Submission in relation to “whether the Coroners Act 1996 (WA) should be amended to require the Government respond to coronial recommendations within a set timeframe” (Term of Reference 4)

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I am an Adjunct Professor of law at La Trobe University, Victoria where I teach a postgraduate course, “Inquests, Inquiries and commissions”. I am the author of a number of papers on coronial law and practice and co-author of a recent national report on the implementation of coronial recommendations, ‘Coronial Recommendations and the prevention of Indigenous Deaths’.1

I thank the Committee for its invitation to provide a submission to the Committee (in its letter dated 15 April 2010). Given my particular knowledge and experience this submission deals only with the issue of mandatory responses to coronial recommendations.

The submission maintains that a fitting and appropriate response to Mr Ward’s death is to amend the Coroners Act 1996 (WA) to require the Government respond to coronial recommendations within a set time frame. Such an amendment would strengthen the role of the coronial system in Western Australia in protecting human life, demonstrate parliament and Government’s commitment to learn lessons from avoidable deaths such as Mr Ward’s and guarantee changes to avoid future deaths.

The Ward Inquest and Coronial Best Practice

National awareness of the importance of learning lessons from avoidable deaths has been heightened by the death in Western Australia of Mr Ward. The inquest into Mr Ward’s death conducted by the State Coroner Alistair Hope provides a best practise example of modern coronial process.2 The State Coroner’s investigations, findings, recommendations and report raised and responded to systemic factors that contributed to Mr Ward’s death and from which lessons may be learned to avoid future deaths.3


2 State Coroner of Western Australia Findings and Recommendations of the Inquest into the Death of Mr.Ward, 12 June, 2009

3 The following account of the Ward inquest is an edited summary of a report compiled by La Trobe University law student Gemma Cafarella and contained in her research report “The Evolving Role of the Coroner: Towards a Broader Preventative Approach?” for the course “Inquests, Inquiries and Commissions” at La Trobe University in 2010.
In January 2008 Mr Ward was apprehended for drink driving near Laverton in Western Australia, and was subsequently taken to the local police station. After being refused bail he was transported, by privatized transportation run by the company ‘GSL’, to the nearest court facility at Kalgoorlie. Mr Ward collapsed at some point during the 360-kilometre journey, and was taken to the Kalgoorlie Hospital, where he died from heatstroke.

The inquest report totals 150 pages, and considers in great depth at a large range of interconnected factors that led to Mr Ward’s death. Coroner Hope inquired into and made findings regarding the condition of the van. Over eight years old, the van had little light, no ventilation, and no seatbelts.

The Coroner also highlighted that there was no effective air-conditioning supplied to the vehicle; the air-conditioning was not functioning, and even when it was functioning, it was not designed to be used in conditions of extreme heat. Further, he found that there was no effective method of communication with the front of the vehicle as the CCTV screen was faulty and the ‘panic’ button was not labelled.

Coroner Hope also rigorously investigated the extent to which the Department of Correctional Services and GSL contributed to the death, looking in particular at their knowledge of the condition of the van that contributed to the death. In addition, the inquest report explored the journey itself in detail. Coroner Hope looked at the fact that the air conditioning was not checked, that the employees drove without stopping, that Mr Ward was given only a 600 ml bottle of water and a meat pie, that the temperatures inside reached approximately 50 degrees celsius, that the employees possibly attempted to conceal evidence that they knew that something was wrong, and that there was an unexplained period of over ten minutes from finding Mr Ward unconscious to his hospitalisation.

Coroner Hope also enquired at length into the arrest and refusal of bail, noting that the ‘transfer of custody would not have happened at all if police and the JP...had complied with the relevant legislation’.

The making of fourteen wide-ranging recommendations also illustrates the emphasis placed on the prevention of future avoidable deaths by Coroner Hope.

The recommendations include, for example, a suggestion that the Western Australian Police review its training procedures to ensure that police officers have a better understanding of the Bail Act, a recommendation that the Department of the Attorney General review procedures to extend the availability of video conferencing, and a suggestion that the Department of Corrective Services ensure that the fleet of prisoner transport vehicles be replaced, and that the budget exists to do so on a regular basis.

Coroners cannot resolve deaths caused by criminal or negligent acts. Determinations of guilt and liability are the domain of the criminal and civil courts. A coroner’s basic responsibility is to find the cause of and the circumstances surrounding a sudden and unexpected death and, increasingly, to make recommendations to prevent similar deaths in the future.

The modern inquest’s fundamental guiding principle should be respect for and protection of human life. This principle should guide coroner’s findings as to the cause of a death, comments about responsibility for the death and recommendations to avoid future deaths.
Respect for and protection of human life as a guiding principle of coronial inquests frequently entails inquiry into systemic failure and recommendations to avoid future life-threatening failure.

Finding the true cause of death at an inquest may sometimes lead to isolated, egregious acts of individuals. More often it is likely to lead to the identification of systemic causes and failures.

Identifying systemic failures and locating institutional responsibility for those failures requires deeper, more thorough and comprehensive investigation of underlying causes. Just as importantly, an inquest that incorporates a systemic approach is more likely to devise recommendations that tackle underlying causes and can prevent future deaths.

In his report of the Ward Inquest, the Coroner set out what he regarded as the correct approach to a modern coronial investigation, derived from the Royal Commission into Aboriginal deaths in Custody:

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. 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.⁴

The Ward inquest exemplified national best practice in coronial identification and response to systemic failures contributing to avoidable death. But coroner’s recommendations can only save lives if they are responded to by responsible agencies and entities.

Who was Mr. Ward and Why Should Government Respond to his Death by Amending the Coroners Act 1996 (WA) to Require Government to Respond to Coronial Recommendations?

An amendment to the Coroners Act 1996 (WA) to require the Government respond to coronial recommendations within a set time frame would be a positive and honourable response by this Inquiry and by the Government and Parliament of Western Australia to Mr Ward’s death.

Such an amendment would finally honour a Western Australian government commitment to

implement a similar recommendation of the Royal Commission into Aboriginal Deaths in Custody, almost two decades ago. Such an amendment would also bring Western Australia into line with the mandatory response and reporting requirements relating to coronial recommendations which are currently in place in every other Australian State and Territory, apart from Tasmania and contribute to the national trend to strengthen the role of coroners in the prevention of death.

Mr Ward was born in the Western Desert but moved to the small community of Warburton when he was quite young. In his 46 years Mr Ward dedicated himself to protecting the traditional culture of the Ngaanyatjarra people. Mr Ward worked with scientists and Landcare in outback Western Australia. He also worked as an interpreter for the police and in native title transactions. In his 30's Mr Ward was elected to be the Warburton Community chairman and represented the Ngaanyatjarra people in Canberra and China. Mr Ward was also a celebrated speaker, dancer and artist. He was an excellent provider for his family and a leader of his community. Mr Ward is survived by his wife, Nancy, and four sons.

Mr Ward straddled the indigenous and non-indigenous cultures in Australia. He is reported as saying:

"I would like my children and my people to maintain their cultural values: the law, the connection to the land. They know they are a part of Australia, but the most important thing for them is their cultural values. There should be a recognition on the part of Australia at large of that value. We have two worlds that people here live in: the traditional way and the Australian citizen way. I want my children also to live in those two worlds."

The Coroner described Mr Ward's death as 'poignant' because he died in the hands of the state that he had worked so hard to encourage Indigenous people to co-operate with.

Almost two decades ago, the Royal Commission into Aboriginal Deaths in Custody recommended legislation requiring governments to respond to coronial recommendations arising out of deaths in custody. A recommendation by this Inquiry for an amendment to the Coroners Act 1996 (WA) to require the Government respond to coronial recommendations within a set time frame, acted upon by Government and Parliament, would be a respectful and especially appropriate response to Mr. Ward's death. Such an amendment would finally give effect to Recommendation 15 of the Royal Commission into Aboriginal Deaths in Custody.

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5 Mr. Ward's background provided in this section of the submission is taken from a Research Report by Lisa Grealy "Systemic Failure and Coronial Inquests: Mr. Ward's Death-A Case Study" compiled for the Monash Law School course "Law Reform and Community Development"


8 The Western Australian Coroner’s Office, Inquest into the Death of Mr Ward’ Report No 9/09 (2009), 10.
The Royal Commission’s Recommendation 15, together with other Commission recommendations for a public reporting and response system of coronial recommendations, was accepted by the Western Australian government at the time. However, to date, no Western Australian government has implemented this Recommendation.

**Recommendation 15**: That within three calendar months of publication of the findings and recommendations of the Coroner as to any death in custody, any agency or department to which a copy of the findings and recommendations has been delivered by the Coroner shall provide, in writing, to the Minister of the Crown with responsibility for that agency or department, its response to the findings and recommendations, which should include a report as to whether any action has been taken or is proposed to be taken with respect to any person.

In Chapter Four of its National Report in 1991 (Volume 1), the Royal Commission provided a comprehensive examination of the investigative process following Indigenous deaths, including police investigations, post-mortem examinations and coronial inquests. It made many recommendations directed to the more effective use of the State and Territorial coronial structures in addressing deaths in custody. The Commission’s recommendations in this area were guided by its view of the potential of coroners to play a vital role in the prevention of deaths in custody.

The Royal Commission emphasised 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 Commission provided for a public reporting and review system of coronial recommendations and responses by governments to them. 9

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9 It is important to set out in full the Commission’s description of the public reporting and review system and its rationale.

It is necessary to establish a formal means to ensure proper public accountability and to provide a system of review which is able to draw from the general experience gained from all inquests held into deaths in custody. The system should require that those government departments and agencies which have been provided with a copy of the coroner’s findings report to their responsible Minister within a three-month period regarding its response to the recommendations, including whether any action has been taken or is proposed to be taken against any person. Copies of these reports should be provided to the coroner who conducted the inquest, to the State Coroner and to all persons who appeared or who were represented before the coroner at the inquest. A State Coroner should also be empowered to call for any further information he or she considers necessary, including a report on the action taken in relation to any recommendation made. Such measures may help to identify general, persistent problems which may not be apparent from an examination of the circumstances of an individual death.

As a further safeguard to ensure proper public accountability, the State Coroner should be required annually to report, 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, and as to responses to such findings and recommendations made by the various agencies or departments. In reporting to the Attorney-
description and analysis of the Royal Commission’s reporting scheme is contained in Appendix A.

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. Recommendation 16 was not supported by South Australia, Tasmania and the Northern Territory.

Coronial Reform and Prevention

Partly because of the work of the Royal Commission into Aboriginal Deaths in Custody, progressive reform of coronial systems has taken place in recent years in Australia and New Zealand. The most recent general coronial reforms were implemented in New South Wales in 2009, Victoria in 2008, New Zealand in 2006, the Northern Territory in 2004 and Queensland in 2003. These developments have, in turn, influenced coronial reform in the United Kingdom in 2009.

General or Minister for Justice, the State Coroner should be empowered to make such general recommendations as the State Coroner deems fit with respect to the prevention of deaths in custody and, perhaps, identify general, persistent problems which may not be apparent from an examination of the circumstances of an individual death.

National Report Volume 1 Chapter 4 paras 4.5.97-4.5.98

The position of the South Australian government at the time was that “the State Coroner should not be put into a policing role. It is a matter for Ministers to follow up on agency action. It is proposed that Ministers require reports to the Justice and Consumer Affairs Committee of Cabinet. This Committee may seek the advice of the Aboriginal justice Advisory Committee” - Aboriginal deaths in custody: response by Governments to the Royal Commission, Canberra, Australian Government Publishing Service, 1992 at p 59.

The position of the Tasmanian government at the time was that “The recommendation can be implemented by the adoption of protocols between the Chief Coroner and the Government and/or relevant agencies. However, 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, Hobart, Tasmania, 1995 at p 35.

The position of the Northern Territory at the time was that “the distribution of reports is supported. However, 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. The process to ensure the adequacy of department/agency actions to accept or implement recommendations of the coroner are: the jurisdiction of the Ombudsman; minister responsibility and accountability in Parliament (i.e. the Minister can make a statement or be asked a question on implementation); public opinion or agitation.” Aboriginal deaths in custody: response by Governments to the Royal Commission, Canberra, Australian Government Publishing Service, 1992
A focus upon prevention has been a critical aspect of this modern coronial reform. Mandatory reporting of responses to coronial recommendations is a critical component of prevention.

Coroner's inquests investigate deaths that might have been avoided. Inquests are lessons learned from the loss of individual lives, to benefit the whole community. A coronial inquest represents a significant investment of public and private resources, both human and financial.

Coronial recommendations have a vital role to play in the development of public policy and action to prevent many kinds of avoidable deaths. Deaths in custody, deaths in care, workplace and mining deaths, child deaths, deaths from fires, and deaths of missing persons are among the deaths that have resulted in coronial recommendations.

All Australian jurisdictions empower a coroner to make recommendations (or comments) in the interests of the preservation of life and the administration of justice.

In Western Australia the Coroners Act 1996 (WA) ss. 25 (dealing with findings and comments) provides that "a coroner may comment on any matter connected with the death including public health or safety or the administration of justice" (ss. 25 (2)) and that "where the death is of a person held in care, a coroner must comment on the quality of the supervision, treatment and care of the person while in that care." (ss. 25 (3))

Section 27 of the Act (dealing with "Reports") provides, relevantly, as follows:

(1) The State Coroner must report annually to the Attorney General on the deaths which have been investigated in each year, including a specific report on the death of each person held in care.

(2) The Attorney General is to cause a report submitted under subsection (1) to be laid before each House of Parliament within 12 sitting days of such House after its receipt by him or her.

(3) The State Coroner may make recommendations to the Attorney General on any matter connected with a death which a coroner investigated, including public health or safety, the death of a person held in care or the administration of justice.

(4) Where a recommendation made under subsection (3) regarding a death of a person held in care is relevant to the operation of an agency, the State Coroner must inform that agency in writing of the recommendation.

Focus on measures to prevent future deaths

The recently revised coronial legislation in Victoria, Queensland, and New Zealand, assigns a central role to prevention in the coronial systems of those jurisdictions.

In Western Australia, as a result of the structure and provisions of the Coroners Act 1996 (WA), recommendations for measures to prevent future deaths are ancillary to the core functions of investigating death to determine who died, when they died, how they died and what constituted their cause of death. Consequently, the role of recommendations in the coronial process in Western Australia depends largely on the discretion of individual coroners. However, it may be expected that the systemic approach adopted by the State Coroner in the inquest into the death of Mr. Ward will serve as a benchmark for the conduct of future inquests in Western Australia and, indeed, in other jurisdictions.

The legislative requirements relating to reporting coronial recommendations in Western Australia are limited. As a result of sub-sections 27 (1) and (2) of the Coroners Act 1996 (WA), the State Coroner must provide an annual report on all deaths investigated each year, including a specific report on the death of each person held in care, to the Attorney General.
for tabling in Parliament. However, the *Coroners Act 1996* (WA) contains no reporting requirements in relation to the implementation of the recommendations, including those in relation to deaths in care.

**Mandatory Reporting of Responses to Coronial Recommendations**

In Australia in the last two decades there have been only two public inquiries into the coronial process. Both inquiries emphasised the preventive role of coroners and recommended mandatory reporting of responses to coronial recommendations. As previously discussed, in 1991, the Royal Commission into Aboriginal Deaths in Custody reported on the role of coroners in death in custody investigations. The Royal Commission recommended a national system for mandatory responses by government agencies to recommendations made by coroners in inquests into deaths in custody.\(^{11}\)

In September 2006, the Final Report of the Victorian Parliamentary Law Reform Committee Inquiry into the Coroners Act 1985 (Vic) reported on that Committee's public review of the coronial system in Victoria. The Committee recommended the introduction of a mandatory reporting system for all coronial recommendations in Victoria.\(^{12}\) The *Coroners Act 2008* (Vic) implemented that recommendation.

Mandatory systems for response to coronial recommendations are now in place in Victoria, New South Wales, Queensland, the Northern Territory, South Australia and the Australian Capital Territory (in the latter two jurisdictions in relation only to deaths in custody). The United Kingdom has also recently introduced a mandatory coronial recommendation response system.

Western Australia and Tasmania are the only Australian jurisdictions currently without a mandatory system for response to coronial recommendations.

**Victoria**

The Victorian mandatory coronial recommendation response and reporting system, contained in the *Coroners Act 2008* (Vic), is as follows:

**Reports and Recommendations (Section 72)**

1. A coroner must report to the Attorney General on a death or fire that the coroner has investigated.
2. A coroner may make recommendations to any Minister, public statutory authority or entity on any matter connected with a death or fire that the coroner has investigated, including recommendations relating to public health and safety or the administration of justice.
3. If a public statutory authority or entity receives recommendations made by the coroner under subsection (2), the public statutory authority or entity must provide a written response, not later than 3 months after the date of receipt of the recommendations, in accordance with subsection (4).

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(4) A written response to the coroner by a public statutory authority or entity must specify a statement of action (if any) that has, is or will be taken in relation to the recommendations made by the coroner and the timetable for implementing the action (if not already taken).

(5) The coroner must: (a) publish the response of a public authority or entity on the Internet; and (b), provide a copy of the response to any person— (i) who has advised the principal registrar that they have an interest in the subject of the recommendations; and (ii) who the principal registrar considers to have a sufficient interest in the subject of the recommendations.

Publication of Findings and Reports (Section 73)

(1) Unless otherwise ordered by a coroner, the findings, comments and recommendations made following an inquest must be published on the Internet in accordance with the rules.

(2) A coroner must order that a report about any documents, material or evidence provided to the coroner as part of an investigation or inquest into a death or fire is not to be published if the coroner reasonably believes that publication would—

(a) be likely to prejudice the fair trial of a person; or (b) be contrary to the public interest.

(3) A person must not publish a report contrary to an order made under subsection (2).

Penalty: 60 penalty units.

Annual Report (Section 102)

(1) As soon as practicable in each year but not later than 31 October, the State Coroner must submit to the Attorney General a report containing:

(a) a review of the operation of the Coroners Court during the 12 months ending on the preceding 30 June; and

(b) any other matters that are prescribed by the regulation; (c) a schedule of all recommendations and responses to recommendations. (2) The Attorney General must cause each annual report submitted to him or her under this section to be laid before each House of Parliament within 7 sitting days after receiving it.

New South Wales

In January this year new coronial legislation, the Coroners Act 2009 (NSW), came into operation in New South Wales. The Coroners Act 2009 (NSW) contains no provisions requiring a response to coronial recommendations. However, in June 2009, a New South Wales Government Memorandum introduced a new process for responding to coronial recommendations directed at Ministers and NSW government agencies. The mandatory response and reporting system in New South Wales is as follows:

A Minister or NSW government agency which receives a coronial recommendation must write to the Attorney General outlining any action being taken to implement the recommendation within six months of receiving the recommendation. If it is not proposed to implement a recommendation, reasons should be given.

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13 New South Wales Government, Department of Premier and Cabinet; M2009-12 Responding to Coronial Recommendations - issued 4 June, 2009.
The Attorney General is to:

- maintain a record of all coronial recommendations made, together with the responses received from Ministers and NSW government agencies;
- arrange for a report to be posted on his Department's website, in June and December of each year, summarising coronial recommendations made and the responses received from Ministers and NSW government agencies; and
- send a copy of the report to the State Coroner for information.

Queensland

Section 46 of the Coroners Act 2003 (Qld) requires a copy of the coroner's comments (which include recommendations) to be given to the Minister responsible for, and the chief executive of, the relevant entity. Section 47 requires a copy of the findings and comments in relation to a death in custody or a death in care to be given to the Minister responsible for, and the chief executive of, the relevant entity. There is no legislative requirement that entities respond to these recommendations.

In April 2008, the Queensland Attorney-General announced that the Queensland Government had introduced an administrative process for monitoring the responses of public sector agencies coronial recommendations that impact on their responsibilities. Under these arrangements, government departments must consider and develop a response to coronial recommendations that relate to their responsibilities. These responses are consolidated into a public report. The Attorney General and Minister for Industrial Relations is responsible for the collation and release of the annual report. The first report, covering coronial recommendations handed down in the period from January 2008 to December 2008, was published in August 2009.

The Northern Territory

The Northern Territory has a mandatory response and reporting system for all coronial recommendations. The Northern Territory Coroners Act 1993 provides that in relation to a death in custody, the Coroner must make such recommendations with respect to the prevention of future deaths in similar circumstances as the Coroner considers to be relevant. The Act provides that this report must be sent without delay to the Attorney-General. In relation to deaths other than 'deaths in custody', the Act provides that the Coroner 'may' make recommendations to the Attorney-General.

In 2002 the Act was amended to require transparent and public government responses to

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16 Coroners Act (NT) ss 46A, 46B.

17 s 26

18 s 27

19 s 35
coronial recommendations.20 These amendments provide that once the Attorney-General receives a coronial report or recommendation (whether in relation to a death in custody or other matter) which contains comment in relation to a Northern Territory agency or the Police Force, the Attorney-General must without delay give a copy of the report or recommendation to the Chief Executive Officer of the agency or the Commissioner of Police. Similarly, if the report or recommendation contains comment in relation to a Commonwealth department or agency, the report must be forwarded to the relevant Commonwealth Minister.21 However, there is no requirement for the Attorney-General to forward the recommendations to any non-government or private sector organisations about whom recommendations may have been made.

The Act provides that the Chief Executive Officer (“CEO”) or Commissioner of Police (“Commissioner”) must provide a written response to the coronial report or recommendation to the Attorney-General within three months of receiving the report or recommendation.22 The response must include a statement of the action taken or proposed to be taken in response to the recommendation.23 There is no requirement for Commonwealth agencies to respond.

On receipt of the response by the CEO or the Commissioner, the Attorney-General must, without delay, report on the coroner’s report or recommendation and on the response from the CEO or Commissioner and lay a copy of his or her report before the Legislative Assembly within three sitting days after completing the report.24

South Australia

In South Australia and the Australian Capital Territory, legislative reporting requirements relating to coronial recommendations and their implementation apply only to deaths in custody.25

The South Australian Coroner’s Act 2003 (‘the Act’) came into effect on 1 July 2005.

Section 25 of the Act deals with the findings on inquest, including the power of a coroner to make recommendations to prevent or reduce the likelihood of a similar future event. Such recommendations are to be forwarded to the Attorney-General, and where the case is a death in custody and recommendations are directed to government, to the relevant Minister, agency or instrumentality.26

20 Amendments commenced 8 August 2002
21 s 46A
22 s 46B(1)
23 s 46B(2)
24 s 46B(3)
25 Coroner’s Act 2003 (SA) s 25; Coroners Act 1997 (ACT) ss 75, 76.
26 Section 25—Findings on inquests. (1) The Coroner’s Court must, as soon as practicable after the completion of an inquest, give its findings in writing setting out as far as has been ascertained the cause and circumstances of the event that was the subject of the inquest. (2) The Court may add to its findings any recommendation that might, in the opinion of the Court, prevent, or reduce the likelihood of, a recurrence of an event similar to the event that was the subject of the inquest. (3) However, the Court must not make any finding, or suggestion, of criminal or civil liability. (4)
Like the Northern Territory Act, the South Australian Act requires the relevant Minister to report to parliament in relation to action taken or proposed to be taken in response to the recommendations. Unlike the Northern Territory however, this mandatory reporting provision applies only to recommendations arising from a death in custody. Recommendations arising from other deaths are not subject to the same level of scrutiny.

The time frame for reporting to parliament provided in the South Australian Act is “within 8 sitting days of the expiration of 6 months after receiving a copy of the findings.”

The Australian Capital Territory

As previously mentioned, in the Australian Capital Territory and South Australia, legislative reporting requirements relating to coronial recommendations and their implementation apply only to deaths in custody.

The ACT Coroners Act 1997 provides that “a coroner may comment on any matter connected with the death, fire or disaster including public health or safety or the administration of justice.” Where a coroner completes an inquest into a death in custody, he or she must provide a report of his or her findings to, among others, the Attorney General, the custodial agency and the Minister responsible for that custodial agency.

Section 76 of the Act provides that the custodial agency must provide a written response to the findings in the Coroner’s report to its responsible Minister within three months of receiving the report from the Coroner. The agency’s response must include a statement of the action taken (if any) or to be taken with respect to the findings in the report. The responsible Minister must then provide a copy of the agency’s response to the Coroner. The Act also requires the Chief Coroner to provide an annual report for presentation to parliament which is to include any agency responses received pursuant to s 76 and any correspondence about those responses.

This requirement for an agency response to the findings in a Coroner’s report applies only in the case of a death in custody. Moreover, the only agency required to respond to a death in

The Court must, as soon as practicable after the completion of the inquest, forward a copy of its findings and any recommendations—(a) to the Attorney-General; and (b) in the case of an inquest into a death in custody—(i) if the Court has added to its findings a recommendation directed to a Minister or other agency or instrumentality of the Crown—to each such Minister, agency or instrumentality of the Crown; and (ii) to each person who appeared personally or by counsel at the inquest; and (iii) to any other person who, in the opinion of the Court, has a sufficient interest in the matter. (5) The Minister or the Minister responsible for the agency or other instrumentality of the Crown must, within 8 sitting days of the expiration of 6 months after receiving a copy of the findings and recommendations under subsection (4)(b)(i)—(a) cause a report to be laid before each House of Parliament giving details of any action taken or proposed to be taken in consequence of those recommendations; and (b) forward a copy of the report to the State Coroner.

27 See s 25(5)
28 See s 25(5)
29 Coroners Act 2003 (SA) s 25; Coroners Act 1997 (ACT) ss 75, 76.
30 s 52(4)
31 Coroners Act 1997 s 75
32 Coroners Act 1997 s 102
custody finding in a Coroner’s report is the ‘custodial agency in whose custody the death occurred’.33

The United Kingdom

In the United Kingdom the Coroners and Justice Act 2009 (UK) (s. 5 (1) (b) and (2) now provides that the purposes of an inquest include not only ascertaining how, when, where and in what circumstances the deceased came by his or her death but also prevention. The United Kingdom mandatory reporting system, contained in the Coroners and Justice Act 2009 (UK) (s. 32 and Schedule 5 paragraph 7), is as follows:

Where a senior coroner is conducting an investigation into a person’s death, and anything revealed by the investigation gives rise to a concern that circumstances creating a risk of other deaths will occur, or will continue to exist, in the future, and in the coroner’s opinion, action should be taken to prevent the occurrence or continuation of such circumstances, or to eliminate or reduce the risk of death created by such circumstances, the coroner must report the matter to a person who the coroner believes may have power to take such action (Schedule 5 paragraph 7(1)).

A person to whom a senior coroner makes such a report must give the coroner a written response to it and a copy of the report, and of the response to it, must be sent to the Chief Coroner (Schedule 5 paragraph 7(2)).

The Chief Coroner then has the task of monitoring the reports and responses and providing a summary to the Lord Chancellor who will then have the report tabled in parliament.34

A Mandatory Reporting System for Western Australia

In Western Australia there is currently no public reporting system for coronial findings and recommendations that:

• provides ready public access to all coronial findings and recommendations;
• guarantees that all coronial recommendations will be considered and responded to by the government agencies or entities to which they are directed;
• records which coronial recommendations have been implemented by responsible government agencies or entities and how they have been implemented; and
• enables evaluation of the impact of coronial recommendations upon the prevention of deaths in Western Australia.

The absence of an accessible and comprehensive public reporting system for coronial findings and recommendations, and responses by government to those recommendations, is a damaging gap in public knowledge about preventable deaths in Western Australia. This knowledge gap may fatally compromise government and community efforts to save lives. Responsible government agencies and organisations committed to preserving human life and

33 Coroners Act s 75(1)(b) and s 76
improving individual and community well-being are all adversely affected. These organisations include those in the health and safety sectors, organisations concerned to 'bridge the gap' in Indigenous mortality, and trade unions.

It is also of fundamental importance that the families of the deceased have knowledge of coronial recommendations, especially whether or not coronial recommendations have been implemented and, where they haven’t been implemented or only implemented in part, the associated reasons.

'Coronial Recommendations and the Prevention of Indigenous Deaths', the only national study to date on the implementation of coronial recommendations, tracked the response of government agencies to 484 coronial recommendations in 185 inquests around Australia, mostly in 2004. 35

The study revealed that fewer than half of coroners' recommendations to prevent future deaths were being implemented by governments across Australia. Half had been implemented in Western Australia (50 per cent), ahead of only New South Wales (48 per cent) Tasmania (41 per cent) and Victoria (26 per cent). The Australian Capital Territory (70%) and the Northern Territory (65%) had the best implementation. In South Australia the figure was 52%. Data for Queensland was unavailable at the time of the study.

The survey revealed ad hoc implementation of coronial recommendations by State and Territory governments and agencies. The fate of coronial recommendations is often left to media pressure, advocacy group intervention, and family and community action.

Coroners may therefore make potentially life-saving recommendations only for them never to be responded to or implemented, with no follow-up and no public awareness of what has happened.

The absence of a mandatory reporting system in Western Australia hinders proper and effective consideration and implementation of coronial recommendations.

The public has a right and a need to know about life and death decisions made by governments and public officials. Mandatory reporting of coronial recommendations and their implementation is essential to support that right and serve that need.

The value of coronial recommendations lies ultimately in their effectiveness in saving lives. Proper recording, monitoring and reporting of coronial recommendations and their implementation supports and enhances their life-saving potential. Greater public access to and improved co-ordination of information about coronial recommendations and their implementation will better inform government public health and safety decision-making and better inform the public about those decisions.

A mandatory coronial reporting system should be seen as an essential part of Western Australia's health and safety infrastructure and a public health initiative strengthening government efforts to prevent avoidable deaths. A mandatory reporting system would better

equip government to initiate and encourage others to take preventive action to save lives.

Conclusion

For the reasons set out in this submission the Coroners Act 1996 (WA)) should be amended to require the Government respond to coronial recommendations within a set timeframe.

Furthermore, the Inquiry should recommend that the Western Australian Government seek to work with the Federal and other state and territory governments to achieve a nationally consistent reporting process that makes publicly available at no cost the decisions and recommendations of all coronial inquests and the responses to the recommendations. This will enable governments and other organisations concerned with health and safety in each state and territory to learn from the deaths in other jurisdictions and implement effective preventive reforms.
Appendix A

Inquiry into Transportation of Detained Persons
Legislative Council Western Australia
Standing Committee on Environment and Public Affairs

Submission in relation to "whether the Coroners Act 1996 (WA)) should be amended to require the Government respond to coronial recommendations within a set timeframe" (Term of Reference 4)

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14 May, 2010

The Royal Commission's Reporting and Review Scheme for Coronial Recommendations arising from Deaths in Custody Contained in Recommendations 14 – 18

The first stage in the RCIADIC's reporting and review process for coronial recommendations arising from Indigenous deaths in custody is provided by Recommendation 14. The coronial findings and recommendation(s) must be provided to the authority responsible for any implementation of the recommendation(s), the families of the deceased and other parties at an inquest.

Recommendation 14: 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.

The second stage of the reporting and review process is contained in Recommendations 15 & 16. Within a recommended time frame, the relevant public authority must provide to the responsible Minister a written response to the coronial recommendation(s), including a report of any action taken or proposed to be taken. The Minister must then provide a copy of this response to the coroner who conducted the inquest, the State Coroner and the parties.
Recommendations 15 & 16 thus require proper consideration of and response to coronial recommendations aimed at preventing custodial deaths by public authorities.

**Recommendation 15:** That within three calendar months of publication of the findings and recommendations of the Coroner as to any death in custody, any agency or department to which a copy of the findings and recommendations has been delivered by the Coroner shall provide, in writing, to the Minister of the Crown with responsibility for that agency or department, its response to the findings and recommendations, which should include a report as to whether any action has been taken or is proposed to be taken with respect to any person.

**Recommendation 16:** That the relevant Ministers of the Crown to whom responses are delivered by agencies or departments, as provided for in Recommendation 15, provide copies of each such response to all parties who appeared before the Coroner at the inquest, to the Coroner who conducted the inquest and to the State Coroner. That the State Coroner be empowered to call for such further explanations or information as he or she considers necessary, including reports as to further action taken in relation to the recommendations.

The third and final stage, contained in Recommendations 17 and 18, provides for the annual publication and systemic review of coronial findings and recommendations in relation to deaths in custody matters and responses to them. The State Coroner must provide an annual report on findings and recommendations made in deaths in custody matters and the responses by the relevant authority to them. The report is to be provided to the Attorney-General or Minister for Justice and tabled in Parliament. In making the annual report the State Coroner is empowered to make such recommendations with respect to the prevention of deaths in custody generally as he or she thinks fit.

This review process, amongst other things, enables a State Coroner to identify ongoing causes of and unresolved problems in deaths in custody and to make further recommendations to prevent deaths in custody. So, for example, it enables a State Coroner to draw from the general experience gained from various inquests held into deaths in custody, to identify general, persistent problems which may not be apparent from an examination of the circumstances of an individual death, and to make recommendations to resolve such persistent problems.

**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.