CORONIAL RECOMMENDATIONS AND THE PREVENTION OF INDIGENOUS DEATH

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> *Coroners ... have a role to play in public health and safety; their recommendations as a result of inquests can pave the way for much-needed social and administrative change.*
>
> – The Honourable Marilyn L Warren AC,
> Chief Justice of the Supreme Court of Victoria[1]

I Introduction

This report details on a national study of the law and practice relating to coronial recommendations undertaken by the authors.[2] The study collected and analysed data on the implementation of coronial recommendations, and carried out a number of case studies which examined the factors impacting upon whether or not coronial recommendations were implemented. An initial aim of the research was to compare the implementation of coronial recommendations arising from Indigenous deaths with the implementation of those arising from non-Indigenous deaths. However, such a comparative study was abandoned when it became apparent that the recording of Indigenous status in relation to inquests is not wholly reliable.[3] It was realised that any meaningful exploration of coronial recommendations in relation to Indigenous deaths needed to be preceded by a national study of coronial recommendation implementation practices more generally. Unfortunately, no such study existed. This research attempts to provide such a study.

Coroners, part of State and Territorial justice systems, are responsible for the investigation of unexpected deaths. Coroners are also empowered to make recommendations aimed at avoiding preventable deaths. All Australian jurisdictions expressly provide for the right of a coroner to make recommendations or comments.[4] Increasingly, coroners bring a preventive focus to their investigations and, accordingly, have a vital role to play in the avoidance of Indigenous deaths.[5] A number of reports have pointed to the significant contribution coronial recommendations can make to the development of public policy and action to prevent avoidable deaths.[6] However, in most jurisdictions there is no statutory obligation on the agency or organisation to which the coronial recommendations are directed to consider or respond to them. Additionally, there is little publicly available information about whether or not coronial recommendations are in fact implemented and the Australian research in this area, although valuable, is limited in scope.[7] It is therefore not possible for governments, coroners or the community to assess the impact of coronial recommendations upon the prevention of deaths in Australia, generally or in any particular kind of death.[8] As Ian Freckelton has observed, it is important for the community to know which proposals are not implemented and the associated reasons. The reasons may be sound, or they may not be, but the families of the deceased and the community generally should be informed of them.[9]

As discussed in greater detail later, the study described in this report considered 185 coronial matters which produced 484 recommendations. The proportion of coronial recommendations implemented in the matters where responses were received by the study varied, from 27 per cent in Victoria, 41 per cent in Tasmania, 48 per cent in New South Wales, 50 per cent in Western Australia, 52 per cent in South Australia, 65 per cent in the Northern Territory and 70 per cent in the Australian Capital Territory. We obtained inadequate information about Queensland coronial recommendations and were therefore unable to include this jurisdiction in the study. However, in 2006, after our study was completed, the Queensland Ombudsman published a report of a study which it had undertaken into practices relating to the implementation of coronial recommendations

in that State. A summary of the Ombudsman's findings and recommendations relevant to our study is included later in this report.

The case studies undertaken and the data collected by our study indicate that a number of factors may affect implementation of coronial recommendations. These factors include:

- the feasibility of a coronial recommendation;
- whether or not implementation of a recommendation accords with government policies and priorities;
- the manner in which a recommendation is formulated or expressed by a coroner;
- the manner in which a recommendation is distributed or communicated by a coroner;
- whether or not a pro-active system for review of recommendations exists within the organisation to whom the recommendation(s) is directed;
- whether or not a mandatory system of reporting organisational responses to recommendations is in place;
- whether or not prior coronial recommendations arising out of similar deaths are drawn to the attention of relevant authorities by coroners or others;
- whether or not an inquest and its recommendations attract media attention; and
- whether or not some form of public advocacy accompanies the recommendation.

Of particular concern were our study's findings of the recurring instances where coronial recommendations had not been communicated or had been miscommunicated, or were lost within bureaucratic processes. In the absence of a legislative system which compels consideration and public report, this seems to be a factor which will hinder the consideration and implementation of recommendations into the future. One of the primary recommendations of the study is that uniform national legislation be enacted compelling public reporting of, consideration of, and response to, coronial recommendations.

So what are the implications of failings in the coronial system for Indigenous communities? Indigenous Australians are one of the most profoundly disadvantaged groups in contemporary Australian society; they continue to fall well below relevant national benchmarks on virtually every measure of wellbeing and socioeconomic status.[10] This profound disadvantage is reflected in Indigenous mortality, health, and injury statistics: Indigenous Australians can expect to die 17 years earlier than their non-Indigenous fellow Australians;[11] Indigenous babies are more than twice as likely to die within their first year;[12] death rates for Indigenous infants are about three times higher than the general Australian population;[13] compared to the rates for non-Indigenous Australians, hospitalisation rates for Indigenous people are higher for most diagnoses, including 14 times higher for care involving dialysis.[14] In the Northern Territory in 2006, the leading cause of premature death amongst Indigenous men was reported to be motor vehicle accidents, and amongst Indigenous women it was reported to be homicide.[15]

Indigenous communities face statistics such as these as a reality of their existence. It is therefore a matter of particular concern for Indigenous communities that coronial recommendations, aimed to prevent further avoidable deaths, are given appropriate consideration and implemented where it is appropriate to do so. A legislative system compelling consideration and response to these recommendations would represent a significant improvement in the situation that this study reveals currently exists.

II Context for the Development of Coronial Law in Australia

A The Royal Commission into Aboriginal Deaths in Custody

> *[T]horoughly conducted coronial inquiries hold the potential to identify systemic failures in custodial practices and procedures which may, if acted on, prevent future deaths in similar circumstances. In the final analysis adequate post death investigations have the potential to save lives.*
>
> – Royal Commission into Aboriginal Deaths in Custody, *National Report*[16]

The Royal Commission into Aboriginal Deaths in Custody ('RCIADIC') was established in October 1987, following public agitation led by members of the Indigenous community, amid growing public concern that there were too many Indigenous deaths in custody. In its *National Report*, handed down in 1991, the Royal Commission concluded that the high Aboriginal custodial death rate resulted not from any special propensity of Aboriginal people to die in custody but from their gross overrepresentation in custody.[17] This finding led the Royal Commission to explore the underlying causes of

Aboriginal overrepresentation in custody and to consider means for reducing the disproportionate incarceration of Indigenous people. The Royal Commission addressed the socially, economically and culturally disadvantaged position in which Aboriginal people find themselves and offered practical suggestions to reduce the risk of Indigenous incarceration and deaths in custody.

Revealed by the Royal Commission was the pervasive and troubling failure of the coronial structure in every State and Territory to supply the critical analysis needed to uncover the reasons for Aboriginal deaths in custody.[18] It was concluded that the failure of coronial inquests to uncover the underlying causes of Aboriginal deaths in custody and to recommend remedial action had contributed to the nation's massive failure to prevent many Indigenous deaths.

The Royal Commission's *National Report* provided an impetus for more widespread reform and modernisation of the coronial jurisdiction. It was concluded by the Royal Commission that Australian coronial systems should accord coroners the status and powers to enable comprehensive and coordinated investigations to take place. These investigations should lead to mandatory public hearings productive of findings and recommendations that seek to prevent future deaths in similar circumstances. The Royal Commission recommended an expansion of coronial inquiry from the traditional narrow and limited medico-legal determination of the cause of death to a more comprehensive, modern inquest; one that seeks to identify underlying factors, structures and practices contributing to avoidable deaths and to formulate constructive recommendations to reduce the incidence of further avoidable deaths.[19] The Royal Commission provides a timeless reminder that every avoidable Indigenous death calls upon us to identify its underlying causes, consider Indigenous disadvantage, uncover the truth about the death and resolve upon practical steps to prevent others.

A series of 34 fundamental and interrelated recommendations concerning the framework for the proper conduct of Indigenous death in custody investigations were made by the Royal Commission. Importantly, five of those recommendations referred to a system of communicating recommendations and reporting on their consideration and implementation.

B Reporting Scheme for Coronial Recommendations

It was emphasised by the Royal Commission that the effectiveness of coronial recommendations in reducing Indigenous death rates depends on proper consideration and response to recommendations by the government agencies responsible for their implementation. Recommendations 14–18 made by the Royal Commission provided for a public reporting and review system of coronial recommendations and responses by governments to them.

> Recommendation 14:
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> That copies of the findings and recommendations of the Coroner be provided by the Coroners Office to all parties who appeared at the inquest, to the Attorney-General or Minister for Justice of the State or Territory in which the inquest was conducted, to the Minister of the Crown with responsibility for the relevant custodial agency or department and to such other persons as the Coroner deems appropriate.
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> Recommendation 15:
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> That within three calendar months of publication of the findings and recommendations of the Coroner as to any death in custody, any agency or department to which a copy of the findings and recommendations has been delivered by the Coroner shall provide, in writing, to the Minister of the Crown with responsibility for that agency or department, its response to the findings and recommendations, which should include a report as to whether any action has been taken or is proposed to be taken with respect to any person.
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> Recommendation 16:
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> That the relevant Ministers of the Crown to whom responses are delivered by agencies or departments, as provided for in Recommendation 15, provide copies of each such response to all parties who appeared before the Coroner at the inquest, to the Coroner who conducted the inquest and to the State Coroner. That the State Coroner be empowered to call for such further explanations or information as he or she considers necessary, including reports as to further action taken in relation to the recommendations.

Recommendation 17:

> That the State Coroner be required to report annually in writing to the Attorney-General or Minister for Justice, (such report to be tabled in Parliament), as to deaths in custody generally within the jurisdiction and, in particular, as to findings and recommendations made by Coroners pursuant to the terms of Recommendation 13 above and as to the responses to such findings and recommendations provided pursuant to the terms of Recommendation 16 above.

Recommendation 18:

> That the State Coroner, in reporting to the Attorney-General or Minister for Justice, be empowered to make such recommendations as the State Coroner deems fit with respect to the prevention of deaths in custody.[20]

The scheme envisioned in these recommendations sought to make governments publicly accountable for their consideration of coronial recommendations aimed at reducing the Indigenous custodial death toll. In recommending the scheme, the Royal Commission gave the following rationale:

> the ultimate decisions on policy, procedures and practices of custodial authorities must reside with the government, relevant ministers or senior administrators. However, just as the holding of an inquest into a death in custody and the making of recommendations to prevent similar deaths are matters of public interest, equally it is in the public interest that some mechanism be established to ensure that the relevant authorities have received and considered those recommendations. It may well be, in some situations, that there are substantial reasons for not adopting the coroner's recommendations. It is not a question of compelling the government or public authorities to act on recommendations, but rather to ensure that they have received proper consideration.[21]

In this report we argue that a reporting scheme for coronial recommendations of the kind first envisaged by the Royal Commission should be applied to recommendations arising from all deaths investigated by a coroner.

After extensive consultation with the Aboriginal and Torres Strait Islander community and through the processes of a joint ministerial forum, the Commonwealth and all State and Territory governments responded to the Royal Commission's recommendations in 1992. The Commonwealth Government and all State and Territory governments supported recommendations 14, 15, 17 and 18. Only recommendation 16 failed to attract unanimous support, with South Australia, Tasmania and the Northern Territory not endorsing it.[22] Unfortunately, despite overwhelming support for the Royal Commission's scheme for mandatory reporting and review of coronial recommendations relating to deaths in custody, that scheme has not been uniformly implemented by legislation throughout Australia, almost two decades later.

C The Current Picture

There is no uniform national system which reports whether or not coronial recommendations have been implemented by responsible government agencies. Nor is there a uniform national scheme which ensures that coronial recommendations are properly considered by responsible government agencies. Furthermore, there is no system in place which ensures that all coronial recommendations arising from Indigenous deaths in Australia are recorded in a form readily accessible to those who could draw from them in helping to prevent Indigenous death – for example, Indigenous communities, Indigenous health workers, coroners, and government and private agencies with a responsibility for, or interest in, Indigenous wellbeing.

Only three jurisdictions, the Northern Territory, South Australia and the Australian Capital Territory, have legislation requiring any response to coronial recommendations by government agencies. In the Northern Territory this requirement applies to all matters in which recommendations are made that relate to a Northern Territory government agency or the police force.[23] In South Australia it applies only in relation to deaths in custody.[24] In the Australian Capital Territory it applies only in relation to deaths in custody and then only with respect to the custodial agency in whose care the person died.[25] Each of these three jurisdictions requires some form of public reporting of responses.[26]

In September 2006, after our study was completed, the Law Reform Committee of the Victorian Parliament, having carried out a review of the *Coroners Act 1985* (Vic), recommended many reforms of the coronial legislation in that State, some of which are also suggested in this report. Acknowledging that coronial investigations 'may be a wasteful exercise if the [resulting] recommendations can be ignored by those to whom they are directed', the Committee recommended the

introduction of a mandatory response regime in Victoria.[27] A mandatory response regime would ensure greater levels of accountability by placing responses on the public record, which would in turn increase the likelihood that coronial recommendations would be brought to the attention of department heads. According to the Committee, such a system would also place coroners' findings, comments and recommendations in the spotlight, ensuring a trend towards greater professionalism within the jurisdiction, while also providing coroners with the tools required to develop more effective recommendations. In addition, the responses would provide the data required for proper assessments of implementation rates and therefore of the effectiveness of the role of coroners. Finally, and importantly, by increasing levels of accountability, a mandatory response system would provide relief to grieving families who rightly demand systemic changes designed to avoid further deaths.[28]

The Committee maintained that the ability of the coronial system to prevent death and injury would be substantially improved by the implementation of the accountability framework recommended by the Royal Commission into Aboriginal Deaths in Custody, particularly the mandatory response regime which has been adopted in different forms in the Australian Capital Territory, the Northern Territory and South Australia. The Committee considered that limiting an accountability framework to deaths in custody would be 'too tentative and difficult to justify on a public policy basis, given the number of deaths which occur in circumstances involving noncustodial agencies.'[29] Advancing the Northern Territory legislation as 'a working example of a mandatory response system that applies to non-custodial matters',[30] the Committee recommended incorporation into Victorian legislation of a mandatory reporting scheme applying to all coronial recommendations.[31] Not only did the Committee consider that mandatory reporting should be required in relation to recommendations directed towards government departments and agencies, it considered that such reporting should extend to recommendations directed to incorporated companies and other private agencies, and to community organisations, peak organisations and individuals where appropriate.[32] The Committee also recommended the inclusion of a summary of all cases in which recommendations had been made in an annual report by the State Coroner's Office to be tabled in Parliament and a monitoring system for compliance with coronial recommendations.[33] In March 2007 the Victorian Government indicated that it preferred voluntary cooperation between the State Coroner's Office and government agencies to coordinate the consideration of and response to coronial recommendations rather than the mandatory legislative system recommended by the Committee.[34] In the result, the Coroners Bill 2008 (Vic), which came out of the Committee's review, contains no provisions relating to the consideration of and response to coronial recommendations by the agencies and organisations to whom they are directed.[35]

III The Research Study

The study considered 185 coronial matters which produced 484 recommendations. The coronial matters and recommendations resulting from them considered by the study were identified from the National Coroners Information Service ('NCIS'),[36] from State and Territory Coroners' websites and from Coroners' annual reports.[37] In Victoria, New South Wales, South Australia and Western Australia the matters considered were those from the 2004 calendar year.[38] This timeframe was extended for Tasmania, the Northern Territory and the Australian Capital Territory due to the small number of coronial matters producing recommendations in these smaller jurisdictions in the year 2004.[39] As mentioned earlier, we obtained inadequate information about Queensland coronial recommendations and were therefore unable to include this jurisdiction in the study.[40] However, in 2006, after our study was completed, the Queensland Ombudsman published a report of a study which it had undertaken into practices relating to the implementation of coronial recommendations in that State. A summary of the Ombudsman's findings and recommendations relevant to our study is included later in this report.

Once the recommendations were identified, a letter of request was sent to the body or person to whom the recommendations were directed, seeking information about implementation of the recommendations.[41] The letter of request asked, in summary: if the recommendation(s) had been implemented; if so, when the recommendation(s) was implemented; how the recommendation(s) was implemented; and if the recommendation(s) had not been implemented, why it had not been implemented. In a limited number of matters, in order to gain a more complete picture of organisational methods of processing and responding to coronial recommendations, requests were issued under freedom of information legislation requesting details of the communication of the recommendation, any discussion of the recommendation and any response to the recommendation.[42]

The study received responses to the majority of inquiries it made about implementation of coronial recommendations. These responses were categorised as described below. In a number of cases no response was received to the inquiries made by our study about implementation of coronial recommendations from the entities responsible for their implementation.[43] Once responses and freedom of information requests were received, each recommendation was categorised as:

- implemented;
- partially implemented;
- not implemented;
- already in place at the time of the recommendation;
- not referred to in the response; or
- insufficient information provided in the response.[44]

A recommendation was assigned to a particular category by an assessment process comparing the response to the text of the recommendation. Other external sources, including legislation, parliamentary debates, public policy documents, other coronial findings and recommendations and media reports, were consulted to assist with categorisation.

The study also carried out a number of case studies which undertook an exploration of factors affecting the implementation of coronial recommendations and an identification of failings in implementation processes. The case studies were compiled from the documentation provided by respondent organisations or obtained from them through freedom of information requests, and from the external sources mentioned above, including parliamentary debates and media reports. Often respondents did not explain why a recommendation had not been implemented. In such cases the external sources were relied upon to gain a better understanding of reasons for non-implementation.

Not all the case studies reported in our study have been included in this report. The case studies included are those which the authors believe best illustrate the variety of factors influencing implementation of recommendations and provide the clearest examples of the kinds of failings uncovered by the study in the organisational methods of processing and responding to coronial recommendations.

IV Data on the Implementation of Coronial Recommendations

A National Overview

As mentioned earlier, the study considered 185 coronial matters which produced 484 recommendations. The proportion of coronial recommendations implemented in the matters where responses were received by the study varied as follows:

- 27 per cent in Victoria;
- 41 per cent in Tasmania;
- 48 per cent in New South Wales;
- 50 per cent in Western Australia;
- 52 per cent in South Australia;
- 65 per cent in the Northern Territory; and
- 70 per cent in the Australian Capital Territory.

B New South Wales Data

The study investigated 24 matters in New South Wales in the 2004 calendar year, which produced 93 recommendations. Responses were received in relation to 47 of the recommendations. Of those 47 recommendations:

- 22 (48 per cent) were implemented;
- three (7 per cent) were already in place at the time of the recommendation;
- eight (17 per cent) were partially implemented;
- 11 (23 per cent) were not implemented; and
- two (4 per cent) did not have sufficient information provided to determine implementation.[45]

Forty-five of the 93 recommendations investigated by the study contained recommendations directed to the Minister for Health, the Director-General of Health or the Chief Health Officer of New South Wales. No responses were received in relation to any of these 45 recommendations.[46]

C Victorian Data

The study investigated 82 matters in Victoria in the 2004 calendar year, which produced 209 recommendations.[47] The study obtained information or received responses in relation to 138 of these 209 recommendations. Of these 138 recommendations:

- 37 (27 per cent) were implemented;
- 13 (9 per cent) were already in place at the time of the recommendation;
- 16 (12 per cent) were partially implemented;
- 23 (17 per cent) were not implemented; and
- 48 (35 per cent) either were not referred to in the response or did not have sufficient information provided to determine implementation.[48]

Of the 71 recommendations for which no response or information was received, 42 of these concerned health matters, 22 concerned police and seven concerned other entities.[49]

D South Australian Data

The study investigated 18 matters in South Australia in the 2004 calendar year, which produced 44 recommendations. The study received information in relation to 40 of these recommendations. Of these 40 recommendations:

- 21 (52 per cent) were implemented;
- two (5 per cent) were already in place at the time of the recommendation;
- six (15 per cent) were partially implemented;
- seven (18 per cent) were not implemented;[50] and
- four (10 per cent) did not have sufficient information provided to determine implementation.

E Western Australian Data

The study investigated 12 matters in Western Australia in the 2004 calendar year, which produced 34 recommendations.[51] Responses were received in relation to 16 of these recommendations. Of these 16 recommendations:

- eight (50 per cent) were implemented;
- three (19 per cent) were partially implemented;
- three (19 per cent) were not implemented; and
- two (12 per cent) did not have sufficient information provided to determine implementation.

F Tasmanian Data

The study investigated 16 matters in Tasmania in the 2002, 2003 and 2004 calendar years, which produced 29 recommendations.[52] Responses were received or information obtained in relation to 27 of the recommendations. Of those 27 recommendations:

- 11 (41 per cent) were implemented (with three already in progress at the time the recommendations were made);
- three (11 per cent) were already in place at the time of the recommendation;
- three (11 per cent) were partially implemented; and
- nine (33 per cent) were not implemented.[53]

G Northern Territory Data

The study investigated 24 matters in the Northern Territory in the 2003 and 2004 calendar years, which produced 65 recommendations.[54] Responses were received or reports obtained in relation to 63 recommendations. Of those recommendations:

- 41 (65 per cent) were implemented;
- three (5 per cent) were already in place at the time of the recommendation;
- seven (11 per cent) were partially implemented;
- six (9.5 per cent) were not implemented; and
- six (9.5 per cent) either were not referred to in the response or did not have sufficient information provided to determine implementation.

The Northern Territory is the only jurisdiction where coroners refer to the Indigenous status of the deceased in the text of their formal findings. Of the 24 matters for the 2003–04 period, 14 concerned Indigenous deaths, producing 36 recommendations. The remaining nine matters concerning non-Indigenous deceased produced 29 recommendations.

In relation to the 36 recommendations concerning Indigenous deaths:

- 21 (58 per cent) were implemented;
- two (6 per cent) were already in place at the time of the recommendation;
- three (8 per cent) were partially implemented;
- four (11 per cent) were not implemented; and
- six (17 per cent) either were not referred to in the response or did not have sufficient information provided to determine implementation.

In relation to the 29 recommendations arising from non-Indigenous matters, responses or reports were received in relation to 27 of the recommendations. Of those 27:

- 20 (74 per cent) were implemented;
- one (4 per cent) was already in place at the time of the recommendation;
- four (15 per cent) were partially implemented; and
- two (7 per cent) were not implemented.

H Australian Capital Territory Data[55]

This study investigated nine matters in the Australian Capital Territory in the 2002, 2003 and 2004 calendar years, which produced 10 recommendations.[56] Of these 10 recommendations:

- seven (70 per cent) were implemented;
- two (20 per cent) were not implemented; and
- one (10%) did not have sufficient information provided to determine implementation.

In one of the seven recommendations characterised as implemented, we were advised that the relevant bodies had not been notified of the recommendation. It would therefore appear that this recommendation was coincidentally put into place.

I Queensland

As noted earlier, we were unable to obtain adequate information about Queensland coronial recommendations and were therefore unable to include this jurisdiction in the study. In December 2006, after our study was completed, the Queensland Ombudsman published a report of an investigation, the Coronial Recommendations Project ('CRP'), it carried out into the administrative practice of Queensland public sector agencies in assisting coronial inquiries and responding to coronial recommendations.[57] What follows is a summary of the relevant aspects of the Queensland Ombudsman's *CRP Report*.

The CRP arose out of a detailed investigation that the Queensland Ombudsman conducted into workplace electrocutions in Queensland, known as the Workplace Electrocution Project ('WEP'). The *WEP Report* examined the adequacy of the responses of government agencies to nine fatal electrical incidents between 1995 and 1999. Each of those incidents was the subject of an inquest.[58] According to the Ombudsman, it became evident during the course of the WEP that, in many cases, little or nothing had been done by public sector agencies to assess and/or implement coronial recommendations designed to prevent deaths occurring in similar situations. To the Ombudsman's surprise, in a significant number of cases it was apparent that the relevant agencies had neither sought nor received a copy of the recommendations in question from the coroner and, in some instances, were unaware that recommendations had been made that concerned legislation they administered. Furthermore, where agencies were aware of recommendations and had agreed to implement them, there was no formal monitoring of the implementation of those recommendations by any independent entity. Accordingly, on most occasions, coroners and the families of the deceased were provided with no information as to what was being done by agencies to prevent a recurrence of the circumstances that had led to the fatal incident.

As a consequence, the Ombudsman decided to conduct an investigation to assess whether these problems evidenced the need for a coordinated system for ensuring that appropriate action was taken by public sector agencies in response to coronial recommendations. The CRP involved the analysis of 72 inquest reports prepared by Queensland coroners in 2002 and 2003 involving 23 agencies. The Project also considered the coronial inquests that were examined during the WEP.[59] Systemic problems that reduce the effectiveness of the coronial system in Queensland were reported by the Ombudsman, one of these problems being that no person or entity has the responsibility of monitoring whether public sector agencies properly consider and, in appropriate cases, implement coronial recommendations.[60] The Ombudsman also reported his view that, while the *Coroners Act 2003* (Qld) has satisfactorily addressed the communication of coronial recommendations to agencies, issues surrounding the formulation and implementation of recommendations remain problematic.[61]

According to the Ombudsman, his audit showed that, amongst other things, a significant reason for public sector agencies not implementing coronial recommendations is that the relevant agency considers that the recommendation is not soundly based or is not practicable,[62] and that the effectiveness of the coronial system is reduced by the fact that public sector agencies to which coronial recommendations are directed are not required to respond to those recommendations.[63]

The Ombudsman made a series of recommendations for amendments to the *Coroners Act 2003* (Qld). Amongst other things, the Ombudsman recommended an amendment to require that, where an agency has been notified by a coroner of a relevant coronial recommendation, the agency must, within six months of the notification, advise the coroner of the action taken or proposed to be taken to implement the recommendation or, if the agency does not intend to take action, its reasons for not doing so.[64] The Ombudsman recommended that the response of public sector agencies to coronial recommendations should be monitored and indicated his view that the Queensland Ombudsman is best placed to undertake this monitoring role.[65] The Ombudsman also recommended that public sector agencies (particularly those frequently involved in inquests) should appoint coronial liaison officers.[66]

V Case Studies

The data collected by our study indicated that a number of factors may affect implementation of coronial recommendations. These factors include:

- the feasibility of a coronial recommendation;
- whether or not implementation of a recommendation accords with government policies and priorities;
- the manner in which a recommendation is formulated or expressed by a coroner;
- the manner in which a recommendation is distributed or communicated by a coroner;
- whether or not a pro-active system for review of recommendations exists within the organisation to whom the recommendation(s) is directed;
- whether or not a mandatory system of reporting organisational responses to recommendations is in place;
- whether or not prior coronial recommendations arising out of similar deaths are drawn to the attention of relevant authorities by coroners or others;
- whether or not an inquest and its recommendations attract media attention; and
- whether or not some form of public advocacy accompanies the recommendation.

The case studies below reveal successes and failures in the coronial and governmental processes attaching to the implementation of recommendations, and illustrate other factors influencing the implementation of coronial recommendations.

A Process Successes

1 Mandatory Reporting

The data and the case studies show clearly that a mandatory reporting scheme provides an effective process through which coronial recommendations are communicated and responded to by responsible government agencies. As discussed before, the Northern Territory is the only jurisdiction in Australia that requires government agencies to respond to all coronial recommendations and for the tabling of such responses in Parliament. In the Northern Territory, unlike in other jurisdictions, there were no matters identified in the study from the 2003 and 2004 calendar years in which coronial recommendations were not communicated to the relevant government agency or were lost or neglected within a government agency. It may be that mandatory reporting is also a factor in implementation of coronial recommendations. In the data collected by the study, the Northern Territory achieved one of the highest rates of government agency implementation of recommendations.

2 Government Agency Internal Systems for Review of and Response to Coronial Recommendations: The WA Department of Health

The Western Australian Department of Health is an example of a government agency with an internal system for the review of and response to coronial recommendations. As discussed previously, the study investigated 12 matters in Western Australia in the 2004 calendar year, which produced 34 recommendations. Four of these inquests and eight of these recommendations concerned the Western Australian Department of Health. The Department responded to all of the inquiries made by the study about these recommendations and provided the study with evidence that all of the coronial recommendations directed to it had been seriously considered. Of the eight recommendations directed to the Department:

- five were implemented;
- two were partially implemented; and
- one was not implemented.

The only coronial recommendation not implemented by the Department of Health was considered by the Department to be beyond its jurisdiction.

The Western Australian Department of Health contains an Office of Safety and Quality in Health Care ('OSQH'). This office was established in 2002 and provides advice to the Minister of Health and the Department of Health on safety and quality issues.[67] That office has established a Coronial Liaison Unit, which incorporates into its processes lessons learned from coronial findings and recommendations. Coronial findings concerning health are now published at the OSQH section of the Department's website. (Three of the four matters considered in this study were published on that site.) In addition, in the 2004 and 2005 calendar years a new process was developed for consideration of coronial recommendations, including a flow chart demarcating the lines of responsibility for action on coronial recommendations and who must be advised of the recommendations and proposed action.[68]

The culture, policies and practices of the Western Australian Department of Health appear designed to encourage serious and effective consideration of, and responses to, coronial recommendations.

B Process Failures: Coronial Recommendations Lost, Neglected or Not Communicated

In contrast to the situation in the Northern Territory and the Western Australian Department of Health case study, the following case studies reveal failures in the processes attaching to the implementation of coronial recommendations. In these cases, drawn from New South Wales, South Australia, Tasmania and the Australian Capital Territory, coronial recommendations were either not communicated to the government agencies responsible for their implementation, or were lost or otherwise neglected by those agencies.

1 New South Wales Case Studies

A number of New South Wales case studies reveal coronial recommendations that were not communicated to the bodies to whom they were directed, or were lost or otherwise neglected by the New South Wales government agencies responsible for their implementation. In some cases, active consideration of coronial recommendations may only have been prompted by our study's request for information concerning implementation of a particular recommendation(s). In five government areas in New South Wales, namely, health, housing, energy, fair trading and police, the case studies reveal significant problems with government organisations responding to coronial recommendations. All matters investigated by the study in New South Wales were matters in which recommendations were made in the 2004 calendar year.

(a) New South Wales Health

In 2004 a number of coronial recommendations arising from deaths involving health care were made and directed by coroners to either the Director-General of the Department of Health, the Minister for Health or the Chief Health Officer of New South Wales. We inquired about the implementation of these health-related recommendations with the appropriate health authorities in early November 2005.[69] After our inquiries, the New South Wales Department of Health wrote to the New South Wales Coroner's Office and informed the New South Wales Coroner's Office that:

> the newly created Corporate Governance and Risk Management Branch of the NSW Department of Health has recently taken over the role of co-ordinating dissemination and follow up of recommendations from coronial reports.[70]

The Department's letter to the State Coroner goes on to indicate that it appeared that reports had not been received in two of the matters which our study had inquired about. The findings in these matters, one concerning a death in the course of a police pursuit and the other a workplace suicide, were handed down in August and November of 2004. The recommendations in these two matters were subsequently forwarded by the Coroner's Office to the relevant health authorities in early 2006.

(b) New South Wales Housing Commission

In this case, a Housing Commission tenant had died in Housing Commission premises and the tenant's body had remained undetected for over two and a half years. In May 2004, after an inquest into the death, the Deputy State Coroner recommended that the Department of Housing take action, such as 'follow-up' visits by client service officers, to ensure earlier detection of Housing Commission deaths. Our study revealed that, almost a year and a half after the Coroner made this recommendation, the Department responsible for

its implementation remained unaware of it. Following the issuing of a freedom of information request to the Department seeking documentation related to the recommendation, including the notification from the Coroner's Office and internal and interdepartmental communication about the recommendation, the Department advised that it did not hold the records we sought. Indeed, it appeared that the responsible Department only became aware of the recommendation as a result of our inquiries.[71] Either the Coroner failed to properly communicate this recommendation to the responsible Department or the Department failed to keep a proper record of the recommendation properly communicated by the Coroner.

(c) New South Wales Department of Energy, Utilities and Sustainability and the Office of Fair Trading

On 9 August 2004, findings were brought down by the Deputy State Coroner, Dorelle Pinch, in relation to the deaths of two women killed when they were electrocuted in their units due to an electrical fault. The Deputy State Coroner made the following recommendation addressed to the 'Minister for Energy':

> [That] Energy Suppliers and appropriate government organisations determine and implement the best way of educating the public about:
>
> 1. the installation of safety switches on lighting circuits as a desirable safety measure to prevent electrocution;
> 2. the use of a detection device to locate electrical wiring prior to inserting nails in floor, wall and ceiling surfaces as a desirable safety measure to prevent electrocution.[72]

Following our forwarding a letter to Carl Scully, the then Minister for Utilities, on 4 November 2005 inquiring into the implementation of these recommendations, we received a response from the Department of Energy, Utilities and Sustainability, dated 23 November 2005, advising that the matters were under consideration and that we would receive a reply as soon as possible. We received a further reply from the Parliamentary Secretary for Utilities, dated 19 December 2005, which advised that the recommendations were primarily the responsibility of the Minister and Office of Fair Trading. In response to a freedom of information request to the Office of Fair Trading in March 2006 seeking documentation relating to notification, communication and implementation of the recommendations, we were advised by the Office in April that no such documents were held. Soon after, the Minister for Fair Trading sent us a letter, which said that the Department of Energy, Utilities and Sustainability had referred the matter for consideration to the Industry Safety Steering Committee in December 2005 (which was, as it happened, after we had initially contacted that Department).[73] According to the Minister's letter, the Office of Fair Trading was awaiting the Steering Committee's advice.

It appears that the Deputy State Coroner's recommendations in August 2004 for safety measures to prevent electrocutions fell onto uncertain ground as to whose responsibility they were for follow-up. In the absence of any apparent system for follow-up or reporting, the safety recommendations appear to have remained in limbo, at least until our letter inquiring about the recommendations.

(d) New South Wales Police

Five New South Wales inquests examined in this study produced recommendations directed to the New South Wales Police – either to the Minister for Police, or to the Commissioner for Police. Those inquests concerned:

1. a death in a police car chase – recommendations were made on 1 July 2004 to the Commissioner of Police;
2. a death by suicide of a mental health patient – recommendations were made on 26 August 2004 to the Minister of Police and the Commissioner of Police;
3. an industrial death – recommendations were made on 19 November 2004 to 'NSW Police';
4. a death by self-inflicted stabbing in the course of a police pursuit – recommendations were made on 29 November 2004 to the Minister of Police and the Commissioner of Police; and
5. a death by drowning where the person had been reported missing – recommendations were made on 14 December 2004 to the Minister of Police and the Commissioner of Police.

Following correspondence in November 2005 between us, the Commissioner of Police and the Assistant Commissioner of Professional Standards in relation to Inquest 1, we were informed of the state of implementation of the recommendations coming out of that inquiry. For Inquests 2–5, however, the process of obtaining information about the

responses to and implementation of recommendations was more complex, as the following timeline shows:

- 8 November 2005: letter sent by us to the Commissioner of Police seeking information about the implementation of recommendations in Inquests 2–5.
- 25 November 2005: email sent by us to the Minister for Police seeking information as to the implementation of the recommendations in Inquests 2, 4 and 5.
- 25 November 2005: the New South Wales Police write to the Coroner in response to the recommendations in Inquest 5. Letter not forwarded to Coroner due to administrative error.[74]
- 20 December 2005: the Assistant Commissioner of Professional Standards indicates he is unable to respond to our inquiries and suggests we contact the State Coroner's Office, 'who received all of NSW Police's formal responses to coronial matters involving police'.[75]
- 21 December 2005: the Assistant Commissioner of Professional Standards writes to the Coroner in response to the recommendations in Inquest 3.
- 24 January 2006: the New South Wales Police write to the Coroner in response to the recommendations in Inquest 4. Letter not forwarded to Coroner due to administrative error.[76]
- 17 February 2006: the New South Wales Police write to the Coroner in response to the recommendations in Inquest 2.

  8 June 2006: the Police responses in relation to Inquests 4 and 5 forwarded to the Coroner.

Given that it had been at least a year between when the recommendations were made in Inquests 2–5 and when the New South Wales Police responses were finally received by the Coroner, and that these responses came after our inquiries to the Commissioner and Minister as to the status of those responses, the timing of these events raises the possibility that the police responses to these coronial recommendations were prompted by our inquiries. Weight is added to this possibility by the particular circumstances of Inquest 3. In that inquest, concerning an industrial death, one of the recommendations was for the New South Wales Police to examine the protocol between the Police and WorkCover relating to industrial death investigation. Our letter of inquiry was sent on 8 November 2005 and acknowledged on 22 November 2005. A response to the recommendations, indicating that the protocol had been examined on 8 November, was sent by the Commissioner of Police to the Coroner's Office on 21 November 2005. In the circumstances, it seems reasonable to conclude that our letter may have prompted the Commissioner's response to the Coroner. In relation to that same inquest, we had a similar experience with New South Wales WorkCover and the Minister for Commerce and Industrial Relations, whose responses to the relevant recommendations came only after we made inquiries, and over a year after the recommendations were originally made.[77]

2 South Australian Case Study

On 16 July 2004 the South Australian State Coroner brought down his findings and recommendations in relation to a homicide/suicide, where the perpetrator was known to be mentally ill. In the course of his findings, the Coroner discussed the importance of an updated Memorandum of Understanding ('MOU') between the South Australian Police and Mental Health Services in relation to their management of threats of violence, the Coroner ultimately recommending that the South Australian Police and Mental Health Services execute and implement an updated MOU without delay. The South Australian Director of Mental Health in the Department of Human Services, Dr Jonathon Phillips, provided a written response to the Coroner's recommendations on 10 March 2005. In relation to this MOU recommendation he advised:

> The MOU has been signed off by all parties except the South Australia Police (SAPOL). It is currently with SAPOL for consideration and sign-off. Once this has occurred, roll-out of the MOU will be progressed.[78]

We wrote to the South Australian Commissioner of Police on 9 November 2005 seeking information as to the implementation of this recommendation. We received a response dated 2 February 2006, which advised:

> In 2000 South Australia Police (SAPOL) established a Memorandum of Understanding (MOU) with Mental Health Services of the Department of Human Services in relation to service response to mental health issues. SAPOL is currently reviewing that MOU as part of the continuous improvement process.[79]

On 16 March 2006 we again wrote inquiring about the cause of the delay in the implementation of the Coroner's recommendation. We received the following response:

> There has been no delay in implementing the recommendation of Coroner Chivell as an MOU formed in 2000 was at that time and remains in operation; however, as I mentioned in previous correspondence, a review of that arrangement is being conducted.[80]

The Coroner's recommendation of July 2004 called for a revised MOU to be executed and implemented without delay. Mental Health Services expressed the view that all parties other than the Police had signed off on the MOU, but the Police were of the view that they had signed off on the MOU. There is clearly no meeting of minds in relation to the 'understanding'. The Coroner's recommendation has not been brought into effect.

3 Tasmanian Case Study

On 11 September 2003 the Tasmanian Coroner brought down findings in an inquest into to the death of a child who had drowned in a backyard pond. He commented that, despite the existence of building regulations relating to swimming pools and spas, the relevant legislation fails to address the potential dangers of ponds, and recommended that the legislative oversight be addressed at a local and national level. The recommendation was forwarded to the Tasmanian Police, KidSafe and the Department of Premier and Cabinet. After we contacted the Department of Premier and Cabinet, they advised that they had no record of receiving the recommendation, but that the relevant legislation and regulations had ceased to be the Department's responsibility prior to the Coroner's findings; they were now the responsibility of Workplace Standards Tasmania. On inquiry with Workplace Standards Tasmania, we were advised that they too had not received the recommendation, and further that swimming pool/pond fencing requirements are governed by the National Building Code of Australia, with the Australian Building Codes Board being the responsible body. As the trail of correspondence demonstrates, there appears to have been a breakdown in the communication of the recommendations in this child drowning inquest.

4 Australian Capital Territory Case Studies

(a) *Minister for Urban Services*

On 24 October 2003, following a motor vehicle death inquest, the Australian Capital Territory Coroner recommended that the Minister for Urban Services consider introducing legislation requiring that lap-sash seatbelts be retrofitted to vehicles without seatbelts. We wrote to the Minister for Urban Services on 14 December 2005, seeking advice in relation to the implementation of the recommendation. In a reply dated 8 February 2006, the Minister advised that

> no formal consideration of retro-fitting seat belts in vehicles has been undertaken as a result of the recommendation of the Coroner. However, a number of national considerations about retro-fitting seatbelts have been in progress ...[81]

In his letter, the Minister went on to detail a review being undertaken by the Australian Road Rules Maintenance Group. A search of the Department of Urban Services' website revealed a media release dated 30 January 2006 advising of the review by the Australian Road Rules Maintenance Group and encouraging public comment to the review.[82] The media release indicated that comments were to close on 3 February 2006. Given the date of our initial inquiry (14 December 2005), the short time frame between the issuing of the media release calling for public comment on the review and the date for close of comments (30 January to 3 February 2006), and the subsequent reply to our correspondence from the Minister (8 February 2006), it may be that our inquiry prompted Ministerial investigation of the recommendation. Alternatively, it may be coincidence.

(b) *ACT Health*

Another Australian Capital Territory inquest concerned the death of a mentally ill woman in a house fire. The Coroner in that inquest recommended that the Government consider wiring smoke detectors in government-owned premises back to a monitored base. Although the deceased woman was not at the time of her death resident in a psychiatric hospital, she was subject to an involuntary psychiatric treatment order under the *Mental Health (Treatment and Care) Act 1994* (ACT). Under s 3C(1)(e) of the *Coroners Act 1997* (ACT), deaths involving persons subject to orders under the *Mental Health (Treatment and Care) Act 1994* (ACT) are classified as deaths in custody.

Coronial recommendations arising out of deaths in custody should trigger the operation of compulsory reporting provisions. These require that the coroner report the findings to the responsible custodial agency and Minister, and to the Attorney-General, amongst others.[83] Further provisions also require that the responsible custodial agency give the

Minister a written response as to any action taken pursuant to the coronial recommendations, and the Minister must then forward that response to the coroner.[84] We made inquiries of ACT Health in relation to the implementation of the recommendations from the death in custody inquest, and received a response from the Chief Executive of ACT Health advising:

> ACT Health has not formally been notified of the Coroner's recommendations in relation to the inquest. However, the report of the Inquest has been obtained since receiving your letter.
>
> In response to the Coroner's report recommendation, I am advised that all properties managed and leased by ACT Health have either smoke or thermal detectors, which are hard wired and back to base monitored.[85]

In response to a freedom of information request we issued to the Office of the Attorney-General seeking documentation relating to the coronial recommendations, we received an undated letter (amongst other things) from the Chief Executive of the Department of Justice and Community Safety to the Chief Executive of ACT Health. The letter makes mention of s 75 of the *Coroners Act 1997* (ACT), a clear indication of the Department of Justice and Community Safety's view that the woman's death was a death in custody. In the 2004–05 *Annual Report*, the Australian Capital Territory Chief Coroner does not record the inquest into the death of the woman as a death in custody and makes the point that the law in relation to what is a death in custody needs to be examined.[86]

Deaths in custody are intended to receive the highest level of scrutiny under the Australian Capital Territory coronial legislation and the failure of communication in relation to the recommendation in this inquest is unfortunate.

C Other Factors Affecting the Implementation of Recommendations

1 Media Attention and Public Advocacy

The following case studies illustrate media attention and public advocacy as factors influencing implementation of coronial recommendations.

a) Child deaths involving blind cords in Tasmania and Victoria

The impact of publicity and lobbying is demonstrated by two remarkably similar child deaths that came before coroners in Tasmania and Victoria. In the Tasmanian case a toddler became entangled in a blind cord and was hung. The Coroner made recommendations aimed to prevent similar deaths. Subsequently, a child blind-cord hanging occurred in Victoria in almost identical circumstances to the Tasmanian toddler's death. On 28 July 2004, the Victorian State Coroner brought down his findings, which adopted the recommendations of the Tasmanian Coroner. The three recommendations were for: (1) the implementation of a public education program regarding the dangers of blind cords; (2) the adoption of an effective approach to render safe blinds and curtains already installed; and (3) the implementation of a mandatory safety standard for window coverings with cords to prevent the risk of infant strangulation. Recommendation 3 has been introduced in Tasmania, but as at the time our study was concluded was yet to be introduced in Victoria. We inquired of the peak body for the blind manufacturing industry and received a response which indicated that they had addressed recommendations 1 and 2 prior to the coronial recommendations being handed down in Victoria.

The deaths were very similar and the recommendations essentially identical, yet legislation had only been forthcoming in Tasmania and not in Victoria, so we attempted to find potential factors to explain the disparity. Our searches could not locate media reports in relation to the Victorian matter.[87] By contrast, media coverage was extensive in relation to the Tasmanian matter. The wide media coverage in relation to the death of the Tasmanian toddler appears to be, at least in part, in response to the public stance taken by the child's mother. The Tasmanian toddler's family also actively campaigned for change and has been acknowledged by authorities to have played a significant role in bringing about change in line with the Tasmanian Coroner's recommendations. This is demonstrated in the response of the Tasmanian Department of Justice to our inquiries about implementation of the recommendations:

> It must be acknowledged that [the child's mother] ... has been instrumental in gaining very significant promotion of the window furnishing safety message. She has been featured in numerous newspapers, television and magazine articles following the tragic death of her daughter. The coverage and

> the personal aspect has brought this to the attention of a very wide national audience. [88]

The mother of the Tasmanian toddler is also given credit for bringing about the change to the Tasmanian regulations. The *Hobart Mercury* reported:

> The State Government is to introduce new safety regulations banning the sale of hazardous blind and curtain cords.
>
> Labor backbencher David Bartlett said the new regulations were brought about by Hobart woman [D H].
>
> ...
>
> She says she is proud her two-year campaign for better regulations is about to start saving lives.
>
> 'We've been through a lot, but we've achieved a lot, ' said [D H].[89]

(b) Death of an elderly man after an altercation with a security guard in South Australia

In the following South Australian case study it appeared that media attention and attention focused by questions in Parliament contributed to the South Australian Government's implementation of a coronial recommendation. On 3 September 2004, the South Australian State Coroner brought down his findings and recommendations in relation to a 73 year old man who had died after an altercation with a security guard at a shopping centre. The elderly man had found a purse at the shopping centre, and had approached the information desk to leave his name and number in case the owner should appear. He was asked to leave the purse, which he declined to do, and was subsequently followed and confronted by the security guard. Having discussed the guard's knowledge of arrest laws, the Coroner recommended that the Minister for Business and Consumer Affairs review the level of training given to licensed security officers. The death, inquest and subsequent criminal action against the guard became the focus of significant media attention.[90] The deceased's death was also taken up by his local member, an Opposition member, who inquired about the Government's response to the Coroner's recommendations in the Legislative Assembly on 14 September and 20 September 2004. The issue raised by the recommendation was subsequently addressed in legislation.

(c) Multiple railway crossing deaths of people with disability in Victoria

On 2 April 2004, Victorian State Coroner brought down his findings and recommendations in relation to the death of a disabled man killed on a railway crossing. There had been two similar fatalities that had occurred within months of each other at railway crossings in metropolitan Melbourne. Each death occurred when the disabled person's wheelchair became trapped on the level crossing in the path of an oncoming train. In the Coroner's findings, it was noted that in addition to the two deaths there had been a number of near-misses in similar circumstances.

While the incidents themselves attracted media attention both when they occurred and through the course of the coronial inquest, the case for change appears to have been significantly assisted by disability advocacy groups. Disability advocates and the actions taken by them were the drivers behind the majority of the media reports, rather than reports being generated by the incidents or inquest themselves.[91] Media reports dealt with the response of advocates to the recommendations, comments by advocates on government action or inaction, legal action taken by advocates against the Government, or reports by advocates of near-misses similar to the fatal accidents.

Representations were also made to the Government by disability advocacy groups in meetings with the Victorian Transport Minister.[92] In addition legal action was taken under the *Human Rights and Equal Opportunity Commission Act* 1986 (Cth) seeking to make rail crossings as safe for wheelchair users as for able-bodied pedestrians.[93]

Whilst all recommendations have not been fully implemented, and no doubt criticism is still made about the level of implementation of various recommendations, it is apparent from the response provided by the Government that the recommendations are actively being considered and implementation is ongoing. Shortly after the second fatality, the Government established a Wheelchair Safety Taskforce, which is still in existence, tasked with addressing the issues.

2 Cumulative Effect of Coronial Recommendations on Implementation

It appears that in some cases the 'cumulative' effect of a number of similar recommendations can prompt action in

relation to implementation. The following Victorian case study illustrates that cumulative effect. On 18 October 2004, an inquest was held into the death of a man who was drowned when his boat capsized. He had not been wearing a lifejacket (or 'personal floatation device' – 'PFD'). The Coroner in the inquest made the following comment:

> Over the last 12 months or so, I have conducted Inquests into deaths by drowning in boating incidents of at least a dozen people and formed the firm view that almost all of the deceased would have survived had they been wearing an appropriate PFD. In virtually all cases, PFD's were on board, but the individual who drowned did not don the 'lifejacket'. I concluded it was perhaps time to legislate for constant wearing of PFD's, at least in small recreational vessels such as 'tinnies' and small 'drive-yourself' hire boats. I formally adopt those previous recommendations for the purposes of this matter.[94]

A search of the NCIS database revealed 14 matters containing recommendations concerning PFDs, the first of these matters being concluded on 27 May 2003.[95]

We wrote to Marine Safety Victoria on 29 November 2005 seeking information about implementation of the recommendation. We received a reply dated 12 December 2005, in which we were advised:

> Marine Safety Victoria ... has implemented new regulations effective 1 December 2005 requiring the occupants of small recreational vessels to wear personal floatation devices at all times, and the occupants of larger vessels at certain times of heightened risk.
>
> The new regulations have been implemented as a direct response to recommendations made by the State Coroner over recent years.[96]

These comments seem to demonstrate that, where coronial recommendations have been repeated across a series of inquests, this can have a positive effect on the implementation of those recommendations.

VI Conclusion

The case studies and the data provided by the study outlined in this report reveal recurring failures in the coronial and governmental processes attaching to the implementation of coronial recommendations. As the data shows, in the absence of mandatory reporting schemes, State and Territory government bodies sometimes had no or inadequate follow-up systems in place to ensure the proper consideration of coronial recommendations. In some cases this led to coronial recommendations being lost or otherwise neglected by the government authorities responsible for their implementation.

A coronial inquest represents a significant investment of public and private resources, both human and financial. Inquests bring individuals, families and communities into contact with the administration of justice at the most stressful of times. They provide government with an opportunity to pay their respects to the dead and those left behind. Inquests are lessons, hard-learned from the loss of individual lives, to benefit the whole community.

It is clear from the study documented in this report that some government departments have developed effective systems to ensure proper consideration of and response to potentially life-saving coronial recommendations. It is equally clear that some government departments have no effective system for monitoring and following through coronial recommendations intended to save lives. In relation to some deaths and the recommendations resulting from them, some government authorities did not or could not answer the simple question posed to them by the study: 'was this recommendation implemented?'

In the absence of effective government systems for responding to coronial recommendations, the implementation of recommendations is ad hoc. The prospects for the implementation of coronial recommendations intended to save lives are improved by such fortuitous factors as media pressure, advocacy group intervention, and family and community action. But proper consideration of coronial recommendations arising out of unfortunate and avoidable individual death is simply too important an issue to leave to chance. It is a matter of proper respect for the dead, compassion for their families and communities, and a serious commitment to 'speak for the Dead to protect the living'.[97]

In our view it is as necessary for governments to legislate to require government responses to coronial recommendations as it is for governments to legislate to enable coroners to make those recommendations. In all jurisdictions, the coronial process is a public one. Coronial recommendations are

publicly recorded and publicly made. Equally, government responses to coronial recommendations should be recorded and made public.

The Northern Territory provides the benchmark for a legislative system to ensure all coronial recommendations are properly communicated, seriously considered and responded to by government. It has the most comprehensive legislative scheme for government reporting and response to coronial recommendations. It has one of the highest rates of government implementation of recommendations. Unlike some other jurisdictions, its scheme appears to ensure that potentially life-saving coronial recommendations are not lost or otherwise neglected by government authorities. South Australia has recently introduced a legislative scheme for government reporting on the implementation of coronial recommendations, but only in relation to deaths in custody. The Australian Capital Territory provides a less vigorous reporting scheme, again only for death in custody matters. No other Australian State or Territory has a legislative system for monitoring government responses to coronial recommendations.

RCIADIC sought to render the coronial justice system a more effective contributor to the prevention of Indigenous deaths in custody. The Royal Commission arose as a response to the Indigenous disadvantage revealed by Indigenous deaths in custody. However, many of the Royal Commission's recommendations for coronial reform apply not only to Indigenous deaths in custody but to coronial systems and processes generally and would benefit all Australians, Indigenous and non-Indigenous alike. Likewise, legislative reforms relating to implementation of coronial recommendations can and should be applied to all avoidable deaths.

Where Indigenous people die 17 years younger than their non-Indigenous counterparts in the general population, it is clear that effective government responses to coronial recommendations designed to avoid every kind of Indigenous death is as important a human rights issue as the issue of Indigenous deaths in custody. If coronial recommendations are sufficiently important to make, they are sufficiently important to respond to, and legislative reporting requirements should, therefore, apply to all coronial recommendations.

In the view of the authors, Commonwealth, State and Territory governments should cooperate to introduce uniform national coronial legislation which provides a mandatory reporting and review scheme for all coronial recommendations. A mandatory reporting scheme would ensure that organisations responsible for the implementation of coronial recommendations are publicly accountable for their responses to recommendations and would safeguard against the kinds of process failings associated with the implementation of coronial recommendations identified by our study. Introduction of a uniform national coronial reporting and review scheme would be a constructive public health initiative strengthening government efforts to prevent Indigenous deaths, including deaths in custody. The potentially vital role of the coroner in avoiding Indigenous deaths will continue to be under-utilised and coronial efforts to reduce Indigenous deaths compromised until such a scheme is implemented.

Introduction of a uniform and universal reporting scheme, evolving from the recommendations of the Royal Commission, would also mean that lessons hard-learned from Aboriginal adversity had finally come to benefit the whole Australian community. Many lives could be saved.

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1 Chief Justice Marilyn Warren, 'Foreword' in Ian Freckelton and David Ranson, *Death Investigation and the Coroner's Inquest* (2006) v.

2 The report was finalised in August 2006. Ethics approval for access to the coronial data used in the study was conditional on our undertaking not to disclose the identity of the deceased. We are, therefore, precluded from providing identifying details of the particular inquests referred to in this report. Those details are on file with the authors.

3 For example, at present the Northern Territory is the only Australian jurisdiction which routinely includes the deceased's Indigenous status in the text of its coronial findings. In the NCIS, the nationwide coronial database, the percentage of matters in which Indigenous status is recorded as 'unlikely to be known' is 89 per cent in South Australia and 20 per cent in Victoria.

4 *Coroners Act 1997* (ACT), s 52(4); *Coroners Act 1980* (NSW), s 22A; *Coroners Act* (NT), ss 26(1)(a)–(b), 26(2) and 35(2); *Coroners Act 2003* (Qld), s 46; *Coroners Act 2003* (SA), s 25(4); *Coroners Act 1995* (Tas), s 30(2); *Coroners Act 1985* (Vic), s 19(2) (comment); *Coroners Act 1996* (WA), s 25(2) (comment).

5 That preventive focus is reinforced by coronial legislation in some jurisdictions and by recommendations for coronial reform. For example, the 'objects' provision of the *Coroners Act 2003* (Qld), s 3(d), declares that the Act is intended to ' 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 public health or safety or the administration of justice.' In September 2006, the Law Reform Committee of the Victorian Parliament, which carried out a review of the *Coroners Act 1985* (Vic), recommended amendments to include the preventive role of the coroner as a purpose of the Act and to include a provision placing a positive duty on coroners to make recommendations in appropriate cases. Law Reform Committee, Parliament of Victoria, *Coroners Act 1985: Report* (2006) ch 7 <http://www.parliament.vic.gov.au/LAWREFORM/inquiries/Coroners%20Act/final%20report.pdf> at 20 November 2008. As a result of the Committee's review, the Victorian Government has introduced the Coroners Bill 2008, which makes death prevention one of its purposes: s 1(c). See also the preamble to the Bill.

6 See, eg, Hal Hallenstein, *The Coroner's Investigation – A Social Catalyst*, State Coroner's Office of Victoria (1992); Victorian State Coroner Johnstone, *Inquiry into Deaths in Custody at Port Phillip Prison* (2000) 297; Ian Freckelton, 'A Glimpse of the Future: The *Coroners Act 1997* (ACT)' (1998) 6 *Journal of Law and Medicine* 26; Justin Malbon, 'Institutional Responses to Coronial Recommendations' (1998) 6 *Journal of Law and Medicine* 35. See also Victorian State Coroner's Office, *Inquest Findings, Comments and Recommendations into Fire and Nine Deaths at Kew Residential Services on 8 April 1996* (1997) 292–340.

7 See especially, Lyndal Bugeja and David Ranson, 'Coroners' Recommendations: A Lost Opportunity' (2005) 13 *Journal of Law and Medicine* 173; Lyndal Bugeja and David Ranson, 'Coroners' Recommendations: Do They Lead to Positive Public Health Outcomes?' (2003) 10 *Journal of Law and Medicine* 399; Boronia Halstead, *Coroners' Recommendations and the Prevention of Deaths in Custody: A Victorian Case Study*, Australian Deaths in Custody Publication No 10, Australian Institute of Criminology (1995).

8 Freckelton and Ranson comment that '[t]here are as yet no data on the extent to which coroners' recommendations have been implemented or have even been capable of implementation.' See Freckelton and Ranson, above n 1, lvii.

9 Ian Freckelton, 'The Myers Oration 2005: Untimely Death, Law and Suicidality' (2005) 12(2) *Psychiatry, Psychology and Law* 265.

10 See, eg, Brian Pink and Penny Allbon, *The Health and Welfare of Australia's Aboriginal and Torres Strait Islander Peoples*, Australian Bureau of Statistics and Australian Institute of Health and Welfare (2008); Steering Committee for the Review of Government Service Provision, *Overcoming Indigenous Disadvantage: Key Indicators 2007*, Productivity Commission (2007).

11 See Pink and Allbon, above n 10, xxii; Australian Institute of Health and Welfare, *Australia's Health 2008* (2008) 68–9 <http://www.aihw.gov.au/publications/aus/ah08/ah08.pdf> at 21 November 2008; Standing Committee on Aboriginal and Torres Strait Islander Health and Statistical Information Management Committee ('SCATSIHSIMC'), *National Summary of the 2003 and 2004 Jurisdictional Reports Against the Aboriginal and Torres Strait Islander Health Performance Indicators*, Australian Institute of Health and Welfare (2006) 48 <http://www.aihw.gov.au/publications/ihw/ns03-04jratsihpi/ns03-04jratsihpi.pdf> at 20 November 2008. But see Brian Pink, *Discussion Paper: Assessment of Methods for Developing Life Tables for Aboriginal and Torres Strait Islander Australians*, Australian Bureau of Statistics (2008).

12 SCATSIHSIMC, above n 11, 51.

13 Pink and Allbon, above n 10, 185; Australian Institute of Health and Welfare, above n 11, 277.

14 Australian Institute of Health and Welfare, above n 11, 74.

15 See 'Culture of Violence Revealed in Central Australia', *ABC News* (online), 16 May 2006, <http://www.abc.net.au/news/newsitems/200605/s1639145.htm> at 21 November 2008; Ben Haywood, 'Our Violent Heart', *The Age* (online), 29 May 2006 <http://www.education.theage.com.au/pagedetail.asp?intpageid=1643&strsection=students&intsectionid=0> at 21 November 2006.

16 Commonwealth, Royal Commission into Aboriginal Deaths in Custody ('RCIADIC'), *National Report* (1991) vol 1, [4.7.4].

17 Ibid, vol 1, ch 5.

18 Ibid, vol 1, ch 4 (especially [4.5]). According to the Royal Commission, '[i]n the few cases where coroners did pursue these matters the issues raised were frequently not brought to the notice of the relevant authority and certainly not to the notice of the public': ibid, vol 1 [1.10.3].

19 See ibid, vol 1, ch 4.

20 Ibid, vol 1, [4.7.4].

21 Ibid, vol 1, [4.5.97].

22 The position of the South Australian Government at the time was that 'the State Coroner should not be put into a policing role' and that '[i]t is a matter for Ministers to follow up on agency action.' See *Aboriginal Deaths in Custody: Response by Governments to the Royal Commission* (1992) 59. A similar sentiment was expressed by the Tasmanian Government: 'it is not believed that the Coroner should be further involved once he/she has delivered a finding and made recommendations to the Government regarding the particular death in question. It is inappropriate for the Coroner to be seen to be policing the Government's response to his/her recommendations.' Tasmania Department of Premier and Cabinet, *Aboriginal Deaths in Custody: Tasmanian Government Progress Report on Implementation to December 1993* (1995) 35. The Northern Territory Government at the time stated that 'a continuing role for the coroner in following up implementation cannot be supported. It confuses the separation of judicial and executive powers. Once the coroner has reported, the coronial function is at an end. The responsible Minister then becomes publicly accountable for any decision to reject the recommendations or failure to implement them. The coroner, a judicial officer, cannot be involved in this process.' See *Aboriginal Deaths in Custody: Response by Governments to the Royal Commission* (1992) 59.

23 *Coroners Act* (NT), ss 46A, 46B.

24 *Coroners Act 2003* (SA), s 25.

25 *Coroners Act 1997* (ACT), ss 75, 76.

26 *Coroners Act* (NT), s 46B(3); *Coroners Act 2003* (SA), s 25(5); *Coroners Act 1997* (ACT), s 102.

27 Law Reform Committee, Parliament of Victoria, above n 5, ch 7, 406.

28 Ibid, ch 7, 407. Freckelton has also pointed to the wider benefits of a mandatory institutional response scheme in relation to coronial recommendations arising out of deaths occurring outside of custody contexts. According to Freckelton, such a scheme would 'shine the spotlight of accountability on coroners. It would enable evaluation of the effectiveness of their contemporary role. Importantly too, it would enable the community to assess whether recommendations and suggestions proffered by coroners are informed, appropriate and worthy of implementation. While giving coroners "teeth", in the limited sense of their comments and recommendations having to be the subject of prompt institutional response, would change the place of coroners within both the legal and public health systems, it may well be that it would transform coroners into entities of real, ongoing relevance.' Freckelton, 'The Myers Oration: 2005 Untimely Death, Law and Suicidality', above n 9, 275.

29 Law Reform Committee, Parliament of Victoria, above n 5, ch 7, 407.

30 Ibid.

31 The Committee recommended that the Victorian *Coroners Act 1985* be amended to incorporate the proposals in RCIADIC recommendations 15, 16 and 17, but that the application of the accountability framework be extended beyond deaths in custody: ibid.

32 Ibid. Additionally, in contrast to the timeframe envisaged by the Royal Commission's recommendation 15, the Committee considered that a timeframe of six months for responses to coronial recommendations would allow adequately for consideration of recommendations directed towards complex systemic problems.

33 The Committee considered that mandatory responses should be subject to an assessment process undertaken by a research unit within the Coronial Services Centre, the report of which should also be included in the Coroner's Annual Report and on the Coroner's website. Coroners would have access to this system to contribute to their decision making but the Committee was of the opinion that coroners should be able to focus on the task of investigating cases rather than monitoring compliance. The Committee envisaged that the Coroner's Office could play a role in following up recommendations which it considers to have particular public importance and therefore recommended that coroners be given the power under the Act to call for additional information in relation to the implementation of recommendations and that guidelines be developed to determine the parameters within which this power would be exercised. Law Reform Committee, Parliament of Victoria, above n 5, ch 7, 408.

34 Government of Victoria, *Government Response to the Victorian Parliament Law Reform Committee's* Coroners Act 1985 – *Final Report* <http://www.parliament.vic.gov.au/LAWREFORM/inquiries/Coroners%20Act/govt%20resp.pdf> at 21 November 2008.

35 The Coroners Bill 2008 (Vic) was introduced into the Victorian Parliament on 9 October 2008. See Victoria, *Parliamentary Debates*, Legislative Assembly, 9 October 2008, 4033ff (Rob Hulls, Attorney-General) for the second reading speech of the Bill.

36 RCIADIC recommended that 'Coroners Offices in all States and Territories establish and maintain a uniform data base

to record details of Aboriginal and non-Aboriginal deaths in custody': RCIADIC, *National Report*, above n 16, vol 1, [4.7.4] (recommendation 40). The NCIS is the national coronial database collating information about coronial matters. It was advertised to contain information about every death reported to an Australian coroner since July 2000, or January 2001 for Queensland. See NCIS, *About NCIS* <http://www.ncis.org.au/> at 21 November 2008. Unfortunately, throughout our study we found a number of deficiencies in the data recorded in the database. Where that is relevant to this report those deficiencies are explained. The NCIS *Annual Report* for 2004–05 notes that, of the 14 329 cases in which coding was reviewed in that period, 32.3 per cent of matters contained at least one critical error: see NCIS, *Annual Report 2004–05* (2005) 11 <http://www.vifp.monash.edu.au/ncis/web_pages/NCIS%20Annual%20Report%200405.pdf> at 21 November 2008.

37 In Western Australia, the time taken to pursue the application process for access to NCIS data was prohibitive and therefore all Western Australian inquests were taken from the Office of the State Coroner's *Annual Reports*. See Coroner's Court of Western Australia, *Publications* <http://www.coronerscourt.wa.gov.au/P/publications.aspx?uid=3381-1551-3746-1537> at 21 November 2008.

38 This period allows reasonable time for implementation of the recommendations, but the matters also remain current and relevant.

39 Australian Capital Territory and Tasmania, 2002–04; Northern Territory, 2003–04.

40 The NCIS search for Queensland returned only seven inquests from July 2001 to June 2006 in which recommendations had been made. All of these were completed/finalised prior to the 2004 period under investigation. A simple media search is sufficient to establish that this information is inaccurate and a large number of cases are simply not recorded on the database.

41 Where it was not sufficiently clear from the text of the recommendation which organisation the recommendation was directed to, inquiry was made of the relevant State Coroner's Office to identify the organisation to whom the recommendation was forwarded. In the Northern Territory, where legislation mandates a system of reporting to Parliament on consideration of recommendations in the majority of matters, the reports to Parliament were generally obtained rather than sending letters of request.

42 Depending on the specifics of the particular recommendation, freedom of information requests sought copies of: notification of the recommendations received by the organisation from the relevant State Coroner's Office; records of all internal communication of the recommendation, including communications by email; records of all external and interdepartmental communications relating to the recommendation, including communications by email; agenda and minutes of meetings in which the recommendation and its implementation were discussed, including interdepartmental and interagency meetings; any policy/ strategy document(s) developed to address the recommendation; and any record of communication with the relevant State Coroner's Office in response to the recommendations.

43 There may be a number of reasons why organisations provided no response, or provided responses which did not address the questions asked. Non-responses may simply indicate busy organisations who have no time, inclination or obligation to contribute to a research study. Non-responsiveness may also be because an organisation is reluctant to disclose voluntarily that it has taken no action to implement a recommendation, or it may be that an organisation cannot answer questions about the implementation of coronial recommendations because it has no effective system for processing coronial recommendations and responses to them.

44 The categories of 'implemented' and 'not implemented' are self-explanatory. Matters were classed as 'partially implemented' where only part of the recommendation had been implemented. These included instances where action called for in the recommendation had been commenced but not completed by the relevant organisation at the time of its response. Partially implemented recommendations also included recommendations which called for the general introduction of a policy or practice, but which had been implemented in a more limited way. An example would be where the uniform adoption of a particular policy or practice had been recommended across all hospitals but the policy or practice was implemented in relation to only one hospital. Partially implemented recommendations also included recommendations directed to more than one body which had only been implemented by one or some of the bodies. The category of 'already in place at the time of the recommendation' covers both those matters where changes were made after the death but before the recommendation was made, and those where the coroner's recommendation was already in place at the time of the death. Many respondents, however, did not provide information about when recommendations were implemented. In these cases other sources were consulted to determine the timing of the claimed initiatives. Matters in which there was a doubt about the timing of changes have been categorised as 'implemented', rather than 'already in place at the time of the recommendation'. The category of 'not referred to in the response' refers to matters where the respondent did not address the recommendation or refused to

answer. The category of 'insufficient information provided in the response' refers to matters where the information provided did not enable a determination of whether the recommendation had been implemented. It also refers to responses which recorded general initiatives or procedures in the subject area of the recommendation that did not address the particular recommendation.

45 One recommendation was no longer applicable because the condition precedent was not implemented.

46 These 45 health recommendations were contained in 13 of the 24 NSW matters investigated by the study.

47 Victoria produced significantly more coronial recommendations than any other coronial jurisdiction. The most accurate and extensive record of coronial information on the NCIS system is in relation to Victoria. The significantly larger number of coronial recommendations in Victoria may in part be a result of this better data reporting and/or recording. It may also reflect a more pro-active coronial culture. Coronial data for the study for Victoria was taken exclusively from the NCIS system. The study did not include a number of matters identified on the NCIS database as having recommendations made. This was because in our analysis these matters did not contain recommendations. Examples include matters in which a coroner made a general statement directed to public debate that fell short of a 'recommendation', matters in which a coroner made a suggestion expressly or implicitly stopping short of a 'recommendation', and matters in which a coroner did not make a recommendation but merely ordered the distribution of reports or previous findings to relevant bodies for information.

48 One recommendation was rendered irrelevant by non-implementation of a recommendation which was a condition precedent.

49 In the early stages of the study we were advised that both the Victorian Police and the Department of Human Services (which has responsibility for health) collate the recommendations relevant to their fields and report back to the State Coroner's Office on implementation outcomes. We attempted to access these reports, first by letters of request dated 3 and 7 November 2005 and subsequently by freedom of information applications forwarded on 9 and 17 February 2006. We received a response from the Department of Human Services on 7 July 2006 that included the Department's responses to the State Coroner in relation to eight of the 36 coronial matters concerning health. Due to the date for completion of this project, further follow up on the remaining 28 coronial inquests was not possible. We had not received a response to the freedom of information application made to the Victorian Police in relation to implementation of coronial recommendations as at 30 June 2006, the date of completion of the study.

50 This figure includes two matters in which the recommendations were apparently not forwarded to bodies with the capacity to act upon them; and therefore no correspondence was forwarded inquiring as to implementation.

51 As previously explained, the main source of coronial data in this study for other jurisdictions was taken from the NCIS database. However, we were unable to gain access to NCIS data in relation to Western Australia within the time frame for this study. Accordingly, all coronial matters for Western Australia were taken from the 2004 calendar year and were identified from the Office of the State Coroner's *Annual Reports* to Parliament: see Coroner's Court of Western Australia, above n 37. Whilst all death in care or custody matters are recorded in these reports, only some of the non-care or -custody matters are reported. The Western Australian data therefore represents a more limited picture of the recommendations made in that State than in the other jurisdictions reported on in this study. In addition, given the delay in accessing data, letters inquiring about implementation of the various recommendations were sent out about four months after those sent to the remainder of the States. As such, the non-response rate perhaps cannot be attributed such significance as is the case in the other jurisdictions.

52 The study did not include a number of Tasmanian matters identified on the NCIS database as having recommendations made. This is because in our analysis these matters did not contain recommendations. An example would be matters in which a coroner made a statement which was too vague or general, or addressed too broadly to be properly regarded as a recommendation and to enable follow up on implementation.

53 One was rendered redundant by subsequent government action.

54 The Northern Territory is the only jurisdiction with a mandatory system of government agency reporting to Parliament on responses to all coronial recommendations. Accordingly, in relation to most matters, the reports to Parliament were obtained rather than letters of request sent off to the relevant parties.

55 In relation to death in custody cases, the ACT legislation requires a response from custodial agencies in a report back to the Minister and Coroner. However, unlike in the Northern Territory and South Australia, these reports are not required to be tabled before Parliament within a relatively short space of time. A review of the *Annual Reports*, provided by the Chief Coroner pursuant to s 102 of the *Coroners Act 1997* (ACT), for the years 2001–02, 2002–03, 2003–04 and 2004–05 reveals that responses to death in custody recommendations (and correspondence in relation to those responses) are frequently not recorded in the *Annual*

Reports, despite this being required by the Act. In the 2001–02 *Annual Report*, one death in custody matter is reported in which recommendations were made. The Report noted that formal findings were made in court on 25 July 2000. No response or correspondence in relation to a response were recorded in the Report: see ACT Department of Justice and Safety, *Annual Report 2001–2002* (2002) 225–6. A response to this matter is, however, recorded in the 2002–03 *Annual Report*, which was presented to the Attorney-General on 5 September 2003: see ACT Department of Justice and Safety, *Annual Report 2002–2003* (2003) 242–5. Assuming the recommendations were made at the time of the formal findings, this response entered the public arena in excess of three years after the recommendations were made. No other recommendations were reported in the 2002–03 *Annual Report* as arising from inquests into deaths in custody. In the 2003–04 *Annual Report*, the Coroner reports lengthy recommendations in relation to a death in custody (CD 94/01): ACT Department of Justice and Safety, *Annual Report 2003–04* (2004) 179–82. No response or correspondence in relation to the response is recorded in the Report. Nor are these documents recorded in the *Annual Report* for the next year. In the 2004–05 *Annual Report* it is indicated that a number of death in custody inquests were heard during the year; however, recommendations had not been formalised and would be reported in the next year's Report: ACT Department of Justice and Safety, *Annual Report 2004–05* (2005) 138. This delay from the time of the inquest to the reporting of the recommendations, and then to the reporting (if any) of a response, is such a long process that it seems the matters fade very easily from the public eye. It is apparent that the reporting system set up by the ACT legislation results in responses to coronial death in custody recommendations not being as open to public appraisal and scrutiny as those, for example, in the Northern Territory system. This lack of public focus appears to have resulted in a failure of the reporting system in those years investigated in this study.

56 All matters from the ACT were sourced from the NCIS. It was apparent that the coronial matters in which recommendations were made that we identified from the NCIS database did not represent all of the matters in which recommendations were made in the ACT for that period. In addition, all the coronial recommendations located on the NCIS were recommendations of the one coroner, Mr Phillip Thompson. We are unable to comment upon the impact of the fact that the recommendations of only one coroner were produced by the NCIS search. It may be that this coroner produced more effective recommendations than other coroners; however, we have no data on which to reach any conclusions.

57 Queensland Ombudsman, *Report of the Queensland Ombudsman: The Coronial Recommendations Project* (2006) ('*CRP Report*').

58 Queensland Ombudsman, *Report of the Queensland Ombudsman: The Workplace Electrocution Project* (2005) xi.

59 Prior to 1 December 2003, Queensland coronial recommendations (made under the *Coroners Act 1958* (Qld), which operated until repealed and replaced by the *Coroners Act 2003* (Qld)) were not required to be communicated by the coroner to the relevant pubic sector agency and Minister. After 1 December 2003, as a result of the commencement of the operation of the *Coroners Act 2003* (Qld), Queensland coroners are required to notify the relevant public sector agency and Minister of recommendations.

60 Queensland Ombudsman, *CRP Report*, above n 57, v.

61 Ibid xiii, 20–6.

62 Ibid 15.

63 Ibid xiii, 31.

64 Ibid 31. Allied to this recommendation were two other amendments: one to require public sector agencies to provide details in their annual reports of coronial recommendations directed to the agency and the agency's response to those recommendations; and one to require the State Coroner to provide particulars of findings and coronial recommendations that relate to public sector agencies to the Office of the Queensland Ombudsman at the same time such information is provided to the agencies. Ibid 31, 38.

65 Ibid 37.

66 Ibid 33.

67 See WA Department of Health, *Office of Safety and Quality in Healthcare: About Us* <http://www.health.wa.gov.au/safetyandquality/about/index.cfm#key> at 21 November 2008.

68 See WA Department of Health, *Annual Report 2004–05* (2005) 20 <http://www.health.wa.gov.au/publications/documents/annualreports/2005/Department%20of%20Health%20Annual%20Report%202004-05.pdf> at 21 November 2008.

69 On 4 and 8 November 2005 we sent letters inquiring about the implementation of these health-related recommendations to either the Director-General of the Department of Health, the Minister for Health or the Chief Health Officer of New South Wales, as they were directed by the Coroner.

70 Letter from NSW Department of Health to NSW Coroner's Office, 19 December 2005 (copy on file with authors).

71 On 4 November 2005, we forwarded a letter to the Director-General of Housing inquiring about implementation of this recommendation. On 24 November 2005, we were contacted by an officer of the Department of Housing charged with preparing the response to our inquiry about implementation of the

recommendation. We were asked if we had a copy of the findings, 'to put the recommendations into context', and were advised that the recommendation was not in the client file. We undertook to try to assist the Department of Housing officer to obtain the findings and made contact with the State Coroner's Office. The State Coroner's Office advised us that in order to obtain a transcript of the findings the Department would need to pay for a copy. Following inquiries made as to whether the Department was represented at the inquest, we were advised that it was not. We understand that in order to prepare a response to our inquiry the Department of Housing did pay for and obtain a copy of the findings.

72 See above n 2.

73 Letter from Diane Beamer, Minister for Fair Trading, to the authors, 18 April 2006 (copy on file with authors).

74 Letter 1 from NSW Police to the State Coroner, 8 June 2006 (copy on file with authors).

75 Letter from Assistant Commissioner of Professional Standards to the authors, 20 December 2005 (copy on file with authors).

76 Letter 2 from NSW Police to the State Coroner, 8 June 2006 (copy on file with authors).

77 As noted, the recommendations were handed down on 19 November 2004. We made an inquiry to WorkCover on 20 March 2006. While documents obtained from a freedom of information request appear to indicate that some efforts were made during 2005 to prepare a response to the recommendations, these efforts were slow and seem to have stalled prior to our inquiry. It was not until 6 April 2006 that the Minister for Commerce and Industrial Relations finally provided the Coroner's Office with a response to the recommendations.

78 Letter from Dr Jonathon Phillips, SA Director of Mental Health, to the Coroner, 10 March 2005 (copy on file with authors).

79 Letter from SA Commissioner of Police to the authors, 2 February 2006 (copy on file with authors).

80 Letter from SA Commissioner of Police to the authors, 7 April 2006 (copy on file with authors).

81 Letter from the ACT Minister for Urban Services to the authors, 8 February 2006 (copy on file with authors).

82 ACT Department of Urban Services (Press Release, 30 January 2006) (copy on file with authors).

83 *Coroners Act 1997* (ACT), s 75.

84 *Coroners Act 1997* (ACT), s 76.

85 Letter from the Chief Executive, ACT Health, to the authors, 18 May 2006 (copy on file with authors).

86 The Report states: 'During the current year a number of deaths were investigated involving supported government accommodation for the disabled. This is not formally a death in custody but has been treated by the ACT coronial service as such. A review needs to be conducted into the areas where matters are to be designated as "deaths in custody".' Chief Coroner of the ACT, 'Annexed Annual Report 2004–05' in Department of Justice and Community Safety, *Annual Report 2004–05* (2005) vol 1, 146.

87 This consisted of a search on Factiva, a media database, for the child's name, which was conducted on 21 May 2006.

88 Letter from the Tasmanian Department of Justice to the authors, 28 February 2006 (copy on file with authors).

89 'Blind Cord Rules Tightened', *The Hobart Mercury* (Hobart), 7 June 2004, 7.

90 For example, a Factiva search of the name of the deceased produced 21 records.

91 For example, a search of Factiva using the name of one of the deceased produced 30 relevant records: five of those were a report of the coronial inquest, the remainder were reports of the actions of the disability advocates or from the perspective of the advocates.

92 See, eg, Rachel Kleinman, 'Death Leads to Wheelchair Safety Action', *Melbourne Yarra Leader* (Melbourne), 10 December 2001, 5.

93 See, eg, ibid; 'Rail Crossing Danger', *Melbourne Yarra Leader* (Melbourne), 12 July 2004, 11.

94 See above n 2.

95 The search was conducted on 5 April 2006 within the following search parameters: Closed Matters, Victoria, 'PFD' in Finding Document, and Review of Results for Recommendations.

96 Letter from Marine Safety Victoria to the authors, 12 December 2005 (copy on file with authors).

97 'We speak for the Dead to protect the living' is the motto of the Victorian State Coroner's Office and the Coroner's Office in Ontario, Canada.

COMMENTARY