RESPECTING THE DEAD, PROTECTING THE LIVING

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The coronial system, the system responsible for the investigation of reportable deaths,[1] has been a constant feature of the Australian legal landscape. As it formed a part of English law in the late 18th century,[2] coronial law was received by the colony of New South Wales upon the colony's establishment.[3] Yet, even prior to the colonisation of Australia, there appear to have existed in Aboriginal societies processes for investigating unexpected deaths. In its study on Aboriginal customary laws, the Law Reform Commission of Western Australia suggests that the concept of a communitarian investigation into an unexpected death was familiar to traditional Aboriginal societies.[4] However, whereas the characteristic purpose of a traditional Aboriginal investigation into a death was to identify those responsible and was likely to be followed by a revenge expedition, the object of an inquest under the English legal system is to inquire into an unexpected death and seek an explanation of its occurrence. A coronial inquest is 'a fact finding exercise and not a method of apportioning guilt. ... It is an inquisitorial process, a process of investigation quite unlike a trial ...'[5] In addition to ascertaining the causes and circumstances of deaths, coronial inquests can also have a preventive function; something that is clearly identified in the motto of the Victorian Coroner's Office: 'We speak for the Dead to protect the living'.[6] A key element of this preventive role is the coronial power to make recommendations to government and other relevant agencies so as to contribute to the prevention of deaths occurring in similar circumstances.

While the coronial system has remained an important legal institution throughout Australia's post-1788 history, it emerged from the Royal Commission into Aboriginal Deaths in Custody ('RCIADIC') that the system was lacking in some respects – including in its preventive role – to produce just outcomes, especially for Aboriginal people. RCIADIC produced 339 recommendations in its *National Report*,[7] with 34 of these recommendations relating to the coronial process (recommendations 6 to 40). Recommendations 14 to 18 specifically addressed the communication of, and response to, coronial recommendations and the monitoring and reporting of such responses. They were not only directed at improving the communication of coronial recommendations to government in death in custody inquests; they also sought to improve the accountability of government and other agencies by making responses to coronial recommendations in death in custody cases mandatory.

Despite the early stated support and commitment from Australian governments to ensure compliance with the Royal Commission's recommendations,[8] those recommendations remain largely unimplemented by State and Territory legislation. While several may be realised in practice, this, as Prue Vines and Olivia McFarlane point out, is largely through departmental protocols or procedures – which are subject to change at the discretion of the relevant department – rather than a legislative statement from Parliaments.[9] Although unimplemented, the 34 coronial-related RCIADIC recommendations remain a standard against which any coronial practice, or proposals for coronial reform, in relation to deaths in custody must be measured. Imprisoned, acutely vulnerable, isolated from family and other supports and mostly invisible to the community, a person in custody is owed a special responsibility by the state while in its control.[10]

Beyond the sphere of deaths in custody, however, it has been recognised that the Royal Commission's proposals for reforming the coronial system hold value for coronial practice more generally. In relation to RCIADIC recommendations 15 to 18 in particular, current law reform proposals seek to

extend a duty to respond beyond that first proposed by the Royal Commission, so as to require mandatory responses to coronial recommendations in *all* inquests.[11] Given the hard-learned lessons[12] from coronial investigations, it is critical for the protection of the community that responsible bodies and agencies take heed of those lessons.

Part I of this paper supports the aspiration to a more fully realised preventive role for coroners, so as to serve a broader public health interest. This paper advocates for an enhanced focus on prevention, not only in the New South Wales Coroner's Office, but also by coroners in all Australian jurisdictions. There is a strong need for a national, coordinated approach to coronial reform rather than piecemeal amendments in each State and Territory.

However, in advocating such reform, this paper recognises that the duty of respecting the dead and the families of the deceased should not be overlooked as a worthy object in itself. The investigation of an individual death, carried out in a respectful manner, remains fundamentally vital to the public interest. Part II of this paper provides two case studies illustrating how the Aboriginal Legal Service of New South Wales and the Australian Capital Territory ('ALS (NSW/ACT)') works in the community to ensure that the voices of the families of the dead are heard in coronial investigations.

I The Potential to Save Lives

Although long recognised at common law as a part of the coronial function, the potentially preventive role of coroners received fresh stimulus from the public health movement of the 1980s.[13] In recent times there has been an increasing acknowledgement of the public health protective opportunity afforded by an inquest to identify possible remedies to those risks made apparent in coronial investigations.[14] The mechanism for suggesting such remedies lies in the power of coroners to make comments and recommendations for the purpose of preventing a recurrence of death in similar circumstances. Such recommendations

> represent the distillation of the preventive potential of the coronial process. The action taken in response to such recommendations carries the promise of lives saved and injury averted. It should be noted that every single death represents the tip of an iceberg of injuries and other high-risk circumstances. A proactive strategy has the potential to avert not only deaths but alleviate risks to health and safety.[15]

The development of such recommendations draws on the 'hard lessons'[16] of the investigation into a death that might have been avoided. It is a matter of 'speaking for the dead to protect the living'.[17] However, the effectiveness of this mechanism is realised not only through its proper exercise by a coroner but in the measures taken in response.

A The Power to Comment or Make Recommendations

At common law, a coroner has the power to make recommendations in relation to any matter connected with the death when delivering their findings.[18] In New South Wales, this power receives statutory recognition in s 22A of the *Coroners Act 1980* (NSW),[19] which provides the examples of 'public health and safety' as matters that can form the subject of a recommendation.[20] Any recommendations made are to be included as a part of the coroner's record.[21]

There are restrictions, however, on a coroner's exercise of this power. While providing examples of matters that coronial recommendations may address, s 22A also precludes a coroner from indicating or 'in any way' suggesting that 'an offence has been committed by any person'.[22] Kevin Waller, a former New South Wales State Coroner, advises that:

> recommendations should arise from the facts of the case under investigation, and ideally should be designed to prevent a recurrence of the death ... in question. They should not emanate from any coroner's personal or political philosophies.[23]

Waller also refers to the leading Victorian case of *Harmsworth v State Coroner*,[24] in which the Victorian Supreme Court noted that a coroner's power to comment or make recommendations is 'not free-ranging'; it is 'inextricably connected with, but not independent of the power to enquire into a death'.[25] Nor is it a 'separate or distinct [source] of power enabling a coroner to enquire for the sole or dominant reason of making comment or recommendation.'[26] Both judicial and academic comment have drawn the important distinction between the investigative powers of the coroner in relation to the specific death under investigation and those, more wide-ranging, of a Royal Commissioner.[27] Waller warns that comments or recommendations made by a coroner are 'formal suggestions' and should only come 'after careful consideration'.[28] Nevertheless, he advises, they should then be made 'fearlessly'.[29]

Yet, while a robust and 'fearless' use of the recommendation-making power may be advocated and of benefit, most Australian coronial legislation in its current form provides little encouragement to a coroner to exercise it. Nor is there detailed guidance from case law in the exercise of this power.[30] In the *Coroners Act 1980* (NSW), the exercise of the coroner's power is discretionary: a coroner 'may' comment or make recommendations, but is not under any positive duty to do so. By contrast, under Tasmanian coronial legislation, a coroner 'must' make recommendations 'whenever appropriate', for the purpose of identifying strategies to prevent deaths in similar circumstances.[31] In the absence of any statutory duty or other clear encouragement (whether from case law or administrative guidelines), the exercise of the recommendation-making power by coroners depends upon the initiative of the individual coroner.[32] As a result, and (as is noted below) in the absence of demonstrated support from governments in response to recommendations made, the use made by coroners of this potentially vital contribution to society is rare.[33]

B The Objects and Purposes of Coroners Acts

Despite statutory recognition of this coronial power to make recommendations, the various Coroners Acts in Australian jurisdictions, with the exception of Queensland,[34] do not contain a provision identifying the prevention of death as an object or purpose. Nor does any statement of the coroner's function include a reference to the preventive role in their jurisdiction. As Freckelton and Ranson suggest, the – mostly discretionary – power to make recommendations requires a 'clear and specific legislative statement' of this role of the coroner to encourage its use.[35]

C Lack of Distribution, Publication or Reporting of Coronial Findings

Although in New South Wales recommendations by a coroner form a part of the record of that inquest, there is no statutory procedure for them to be forwarded to the relevant Minister or government agency, or even to be submitted to the Attorney-General for distribution. [36] In addition, while the State Coroner is required to provide an annual report on deaths in custody and police operations,[37] there is no statutory responsibility to report to the Attorney-General or the Parliament on recommendations made by New South Wales coroners in other inquests.

Some Coroner's Offices publish the findings and recommendations of coroners, or a selection of matters considered to be in the public interest, on their websites; but again, there is no legislative requirement for their consistent publication as in the case of other court and (some) tribunal reports. Nor are they readily accessible to the community, even upon request. There is thus no systematic opportunity for both government and non-government agencies to study and learn from the recommendations that coroners may have made for the purpose of preventing death and injury, unless the agency was specifically involved in a particular case.

D Responding to Coronial Recommendations and Monitoring Responses

Most importantly, there is no consistent legislative requirement for State and Territory governments and relevant government agencies to respond to those recommendations made by coroners. As RCIADIC pointed out, the value of such recommendations lies in the response they receive.[38] The Royal Commission explained that such a response did not necessarily require compliance with and implementation of each recommendation, but should involve a written response demonstrating that the recommendations were properly considered and giving an account of what measures were proposed to address the needs identified.[39] Only in the Northern Territory are government agencies under a statutory duty to respond to all coronial recommendations.[40] In addition, the Attorney-General is required to report on those responses.[41] In South Australia and the Australian Capital Territory, government agencies are under a statutory duty to respond to recommendations made by a coroner, but only to those arising from an inquest into a death in custody.[42]

Apart from any commitment by the relevant Minister or government agency to improve public health (if the recommendations are received, which Watterson, Brown and McKenzie's report illustrates cannot be assumed), the only inducement for compliance or at least serious consideration may be from adverse media publicity and the possibility that a subsequent inquest into a further death may draw attention to the ignored recommendation.[43] Moreover, there is an absence of a clear legislative procedure to monitor and evaluate what, if any, has been the response by governments or government agencies to those recommendations that have been received.[44] In the absence of such monitoring mechanisms, it is difficult to effectively measure what impact

coronial recommendations have had on public health and the prevention of avoidable death.[45]

In their study, Watterson, Brown and McKenzie sought to trace the responses by relevant government agencies to the recommendations made by coroners in most Australian States and Territories during a defined period.[46] The coronial recommendations that were the subject of their research were recorded on the National Coroners Information System, to which the authors were given limited access for this purpose. Information on the responses by government agencies was obtained by contacting the relevant agencies in writing. Their findings indicated that in a comparatively small number of inquests coroners were making formal recommendations, and that those recommendations were not always received by the agency concerned. Agencies that did receive the recommendations frequently failed to consider them, let alone took steps to implement them to any degree. While these findings support the perception that the preventive opportunity offered by coronial recommendations remains unrealised, what is of equal concern is that this information required retrieval through the research methods employed, rather than being available from publicly accessible sources.

E Proposals for Coronial Reform

At present, the public resources invested in the coroner's inquest, while providing a thorough investigation of the individual death, only occasionally benefit the wider community. Though the family of a deceased may be satisfied with the thoroughness of the coroner's investigation and, to a certain extent,[47] the conduct of the hearing, they may experience frustration when they learn that the recommendations arising out of the inquest of a family member are ignored and unable to prevent a further death.[48]

As already noted, while some coroners may attempt to make recommendations whenever appropriate, many do not. This may be due to a limited encouragement from the legislation and lack of guidance from other sources, and may also stem from the knowledge that any recommendations made may well be, as RCIADIC pointed out, frequently ignored or disregarded.[49]

If the potential to enhance the preventive aspect of the coronial function is accepted and the fuller realisation of this potential is recognised as an objective, what is required is a national, coordinated approach to reform of coronial legislation, one that provides a legislative framework of accountability and transparency through:

- statutory recognition of the role of coroners in preventing death and injury;
- procedures for the distribution of coronial recommendations to relevant Ministers and government agencies;
- a requirement for the publication of, and the provision of public access to, coronial findings and recommendations;
- mandatory responses by relevant Ministers and government agencies to such recommendations; and
- the implementation of monitoring and evaluation mechanisms of responses by relevant agencies of such responses, together with their public reporting.

Such reform will require careful consideration, consultation and development. While the relevant needs and strategies are, in broad terms, visible, the details of their implementation will present challenges requiring policy choices. For example, in the establishment of monitoring mechanisms, one question will be whether tracking and evaluating responses by agencies should be the responsibility of the State or Territory Coroner's Office or that of another agency (for example, the relevant Ombudsman).[50] Another is whether responses should be mandatory only from government agencies or be also required from agencies in the community and private sectors.[51] Furthermore, in the publication of coronial findings and recommendations, issues of privacy, family sensitivities and cultural considerations may require the removal of identifying information and even editing. A program of coordinated reform will also require cooperation between governments to achieve it on a national level, rather than through piecemeal, State- and Territory-based approaches.

F Justification for Reform

Aboriginal people continue to be the most disadvantaged group in Australian society. In their study, Watterson, Brown and McKenzie refer to the prominent indicators of overrepresentation in prisons, high infant mortality rates, systemic public health failures and the reduced life expectancy of Aboriginal people.[52] A recurrent question of government inquiries is how to overcome Aboriginal disadvantage and, specifically, address a 17 year gap in life expectancy between Aboriginal and non-Aboriginal Australians. A coordinated

approach to coronial legislative reform would be *one* strategy to reduce this gap, by learning lessons from avoidable deaths. As RCIADIC's *National Report* suggested, it would have the 'potential to save lives'.[53] The Royal Commission's report and recommendations addressed Aboriginal deaths in custody. Given the pronounced disadvantage of Aboriginal people through systemic public health failures, the introduction of such legislative reform measures proposed could result in a vital and beneficial impact on Aboriginal communities. But the benefits would not be restricted to Aboriginal communities, and these measures would equally have the capability to save the lives of individuals from other vulnerable groups in society, as well as all sectors of society.

II Respecting the Deceased and Their Families

While there is increasing support for the coronial function to adopt a more preventive public health focus, advocacy for this aspect of the coroner's role need not – and should not – be to detract from the fundamental coronial duty of investigating the specific death reported. The inquest into an unexpected death and its outcome remains a vital activity both in the public interest and in respecting the deceased and their family.

The need for a judicial determination of the manner and cause of death assumes a particular prominence in those cases in which the circumstances surrounding the death are 'suspicious' or where the culture of a government agency or its officers forms a backdrop to that death. In such cases, the rights of the family of the deceased and the broader public interest each demands a satisfactory understanding of how – and why – the death occurred. This continuing relevance of the precise finding of any inquest is illustrated by the two case studies set out below in which the ALS (NSW/ACT) represented the family of the deceased.

A *Inquest into the Death of P*[54]

P was a 21 year old Aboriginal man who died at Narromine in the early hours of the morning of 29 November 2003. He died after being tackled and assaulted by an off-duty police officer and a Corrective Services officer, both of whom initially claimed that P, suspected of theft, had tripped while being chased by them. Ambulance officers were unable to revive P and he died less than half an hour later. The ALS (NSW/ACT) was granted leave to represent P's family at the inquest,[55] which commenced on 19 March 2006 and was conducted by the Deputy State Coroner at Dubbo. At the inquest, 38 witnesses were called, including three eye-witnesses to the tackle and assault of P by the two officers and six who arrived at the scene shortly afterwards to find P lying unconscious on the ground.

There were two primary issues. The first was whether the two officers – who were 'persons of interest' in the inquest – tackled and assaulted P. The second was whether, if the officers had tackled and assaulted P, that assault had caused P's death. The evidence of the eye-witnesses was consistent that P had been tackled and assaulted by the two officers and had not tripped. The issue of causation was, however, less straightforward. P was epileptic and had been fitting and medicated for his condition in the weeks before his death. The medical evidence disclosed a clot in his brain, which, of itself, would not have been fatal. A toxicology report revealed a combination of alcohol, cannabis and methadone in his system at the time of his death.

Although the nature of an inquest is acknowledged to be inquisitorial,[56] in cases in which the death occurs in custody or police operations, or where there are allegations of negligence or criminal behaviour, the inquest may well assume a 'hybrid' character, containing both inquisitorial and adversarial elements.[57] This shift is of especial relevance to New South Wales, where, alone among Australian jurisdictions,[58] the coroner retains the power to commit a person for trial.[59] Such an inquest can involve the clash of two fundamental principles. One is the duty of the coroner to investigate the death in the interests of justice. The other is a basic principle of common law and human rights law: that no person should be required to incriminate themselves.[60] The privilege of a person against self-incrimination receives statutory recognition in s 33 of the *Coroners Act 1985* (NSW). Section 33AA, however, empowers a coroner to order a witness to give evidence, notwithstanding their objection on the ground of self-incrimination, if the coroner is satisfied that the evidence is necessary 'in the interests of justice'.[61] In such circumstances, the witness receives some measure of protection against their evidence by the provision's requirement that the coroner issue a certificate disallowing use of the evidence in any proceedings against that person in a New South Wales court.[62]

At the *Inquest into the Death of P*, the two officers objected to giving evidence on the basis that, while a certificate under s 33AA would preclude the use of their testimony in a

criminal or civil trial, such a certificate would afford them no protection in disciplinary proceedings to which they might well be exposed. Their objection was upheld and they were excused, with the result that no s 33AA certificate was issued.

However, on the 12th day of the inquest, the Coroner indicated that he had formed an opinion under s 19(1)(b) of the *Coroners Act 1980* (NSW) and, in the exercise of his discretion, terminated the inquest, forwarding the papers to the Office of the Director of Public Prosecutions (as required by s 19(2)). The findings of the inquest were confined to P's identity and the date and place of his death.[63] As the inquest had been terminated under s 19, no finding was made as to the 'manner and cause' of his death.[64]

P's family said that they were satisfied with this outcome as, over the 12 days of coronial hearing, evidence had been given as to the circumstances surrounding P's death and that, with the termination of the inquest, in all likelihood the two officers would be charged with P's homicide. The Office of the Director of Public Prosecutions has advised ALS (NSW/ACT) that the two officers have since been charged with manslaughter and were to face trial in October 2008.

The family were satisfied not only with the outcome, but with the process of the ALS (NSW/ACT): a collaborative approach of using a legal representative working with an appropriate Aboriginal field officer or community worker to provide support to the client(s) – in this case, members of P's family – to explain court procedures to them and assist their legal representative in communicating with them.[65]

B *Inquest into the Death of L*[66]

L was a 27 year old Aboriginal woman who died on 23 March 2005 while in custody at Bathurst Correctional Centre.[67] As her death occurred while she was in custody, an inquest was mandatory[68] and was to be conducted by either the State Coroner or the Deputy State Coroner.[69] The ALS (NSW/ACT) was granted leave to represent the family at the inquest and briefed counsel.

In delivering his findings, the Deputy State Coroner ('the Coroner') gave a brief account of L's life and the circumstances leading up to her death.[70] L had, the Coroner noted, a disrupted family life. Both parents had histories of substance abuse and had spent periods in custody. At the age of 14, L was made a ward of the state and placed in the care of an aunt living in Dubbo. While in her teens, L began experimenting with drugs. At the age of 17, she gave birth to a son, who was cared for by his grandmother. From 1995 to 2000, L became caught in a cycle of drug abuse and drug-related crimes and spent several periods in custody. In 2000, she was convicted of robbery and served a lengthy custodial sentence in Mulawa Correctional Centre until 2003. While in Mulawa, she commenced a methadone program. At the same time, she suffered from depression and engaged in several altercations with fellow inmates. During this period, L self-harmed by slashing her wrists and attempting to hang herself. From 2004 to 2005, L served two further custodial sentences, during one of which she again attempted to hang herself.

On 18 March 2005, L was arrested for a drug-related dishonesty offence. Refused bail, she was observed banging her head against the cell wall and kicking and punching the walls. L told her aunt that she was frightened of being returned to protective custody – the 'bone yard'– and that if she was, she would kill herself. Her aunt informed the Justice Health nurse of this conversation and the nurse made a notation on the file that L was to be reassessed if refused bail, as she was withdrawing from drugs and susceptible to self-harm.

Over the days following, L twice applied for bail, but was refused on each occasion. Remanded to appear again on 4 May, on 21 March she was transported back to Bathurst Correctional Centre for assessment by Justice Health. L, still afraid of protective custody measures such as the Detox Unit requested another nurse and, having not disclosed her history, she was placed in the Women's Unit, described by the Deputy State Coroner as a 'minimum risk facility'.[71]

Upon arrival at the Women's Unit, L was screened by a Corrective Services officer, a nurse. However, this officer had only recently returned from leave and her password to the Offender Index Management System had lapsed, with the result that L's profile, including her history of self-harm, could not be accessed. The screening officer was of the view that, although L was in stages of drug withdrawal, she did not exhibit signs of self-harming. L was placed in the Women's Unit with another inmate, who was currently on a methadone program.

On the evening of 22 March at about 8 pm, the inmate with L in the Women's Unit fell asleep. She awoke at about 1 am

on the morning of 23 March to find L hanging from the frame of a toilet cubicle. An examination of the scene by police disclosed no suspicious circumstances. The post-mortem report confirmed that there were no defensive marks on L's body and recorded the cause of her death as the result of hanging.

In his report, the Coroner noted that, following L's death, the Department of Corrective Services conducted a review of the Women's Unit, including the removal of significant hanging points and repositioning of the CCTV monitors. The Coroner, while acknowledging the usefulness of these measures at the time, remarked that they were now of 'little relevance' as the decision had been made to no longer place women at Bathurst Correctional Centre but at the new facility at Wellington, which was to open the day after the inquest.[72] The Coroner made no formal recommendations as, he explained, those he contemplated had already been implemented. (The Coroner commented critically on the role of the Corrective Services screening officer, noting that she was to be subject to remedial action.) In conclusion, the Coroner stated that L's death 'in my view, could have been avoided'.[73] L's death will be rememberd by her family. In the New South Wales State Coroner's Office, L's death is recorded as a death in custody of an Aboriginal woman, aged 27, which was reported during 2005.[74]

The case illustrates how the investigation into a reportable death and the report that is produced are still vital contributions to society and of equal importance to any public health benefits that may ensue. As noted, the Coroner made no formal recommendations as, for the reasons stated above, they would have been otiose. Critical comment on the practice of the Corrective Services officer and departmental procedures was limited, as each had already been addressed internally. Yet the Coroner's investigation, inquest and report served the public interest by ensuring that L's death was investigated, that her family had a voice and that the story of L's death was, as far as possible, heard in open court. Even without any wider public health benefits, these should continue to be seen as worthy objects of the coronial system in themselves. They accord with our notions of the fundamental dignity of the human person and the respect that is due, even in death.

III Conclusion

One way in which the contemporary Australian legal system demonstrates its respect for human life is to require any death to be registered[75] and, to some extent, explained. In the vast majority of cases, a satisfactory explanation is achieved by a relevant doctor issuing a notice of death identifying the cause of death.[76] Those deaths that cannot be so immediately explained, or occur in circumstances prescribed by legislation, are reported to the State or Territory Coroner for investigation.[77] Of those, only some will be the subject of an inquest.[78] The very fact that a coroner's consideration of a death proceeds to an inquest[79] means that there are questions that must be asked and answered in a public hearing.

In determining the 'manner and cause' of a person's death at an inquest, the coroner is presented with the opportunity to recommend measures that could avoid a future death in similar circumstances. Yet, as discussed above, this 'potential to save lives'[80] remains unrealised: the coroner's power is underutilised, receives limited legislative direction and, when it is exercised, may be of little effect. This potential should not be dependent on factors such as the initiative of individual coroners, the media appeal of a particular case or the discretion of government agencies. What is needed is a clear and robust coronial legislative framework in all Australian jurisdictions, identifying objectives and responsibilities and establishing procedures premised on transparency and accountability: one that ensures respect for the dead and the sensitivities of their family and which is also – effectively – able to seek to protect the living.

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1 Not all deaths are reportable to the Coroner; only those that are unexpected, 'suspicious' or occur under prescribed circumstances (for example, where a certification of death is not immediately available) will qualify. Moreover, not all deaths reported to the Coroner are the subject of an inquest, although in certain circumstances (for example, deaths in custody) an inquest is mandatory. Coronial legislation in each jurisdiction outlines the circumstances in which a death is to be reported to, and investigated by, the Coroner.

2 The coronial function of the investigation of unexpected death dates from, at least, the Council of Eyre in 1194. The office of Coroner, as an official of the Crown (albeit with different functions), can be traced to Anglo-Saxon law: Ian Freckelton and David Ranson, *Death Investigation and the Coroner's Inquest* (2006) 4–6; Kevin Waller, *Coronial Law and Practice in New South Wales* (3rd ed, 1994) 1–2.

3 The *Australian Courts Act 1828* (Imp) 9 Geo 4, c 83, was a declaratory Act. In *Mabo v Queensland (No 2)* (1992) 175 CLR 1, Deane and Gaudron JJ (at 78–9) considered that the colony of New South Wales received English law, as far as it was applicable, on 7 February 1788, on the colony's establishment with the reading and publication by Captain Arthur Phillip of his second Commission as Governor of the new colony. In *Attorney-General v Maksimovich*, (1985) 4 NSWLR 300, Kirby P (at 305) noted that the office of Coroner for New South Wales was created by Letters Patent of 1787.

4 Law Reform Commission of Western Australia, *Aboriginal Customary Laws*, Project No 94, Discussion Paper (2005) 300 <http://www.lrc.justice.wa.gov.au/2publications/reports/ACL/DP/Part_06.pdf> at 21 November 2008.

5 Lord Lane CJ in *R v South London Coroner; Ex parte Thompson* (1982), *The Times* (London), July 9, 1982, cited by Toohey J in *Annetts v McCann* (1990) 170 CLR 596, 616, referring to a citation of the case in John Jervis, *Jervis on the Office and Duties of Coroners, With Forms and Precedents* (10th ed) (1986) 6. The case is also reported as (1982) 126 Sol J 625.

6 The words are attributed to Thomas D'arcy McGee, a 17th Century Irish-Canadian politician. See Law Reform Committee, Parliament of Victoria, *Coroners Act 1985: Final Report* (2006) 321 <http://www.parliament.vic.gov.au/LAWREFORM/inquiries/Coroners%20Act/final%20report.pdf> at 21 November 2008.

7 Commonwealth, Royal Commission into Aboriginal Deaths in Custody ('RCIADIC'), *National Report* (1991) <http://www.austlii.edu.au/au/special/rsjproject/rsjlibrary/rciadic> at 21 November 2008.

8 Ray Watterson, Penny Brown and John McKenzie, *Coronial Recommendations and the Prevention of Indigenous Death*, Report by Many Rivers Aboriginal Legal Service (2006) 7–8 (unpublished, copy on file with author) (see now Ray Watterson, Penny Brown and John McKenzie, 'Coronial Recommendations and the Prevention of Indigenous Death' (2008) 12(SE2) *Australian Indigenous Law Review* 4). Watterson, Brown and McKenzie also note the concerns that some States expressed over RCIADIC recommendation 16 (which addresses the monitoring of responses by State Coroner's offices) on the basis that such action would breach the principle of separation of powers.

9 Prue Vines and Olivia McFarlane, 'Investigating to Save Lives: Coroners and Aboriginal Deaths in Custody' (2000) 4(27) *Indigenous Law Bulletin* 8.

10 This special responsibility to prisoners was recognised as a duty owed by the state as early as 1276 in the statute *De Officio Coronatoris*: Freckelton and Ranson, above n 2, 10; Waller, above n 2, 2.

11 See, eg, Law Reform Committee, Parliament of Victoria, above n 6.

12 Watterson, Brown and McKenzie, above n 8, 12.

13 Freckelton and Ranson, above n 2, 719.

14 Lyndal Bugeja and David Ranson, 'Coroners' Recommendations: A Lost Opportunity' (2005) 13(2) *Journal of Law and Medicine* 173.

15 Boronia Halstead, 'Coroners' Recommendations Following Deaths in Custody', in Hugh Selby (ed) *The Inquest Handbook* (1998) 187.

16 Watterson, Brown and McKenzie, above n 8, 12.

17 See above n 6.

18 *R v Harding* (1908) 1 Cr App R 219.

19 *Coroners Act 1980* (NSW) s 22A (1); a similar provision is included in Coroners Acts in all Australian jurisdictions.

20 *Coroners Act 1980* (NSW), s 22A(2).

21 *Coroners Act 1980* (NSW), s 22A(3).

22 *Coroners Act 1980* (NSW), s 22A(3).

23 Waller, above n 2, 95.

24 [1989] VR 989 ('*Harmsworth*').

25 Ibid 996 (Nathan J).

26 Ibid.

27 *Musumeci v Attorney-General(NSW)* [2003] NSWCA 77, [34] (Ipp JA) ('*Musumeci*'). See also Freckelton and Ranson, above n 2, 722; Law Reform Committee, Parliament of Victoria, above n 6, 363ff.

28 Waller, above n 2, 95.

29 Ibid.

30 Freckelton and Ranson, above n 2, 720, 745; Law Reform Committee, Parliament of Victoria, above n 6, 376.

31 *Coroners Act 1995* (Tas), s 28(2). In the Northern Territory, a coroner is required to make recommendations in an inquest into a death in custody: *Coroners Act* (NT), s 26(2).

32 Law Reform Committee, Parliament of Victoria, above n 6, 325. The Committee also notes that many coroners do not consider the making of recommendations to be a part of their role: at 379.

33 Freckelton and Ranson, above n 2, 722, 739; Watterson, Brown and McKenzie, above n 8, 13; Law Reform Committee, Parliament of Victoria, above n 6, 325.

34 *Coroners Act 2003* (Qld), s 3(d).

35 Freckelton and Ranson, above n 2, 722.

36 In the Northern Territory, the *Coroners Act* (NT) requires the forwarding of coronial recommendations to the Attorney-General

(s 27(1)) and the distribution of these recommendations, by the Attorney-General, to the relevant agency (s 46A(1)).

37 *Coroners Act 1980* (NSW), ss 12A(4)–(5).

38 Commonwealth, RCIADIC, above n 7, vol 1, [4.5.91].

39 Ibid, vol 1, [4.5.97]–[4.5.98].

40 *Coroners Act* (NT), s 46B(1).

41 *Coroners Act* (NT), s 46B(3).

42 *Coroners Act 2003* (SA), s 25(5)(a) ; *Coroners Act 1997* (ACT) s 76(1).

43 Freckelton and Ranson, above n 2, 741; Victorian Coroner's Office, quoted in Law Reform Committee, Parliament of Victoria, above n 6, 397.

44 Law Reform Committee, Parliament of Victoria, above n 6, 370.

45 Freckelton and Ranson, above n 2, 742; Law Reform Committee, Parliament of Victoria, above n 6, 398.

46 Watterson, Brown and McKenzie, above n 8.

47 The ALS (NSW/ACT) is aware that coronial legislation also requires reform in relation to the rights of families and to procedures for communication by Coroners' Offices with family members. The ALS (NSW/ACT) intends to address and identify these needs following appropriate consultation with Aboriginal communities in New South Wales and the Australian Capital Territory. The ALS (NSW/ACT) also notes that s 69(1) of the *Coroners Act 1997* (ACT) requires the notification of an inquest into a death in custody of an Aboriginal or Torres Strait Islander person to the deceased's family and the relevant Aboriginal legal service. While this may be the current practice in those jurisdictions where there is not a similar legislative provision, such procedures, as Vines and McFarlane observe, require legislative force, not merely departmental discretion: see Vines and McFarlane, above n 9. In addition, when providing for communication with the family of an Aboriginal deceased, any reformed coronial system must take account of Aboriginal concepts of family and kinship. Such considerations also require legislative, rather than procedural, recognition.

48 Law Reform Committee, Parliament of Victoria, above n 6, 477.

49 Commonwealth, RCIADIC, above n 7, vol 1, [4.1.4]–[4.1.5].

50 Law Reform Committee, Parliament of Victoria, above n 6, 403–5.

51 As suggested by the Law Reform Committee, Parliament of Victoria, above n 6, 399. The Committee noted that some prisons and detention centres are operated by private corporations.

52 Watterson, Brown and McKenzie, above n 8, 2–3.

53 Commonwealth, RCIADIC, above n 7, vol 1, [4.7.4].

54 Out of respect for the deceased and his family, his name is not used in this paper.

55 *Coroners Act 1985* (NSW), s 32(2).

56 See text accompanying above n 5.

57 *Musumeci* [2003] NSWCA 77, [33].

58 Freckelton and Ranson, , above n 2, 715.

59 Section 19 of the *Coroners Act 1980* (NSW) applies if the coroner forms the opinion that, having regard to all the evidence: there is evidence capable of satisfying a jury beyond reasonable doubt that a known person has committed an indictable offence (s 19(1)(b)(i)); there is a reasonable prospect that a jury would convict that person of that offence (s 19(1)(b)(ii)); and the offence is one in which the question in issue is whether the person charged cause the death of the deceased (s 19(1)(b)). If s 19 applies, the coroner may either continue the inquest, recording the findings required under s 22(1) (findings as to the identity of the deceased and the date and place of their death) or terminate it and forward the depositions taken and the name of the known person and particulars of the offence to the Director of Public Prosecutions (s 19(2)). If the coroner terminates the inquest under s 19, no finding is to be made as to the manner and cause of the deceased's death (s 22(1)).

60 *Sorby v Commonwealth* (1983) 152 CL 281, 288–9 (Gibbs CJ); *International Covenant on Civil and Political Rights*, opened for signature 16 December 1966, 999 UNTS 171, art 14(3)(g) (entered into force 23 March 1976).

61 *Coroners Act 1980* (NSW), s 33AA(3).

62 *Coroners Act 1985* (NSW), s 33AA(4). In *Decker v State Coroner of New South Wales* [1999] NSWSC 369 ('*Decker*'), a witness (a geologist), called to give evidence in the inquest into the deaths of 18 people in the 1998 Thredbo landslide disaster, objected on the basis that his evidence would tend to incriminate him. The Coroner upheld the objection, noting that any relevant question would tend to incriminate him, while any irrelevant question would not be permitted. Following *Decker*, the *Coroners Act 1980* (NSW) was amended by the *Courts Legislation Amendment Act 2000* (NSW), which inserted s 33AA. This amendment was considered in *Correll v Attorney-General (NSW)* [2007] NSWSC 1385, [42] (Bell J).

63 As required by *Coroners Act 1980* (NSW), ss 22(1)(a)–(b).

64 *Coroners Act 1980* (NSW), s 22(c).

65 In this case, the services of a specialist community worker from an associated agency were engaged to work with counsel and members of P's family.

66 Out of respect for the deceased and her family, her name is not used in this paper.

67 Westmead Coroners File No 327/2005.

68 *Coroners Act 1980* (NSW), ss 13A(1)(a), 14B(1)(b).

69 *Coroners Act 1980* (NSW), ss 13A(2), 14B(1)(b).

70 Westmead Coroners File No 327/2005, above n 67.

71 Ibid 5.

72 Ibid 7.

73 Ibid 9.

74 Under s 12A(4) of the *Coroners Act 1980* (NSW), the State Coroner is required to submit to the Attorney-General an annual report of deaths in custody and police operations. See *Report by the NSW State Coroner into Deaths in Custody/Police Operations 2005* (2005) Appendix 2, 158 <http://www.lawlink.nsw.gov.au/lawlink/Coroners_Court/ll_coroners.nsf/pages/coroners_deathsincustody> at 21 November 2008; *Report by the NSW State Coroner into Deaths in Custody/Police Operations 2006* (2006) Appendix 2, 135 <http://www.lawlink.nsw.gov.au/lawlink/Coroners_Court/ll_coroners.nsf/vwFiles/dic2006.pdf/$file/dic2006.pdf> at 21 November 2008.

75 *Births, Deaths and Marriages Registration Act 1995* (NSW), s 36(1). Similar provisions exist in other Australian jurisdictions.

76 *Births, Deaths and Marriages Act Registration Act 1995* (NSW), s 39(1).

77 *Births, Deaths and Marriages Act Registration Act 1995* (NSW), ss 39(2), 39(3).

78 See above n 1.

79 Whether it be due to the unresolved circumstances of the case or to its belonging to a category of cases prescribed by legislation which require an inquest; see above n 1.

80 Commonwealth, RCIADIC, above n 7, vol 1, [4.7.4]; see above n 53.