REVIEW OF THE CORONERS ACT 2009

Submission on behalf of

Legal Aid NSW

To the Department of Justice

Legal Aid NSW welcomes the opportunity to make a submission to the review of the Coroners Act 2009 currently being conducted by the Attorney General in accordance with section 109 of that Act in order to:

> *"… review this Act to determine whether the policy objectives of the Act remain valid and whether the terms of the Act remain appropriate to securing those objectives."*

Legal Aid NSW provides assistance to disadvantage persons who are granted leave to appear at coronial inquests where there is a significant public interest. Most usually this involves us providing assistance and representation to family members of deceased persons. Particularly in matters where systemic issues appear to have contributed to someone's death and/or where such problems might be remedied by the Court making appropriate recommendations in relation to matters of public health and safety.

Since the introduction of the current Act in 2009 Legal Aid NSW has gained valuable first-hand experience in seeing the operation of the Court from the perspective of family members.

Based on our experience in coronial matters, Legal Aid NSW has made comment regarding the classes of matters that attract mandatory inquests, and the provisions relating to the Coroners' recommendation-making powers and how the provisions might be made more effective, including the monitoring of recommendations and their implementation.

1. Matters that require an inquest to be held

Section 26 of the Act makes the holding of an inquest mandatory in certain circumstances. These include where the Coroner's jurisdiction arises under section 23 of the Act.

Section 23 includes where a death occurs "*while in the custody of a police officer or in other lawful custody*". In the past there has been some inconsistency in interpreting this provision in relation to whether "other lawful custody" includes involuntary detention at a mental health facility under the Mental Health Act 2007 (MHA).

In some instances Coroners have assumed that the reference to "other lawful custody" includes detention under the MHA.[1] More recently however the Court has taken the view, based on advice sought from the Crown Solicitor's Office by the former State Coroner Ms Jerram, that the expression should not be interpreted to include such detention.

The basis for this advice appears to be that the legislative history of the provision derives from the recommendations of the Royal Commission into Aboriginal Deaths in Custody, and that the deaths with which the Commission was concerned were those occurring in police and prison custody.

Most other Australian jurisdictions have provisions in their legislation that mandate the holding of an inquest where the death occurred under mandatory detention in a mental health facility. This is done either by defining "custody" to include detention under mental health legislation, or alternatively creating a distinct category of a "death in care" that is part of the class of matters in which an inquest must be held.

In the ACT for example, it is mandatory to hold an inquest in relation to a "*death in custody*". A death in custody is specifically defined to include a death that occurs "*while being taken into or detained in custody, or subject to an order, under the Mental Health (Treatment and Care) Act.*"[2]

In Tasmania, it is mandatory for a Coroner to hold an inquest into a death he or she investigates where "*the deceased was immediately before death a person held in care or a person held in custody*". A person held in care is defined as "*a person detained or liable to be detained in an approved hospital within the meaning of the Mental Health Act 2013* …"[3]

The Northern Territory, Western Australia and Victoria all have provisions requiring the holding of inquests for deaths that occur "*in care*" (defined to include deaths while detained mental health legislation).

In South Australia inquests are mandatory in relation to deaths in custody, which are broadly defined to include a death that occurs in relation to any person detained under any State law (thus including those subject to detention under mental health legislation).

When the State detains someone, whether it be through the criminal justice system or under mental health legislation, it assumes a substantial duty of care for their welfare. The person's usual freedoms are curtailed and the actions of those who are responsible for them are less readily open to scrutiny.

In addition, those detained in facilities under mental health legislation are inherently likely to be particularly vulnerable due to the state of their mental health.

Legal Aid NSW is of the view that the Coroners Act should include a provision that makes the holding of an inquest mandatory where the relevant death occurred while the person was detained under the MHA.

The mandatory holding of an inquest in relation to such matters avoids potential inconsistencies between Coroners when determining whether an inquest ought to be held on a discretionary basis. It also helps ensure public confidence in the conduct of the responsibilities of those entrusted with the care of vulnerable members of the community.

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[1] For example the findings of Deputy State Coroner MacMahon dated 13 December 2011 in the matter of Samuel Dibley at paragraph 14.
[2] See section 13(1)(k) and section 3C(1)(d) of the *Coroners Act 1997 (ACT).*
[3] See sections 3 and 24(1)(b) of the *Coroners Act 1995 (Tas).*

Legal Aid NSW recommends that the Act be amended so that the death of someone subject to detention under the Mental Health Act 2007 is subject to a mandatory requirement that an inquest be held.

Another less common type of death is in relation to a person who dies while a resident at a Corrective Services Community Offender Support Program (COSP) centre.

COSP centres are staffed by employees of the Department of Corrective Services, housing prisoners who have recently been released to parole and are subject to strict parole conditions. Such people effectively have no other option but to live at such a facility as they are unable to secure other suitable or acceptable accommodation.

An example is the recent death of a man who was compelled to reside at a COSP facility and obey the directions of COSP and Probation and Parole Service (PPS) staff in order to comply with his parole conditions. He was not permitted by the PPS to reside with either his mother or his partner. Given he was not at liberty to live elsewhere and died within the facility, his family have been concerned that a thorough examination should be undertaken into whether the facility discharged its responsibilities to him, including whether staff acted appropriately and in accordance with procedures in the period leading up to his death.

Legal Aid NSW believes that the same underlying policy concerns that require inquests to be held in relation to deaths in custody are equally significant to the death of a resident at a COSP facility.

Legal Aid NSW recommends that the Act be amended so that that deaths that occur in facilities such as COSP centres are also subject to mandatory inquests.

2. Monitoring of responses to coronial recommendations

One of the main rationales for the provision of legal aid in coronial inquests is the public interest arising through changes made to institutional practices as a result of recommendations made by Coroners in relation to any matter connected with a death under section 82 of the Act.

Under section 82(4), the Coroner is to ensure that a copy of the recommendations goes to:
(a) the State Coroner (unless the coroner is the State Coroner), and
(b) any person or body to which a recommendation included in the record is directed, and
(c) the Minister, and
(d) any other Minister (if any) that administers legislation, or who is responsible for the person or body, to which a recommendation in the record relates.

However, there is no legislative provision that mandates the response to recommendations or the monitoring of the implementation of the recommendations.

Instead, NSW Ministerial Memorandum M2009-12 titled "Responding to Coronial Recommendations[4]" provides that:

> *Within six months of receiving a coronial recommendation, a Minister or NSW government agency should write to the Attorney General outlining any action being taken to implement the recommendation. If it is not proposed to implement a recommendation, reasons should be given (e.g. the recommendation will not achieve the intended outcome; the outcome can be achieved in another way; the*

[4] http://arp.nsw.gov.au/m2009-12-responding-coronial-recommendations

recommendation is impractical to implement having regard to the cost and potential benefits; there are other considerations that make implementation of the recommendation not feasible).

It also provides that:

The Attorney General will 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. The Attorney General will also send a copy of the report to the State Coroner for information. State Owned Corporations are encouraged to adopt the provisions of this Memorandum.

Family members represented by Legal Aid NSW frequently have a strong interest in the Coroners' recommendations following the death of their loved ones. An analysis of responses indicates the common response is to state that a matter is being considered. The expectation is that in the next 6 month reporting period, a substantive response will be produced and published. However this in practice almost never occurs and no further response is being published.

For family members the current practice undermines their faith with the recommendation-making function of the Court.

Legal Aid NSW believes that the Coroners Act should include provisions that clearly spell out how Ministers and agencies must respond to Coroners' recommendations and how such responses are to be published.

A number of other Australian jurisdictions have provisions that mandate the need for responses to be made by Agencies, as well as requiring such responses to either be tabled in parliament or published on the internet.

In the Northern Territory, agency heads must provide the Attorney General with responses to recommendations within 3 months. The Attorney General must then see that the responses are laid before parliament within three days.[5]

In Victoria there is a legislative requirement that agencies provide a written response to recommendations within 3 months "*that must specify a statement of action that has or will be taken.*" Responses must be published on the internet and copies of the responses provided to any person who has advised the Court that they have an interest in them.[6]

As one of the primary rationales of the coronial jurisdiction is the remedial effect of its recommendation-making role, an effective regime includes the results of the consideration of to its recommendations.

Legal Aid NSW recommends that the Act is amended to provide that:

- ***Agencies to which recommendations are directed are to provide timely and substantive responses to the Court and the Attorney-General indicating how recommendations are being implemented or alternatively, why they have not been;***
- ***Such responses are to be tabled in parliament; and***

[5] See sections 34, 35, 46A, 46B *Coroners Act 1993 (NT)*.
[6] See section 72 & 73 *Coroners Act 2008 (Vic).*

- ***Responses are also to be made available, through the Court, to family members of deceased persons.***

Thank you for the opportunity to provide these comments. Should you require any further information, please contact William de Mars, Solicitor Advocate, Coronial Inquest Unit at william.demars@legalaid.nsw.gov.au.