by police for the coroner has significantly improved in the years since the Act first came into operation. This positive working relationship has also led to significant improvements in a range of areas where public health and safety is an issue.

However, there seems to be a view among some officers in Victoria Police Command that the police fulfil their statutory duty to the State Coroner in providing quasi-prosecutorial assistance in inquests. Under this interpretation, any other work undertaken as part of a coronial investigation by police is under the control of the Chief Commissioner and accordingly, whilst not suggesting that this would occur, there is a capacity to limit resources provided to coroners' investigations.

\[233\] s. 447A Police Powers and Responsibilities Act 2000 (Qld).
\[234\] s. 9 Coroners Act 2003 (SA).
\[235\] s. 25 Coroners Act (NT).
\[236\] ss. 13(1), 14(2) & 39 Coroners Act 1985.
In the area of police assistance, because of the reliance the coronial system has on police throughout the State to undertake investigations and assist in the inquest hearing, it is important to ensure that this is adequately enshrined in the legislation.

Therefore, as a matter consequential to the recommended amendment to the definition of inquest, the State Coroner’s Office recommends:

**RECOMMENDATION 5.7**

That Parliament amend section 18A of the *Police Regulation Act 1958* to read:

“18A. Assistance to coroners

The Chief Commissioner of Police shall direct that a sufficient number of members of the police force be present at any place at which a coronial investigation is being undertaken (whether or not an inquest is being held) whenever a coroner so requests.”

**Independent and specialist investigators**

There are some cases where police are directly involved in the death. In ideal circumstances, it would be preferable for a specialist and independent team to undertake these investigations for the coroner. This issue has been discussed in a recent finding by the State Coroner in a police shooting matter. In that case, the State Coroner was of the view that, ultimately, the issue is one of practicality and resources. 237

The Fundamental Review discusses the arrangements for the coroner’s investigation of deaths "apparently involving the Northern Ireland Police service" and suggests that, for police-related deaths:

"when suitable legislative opportunity occurs the legality of the investigative support to coroners by the Northern Ireland Police Ombudsman should be put beyond doubt." 238

In some coronial investigations, there may be a need to involve other specialist investigators working for the State Coroner’s Office. By way of example, some fire investigators have spent time learning about the coronial process. This has also provided those working in the State Coroner’s Office with a valuable insight into other investigatory methodologies.

Specialist investigators within the State Coroner’s Office would have benefits for the coronial investigation system and help provide a multi-disciplinary team. Already some of these benefits have resulted from implementation of the State Coroner’s Clinical Liaison Service.

---

237 Record of Investigation into the Death of Mark Andrew Kaufmann case No 201/02, 4 August 2005.
Section 9 of the South Australian Coroners Act 2003 provides:

Appointment of investigators

(1) The Attorney-General may, by notice in the Gazette, appoint a person to be an investigator for the purposes of this Act.

(2) The Attorney-General must provide each investigator appointed under this section with a certificate of identification in a form approved by the Attorney-General.

(3) On ceasing to be an investigator, the former investigator must surrender the certificate to the Attorney-General.

Maximum Penalty: $2,500

(4) An investigator must produce the certificate (or, in the case of a police officer not in uniform, his or her warrant card) at the request of any person in relation to whom the investigator is exercising powers under this Act.

The State Coroner's Office is of the view that similar provisions would assist in Victoria. Therefore, the State Coroner's Office recommends:

RECOMMENDATION 5.8

That Parliament amend the Coroners Act 1985 to allow the State Coroner to appoint investigators (other than police).

Use of lawyers by the coroner

In Queensland, the Act provides for coroners to seek help from a lawyer or other person if he or she reasonably believes they can help investigate the death, but there is no provision for legal or other professional assistance for coroners in their investigations in Victoria.

In South Australia, the Attorney General may appoint investigators to assist the State Coroner. In the ACT, the coroner may appoint his or her own investigators.

In Victoria, the State Coroner routinely seeks assistance from the Director of Public Prosecutions in the investigation of matters involving police and some other sensitive or controversial matters. Decisions about their involvement are taken on a case-by-case basis subject to a Memorandum of Understanding between the State Coroner and the Director of Public Prosecutions. In some other cases, such as the Australian Grand Prix case, the State Coroner has briefed a member of the Bar directly to assist him in his investigations and the inquest. In other cases, the State Coroner may seek expert assistance from engineers or other professional specialists, as in the multiple inquests into the Mistral Fan Fire incidents.

239 s. 15 Coroners Act 2003 (Q'ld).
240 s. 9 Coroners Act 2003 (SA).
241 S. 59 Coroners Act 1997 (ACT).
242 Finding in the Investigation into the Death of Graham Beveridge, Case No 621/01.
243 Finding in the Investigation into the deaths of Daniel Stott and Matthew Stott, Case No 25/88.
or in the recent inquest into the deaths of the five volunteer fire fighters at Linton.244

There is no statutory bar to dealing with these professional requirements on a case-by-case basis and the State Coroner’s Office does not seek statutory support for this investigatory machinery. However, the resources costs are an issue that require attention by Government.

**State Coroner’s Clinical Liaison Service**

Over 80% of deaths occur in hospitals, nursing homes or other similar settings.245 Of these, about 18,000 Australians die each year in hospitals due to medical mistakes, and more than 50,000 patients suffer permanent disabilities due to complications caused by health care. 246 The frequency of these deaths is not decreasing:

“The Coroner regularly and repeatedly identifies the same factors underlying fatal adverse events.....

Despite this knowledge, and the fact that many adverse events are predictable and preventable, there is little evidence that the incidence of medical fatalities is appreciably declining.

“If government and health bureaucrats are serious about preventing fatal adverse events, then significant attention needs to be given to implementing recommendations handed down by the Coroner.”247

Further, a review of the interaction between coroners and healthcare professionals was undertaken for the Australian Council for Safety and Quality in Health Care in 2003.248 This review found that the Coroners’ Offices and the healthcare sector in Australia are both ready and enthusiastic about opportunities to improve patient safety and healthcare that have arisen out of the recent substantial shifts in the international and national approach to improving safety and quality in healthcare.

However, there is substantial variation within and between jurisdictions in the level and nature of the communication between the coronial and health care sectors. The forms of communication between the coroners, health departments and health care professionals are usually limited, legalistic in nature and conducted in a very formal setting. Further, it was *ad hoc*, patchy, reactive and occurred in one direction, that is from the coroner to the healthcare sector rather than the other way. It found that the work of the Australian Council for Safety and Quality in Health Care could directly and readily assist in achieving this working relationship and implementing the project’s specific recommendations to achieve it.

---

244 Report of the Investigation into a Wildfire and the Deaths of five Firefighters at Linton on 2 December 1998.
245 Anne Tolan, Death and Dying, Developmental Psychology Lecture, Australian Catholic University, 2003.
Following a request by the State Coroner, in recognition of this area of risk and workload it places on the coronial system, the State Coroner's Clinical Liaison Service was established in 2003 by way of pilot funding from the Courts Branch of the Department of Justice. Its funding and management was transferred to the Institute to allow for appointments outside those able to be made under current Courts guidelines. The service was reviewed in 2004 by Impact Consulting Group. A copy of this report was forwarded to the Committee by the State Coroner on 11 April 2005. The Department of Justice is committed to its on-going funding.

The State Coroner's Clinical Liaison Service is intended to provide coroners with professional investigation of hospital related deaths. A detailed description of its work is included in Appendix D. The Flow Chart of the process involved in an investigation undertaken for the coroner by the Clinical Liaison Service is included below (Fig. 15).

The State Coroner’s Office understands that the State Coroners' Clinical Liaison Service has made its own submission to the Committee. However, it highlights the recommendation of the Review of the State Coroner's Clinical Liaison Service that, in the light of the large numbers of psychiatric deaths that are investigated each year under both mandatory reporting and inquest provisions and as reportable deaths, more resources should be committed to specialist psychiatric investigations.

**State Coroner's Work-related Death Investigation and Resource Unit**

On 24 October 2004, following a submission by the State Coroner, in part supported by a thesis by Dr. Tim Driscoll which identified the need for specialist investigation of work-related deaths. The Attorney General and WorkCover Minister announced funding of $2m over four years to establish a Work-related Death Investigation and Resource Unit in the State Coroner's Office. The funds are provided by Workcover to the Department of Justice to enable the Unit to be established. This funding and management has been transferred to the Institute to allow for appointments outside those able to be made under current Courts guidelines. There is a Memorandum of Understanding between the State Coroner’s Office and the Institute, 20% of the funding is taken by Institute for management costs excluding salaries. The Unit is currently being set up, building works for accommodation in the State Coroner’s Office are underway and contracts for establishment staff are being finalised. Administrative management of the Unit is assisted by a Steering Committee chaired by the State Coroner.

---

**National Coroners Information System**

The National Coroners Information System provides coroners and policy makers with a national system for identifying similar kinds of deaths and previous relevant recommendations. However, it is limited by the content
of coronial investigations and findings and it does not include all the information available to the coroner determining each case. It assists in identifying trends or similar cases and extends the analysis of the particular coroner's file. A detailed description of its work is included in Appendix D.

In Queensland, the Coroner Act 2003 provides:

"93 National coronial database

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

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

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

(a) the entity has a legitimate interest in storing information in the database; and

(b) the entity will make the information available only to persons with a legitimate interest in obtaining it; and

(c) the conditions for making the information available to database users are reasonable."

(4) This section does not affect, and is not affected by section 53."

Section 53 of the Queensland Act also provides a detailed structure for research applications.

The State Coroner's Office is of the view that the National Coroner's Information System will be an important part of future investigation processes and collection of information on similar cases and trends in health and safety issues. Therefore, it should be protected in the legislation.

The State Coroner's Office recommends:

**RECOMMENDATION 5.9**

That Parliament amend the Coroner Act 1985 to include protection of data collection and analysis by an entity similar to the National Coroners' Information System.

**State Coroner’s Office Researchers**

Currently there is one research position attached to the State Coroner’s Office. The suicide research position funded by the Department of Justice is vacant. A work-related death researcher was funded by Workcover but the position has been subsumed into the State Coroner's Work-related Death Investigation and Resource Unit. A general injury researcher funded by the Department of Human Services has lapsed.

A list of the publications of the researchers and some of their executive summaries or conclusions is attached in Appendix A.

The State Coroner's Office is of the view that well-directed research is useful to:

- Identify trends, I
- Inform investigations and prevention activity,
- Provide an education component to coronial work.
In addition to appropriate resources for a research unit, the State Coroner's Office also needs a management structure that helps support and manage research.

The State Coroner's Office recommends:

RECOMMENDATION 5.10

That the State Government provide adequate funding for a managed research unit in the State Coroner's Office.

**Autopsies**

Hospital and coronial autopsies have long been considered a vital tool for the advancement of medical knowledge and a key indicator of the safety and quality of the health care system. There has been a substantial decline in autopsies undertaken by hospital pathologists.\(^{250}\) This decline has been mirrored in the frequency of coronial autopsies and increase in external inspections in the last five years. (see Fig. 16).

*Fig. 16 Coronial autopsies in Melbourne*

The decline in the number of autopsies has been greater in regional areas than for metropolitan Melbourne (Fig. 17).\(^{251}\)

---

\(^{250}\) For example, The Age, "Doctors concerned that a body of evidence is increasingly neglected", Tom Noble, 1 May 2004; Sydney Morning Herald, "Body of evidence mustn't be ignored", 1 April 2004; "Cause-of-death accuracy questioned after decline in hospital autopsies" 15 March 2004.

\(^{251}\) HLB Mann Judd Consulting, "Review of the provision of Autopsy Services in Rural and Regional Victoria", October 2004.
The Committee has sought advice on the following questions in relation to autopsies:

- Should there be any circumstances where a coroner may order an autopsy without first contacting an available senior next of kin to determine if that person has any objections to autopsy?
- Should the Act permit anyone other than the senior next of kin to object to an autopsy?
- Should the Act consider the appropriateness of less invasive forms of autopsy?
- Is the Supreme Court the appropriate appeal avenue for people wishing to object to autopsies?
- Should the Act require coroners to inform the senior next of kin when tissue of a body part has been retained after autopsy and what options are there when the coroner decides it is no longer necessary to retain the tissue or organ?
- What options should the family have when the coroner no longer requires the tissue or organ?\(^{252}\)

Sections 24, 27(1), 66 and 73 of the Act provide authority for a coroner or the State Coroner to direct the Director of the Institute to provide

---

pathology and toxicology services as part of their investigations of reported and reportable deaths:

"73. Director's duties relating to autopsies

If a coroner directs the Institute to perform an autopsy on a body under section 27, or the Supreme Court orders the State Coroner to require the Institute to perform an autopsy on a body under section 28, the Director must--

(a) ensure that an autopsy is performed; and

(b) report the results of the autopsy to the coroner or State Coroner; and

(c) keep a record of the autopsy."

This authority to direct performance of pathology services is fundamental to all coronial investigations. In Tasmania, as similar provision in the Coroners Act 1995 provides for appointment of a State Forensic Pathologist who must respond to a request by a coroner to perform autopsies and other pathological examinations. More general authority to order doctors to perform autopsies and otherwise assist coroners in their investigations is included in the coroners' legislation in the ACT, New South Wales, Queensland, and Western Australia.

Under section 19 of the Act, coroners have ultimate responsibility for determining the cause of death in cases reported to them. This cause of death is constituted by the both medical cause of death and the factors that led to the medical cause of death. Coroners routinely devolve professional responsibility for determining medical cause of death to forensic pathologists in autopsy cases, applications for no autopsy where they express their opinion of cause of death based on inspection of the body, and deaths reported by the Registrar of Births Deaths and Marriages where the medical cause of death is determined on the basis of the medical file. In turn, forensic pathologists usually rely on the advice of forensic toxicologists in relation to performance and interpretation of their analyses. In some cases, they rely on DNA matching, forensic odontologists and entomologists to advise coroners on the identity of the person or the time of death.

For example, the medical cause of death determined by the forensic pathologist on the basis of external inspection may be multiple injuries. The injuries may be caused by a motor vehicle collision in which the deceased was a passenger. This matter would routinely be subject to autopsy and, in that process, the pathologist may find the passenger had also suffered a heart attack. Then, the medical cause of death becomes a matter of expert interpretation of timing and degree of injury. The decision can influence the culpability of the other participants in the collision as well as road safety statistics and policy.

---

253 ss 17 & 18 Coroners Act 1995 (Tas.).
254 ss. 3 & 21 Coroners Act 1997 (ACT), s. 47A Coroners Act 1980(NSW), s. 34 Coroners Act 1996(WA).
Unless otherwise challenged, the coroner will usually adopt the forensic pathologist’s opinion as to medical cause of death and the level of proof adopted by the pathologist is generally determined using the ‘but for’ test but it may also be a matter of common sense.\textsuperscript{255} In cases involving potential criminal charges, the level of proof of cause of death required by the prosecution must be beyond reasonable doubt.

When they have doubts about the medical cause of death, forensic pathologists indicate the alternative causes of death which are consistent with the information available to them at the early stage of the investigation where they are involved or, in some cases, they say they are unable to determine the medical cause of death. However, in an example like this one, the coroner must always determine for themselves, taking into account all the surrounding evidence, whether the fatal injuries were sustained in a motor vehicle collision or from natural causes and whether the deceased was a passenger. Further, under the amendments recommended in this submission, the coroner may have to assess whether the death was preventable on the basis of this finding of cause of death and whether to make appropriate public safety or prevention comments and recommendations. The Fundamental Review also makes some interesting observations on the role of autopsies and when they should be performed:

"84. Any medical investigation ordered by the coroner or Statutory Medical Assessor, whether autopsy or other test, should be to clarify a defined uncertainty or range of uncertainties about the death and should be at the lowest level of invasiveness likely to resolve the uncertainty. Referrals for autopsy or other technical investigations should never be routine or automatic. This may apply equally after traumatic deaths though when forensic autopsies are required for criminal investigations they should be carried out.

85. Where possible before any significant technical investigation is ordered, the medical records should have been scrutinised, the doctors and others who had attended the patient should be contacted as well as the family.

86. In cases where the family object to an autopsy it should not be proceeded with unless there is positive indication of the need to investigate a possible crime or lack of medical or other care, or a public health risk that requires the cause of the individual death to be established, in order to prevent similar fatalities.\textsuperscript{256}

In Melbourne, external inspections and autopsies are performed by forensic pathologists who are employed by the Victorian Institute of Forensic Medicine or in hospitals.\textsuperscript{257} In regional Victoria, autopsies may be performed by pathologists credentialed at the local hospital on a fee-for-service basis under informal arrangements with the Institute of


\textsuperscript{257} See s. 73 Coroners Act 1985 and s 3 Human Tissue Act 1966.
Forensic Medicine, except for St John of God Hospital in Ballarat and Mildura Base Hospital who have specific agreements with the Department of Human Services. Coronial Services is responsible for paying transport costs when autopsies have to be performed elsewhere. Serious and unusual cases are usually taken to Melbourne.

In most cases, the time taken for performance of autopsies is the most decisive issue in determining when a body is released. The Institute is responsible for the quality and performance of the entire coronial autopsy system. Their target is to achieve a 70% turnaround time for bodies requiring autopsies of 18 working hours from the time the autopsy is ordered. This was achieved at 78.5% in 2002/3 and 83.3% in 2003/4. Further, the expected time for production of the autopsy report ranges from 14 to 70 working days depending on the type of case and whether toxicology is required. The cost for a natural death investigation is estimated at $1354.00.\textsuperscript{258}

The time taken to perform autopsies differs for each quarter of 2002, 2003, 2004 and 2005. (Fig 18).\textsuperscript{259} In most of these time periods, less than 80% of cases were completed within 48 working hours.

\textbf{Fig. 18 Time from admission to completion of autopsy}

The forensic pathologist frequently seeks to retain some tissue after the body is otherwise available for release, for example when the brain requires histological examination or there are microbiological cultures to be performed. In these cases, the coroner's clerks routinely contact the family to discuss the options for managing the case. These include:

1. Retention of the body until the tissue is available; or

\textsuperscript{258} HLB Mann Judd Consulting, "Review of the provision of Autopsy Services in Rural and Regional Victoria", October 2004.

\textsuperscript{259} q1 is Jan-Mar; q2 is Apr-Jun, q3 is Jul-Sep, and q4 is Oct-Dec.
2. Release of the body with following release of the tissue;
3. Release of the body and authorisation to destroy the retained tissue and notify the family of this destruction;
4. Release of the body for a memorial service before the autopsy is performed on the undertaking of the funeral director that it will be returned to allow the investigations to be performed.

The State Coroner's Office is of the view that these issues vary so much from case to case that they could not practically be dealt with by legislation.

There are six forensic pathologists working in the Institute on a salaried basis. They perform all autopsies on bodies admitted to the Coronial Services Centre as well as performing training roles for junior and international medical practitioners and providing expert advice interstate and overseas and providing pathology services to national and international disaster response agencies.

The State Coroner’s Office is guided by the forensic pathologist's advice that it is professionally inappropriate for them to perform limited autopsies unless this limitation means only external inspection and taking of body fluids for toxicological analysis. This interpretation is included in the State Coroner’s Office recommended amendment of the definition of autopsy. However, occasionally in spite of this advice, a coroner will order a limited autopsy. Therefore, the State Coroner’s Office makes no further recommendation on this matter.

In October 2004, the Department of Justice commissioned a review of forensic pathology services in Rural Regional and Victoria.260 This review found that appropriate quality controls in relation to the Institute’s responsibility for these regional services was unlikely to be occurring to the satisfaction of the Institute or the regional coroners. Fewer medical registrars have trained in general pathology and cooperative efforts to increase the number of pathologists in Victoria will not come on line for at least five years. Recruitment from this limited pool to regional areas is difficult.

The State Coroner’s Office is of the view that the current system where coroners’ clerks acting on authority of the State Coroner order autopsies in metropolitan Melbourne and regional Victoria unless otherwise advised needs review. Delays due to priority setting in the Institute and availability of forensic pathologists in regional areas can be expected to be the major factor influencing delays in release of bodies for the foreseeable future.

Section 28 of the Act provides for anyone to seek an autopsy. Section 29 provides for the senior next of kin to object to an autopsy. The following

The table indicates the numbers of applications made under section 29 of the Act each year\textsuperscript{261}, the numbers granted and the numbers refused (Fig. 19).

The increase in applications under section 29 of the Act for no autopsy to be performed coincides with introduction of the Family Contact Program which has ensured that families in metropolitan Melbourne are aware of their rights to object to autopsy. Some issues that have arisen in determining the senior next of kin and whether the senior next of kin designated by the definition in the current Act is the appropriate decision maker have been discussed under the proposed new definition of senior next of kin in Chapter 1 of this submission.

Fig. 19 Section 29 Application Outcomes in Melbourne

Further, the State Coroner’s Office has attempted to clarify some of the issues around understanding of the definition of autopsy in proposing a precise definition and, in effect, authorising inspection of the body and taking of body samples for toxicology on the orders of the pathologist or the investigating coroner.

In determining the medical cause of death, another real issue arises when the deceased is a child or a member of a cultural group with well-founded objections to autopsy but the death is unexpected and unable to be diagnosed from external examination. For example, in some cases such as epilepsy, some heart conditions and Sudden Infant Death Syndrome, it is impossible for a forensic pathologist to determine a medical cause of death.

\textsuperscript{261} The number of applications includes the number withdrawn. Some applications are withdrawn voluntarily when the senior next of kin is informed that the coroner determining the application intends to refuse it because of the 48 hour time delay in autopsy and release of the body if the application remains on foot.
death at the relevant standard of proof without an autopsy. Where these conditions may be relevant, the coroner must consider whether an application objecting to an autopsy should be refused on the grounds that he or she cannot fulfil his or her statutory functions without it. Further, if the Committee accepts that public health and prevention are a core function of the coroners’ role, it is essential for diagnoses such as these to be correct.

However, although, many families withdraw their objection in writing rather than proceed to review of the coroner’s decision, when these cases are taken to judicial review, the Supreme Court has almost always granted the application. In these cases, the coroner’s only recourse is to determine the cause of death as unascertained and the opportunity is lost for vital prevention information to be obtained. Further, applications to the Supreme Court are unnecessarily expensive, challenging and time-consuming for families at a traumatic period in their lives.

Therefore, the State Coroner’s Office is of the view that the Supreme Court is not the appropriate appeal avenue for decisions on applications under section 29.

Rather the State Coroner’s Office recommends:

**RECOMMENDATION 5.11a**

That Parliament amend sub-sections 29(3) and 29(4) of the Coroners Act 1985 to read:

“(3) Within 48 hours after receiving notice of the decision, the senior next of kin may apply to the State Coroner for an order that no autopsy be performed.

(3) The State Coroner may make an order that no autopsy be performed if he or she is satisfied that the cause of death is able to be determined without an autopsy or it is otherwise desirable in all the circumstances.”

Alternatively, the Act should require the Supreme Court to hear evidence from the forensic pathologist who advised the coroner determining the application about his or her capacity to accurately diagnose the medical cause of death without an autopsy and the public safety and prevention implications of this failure to accurately diagnose the medical cause of death.

In the alternative the State Coroner’s office recommends:

**RECOMMENDATION 5.11b**

That Parliament amend sub-sections 29(3) and (4) of the Coroners Act 1985 to read:

“(3) Within 48 hours after receiving notice of the decision, the senior next of kin may apply to the Supreme Court for an order that no autopsy be performed.
(4) After hearing evidence from the forensic pathologist who performed the physical inspection of the body and advised the coroner, the Supreme Court may make an order that no autopsy be performed if it is satisfied that the cause of death is able to be determined without an autopsy or it is otherwise desirable in all the circumstances.”

Coroners also retain authority to order or authorise an autopsy and associated retention of the body and/or removal of tissue from reportable deaths. This work is coordinated by the Donor Tissue Bank of Victoria which is a subsidiary of the Institute.

Section 27(1) of the Human Tissue Act 1982 provides:

“If the designated officer for a hospital or, in a case to which section 26(2) applies, the registered medical practitioner or the authorized person has reason to believe that the circumstances applicable in relation to the death of a person are such that a coroner has jurisdiction under the Coroners Act 1985 to investigate the death of the person, the designated officer or the registered medical practitioner or the authorized person, as the case may be, shall not authorize the removal of or remove tissue from the body of the deceased person unless a coroner has given his consent to the removal.”

Section 30(3) of the Human Tissue Act 1982 further provides:

An order by a coroner under the Coroners Act 1985 directing a post-mortem examination is, subject to any order to the contrary by a coroner, authority for the use, for therapeutic, medical or scientific purposes, of tissue removed from the body of the deceased person for the purpose of the post-mortem examination.”

These provisions are essential protection for the community against unaccountable removal and retention of tissue from reportable deaths for donation or research purposes. In some cases, these provisions are also essential in order to protect evidence required for the coroner’s investigation.

Suitable reported cases for tissue donation are identified by the Initial Investigation Office when the deceased is a registered donor and by forensic pathologists during inspection or autopsy. Families are approached by the Tissue Bank coordinators.

The frequency of approaches for tissue donation from bodies in reportable deaths has increased rapidly over the last five years (Fig. 20).

In 40 of 435 potential donors whose families were approached in 2004, the senior next of kin objected to autopsy. Autopsy is an essential screening tool for tissue from cadaveric donors.

Further, in 2004, 13.4% of consents to donation were not implemented because of unsuitability factors including lifestyle factors, time limits, medical contraindications and damaged tissue. In 2003, this figure was 20%. The coronial and Tissue Bank audit role in maintaining the quality of donor tissue is crucial to ensure on-going donation and the health of recipients.

---

262 s. 27 Coroners Act 1985; Section 29(2) of the Human Tissue Act 1982.
Powers of entry, inspection and possession

Section 26 of the Act provides:

“(1) A coroner who has jurisdiction to investigate a death may, with any help thought fit--

(a) enter and inspect any place and anything in it; and
(b) take a copy of any document relevant to the investigation; and
(c) take possession of any thing which the coroner reasonably believes is relevant to the investigation and keep it until the investigation is finished.

(2) A coroner may only exercise those powers if the coroner reasonably believes it is necessary for the investigation.”

These powers of search and seizure are similar to those in other Australian jurisdictions.263

Coroners’ authorities differ from other warrants as indicated in Figure 21.

The Committee seeks advice about:

- Are there any problems or issues of concern with the current powers of entry, search and seizure?
- Are you aware of any challenges of criticisms of the exercise of these powers?264

---

263 s. 33 Coroners Act 1996 (WA), ss. 59 & 59A Coroners Act 1995 (Tas.), s. 67 Coroners Act 1997 (ACT), s. 19 Coroners Act (NT).

**Fig. 21 Comparison of Coroners’ Authorities and Warrants**

<table>
<thead>
<tr>
<th>Powers of Coroner</th>
<th>Warrants</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Coroner is the issuing and executing authority.</td>
<td>Courts issue warrants but they are sought and executed by other agencies: Courts do not have power to enter, inspect and take possession. Rather, the person or entity that needs the power applies to the court or other authority empowered to issue the warrant.</td>
</tr>
<tr>
<td>Coroners have statutory right to enter, inspect and take possession from scene of death and fire or to delegate these functions to act on his or her behalf.</td>
<td>The person or entity who seeks and executes a warrant must present evidence to the Court or other authority to satisfy the applicable standard to justify the issue of the warrant.</td>
</tr>
<tr>
<td>The Coroner must reasonably believe his or her entering, searching and seizing or delegating these powers to act on his or her behalf is necessary for an investigation of a reportable death.</td>
<td>Many warrants have additional obligations and restrictions attached by legislation, such as limits on how long the warrant remains valid and a requirement to submit a report on the execution of the warrant to the issuing authority.</td>
</tr>
<tr>
<td>The common law requirements concerning the execution of search warrants do not apply in that there need be no limitation imposed on a Coroner’s authority by the time of day or night at which the warrant is executed.</td>
<td>The power to issue a warrant is restricted by the specific statutory reasons for its execution.</td>
</tr>
<tr>
<td>The Coroner’s power and authority is limited to his or her own functions which do not involve criminal or civil liability. That is, if criminal investigation is involved then the requirements of the criminal law have to be met.</td>
<td></td>
</tr>
</tbody>
</table>

The differences between coroner's authorities and other warrants are justified by the inquisitorial nature of the coronial jurisdiction and the statutory limits on coroners’ powers to identify criminal activity. The State Coroner’s Office is not aware of any Supreme Court challenges to this part of its jurisdiction.

On the contrary, the powers facilitate availability of files for the Coroner including medical files and Corrections files. For example, they were used in the investigation into a series of about 100 fires involving Mistral Fans. These powers have also been used to great advantage in cases like the Longford gas explosion and fire where the State Coroner’s authority was used to seize the information that eventually assisted the Royal Commission. The Royal Commissioners noted:
"Esso's own investigation, which resulted in the McNeil Report, involved the production of a document which was apparently a draft to be used in the compilation of the final report. The draft document was seized by the Coroner shortly after the explosion and fire. It contained the unequivocal statement "The lack of a detailed HAZOP for GP1 is considered a contributing factor to this incident." That statement did not appear in the McNeil Report in its final form, but there was no evidence to explain its conclusion..." 265

The Royal Commissioners also remarked that:

"... the Coroner acted under his statutory powers to seize certain documents and critical equipment and to preserve the integrity of the site of the incident at Longford, including the control room of GP1." 266

On this basis, the State Coroner's Office makes no recommendation for change of these provisions.

Confidentiality of information during an investigation

Sections 34 and 37 of the Coroners Act 2003(SA) protect the confidentiality of information provided to coroners' clerks which is not otherwise in the public arena.

The State Coroner's Office is of the view that a similar clause would assist coronial staff and police to refuse to provide personal information when requested by, say, the media or other people not otherwise involved in the coronial investigation (see also discussion in this submission under the sub-heading "Individual privacy, the investigation, principals of open justice and public health and safety").

Therefore the State Coroner's Office recommends:

RECOMMENDATION 5.12

That Parliament amend the Coroners Act 1985 include a new clause in that reads:

" Confidentiality

A person must not divulge information about a person obtained (whether by the person divulging the information or by some other person) in the course of the administration of this Act, except—

(a) where the information is publicly known; or

(b) as required or authorised by this Act or any other Act or law; or

(c) as reasonably required in connection with the administration of this Act or any other Act; or

(d) for the purposes of legal proceedings arising out of the administration of this Act; or


(e) to a government agency or instrumentality of this State, the Commonwealth or another State or a Territory of the Commonwealth for the purposes of the proper performance of its functions; or

(f) to a bona fide research organisation or individual researcher for public health or safety purposes; or

(g) with the consent of the person to whom the information relates.

The media and investigation confidentiality

Section 58 of the Act provides:

58. Restriction on publication of reports

(1) A coroner must order that no report of an inquest or of any part of the proceedings or of any evidence given at an inquest be published if the coroner reasonably believes that it would--

(a) be likely to prejudice the fair trial of a person; or

(b) be contrary to the public interest.

(2) A person must not publish a report contrary to an order.

Penalty: 10 penalty units or imprisonment for three months.

In practical terms, this means that an inquest must have been opened before the investigating coroner has jurisdiction to make a restriction order. Formally opening an inquest for this reason alone may, of itself, be prejudicial to interested parties. It may also be impractical or premature.

Accordingly, the State Coroner's Office is of the view that, as well as retaining authority for investigating coroners to make suppression orders during an inquest, the State Coroner should have power to make or vary a suppression order on evidence at any stage of the investigation.

Therefore, the State Coroner's Office recommends:

RECOMMENDATION 5.13

That Parliament amend section 58 of the Coroners Act 1985 to allow the State Coroner to restrict publication of reports of an investigation or vary or set aside such an order if the State Coroner believes that publication would prejudice or compromise the investigation.

Individual privacy, the investigation, principals of open justice and public health and safety

Another issue not directly raised in the Discussion Paper is the matter of individual and family privacy. Because of recent privacy legislation and publicly expressed concern over release of medical records from a coroner's file, the traditional approach of the coroner that the investigation file once complete is part of the public record needs re-consideration.

In this debate on privacy there is a need to find a balance between the individual investigation (or multiple investigations), the principal of open
justice, the balance with criminal justice system and matters of public health and safety. Where the balance is set may vary in accordance with the individual circumstances of a case or particular public issue. Public safety issues flowing from coroners’ findings are, understandably, of significant importance for the community. In the past, many public safety issues have remained not addressed, buried in coroner’s files, to the detriment of other individuals and their families.

Australian coroners and the community now have a new system to look for unidentified trends in a timely way. As indicated, this is the National Coroners’ Information System. The National Coroners' Information System collects data from coroners' records, including initial statements of circumstances, autopsy and toxicology reports, coroners' findings and recommendations. This enables common problems to be identified by coroners and their investigators, health and safety experts and governments. Having identified the problem often it is necessary to access the file to find more detail. This information system has been running from mid 2000 and there are now 95,000 individual deaths registered. The data is available under strict access criteria to governments and for research on health and safety. The data is also available to coroners or coroners' investigators for investigation purposes and for public health and safety purposes. The State Coroner's Office is of the view that it is important that any privacy rules adequately allow for the collection and use of coroners’ data in the wider public interest.

It is noted that a Committee of the Victorian Courts Consultative Council is currently examining the issue of release of court records to third parties. The Principal Registrar of the State Coroner’s Office is on the working party of the Consultative Council.267

The word "privacy" is not mentioned in the current Coroners Act and therefore it is necessary to look at other legislation like the Information Privacy Act 2000, the Health Records Act 2001 or relevant Commonwealth legislation.


(1) Before completion of:
(a) an investigation or an inquest into a death; or
(b) an investigation or inquest into a fire...

a coroner's file or any part of it must be made available to such people or class of people as the coroner directs.

(2) After the completion of:
(a) an investigation or an inquest into a death; or
(b) an investigation or inquest into a fire...

267 See Department of Justice, Release of Court Documents, Issues Paper, Court Services, August 2005.
The coroner’s record and file is to be open to public access unless the coroner orders otherwise.

The Fundamental Review considered this issue in relation to inquests:

".... the coroner should have a power to forbid the publication of detailed material or evidence given in an inquest if he is satisfied that to do so would be in the interests of the privacy and well-being of the bereaved and that there is no overriding public interest in access to the material." 268

The review also commented on privacy and public interest in relation to what Victoria calls "chambers findings":

"However, in cases reported to the coroner for circumstantial investigation which result in an administrative investigation but not an inquest, the outcome would be made publicly available, mostly on application but some proactively as the coroner sees fit, even though the investigation had not been held in public. The coroner would however, have a discretion to expurgate the private information, e.g. a suicide note, from the record of the outcome, and describe the outcome in summary terms." 269

And:

"...the government an intention to preserve as private information accessible only to families and bona fide researchers certain details comprised within the registration of deaths, including the medical cause of death that are now accessible to the general public on payment of a fee."270

On deaths from natural disease:

"Deaths reported to the coroner's office which are found to be from natural disease should be treated as though they had been certified by the general practitioner or hospital doctor in the normal way. In these cases, therefore, the medical cause of death would not be accessible to the general public." (Ch 21, p.223, para 27)271

The State Coroner's Office is of the view that the provisions that relate to access to files and parts of files should be in the Act and not the Regulations.

As there are a range of considerations to balance in any one case or series of cases from privacy to public safety and open justice principles


the decision of what should be open to public access should be a matter for the coroner. Families, other sufficiently interested parties or public applicants for access should have the right to make submissions on access issues.

At the completion the finding each file should have a documented privacy assessment and coroner's order (that order may be subject to variation depending on later applications).

In the context of privacy issues, the State Coroner's Office notes the importance of balancing the principals of open justice, the appropriate public use of information for investigation purposes and collection and use of coronial data for public health and safety. Accordingly, the State Coroner's Office considers that file access on completion of the coroner's investigation should be in the discretion of the coroner. A set of guidelines need to be developed to assist in the exercise of that discretion.

Generally, subject to an order of the investigating coroner, the chambers or inquest finding and the information on which it is based should be part of the public record. Also subject to an order of the coroner, prima face natural cause deaths should not be public documents (but available for legitimate health or safety research).

The State Coroner's Office is also of the view that, in considering this issue, the discussion and recommendations in the Luce Report are useful. Ultimately, when dealing with the privacy issues, each individual case or each of the cases in a series of cases will have different considerations. Accordingly, the State Coroner's Office considers that the decision should be a matter for the individual coroner in accordance with structured guidelines.

The State Coroner's Office recommends:

RECOMMENDATION 5.14

That Parliament amend the Coroners Act 1985 to provide:

“(1) Before completion of:

(a) an investigation or an inquest into a death; or
(b) an investigation or inquest into a fire...

a coroner's file or any part of it must be made available to such people or class of people as the coroner directs.

(2) After the completion of:

(a) an investigation or an inquest into a death; or
(b) an investigation or inquest into a fire...

the coroner's record and file is to be open to public access unless the coroner orders otherwise.”
Chapter 6
Investigation of Fires

Section 31(1) of the Act provides:

“A coroner has jurisdiction to investigate a fire if the fire occurred in or partly in Victoria and the coroner believes it is desirable or the Country Fire Authority or the Metropolitan Fire Brigade requests an investigation.”

The coronial jurisdiction to investigate non-fatal fires reflects the public safety issues associated with fires and are has followed its evolution in the United Kingdom and elsewhere. In cases where public safety and protection have been threatened by fires, there is a continuing need for their independent investigation. This is particularly the case in Victoria where there is a high risk associated with fires and where the Victoria Police, the Metropolitan Fire Service, the Country Fire Authority and the Department of Infrastructure, who also maintain investigatory capacity, are also responsible for fighting fires or coordinating fire responses under the State-wide Disaster Plan.

The Committee is considering whether the coronial system should continue to investigate non-fatal fires.272 Section 36 provides:

(1) A coroner investigating a fire must find if possible--
(a) the cause and origin of the fire; and
(b) the circumstances in which the fire occurred; and
(c) the identity of any person who contributed to the cause of the fire.

(2) A coroner may comment on any matter connected with the fire including public health or safety or the administration of justice.

Section 38 provides:

(1) A coroner may report to the Attorney-General on a fire which the coroner investigated.

(2) A coroner may make recommendations to any Minister or public statutory authority on any matter connected with a fire which the coroner investigated, including public health or safety or the administration of justice.

(3) A coroner must report to the Director of Public Prosecutions if the coroner believes that an indictable offence has been committed in connection with a fire which the coroner investigated.

Section 41(1) provides:

A coroner who has jurisdiction to investigate a fire may, with any help thought fit--
(a) enter and inspect any place and any thing in it; and
(b) take a copy of any document relevant to the investigation; and
(c) take possession of any thing which the coroner reasonably believes is relevant to the investigation and keep it until the investigation is finished.

As previously discussed, the coroners' authority to investigate non-fatal fires was established during the eighteenth century when legislation was passed in England vesting coroners with a limited power to conduct inquiries into non-fatal fires. The City of London Records Office holds records of on-fatal fire inquests dating from 1888.

In parallel with these changes in England, the Coroners Act 1890 in Victoria required coroners to:

"... inquire into the cause and origin of any fire whereby any building ship of merchandise or any stack of corn pulse or hay or any growing crop within such district shall be destroyed or damaged....

Notwithstanding anything hereinbefore contained no coroner or deputy coroner shall have jurisdiction (unless thereto authorized in writing by the Minister in whose department this Act is administered) to inquire into the cause and origin of any fire whereby any property shall have been destroyed or damaged until some person shall in respect of such inquisition pay the sum of five pounds and five shillings to the coroner, or to some receiver of revenue, and in the latter case produce to the coroner a receipt for the said sum."273

The coroners' discretion to investigate non-fatal fires has been perpetuated in the coroners' legislation in the ACT, New South Wales and Tasmania.274 It has been repealed in more recent legislation in Western Australia, the Northern Territory and South Australia.

In 2003, in response to submissions relating to bush fires made to a broad-ranging review of their Act, the New South Wales Parliament extended their coroners' fire jurisdiction to allow broader investigation into fires if requested by the Attorney General, the State Coroner, the Commissioner of Rural Fire Service or the New South Wales Fire Brigades. This amendment was intended to expedite investigation of otherwise authorised non-fatal fires to cause and origin of the fire so that any recommendations can be implemented before the next bushfire season:

"...the government is of the view that delays in holding coronial fire inquiries could best be avoided by clarifying the scope of the inquiry to cause and origin of the fire rather than the broader and less easily defined term, "circumstances"."

Fire investigation requires sophisticated professional expertise. In Victoria, fires are routinely investigated by the Metropolitan Fire Service, the Country Fire Authority, Parks Victoria, Victorian Forensic Science Centre and/or the Victoria Police Arson Squad as well as by the Office of Gas Safety or WorkSafe. All these agencies co-operatively investigate appropriate fires under the State's "Fire Investigation Policy and Procedures".276 Following the Longford gas explosion and fire, the Royal Commissioners commented:

---

273 ss 4 & 5 Coroners Act 1890.
274 s 18 Coroners Act 1997 (ACT), ss 15, 15A & 15B Coroners Act 1997 (NSW), ss 40 & 43 Coroners Act 1995 (Tas.).
"The Victorian Fire Investigation Policies and Procedures, published by the
Department of Justice in March 1998, established policies and procedures for the
co-ordination of the various agencies with obligations or interests relating to the
investigation of fires. The agencies were the Victoria Police, the Department of
Conservation and Natural Resources, the Country Fire Authority, the Metropolitan
Fire Brigade, the State Forensic Science Laboratories and, more recently, the
Victorian Workcover Authority. There is a steering committee chaired by the
State Coroner. Immediately following the explosion and fire Longford on 25
September 1998, the Coroner established a task force to investigate the incident.
Those involved were the Arson Squad from the Victoria Police, the Country Fire
Authority and the Victorian Workcover Authority. The Arson Squad took the lead
and the investigation was co-ordinated by Detective Senior Sergeant Hughes.
Forensic experts were engaged...Their roles were co-ordinated by Inspector Willis
of the Victorian Forensic Science Centre..." 277

When requested, the State based agencies investigate fires on behalf of
the State Coroner. Further, the Metropolitan Fire Service and the Country
Fire Authority can request coronial involvement in fire investigations. A
person can request a fire investigation. Also, the Attorney General can
request a fire investigation or direct an inquest into a fire. The State
Coroner can also direct another coroner to hold an inquest into a fire. In
the late 1980s and early 1990s the State Coroner's Office was working
with the fire agencies (Metropolitan Fire Service and the Country Fire
Authority) on the issue of compulsory installation of residential smoke
detectors. This work followed as a result of both the Coroner's death and
fire jurisdictions.

Current examples of the potential safety use of this jurisdiction include the
coronial investigation (and inquest) into the Gisborne railway line fires, the
investigations into the Wilson's Promontory fire and the Bogong Village
fire. Also an investigation is being undertaken into a series of arson
related fires in school buildings with a view to looking at how the fires
occurred in addition to the safety and warning systems.

Another multiple fire inquest that is relevant to this discussion is the 1997
Dandenong Ranges Fires inquest. Although the Dandenong Ranges
Fires involved the deaths of three residents in one fire (Ferny Creek) there
were also series of fires in the area, each having particular
characteristics. The coroner's fire jurisdiction enabled all the fires to be
considered in one joint inquest and number of lessons learnt (including a
unique fire warning system for Ferny Creek and assisting in the
development of the "Model of Fire Cover for Victoria"). Without the
ability to look more broadly at the other fires a number of additional safety
issues could not have been considered like fire refuges and emergency
shelters, individual risk assessments in areas of high fire risk, review of
the approach to risk management and fire preparedness, communication,
road access to fire, etc. The Dandenong Ranges fire inquests also cited a

Investigation", p. 246, paras A.17 and A.18. 13.56 Under the heading "The McNeil Report" the
Commissioners.
278 Upwey, Kolorama, Montrose and Mount Dandenong.
previous Deputy-State Coroner's fire inquest findings, comments and recommendations into a major fire at Warrandyte in 1991.

Another example of a fire investigation and inquest that has had significant public safety implications is the Tuna Offshore Oil Rig fire in the Bass Strait in April 1989. Difficulties with the system of danger tagging and lock-out procedures were considered in this investigation and recommendations and comments were made on these systems, fire fighting equipment testing and audit. The fire at Piper Alpha in the North Sea eight months previously in July 1988 (with the loss of 167 lives) had similar issues (with difficulties in danger tagging and lock-out procedures) and Lord Cullen's preliminary report on the systemic issues was being worked on by Australian governments and the petroleum industry before the Tuna fire.

While the coroner was investigating a number of deaths in Port Phillip Prison, there were also a series of fires in prison cells. The coroner commenced an investigation under the 'fire' jurisdiction and, as part of that investigation, using a mock-up cell a scientific fire test and demonstration was held by the Metropolitan Fire Service. Representatives from a number of interested agencies were present and, from a fire safety perspective, the demonstration led to significant change in cell design, furniture and bedding standards.

Although the State-based agencies investigate fires, there is no independent coordinating body with power and authority to investigate and promulgate lessons from serious fires about causation, prevention and public safety, particularly the safety of fire fighters in risky situations such as bush fires.280

Therefore, in order to continue the State Coroner's role in public safety and prevention in relation to non-fatal fires and, to remain consistent with recent interstate coronial legislation, the State Coroner's Office makes no recommendation with respect to removal of the State Coroner's fire jurisdiction in section 1(c) of the Act. However, there are some recommendations made to clarify and strengthen the role in public health and safety.

Therefore, the State Coroner's Office recommends:

RECOMMENDATION 6.1

That Part 6 continue to provide coronial jurisdiction to investigate non-fatal fires, particularly where issues of public health and safety arise.

Accordingly, the State Coroner's Office recommends:

RECOMMENDATION 6.2

That Parliament amend section 31(1) of the Coroners Act 1985 to read:

"31(1) A coroner has jurisdiction investigate a fire if the fire occurred in or partly in Victoria and the coroner believes it is desirable on the grounds of public health and safety or the Country Fire Authority or the Metropolitan Fire Service requests an investigation on the same grounds."

In addition, consistent with the coroner's role in prevention of death, under the suggested amendment to sections 1 and 19(1) of the Act should be also amended to include the preventative role.

The State Coroner's Office is of the view that, consistent with the coroner's mandatory finding requirements in relation to death (s.19(1)), the necessity to find under section 36(1)(c) "the identity of any person who contributed to the cause of the fire" should be deleted from the Act.

The State Coroner's Office recommends:

RECOMMENDATION 6.3

That Parliament amend section 31(1) of the Coroners Act 1985 to read:

"36(1) A coroner investigating a fire must find if possible-
   (a) the cause and origin of the fire; and
   (b) the circumstances in which the fire occurred; and
   (c) whether or not the fire was a preventable fire."
Chapter 7
Inquests into Deaths and Fires

Part 7 of the Act provides the rules that limit the way in which a coroner manages an inquest. In this role, a coroner is not subject to the direction of the State Coroner. In Chapter 3, the State Coroner’s Office has recommended that the definition of inquest be changed to:

“‘Inquest’ means a formal hearing which may be part of the coronial investigation process.”

In Chapter 5 of this submission, the State Coroner’s Office addresses issues around whether or not an inquest is or should be held.

Historically, a coroner’s investigation of a reportable death or fire only involved gathering of sworn evidence at an inquest. The presiding officer at the inquest was the coroner, who could be a police magistrate, barrister, solicitor or doctor. In addition to determining the cause of death, an inquest could be held into the cause and origin of any fire that resulted in destruction or damage to property as defined in the Coroners Act. When an inquest was held it was generally held locally.

Until the 1999 amendments of the Act in Victoria, juries could perform this fact-finding role at inquests. Removal of their role in the coronial system brought Victoria in line with all other States except New South Wales and was a “most important shift toward ‘expert’ decision-making in coroners’ courts and removal of the role of the ordinary person from the process.”

Although amendments to the Act removed this role to coroners acting alone, a vestige of the jury system remains in Regulation 20 of the Coroners Regulations 1996.

Now:

“An inquest is not a proceeding inter parties. It is part of an investigative process which is concerned, inter alia, to set the public mind at rest where there are unanswered questions about a reportable death....

The Act draws a clear distinction between the investigation of ‘reportable deaths’ and the holding of inquests. That is so despite the definition of ‘investigation’ in s 3, explicable in that an inquest may be part of the investigative process.”

The Committee has sought advice on the following issues:

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

---

281  s. 16 Coroners Act 1985.
time and place of hearing—whether reasonable efforts have been made to do so?

- Do you have any issues or concerns in relation to the right to legal representation at an inquest?
- Are there any issues or concerns regarding the requirement of the Act that a coroner may make available any statements that the Coroner intends to consider at an inquest to “any person with sufficient interest”?
- Should the Act define the circumstances in which multiple deaths inquests are permitted?285

In Melbourne, the coroner’s clerks in the Main Office routinely list inquests and, in this process, they notify all interested parties about its date and place. In regional Victoria, this task is performed by clerks in Magistrates’ Court their role of coroner’s clerks. The State Coroner’s Office has no reason to believe that family members who are recorded on the coroner’s file are not informed of these dates and places.

Coroners have wide powers at inquests and are not subject to direction by the State Coroner.286 However, although they are not bound by the rules of evidence287, coroners are required to abide by the rules of natural justice and privilege.288 In particular, witnesses can claim legal professional privilege289 and the privilege against self incrimination290. The State Coroner’s Office has made recommendations in relation to the latter in Chapter 1 of this submission.

Further, coroners contemplating making an adverse finding against an interested party in an investigation are bound to give that person the opportunity to respond:

“Some of the material (in the report) could be properly characterised as capable of having high prejudicial effect but minimal probative value... The report was of such significance that if it was to be used at all by the board, it should have been actually provided, desirably before the hearing, or at least in such a way as to afford the relevant persons a meaningful opportunity of evaluating and responding to the report or if thought fit objecting to the whole or parts of the report. That provision (s 44) would not ordinarily entitle the board to act on material of little or no probative weight, specially when it has significant prejudicial effect.”291

Before making a finding that a professional person contributed to the cause of death of another within the course of his or her professional duties, there must exist a comfortable satisfaction that there has been a

286 ss. 33 & 43 Coroners Act 1985.
287 s. 44 Coroners Act 1985.
288 Annetts v McCann [1990] HCA 57; Barci v Heffey 1/2/1995 (SCVic) 4306/95.
289 The Daniels Corporation International Pty Ltd v Australian Competition and Consumer Commission [2002] HCA 49; (2002) CLR 543
290 Re O’Callaghan (1899) 24 VLR 957.
departure from normal standards (negligence) which contributed to the death.\textsuperscript{292}

Therefore, subject to public interest protections, coroners routinely provide all witnesses at inquests and interested parties including family members with most of the relevant evidence in their investigations.

Matters of bias are currently before the Supreme Courts in Victoria, Tasmania and just been completed in the Supreme Court of the Australian Capital Territory. These determinations will help clarify the degree to which coroners and other judicial officers can have contact with professional witnesses during hearing of a case.

Therefore, the State Coroner’s Office is of the view that interested parties are well protected by common law and natural justice protections of their rights. It makes no further recommendations in this matter.

**Legal Aid**

Difficulties frequently arise for families and other interested parties who are not professionally involved in a coronial investigation when they do not have legal representation. They tend to rely on the Coroner’s Assistant or the police informant to provide them with support and legal advice. This creates conflicts of interest during the investigation and at the inquest, where the person who is assisting the coroner is also the person supporting and *de facto* appearing for the family. The State Coroner’s Office is of the view that families involved in cases that proceed by way of inquest should have the right to publicly funded legal representation, probably through Victoria Legal Aid. The Fundamental Review commented on legal aid in the context of the rules in England.\textsuperscript{293} In the context of discussing the legal aid provisions, it noted that:

"The inquest should so far as possible be conducted in a style that is accessible to unrepresented lay people..."  

Luce also says that in the legal aid system applicants are subject to an income test and "cases are assessed on whether there is a significant wider public interest or overwhelming importance to the client." (In England and Wales legal aid is expected in cases which engage Article 2 of the Human Rights Convention and for inquests into disasters with multiple deaths). Luce also comments on a range of submissions directed to the potential unfairness in a hospital death inquest where the hospital is represented but the family are not.\textsuperscript{294}

\textsuperscript{292} Secretary to the Department of Health and Community Services v Gurvich [1995] 2VR 69 applying Dixon J in Briginshaw v Briginshaw [1938] HCA 34; (1938) 60 CLR 336; Anderson v Blashki [1935] 2 VR 89.

\textsuperscript{293} It should be noted that Luce discusses the issue of availability of legal aid in England and Wales and also in Northern Ireland. Luce T. et al, 2003, “Report of a Fundamental Review - Death Certification and Investigation in England, Wales and Northern Ireland.” Chapters 12 and 21 (Summary of Recommendations, p.228, Recommendations 70 and 72).

The Victoria Legal Aid general guidelines apply to every application for assistance. There is a guideline applying to inquests:

"4 Coroner's Inquests
VLA may grant assistance for coroner's inquests if:

(i) there is a reasonable likelihood that the applicant will be charged with a serious offence, for example murder, manslaughter or culpable driving; or

(ii) it is in the public interest for the applicant to be represented."

The State Coroner has had occasion to critically comment on the inadequate provision (or no provision) of legal aid to families in some cases.295

Therefore, the State Coroner's Office recommends:

**RECOMMENDATION 7.1**

That Victoria Legal Aid review its guidelines to provide for wider representation of families and other interested parties involved in coronial inquests.

*Multiple Inquests*

Section 43 of the Act provides the State Coroner to order a single inquest as part of the investigation into multiple deaths or fires. This has been interpreted by the State Coroner to mean more than one unrelated death or fire with similar issues.

Coroners routinely refer similar cases that come to their notice to the State Coroner for him to decide about whether to hold a multiple death inquest or multiple fire inquest.

Multiple inquests into similar events have been instrumental in identifying dangerous practices or design issues and significantly changing the approach of governments, the community and industry to various health and safety issues. The range of examples that run over the 19 years the current Act has been in operation include:

- railway level crossing safety,
- tractor safety (rollovers),
- truck-related deaths,
- Mistral Fan Fire Inquests,
- Lynch's Bridge,
- Toyota Skid-Steer Loaders,
- Doctor shopping,
- drownings of children in backyard swimming pools,
- Scuba Diving related deaths;
- Police Shootings,

---

295 Report of Investigation into the Death of Frederick Lewis, Case No. 3334/95.
- Ambulance and emergency response,
- some of the cases in the single vehicle collision study,
- Methadone Inquests,
- the Dandenong Ranges Fires and deaths,
- heroin-related inquests,
- recreational boating and commercial fishing safety,
- stunt-related deaths during filming,
- inquests into nine freeway crossover deaths (Brifen wire rope barriers),
- disabled pedestrians and railway crossings,
- deaths in custody at Port Phillip Prison, and
- all terrain vehicles (part heard).

The State Coroner's Office is aware from its experience with a multiple heroin-related death inquest that a multiple inquest will invariably slow down the process for families who are involved in earlier deaths in the group and it may also become side-tracked on to issues that are not all relevant to all cases in the group. Legal representation with multiple parties also tends to slow the process and be costly for families and others. Therefore, the State Coroner only orders multi-death or fire inquests when the deaths or fires all occurred in or arose from the same incident or the costs will be significantly reduced if a multi-death or fire inquest is held or the same public safety and prevention issues in the cases justify their amalgamation. These issues do not lend themselves to general definition in the Act.

Multiple inquests are used sparingly and only when the public safety issues are such as they reasonably require this type of process. By running a series of cases together it enables a far greater level understanding to be gained into the various factors involved in the events and the countermeasures are explored in greater detail.  

During the investigation of 25 deaths over a three year period associated with police pursuits, the State Coroner also used a system of back-to-back inquests. He ran three of the incidents back-to-back to enable a broader look at the issues and heard the evidence relating to the others on a case by case basis. This avoided requiring families' involvement over an extended period and compartmentalisation of the individual investigations while still allowing the lessons learned from individual cases to be drawn together at the end of the three separate inquests. This variant of the multiple inquest system appears to be helpful.

---

296 The multiple inquest system is also used elsewhere. See for example in South Australia in 1997 where six inquests were conducted into deaths where the deceased or perpetrator suffered from a schizophrenic disorder or a series of inquests in that state into petrol sniffing in remote aboriginal communities.
Further, the provisions in the Act that relate to re-opening inquests have been operating effectively. The State Coroner does not exercise them without considering all the circumstances of the case including the public interest issues and the interests of the families and others involved in the death. Therefore, the State Coroner’s Office makes no recommendation on these matters.
Conclusion

The coronial investigation system in Victoria is a unified well established process that begins when a death is reported to the State Coroner through the Initial Investigations Office and ends when a coroner determines the identity of the deceased, the time and place of death, the cause of death and the other facts required for registration of the death by the Registrar of Births Deaths and Marriages. It is the envy of many who still work in environments where coronial work is secondary to their main job or is attached to the end of a large judicial organisation.

It was not always so.

In 1984, the Second Reading Speech for the Coroners Bill stated:

"At present, regional magistrates sit as coroners as required. There is no central coordination or regulation of the performance of these functions. It will be one of the principal responsibilities of the State Coroner to ensure that there is a coronial system in place of the existing patchwork quilt."

In 1988, the new Coronial Services Centre was opened in Southbank in Melbourne to co-locate coronial and forensic pathology services after the new Coroners Act 1985 came into operation. An innovative system of service delivery has developed around the management of bodies and coronial investigations which has allowed coroners and forensic pathologists to perform their essential roles with mutual professional interdependence within the legal hierarchy imposed by the Act.

The State Coroner's Office mission is to:

Speak for the dead to protect the living.

Historically, the secret to this success has been long-term commitment of State Coroners Hallenstein and Johnstone and the Chief Magistrates' continuing dedication of legally trained magistrates to full-time work as coroners at the Coronial Services Centre. The specialist nature of coronial work and the need to work in an inquisitorial, investigatory, multidisciplinary environment means it is difficult for anyone to properly commit to coronial work when it is not their main job and the mortuary, pathology and other support services are physically separated from the coroners' workplace.

In a demographic environment where the numbers of reported deaths can be expected to rise, the State Coroner's Office believes it is important to learn from and maintain this successful strategy, while at the same time identifying areas where there is most scope for improvement.

Significantly, the Attorney General has committed himself to developing the public safety and prevention capacity of the State Coroner's Office. In particular, he has committed the Justice Department to increasing their emphasis in his 2004 Justice Statement and he has funded the State Coroner's Clinical Liaison Service and the State Coroner's Workplace Death Investigation and Resource Unit funded by Workcover to provide for expert investigations in two socially and numerically important categories.

---

of preventable death. In this submission, the State Coroner’s Office has recommended a number of changes to the Act which are intended to facilitate this development. These include making public safety and prevention a core purpose for the State Coroner’s Office, allowing coroners to determine whether a death was preventable and requiring the State Coroner to report annually to Parliament.

The second main thrust of this submission is intended to support this public safety and prevention role of the State Coroner’s Office by ensuring the independence and authority of the State Coroner. The State Coroner’s Office has recommended that the Parliament create a Coroner’s Court which is consistent with public perception that it already exists. Associated with this would be a changed funding and employment environment where appointments are not restricted by the same limitations that apply in the Magistrates’ Court and the State Coroner’s Office can support its own independent specialist investigatory and research teams.

It has become clear to the State Coroner’s Office that our third major hurdle is to find ways of delivering the coronial service enjoyed in Melbourne to communities in regional and rural Victoria. There, it seems, the Attorney General's ‘patchwork quilt’ remains in operation despite efforts to provide training, support and backup to country coroners, coronial staff, police investigators and pathologists. Further, although from a strictly numerical point of view, the demographic statistics suggest that the expected increased death rate is likely to be mostly centralised in Melbourne, death is a very personal, cultural event and coronial services must be properly delivered at the local level.

There is already a problem with obtaining regional pathology services. Country magistrates frequently perform coronial duties and they would benefit from regular professional development courses in this jurisdiction. Police and court staff in the country and not necessarily focussed primarily on coronial investigations.

Further, there are few trained coronial support workers who can assist families and others affected by the death and the coronial process. In order to underline the importance of existing coronial support services and extending the current Melbourne service to regional areas, this submission recommends that provision of short term counselling and support services becomes acknowledged in the Act.

The State Coroner and the State Coroner’s Office recognises that this inquiry will point to areas that require improvement and we accept the responsibility for trying to meet this challenge. However, it will also need Government and community support and good will.
Appendices