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Coroners Act Reform Team
Strategic Policy and Legislation
Department of Justice
GPO Box 149
Brisbane QLD 4001

By email: CoronersActReform@justice.qld.gov.au

Dear Coroners Act Reform Team,

Re: Coroners Act 2003 Review

Thank you for the opportunity to provide comments on the current review of the *Coroners Act 2003* (**Review**). In this submission, we have outlined for your consideration proposed amendments to the *Coroners Act 2003* (**Act**) which we consider would promote system efficiencies, enable the Act to better align with community expectations and better meet the needs of families of the deceased. We have sought to address each of the 3 Reform Pillars for the Review, namely: 1. A Contemporary Coronial System; 2. An Efficient and Effective Coronial System; and 3. Responsible to Queenslanders' Expectations.

Preliminary consideration: Our background to comment

The Aboriginal and Torres Strait Islander Legal Service (Qld) Limited (ATSILS), is a community-based public benevolent organisation, established to provide professional and culturally competent legal services for Aboriginal and Torres Strait Islander peoples across Queensland. The founding organisation was established in 1973. We now have 25 offices strategically located across the State. Our Vision is to be the leader of innovative and professional legal services. Our Mission is to deliver quality legal assistance services, community legal education, and early intervention and

prevention initiatives which uphold and advance the legal and human rights of Aboriginal and Torres Strait Islander peoples.

ATSILS provides legal services to Aboriginal and Torres Strait Islander peoples throughout Queensland. Whilst our primary role is to provide criminal, civil and family law representation, we are also funded by the Commonwealth to perform a State-wide role in the key areas of Community Legal Education, and Early Intervention and Prevention initiatives (which include related law reform activities and monitoring Indigenous Australian deaths in custody). Our submission is informed by over five decades of legal practise at the coalface of the justice arena and we, therefore, believe we are well placed to provide meaningful comment, not from a theoretical or purely academic perspective, but rather from a platform based upon actual experiences.

Comments on the Bill

Reform Pillar 1 - A contemporary coronial system - *Identify areas where the Act may better support contemporary coronial practice or medical and technological developments*

Use of technology

In our view, the Coroners Court of Queensland (**CCQ**) has adopted technology well. There is a notable amount of flexibility with the use of phone and video links making the experience more accessible than some other courts. The electronic sharing of documents for Body of Evidence (**BOE**) disclosure flows reasonably well. We also see some opportunities for improvement of the use of technology.

We recommend consideration of the development of a secure coronial portal akin to the Commonwealth Courts Portal in the Federal Circuit and Family Court of Australia (**FCFCOA**). In our view, this would be beneficial as there is no need for links to continually be sent out manually by CCQ to parties. A feature of this system is an automatic notification system to parties whereby when you sign into the portal account, it will notify you that new material has been added to the BOE. This avoids issues associated with human error, for example, exhibits missing from briefs and will avoid the Coroners Court office having to repeatedly provide updated indexes to the brief every time there is a new exhibit.

For a cross-jurisdictional example, we make particular mention of the Northen Territory Coroner's Court's recent handling of the Kumanjayi Walker Inquest, which

we considered to be very effective and one that could be adopted in this jurisdiction which included the live streaming of proceedings, transcripts being released daily and exhibits, submissions and rulings being available on the court website for the public to view and download. We recommend live streaming of the proceedings in cases where there is significant public interest, and the family are in favour of such.

Reform Pillar 2 - *Comment on legislative amendments that would improve procedural efficiency while preserving procedural fairness and the integrity of coronial investigations*

Reportable deaths

We acknowledge that the Coroners Court is a busy jurisdiction. However, we would caution against any proposed reforms of the Act that would narrow the definitions of reportable deaths resulting in less deaths meeting the relevant threshold. In fact, in our view, there are deaths that should currently be investigated that do not fall under the existing definitions of the Act.

In particular, we recommend that the Act be amended as follows:

1. Section 27 (When an inquest must be held)

There is currently no requirement for all health care related deaths to proceed to a mandatory inquest. While health care related deaths are reportable deaths under the Act, they are not included among the categories of death for which an inquest must be held under section 27.

We recommend that section 27 be amended to provide that if a death is a health care related death, the coroner must consider whether an inquest is required having regard to certain prescribed matters including: whether the family disputes the medical explanation; whether there are allegations of systemic failures; whether multiple providers were involved (for example, going from aged care into the hospital); whether there is significant public interest; whether similar incidents have previously occurred; and whether the death raises issues affecting patient safety.

2. Clearer definition for health care deaths

Statutory definitions relating to health care related deaths could be clarified. In particular, the Act could more clearly distinguish health care related deaths from deaths in care, provide additional guidance regarding the concepts of "unexpected

outcome" and causation and include examples of circumstances in which a death might be considered to be health care related. Clearer definitions have the potential to improve consistency in reporting practices.

Timeliness of case management and investigations, accountability and the impact on families

We recommend that the Act be amended as follows:

3. **Legislatively stipulated timeframes for case management and investigations to ensure that such is undertaken in a timely and predictable manner**

In our experience, it is not uncommon for coronial investigations to take more than two years to be finalised. There are multiple delay points at play. Autopsy reports can take up to 12 months. The QPS investigator's investigation, drafting of their report and compilation of the BOE can often involve lengthy timeframes. Once the QPS report is in, it might take another six months for the relevant Counsel Assisting to review and task additional investigations or engage an expert. Expert reports can take several months to be completed. As expert reports are generally done before any material is disclosed to the other parties, there might be a further delay if issues are raised by the expert report. We acknowledge that there is a delicate balance between completing an investigation in a timely manner and ensuring it that the process is not rushed.

We recommend that the Act be amended to impose stipulated timeframes for case management and investigations to ensure that such is undertaken in a timely and predictable manner. Whilst we appreciate that some deaths are complex and this translates to investigations taking longer to complete, we consider that having a maximum timeframe within which an investigation, the length of which could be the subject of consultation with relevant stakeholders, will help promote timeliness.

Additionally, in the interests of efficiency and accountability, we recommend that the Act be amended to impose a legislative obligation on the State Coroner to report annually in its Annual Report as to its performance against the stipulated timeframes along with how long it takes for matters to reach the finalisation stage.

4. **Introduction of a Mention or Directions Hearing at set periods**

Rather than most matters having just the one Pre-Inquest Conference and then an inquest, we recommend that the Act be amended to provide for an early case

management Mention or Directions Hearing at a set period (i.e., 12 months into a matter) to discuss the status of the investigations, material to be obtained and what timeframes should be attached, etc. Such would provide an opportunity for the coroner and interested parties to review the progress of the investigation, identify any outstanding investigative steps or evidence yet to be obtained, establish realistic timeframes for their completion and resolve any emerging procedural issues. This would promote greater transparency and accountability throughout the investigative process and ensure that families and their legal representatives are kept appropriately informed of the progress of the investigation, rather than remaining uncertain about its status for extended periods.

Additionally, whilst this might not be a matter for legislative amendment, we wish to express the value in, where appropriate, holding a pre-inquest conference soon after high profile deaths. Consideration should also be given to amending the Act to require the coroner, when convening a pre-inquest conference that involves an Aboriginal or Torres Strait Islander deceased person, to consider whether the manner, timing and location of the conference should be adapted to facilitate culturally safe and meaningful participation by the deceased's family and community.

5. Mandatory family engagement framework and disclosure obligations

Currently, where an investigation is taking place and is ongoing, CCQ will send out generic letters to families every six months to update them that the investigation is ongoing. The letters do not contain any level of detail that would provide a meaningful update as to where the investigation is up to. In order to obtain any substantive information regarding the status of the investigation, we need to contact CCQ, specifically request that information and follow up CCQ.

We recommend that the Act include a mandatory family engagement framework which prioritises regular and meaningful/substantive updates to the family. The update letters should, for example, distinguish between when the coroner is still awaiting receipt of an expert report as opposed to receipt of other material relevant to their investigation, whether they are waiting on medical reports, etc.

Whilst we acknowledge that we receive some material disclosed during investigations, we are aware that the Victorian coronial framework includes mechanisms for keeping families and interested parties informed during investigations, including the provision of coronial process information and access to documents for recognised parties. In our view, such a model allows parties to raise issues with investigators throughout the

investigation, rather than at the end. Accordingly, we strongly adoption of the Victorian Coroners Act model (including notably section 115, *Coroners Act 2008* (Vic).

6. **Provision of information relating to medical procedures and medical reports**

We recommend that the Act be amended to strengthen families' access to medical evidence obtained during coronial investigations. The current Queensland framework relies upon families making an application for access to coronial documents or "another type of investigation document" (see section 54).

As noted in our earlier comments, we recommend that the Act adopt similar provisions to that which is contained in section 115 of the *Coroners Act 2008* (Vic) which, in the context of medical reports, requires, inter alia, that, unless otherwise ordered by the coroner, the principle registrar must provide the senior next of kin of a deceased person with written notice that reports have been given to the coroner as a result of a medical examination performed on the deceased, that the senior next of kin may request copies of those reports and the manner in which such may be requested. In our view this model appropriately balances transparency and family participation with the need to protect privacy and prevent disclosure of irrelevant or sensitive information. The coroner should retain discretion to withhold or redact material where appropriate, for example, where it is unrelated to the circumstances of death.

7. **Express disclosure obligations in relation to all coronial information**

Currently, the Act does not contain express disclosure obligations in relation to all coronial information.

The State Coroner's Guidelines (2013) emphasise the right of family members to be informed and consulted about key decisions in the coronial process (see Chapter 2.4, 2.7, 2.9 and 2.12), for example, that families are entitled to be given as much information as possible about the cause of death and the steps in the coronial system, including the preliminary autopsy findings and the final autopsy report (unless this would compromise the investigation, for example, if a family member is implicated) and that families must be regularly updated on the process of the investigation, unless this would compromise the investigation. However, the Guidelines do not have the force of law.

In practice, we have observed that there is currently an inconsistent and sometimes ad-hoc approach amongst coroners in relation to the provision of coronial documents to families of the deceased and their legal representatives. In some instances, we have

been advised by staff of a coroners' office that the coroner will not provide substantive information about the circumstances of the passing until the coronial findings are released. As an example, our lawyers have – in the past - requested access to the Form 1 (police notification of death to the coroner) for a range of matters. These are not currently routinely provided to the family/legal representative of the family. We need to specifically request them. When they are requested, some coroners refuse the request, even when the purpose of requesting the document is to provide legal advice to our client.

In our view, legislated disclosure obligations may allow for greater efficiency and procedural fairness as parties will have ability to provide feedback and input during the investigation and before experts are engaged to ensure that all relevant material is obtained and any expert report encompasses appropriate information and considerations so there isn't a need to go back and get a second opinion at the inquest stage. Legislated disclosure obligations will also promote a more consistent practice amongst coroners.

We appreciate that the coroner should retain discretion with respect to the withholding or redaction of information where appropriate, for example, where such might contain graphic material or impact the provision of witness evidence.

8. **Amendments to section 16 (Duty to help investigation) to allow for contemporaneous capture of evidence**

Section 16 of the Act provides that where a coroner is investigating a death and the coroner reasonably believes a person may be able to give the coroner information, a document or anything else that is relevant to the investigation, the coroner may require the person to give the coroner the information, document or other relevant thing. Pursuant to section 16(5), it is an offence to not comply with the requirement, unless the person has a reasonable excuse. Section 16(6) then provides that it is a reasonable excuse for a person to fail to comply with the requirement if complying with it would tend to incriminate the person.

We understand that QPS officers may be directed by the Commissioner of Police to participate in an investigative interview as part of a coronial investigation. However, there does not appear to be an equivalent statutory mechanism to ensure that other witnesses who may hold critical information, provide contemporaneous accounts during the investigation stage.

Delays in obtaining witness statements can significantly affect the quality and reliability of the evidence. For example, concerns have been raised about an inquest in which statements from attending paramedics were not obtained until several years after the death. By the time the statements were provided, the witnesses were unable to recall important aspects of the events because of the passage of time.

Section 16 of the Act should be reviewed, and amendments should be considered to ensure that coronial investigations facilitate the timely capture of relevant evidence.

9. Explicit power for the Coroner to review relevant CCTV footage

We recommend that the Act be amended to give the coroner an explicit power to obtain and review relevant CCTV footage where it may assist in the investigation of a death. This would ensure that coroners have direct access to important evidence and are not solely reliant on the actions of other investigating agencies to obtain and provide such material.

10. Provide the ability for family to provide evidence/information directly to the coroner

We recommend that the Act be amended to provide families with an express and standalone ability to provide information to the coroner and alert the coroner as to the existence of relevant evidence during the investigation stage. While police investigations will often provide an important source of information for coronial investigations, the coronial process should not be wholly reliant upon the scope and outcomes of an external investigation, particularly where families may hold unique information about the deceased person, their circumstances, relationships, communications or events preceding the death. In some matters, relevant evidence might not be identified or preserved at an early stage, including digital evidence such as social media content, messages or other online material that might be capable of being altered or lost over time. Providing families with a clear mechanism to alert the coroner to the existence of potentially relevant evidence would strengthen the independence and completeness of coronial investigations and provide an important safeguard where there may be gaps or limitations in other investigative processes. This mechanism should be supported by appropriate case management powers to enable coroners to assess the relevance and significance of material provided, recognising that families might provide information of varying relevance and volume. The objective should not be to replicate a police investigation or require the coroner to investigate every matter raised by a family, but rather to ensure that families have a

meaningful avenue to identify relevant evidence that might assist the coroner in determining the circumstances of a death.

11. Section 24 (Removing tissue for autopsy testing)

We recommend that where tissue has been kept without the family's consent for further testing, there should be an obligation on the State to provide financial assistance such that the family does not have to pay a second round of burial costs for their loved one.

12. Section 30 (Applying for an inquest to be held)

Under section 30(1), a person may apply to the coroner investigating a person's death to hold an inquest into the death. If the coroner decides not to hold an inquest, subsection (4) provides that the person can apply for an order that an inquest be held to the relevant party/forum as outlined in that subsection. Section 30(5) provides such an application must be made within 14 days after the person receives the written reasons for the coroner's decision.

In our view, 14 days is not long enough in circumstances where the client is difficult to contact or might be grieving and not in a headspace to be able to provide instructions at that time. Additionally, we have observed that, often, a decision not to hold an inquest is accompanied by non-inquest findings. Therefore, family members are dealing with this along with needing to make quick decisions to "appeal". The short timeframe does not lend itself to giving the client enough time to properly consider what has happened and provide instructions. We recommend that the 14-day timeframe be amended to allow for 30 days to apply for the relevant order.

13. Section 41 (Prohibited publication orders)

Section 41 enables a coroner to, either before, during or immediately after the holding of an inquest or pre-inquest conference, make an order prohibiting the publication of information relating to, or arising at, an inquest or pre-inquest conference. The former *Coroners Act 1958* (repealed) did not contain an equivalent express discretionary power enabling a coroner to make prohibited publication orders (**PPOs**) of the kind now provided for under section 41 of the Act. While the former regime contained certain publication-related restrictions, it did not appear to provide an equivalent publication suppression power exercisable on a case-by-case basis. In the context of legacy matters that continue to be dealt with under the former legislative regime, consideration could be given to transitional amendments that would permit

the making of PPOs under section 41 in relation to those matters, thereby extending the protection available under the current Act to affected families, witnesses and other participants.

14. Section 46 (Coroner's comments)

The Act currently does not mandate a government/agencies response to coronial recommendations, however this should be amended and made mandatory for all government and non-government entities who are subject to recommendations. Families and the community often expect coronial recommendations to produce meaningful change. A statutory response framework would improve accountability and public confidence.

15. Section 54 (Access to investigation documents)

This section outlines how investigation material can be disclosed and essentially provides that provision of this material is at the discretion of the coroner. There is no obligation to provide investigation documents to families when there was no inquest.

Whilst we appreciate that there should be an element of discretion about what to release to families, consideration should be given to the introduction of a review option where a decision to deny a request for coronial information or investigation documents could be challenged by application to the state coroner and, if unsuccessful, the District Court (similar to other sections in the Act).

Reform Pillar 3 - Responsive to Queenslanders Expectations - *Provide submissions on how legislative reform could better support family engagement, transparency, and the public interest*

1. Structural improvements to the Act to promote integrity and impartiality

The Review offers an opportunity to recalibrate the Act to ensure that it prioritises maintaining public confidence in the coronial system, i.e., a system that operates independently, transparently and with procedural safeguards that ensure all evidence is scrutinised equally. We recommend consideration of legislative reforms to strengthen mechanisms that promote equality of participation, transparency in decision making and independent scrutiny in matters involving state authorities. We consider such to be consistent with the Royal Commission into Aboriginal Deaths in Custody as it will promote improved confidence of Aboriginal and Torres Strait Islander peoples in the Coronial system.

As an example, we recommend consideration of amendments to the Act that would expressly recognise and facilitate the opportunity for families to provide a statement about the deceased and the impact of their loss as part of the coronial process. While coroners may currently permit families to provide information or make submissions, there is no clear statutory mechanism recognising a family's right to have their voice heard in this way. A family statement can provide important context about the deceased person, including relating to their relationships, cultural connections, life experiences and the impact of their death on those who knew and loved them. This is particularly important in ensuring that the deceased is not reduced to the circumstances of their death, but is recognised as a person within their family and community. Consideration should be given to allowing such statements to be provided at an early stage of the coronial process, including during the investigation stage at an initial hearing or pre-inquest conference to ensure that the coroner and interested parties understand the human impact of the death from the outset. The ability for families to provide such statements should be balanced with the need to ensure procedural fairness and the integrity of the coronial process. For example, a coroner might need to manage content that contains allegations against individuals or agencies. These considerations should be addressed through appropriate case management and guidance rather than preventing families from having a meaningful opportunity to be heard.

2. Long delays waiting for findings to be published or released

Coroners' findings can take a long time to be released. Whilst we appreciate that some inquests can be complex and decision-making can take time, for affected families of the deceased, delays in findings can result in families not being able to achieve closure, finalise cultural obligations or pursue related legal or administrative processes. The Act currently does not impose a timeframe within which findings must be delivered. It also does not require coroners to provide updates or reasons where matters remain reserved for lengthy periods.

Some examples of amendments that could be made to the Act to address this issue are outlined below:

(a) insertion of a legislative obligation on the coroner to deliver findings as soon as reasonably practicable and no later than 6 months after the conclusion of submissions;

(b) insertion of a provision that states that if findings are not delivered within the prescribed period, that the coroner must notify interested parties of: the reason

for the delay; the anticipated timeframe for delivery; and any significant developments affecting the progress of the matter; and

(c) a requirement that the State Coroner be required to report annually on the average time taken to deliver findings, the longest outstanding reserved findings and the number of matters exceeding the specified benchmarks.

3. Insert a new Part into the Act containing a charter of minimum rights for families involved in coronial investigations

We strongly recommend that the Act be amended to insert a new Part which contains a charter of minimum rights for families involved in coronial investigations, similar to a statutory charter of family rights. While many of these practices already occur administratively, placing them in legislation would create a consistent statewide standard and clearer expectations for families.

4. Strengthening of the ability for families to access information in coronial investigations

We refer to our earlier comments regarding the often-lengthy duration of coronial inquests and the limited substantive information currently provided by the Coroners Court to families about the status and progress of investigations or other processes associated with an inquest. Bereaved families consistently expect to be kept informed about the progress of the coronial investigation into their loved one's death. In practice, however, they are frequently disappointed. We have observed that many express feeling shut out, disempowered and suspicious of the investigative process, particularly where police are involved. A major contributor to this problem is the coroner's broad discretion to withhold coronial information, even from senior next of kin or their legal representatives, despite the Coroner's Guidelines repeatedly emphasising the importance of timely updates and transparent communication.

We recommend that the Act be amended to strengthen families' access to information in coronial investigations <u>including where a matter is finalised without an inquest</u>.

Whilst the Act currently provides a mechanism for those with a sufficient interest to seek access to coronial documents, access remains discretionary and there is no general entitlement for families to receive the material that the coroner relied upon in making findings. The current framework places the burden on families to justify why they should receive information, rather than on the coroner to justify why they should not. Where a matter is finalised without an inquest, this can result in families receiving a final outcome without having had a meaningful opportunity to understand, review or

respond to the evidence underpinning the outcome. This is out of step with contemporary expectations of trauma-informed practice, procedural fairness and public confidence in the coronial system.

We ask that consideration be given to inserting a presumption that immediate family members are entitled to access relevant coronial material, with non-disclosure permitted only in clearly defined, exceptional circumstances. In circumstances where the coroner decides that access will be refused or limited, the Act should require that reasons must be given in writing to the family with an associated pathway to seek a review of the decision, to either the State Coroner or the District Court, as appropriate.

Thank you for the opportunity to provide feedback on the Review.

Yours faithfully,

Shane Duffy
Chief Executive Officer