



**Submission to the NSW Attorney General:
review of the *Coroners Act 2009* (NSW)**

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1. Introduction

The Public Interest Advocacy Centre (PIAC) is an independent, non-profit law and policy organisation that works for a fair, just and democratic society, empowering citizens, consumers and communities by taking strategic action on public interest issues. PIAC has developed expertise in the operation of the *Coroners Act 2009* (NSW) (Coroners Act) through its representation of families of the deceased in a number of inquests since the Act came into force. Accordingly, PIAC welcomes the opportunity to make a submission to the NSW Attorney General regarding its review.

PIAC notes that, while beyond the scope of this statutory review, which is tied to the current objectives listed in the Act, there is a need for general and holistic changes to the coronial system in NSW and across all Australian jurisdictions. For example, PIAC supports the conclusion drawn by the Australian Inquest Alliance, of which it is a member, that there needs to be coronial reform across Australia so that every state and territory has an independent and effective coronial system that:

- responds to deaths and seeks to prevent further deaths through the making of broad and systemic recommendations;
- addresses social justice issues arising from the inquest; and
- facilitates the participation of families in investigations, inquests and all other aspects of the required systemic response.¹

In this submission, PIAC makes a number of recommendations regarding the procedural aspects of the Act as it currently operates, based on PIAC's direct experience in the conduct of inquests in NSW. These recommendations aim to ensure the procedures under the Act positively impact, as much as possible, families of the deceased and operate to the benefit of the wider public by identifying and promoting systemic change to prevent avoidable deaths in future.

1.1 The Public Interest Advocacy Centre

PIAC identifies public interest issues and, where possible and appropriate, works co-operatively with other organisations to advocate for individuals and groups affected. PIAC seeks to:

- expose and redress unjust or unsafe practices, deficient laws or policies;
- promote accountable, transparent and responsive government;
- encourage, influence and inform public debate on issues affecting legal and democratic rights;
- promote the development of law that reflects the public interest;
- develop and assist community organisations with a public interest focus to pursue the interests of the communities they represent;
- develop models to respond to unmet legal need; and
- maintain an effective and sustainable organisation.

¹ Federation of Community Legal Centres *Saving lives by joining up justice: Why Australia needs coronial reform and how to achieve it*, On behalf of the Australian Inquest Alliance, March 2013, available at http://www.fclc.org.au/cb_pages/news/new-report-urges-national-coronial-reform.php.

Established in July 1982 as an initiative of the (then) Law Foundation of New South Wales, with support from the NSW Legal Aid Commission, PIAC was the first, and remains the only broadly based public interest legal centre in Australia. Financial support for PIAC comes primarily from the NSW Public Purpose Fund and the Commonwealth and State Community Legal Services Program. PIAC also receives funding from NSW Trade and Investment for its work on energy and water, and from Allens for its Indigenous Justice Program. PIAC also generates income from project and case grants, seminars, consultancy fees, donations and recovery of costs in legal actions.

1.2 PIAC's work on coronial inquests

PIAC's has represented a number of families in coronial inquests, including:

- the family of Tracy-Lee Brannigan, who died of a heroin overdose while being held in Dillwynia Correctional Centre;²
- the siblings of Mark Holcroft, who died after suffering a heart attack in the back of a prison van, which was being driven from near Bathurst to Wagga Wagga;³
- two members of Tut Nyal's family, a man who died while imprisoned in Long Bay gaol;⁴
- the family of Scott Simpson, who committed suicide in Long Bay gaol after spending the two years prior to his death in isolation;⁵ and
- the mother of Jason Szczepek, who committed suicide following his discharge, against his wishes, from Sutherland Hospital's psychiatric unit.⁶

PIAC has also contributed to the development of coronial law reform. In 1988, PIAC produced several papers advocating law and policy reform of the coronial system in NSW. In 1991, PIAC produced a guide setting out accessible information on the coronial system for families and friends of the deceased. In 1989, PIAC published *Death in the Hands of the State*, which addressed deaths in custody. More recently, PIAC provided a detailed submission to the Western Australian Law Reform Commission's Discussion paper reviewing coronial practice in that state.⁷

PIAC is also a member of the Australian Inquest Alliance, recently contributing to the *Saving lives by joining up justice* report published in March 2013.⁸

² 'Drugs problem 'endemic' in prison system: Coroner', *Media Release*, 16 June 2014, Public Interest Advocacy Centre, available at <http://www.piac.asn.au/news/2014/06/drugs-problem-'endemic'-prison-system-coroner>.

³ Dodd, P *The Holcroft Inquest: prisoners deserve more human prison transportation*, 25 May 2012, Public Interest Advocacy Centre, available at <http://www.piac.asn.au/publication/2012/05/holcroft-inquest>.

⁴ 'Tut Nyal Inquest raises concerns about suicide risk', *Media Release*, 9 September 2011, Public Interest Advocacy Centre, available at <http://www.piac.asn.au/news/2011/09/tut-nyal-inquest-raises-concerns-about-suicide-risk>.

⁵ 'A mother's fight for justice vindicated', *Media Release*, 23 September 2008, Public Interest Advocacy Centre, available at <http://www.piac.asn.au/news/2008/09/mother's-fight-justice-vindicated>.

⁶ 'Jason Szczepek inquest highlights need for coronial law reform', *Media Release*, 3 June 2010, Public Interest Advocacy Centre, available at <http://www.piac.asn.au/news/2010/06/jason-szczepek-inquest-highlights-need-coronial-law-reform>.

⁷ Dodd, P *Western Australia: an opportunity to take the lead on coronial law reform*, 24 August 2011, Public Interest Advocacy Centre, available at <http://www.piac.asn.au/publication/2011/09/western-australia-opportunity-take-lead-coronial-law-reform>.

⁸ Above, note 1.

2. Is the Coroners Act fulfilling its policy objectives?

The first statutory review of the Coroners Act requires the Attorney General to determine whether the Act is still meeting its policy objectives.⁹ PIAC's experience, and consequent recommendations, primarily relate to certain objectives of the Act, namely,

- 'to enable coroners to investigate certain deaths and make coronial recommendations';¹⁰ and
- 'to enable coroners to make recommendations in relation to matters in connection with an inquest or inquiry (including recommendations concerning public health and safety and the investigation or review of matters by persons or bodies)'.¹¹

PIAC believes that there are a number of flaws in the coronial system that hinder the fulfilment of the objectives in section 3. In particular, PIAC is concerned that there are limitations on the ability of coroners to fully investigate systemic factors that are causative or contributory to a death and make recommendations on that basis.

There are four areas of NSW coronial law and practice that PIAC considers require reform and amendment.

2.1 Clarifying and strengthening the coroner's role in prevention

PIAC considers that coroners have the potential to play an essential role in preventing deaths in NSW. However, in PIAC's experience, a coroner's ability to make recommendations that would lead to long-lasting systemic change is limited by the parameters of the legislation.

There has undoubtedly been an increasing trend across all jurisdictions for Australian coroners to make findings and recommendations that are aimed directly at preventing future deaths. In certain cases findings have gone beyond responding to the immediate cause of death to making comment about more systemic issues, such as institutional and structural causes of the death in question. This has, for example, led to recommendations that there be changes made in the operation of government authorities and provision of government services, as well as by organisations and private bodies, that are aimed to bring about law reform and systemic change for the benefit of public health and the avoidance of unnecessary deaths.

In other cases, however, families and their legal representatives have been prohibited by coroners from raising matters that are seen as too remote from the immediate 'manner and cause of death'.¹² Similarly, coroners are often reluctant to make recommendations considered too remote from the immediate and direct cause of death. For example, in a death by suicide, coroners may be willing to examine events that occurred in the days or weeks before a person's death, but are reluctant to deal with systemic failures that may have occurred in the preceding months or even years, which can at least be argued are as much contributing factors towards the death as those occurring immediately beforehand. In *X v Deputy State Coroner of NSW*,¹³ for example, O'Keefe J found that the making of recommendations was not one of the 'primary duties' of a coroner in NSW.

⁹ Section 109 *Coroners Act 2009* (NSW).

¹⁰ Section 3(c) *Coroners Act 2009* (NSW).

¹¹ Section 3(e) *Coroners Act 2009* (NSW).

¹² Section 3(c) *Coroners Act 2009* (NSW).

¹³ [2001] NSWSC 46.

PIAC accordingly recommends that the policy objectives of the Act would be better achieved with a clear legislative mandate giving coroners broader powers to make appropriate recommendations. Based on PIAC's experience, it is clear that a basic power to 'make recommendations' has been insufficient to ensure that coroners can, and indeed are encouraged to, refer to relevant systemic issues that have contributed to a death. It should be made clear in the Act that in interpreting the power to make recommendations in relation to the 'manner and cause of death', the Coroner is able to include all matters that could have prevented it.

Amending the Act to clarify the role of coroners in this way should not be controversial, nor without precedent. In New Zealand, the *Coroners Act 2006* (NZ) specifically gives coroners the power to

make specified recommendations or comments that, in the coroner's opinion may, if drawn to public attention, reduce the chances of the occurrence of other deaths in circumstances similar to those in which the death occurred.¹⁴

It was also a recommendation of the Royal Commission into Aboriginal Deaths in Custody, released over 20 years ago, that broader powers be granted to coroners in order to prevent death. Citing recommendations made by PIAC at that time, the Commission concluded:

A coroner inquiring into deaths in custody should be required by law to investigate not only the immediate cause and circumstances of death, but also the quality of the care, treatment and supervision of the deceased prior to death.¹⁵

Recommendation – coroner's ability to make systemic recommendations

PIAC recommends that the Coroners Act be amended so that it is clear that the coroner should make recommendations related to any broader systemic issues that contributed to the death being investigated, with the aim of preventing similar deaths occurring in the future.

2.2 Ensuring that governments listen and respond to the recommendations of coroners

One of the most significant issues undermining the role of the coronial system in NSW is the lack of administrative and legal mechanisms to mandate responses to coroners' recommendations by government and other bodies.

In a recent study tracking the response of government agencies to 484 coroners' recommendations in 185 inquests around Australia, it was discovered that fewer than half of coroners' recommendations are being implemented in NSW.¹⁶ It is clear that the ad hoc approach to implementing coroners' recommendations is a missed opportunity to improve public health and prevent unnecessary deaths from occurring.

¹⁴ Section 4(2)(b) *Coroners Act 2006* (NZ).

¹⁵ Commonwealth, Royal Commission into Aboriginal Deaths in Custody, *National Report* (1991) Vol 1, at [4.7.4].

¹⁶ Watterson, R et al 'Coroners and Indigenous Death' (Paper presented at the 4th National Indigenous Legal Conference, Adelaide, 24-25 September 2009). Outlined in detail in Dodd, P, above note 7, at pages 5-6.

PIAC submits that a provision, which clearly mandates government to respond to coronial recommendations, should be inserted into the Coroners Act. Section 72 of the *Coroners Act 2008* (Vic) provides that if a public statutory authority or entity receives a coronial recommendation, they 'must provide a written response, not later than 3 months after the date of receipt of the recommendations', stating what 'action (if any) that has, is or will be taken in relation to the recommendations made by the coroner'.

PIAC also recommends that where a person dies in the care of the state, in particular where that person was in custody, including police custody, parliament as well as the executive should be part of the process that responds to coroners' recommendations. This would add an additional layer of public scrutiny and go some way to ensuring that action is taken to prevent avoidable deaths. Section 25 of the *Coroners Act 2003* (SA) reflects this position, mandating the reporting to Parliament of recommendations and the tabling of a timely response by government in relation to inquests arising from deaths in custody.

Recommendation – mandating a response to coroners' recommendations

- 1. PIAC recommends that where a recommendation is made by a coroner and referred to a public authority or government entity, there should be a statutorily mandated period within which the authority or entity must respond, detailing the steps that will be taken to make the necessary changes to systems and processes as required by the coroner.*
- 2. Where a death occurs while the person is in the care of the state and a recommendation is made in relation to that death, PIAC recommends that a report be made by the relevant minister to parliament outlining how the government will respond to the recommendation in question.*

2.3 The investigation of deaths in custody or deaths where there is a police presence

PIAC considers that where a person dies due to police action, while held in police custody or in the custody of Corrective Services, there ought to be a transparent and independent process by which the death is investigated. The current procedure under the Act, whereby the police prepare the coroners' brief and assist in the investigation, following an internal review, raises a considerable conflict of interest. PIAC believes the way inquests proceed in the context of this specific category of deaths can undermine the objective of identifying the 'manner and cause' of the death.

Investigations of this specific category of deaths should be independent and free from apparent or actual bias. Even a perception on the part of the family or public that police investigating police will not get to the truth of what happened to their loved one undermines the operation of the coronial inquest which follows and the overarching principle that justice should not only be done, but be seen to be done. If lessons are to be learned so that these types of deaths are avoided, it is vital that the public's perception of neutrality in the investigation is maintained, even if it is accepted that in the majority of inquests involving deaths where police are present there is no evidence of actual bias. The need for an independent body and a streamlined system of investigation is particularly important given recently released evidence showing that this category

of deaths is increasing in number with considerable delays experienced in the conduct of the inquest.¹⁷

Recommendation – deaths in custody or as a result of police action

PIAC recommends that an independent body be established and funded to investigate, in a timely and transparent way, all deaths that occur at the hands of police, while a person is in police custody or in the custody of Corrective Services. Such a body should have the power to investigate all the causative factors and to make systemic recommendations to avoid, as much as is possible, similar deaths in future.

2.4 Legal representation of families at inquests

PIAC believes that families seeking answers as to why their loved ones died have an important role to play in coronial inquests and have interests that require protective advocacy. While coroners do not usually create barriers to families of the deceased person being given leave to appear at inquests, the funding of legal representation of families does. In PIAC's experience, there is an acute imbalance created in proceedings where government agencies or hospital staff, for example, involved in a death all have legal counsel to represent them and the family of the deceased has no one to represent their interests.

PIAC welcomed the establishment by Legal Aid NSW of a coronial unit that provides representation, and some limited grants, at inquests, including for families, subject to the usual legal aid guidelines. Given there is both a forensic and therapeutic purpose in families being represented at inquests, PIAC submits that more resources should be allocated to ensure that legal representation is always provided to those families who cannot afford it themselves.

PIAC supports the conclusions drawn by the Australian Inquest Alliance that:

many families find inquest proceedings highly formal and intimidating, especially when there are issues involving government departments or corporations, whose interests are often advanced in an adversarial manner via legal representations. The legal issues can also be very complex and time-consuming, and the whole process may be the subject of intense media interest. Unrepresented families tend to rely on the Counsel assisting the Coroner or the police informant for legal information, which raises conflicts of interest.¹⁸

In addition, given the input families may directly feed into the findings of the coroner investigating the death of their relative, it is vital that families are properly represented. Their role should not be diminished in the coronial system by reason of an inability to fund their legal costs.

For similar reasons, PIAC also recommends that where a death has occurred in custody, that Corrective Services or the police appoint an officer as a dedicated contact person for the family of the deceased, from whom the family can obtain information regarding the whereabouts of the deceased's body, funeral arrangements, status of the police investigation and process of referral to the Coroner.

¹⁷ See, for example, Ting, I 'Deaths in custody hit 16-year high in NSW facilities', 7 November 2014, *Sydney Morning Herald*, available at <http://www.smh.com.au/nsw/deaths-in-custody-hit-16year-high-in-nsw-facilities-20141107-11er2a.html>.

¹⁸ *Saving lives by joining up justice*, above note 1, at page 51.

Recommendation – legal representation for families

- 1. PIAC recommends that there be sufficient resources made available via legal aid for families to obtain legal representation at coronial inquests.*
- 2. PIAC recommends that where a death in custody occurs that Corrective Services or the NSW Police appointed a specific liaison as a contact for the family to provide support and information in the early stages of the coronial process.*