

Submission to the National Human Rights Action Plan Baseline Study Consultation

Australian Inquest Alliance

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Introduction

The Australian Inquest Alliance (the Alliance) consists of a growing number of organisations and individuals across State and Territory borders, including community legal centres, Aboriginal and Torres Strait Islander Legal Services (ATSILS), advocates for imprisoned women and men, and academic researchers.

The Alliance has a significant depth of advocacy, research and social policy experience and expertise over many years. This knowledge encompasses coronial investigations, inquests, human rights and broader coronial frameworks across jurisdictional boundaries.

The Alliance seeks systemic change in order to eliminate and reduce preventable deaths. We believe that this requires each State and Territory to effectively address the structural issues underpinning preventable deaths.

We welcome the opportunity to comment on Australia's National Human Rights Action Plan Baseline Study.¹ The focus of our submission is inclusion of issues for reform of coronial systems across Australia in the Baseline Study and subsequent National Human Rights Action Plan, so that social justice may be effectively pursued for those who have died in circumstances where the death may have been prevented.

Overview of the submission

The Baseline Study Consultation Draft (Baseline Study) aims to facilitate identification of priority areas of action for inclusion in the National Human Rights Action Plan, in order for human rights to be further respected, protected and fulfilled. It seeks to do this by providing a summary of how human rights are currently protected in Australia.

With respect to preventable deaths, the Baseline Study does not draw on the relevant human rights jurisprudence and mechanisms concerning Australia's obligations, and does not adequately outline the relevant evidence.² Accordingly, the Baseline Study fails to sufficiently document the current state of affairs in which the right to life is not being sufficiently respected, protected or fulfilled in Australia.

We first identify the gaps in the Baseline Study concerning protection and promotion of the right to life. We explain why the Australian Government is further obligated to address violations of the right to life, by fleshing out the human rights obligations

¹ The principal author of this submission is the Federation of Community Legal Centres Victoria. The submission is endorsed by: Ray Watterson, Adjunct Professor of Law, La Trobe University; Sisters Inside; Aboriginal & Torres Strait Islander Legal Service (Qld) Ltd; Victorian Aboriginal Legal Service Co-operative Limited; Deaths in Custody Watch Committee WA.

² There is some brief reference to different kinds of deaths such as those resulting from TASERs (12-13) and youth suicide (40-41), but no links are made to Australia's obligations concerning the right to life. Other than briefly noting UPR Recommendations concerning Aboriginal and Torres Strait Islander deaths in custody (27), the Baseline Study does not discuss any implications for the coronial system.

documented in the Baseline Study. We then suggest additions to the Baseline Study in the form of evidence of human rights violations concerning the right to life.

We understand that the Australian Government is committed to further community consultation concerning the content of the National Human Rights Action Plan. In the final part of our submission, we make some preliminary comments concerning necessary measures and specific actions to improve Australia's human rights situation concerning the right to life, with the focus on Australian coronial systems.

Protection and promotion of the right to life

Relevant human rights

The right to life³ is a fundamental human right that is now understood to include the requirement that States must protect individuals against the actions of not only State but also private actors,⁴ and to encompass freedom from violence against women that is life threatening.⁵ In this last respect we endorse the submission of the Federation of Community Legal Centres Victoria concerning the need for 'joined up' domestic/family violence death reviews.

The right to life and the right to an effective remedy for violation are breached where the Australian Government does not take adequate steps or measures to intervene or protect lives.⁶

The right to life also requires that families of the deceased be fully informed and empowered to participate in the coronial process, with genuine access to legal representation in inquests.⁷ The right to life further requires that the coronial process take place in an accountable and genuinely preventative framework.⁸

Other human rights relevant to preventable deaths include the right to freedom from torture, inhuman or degrading treatment;⁹ the right to freedom from discrimination;¹⁰

³ Article 6, International Covenant on Civil and Political Rights 1966, GA res. 2200A (XXI), 16 December 1966, 999 UNTS 171 (entered into force 23 March 1976).

⁴ See eg Alice Edwards, *Violence Against Women Under International Human Rights Law* (2011) 264.

⁵ UN Human Rights Committee, Concluding Observations on Peru, UN Doc. A/52/40 (Vol. I) (1997); UN Human Rights Committee, Concluding Observations on Colombia, UN Doc. A/52/40 (Vol I) (1997); UN Human Rights Committee, General Comment No. 28: Equality of Rights Between Men and Women.

⁶ *Kontrova v Slovakia* [2007] ECHR 419 (31 May 2007).

⁷ *R on the Application of Amin v Secretary of State for the Home Department* [2004] 1 AC 653, 25, 43, 44, 50, 51; *R on the Application of D v Secretary of State for the Home Department* [2006] All ER 946, para 9(iii); *Jordan v United Kingdom* (2001) 37 EHRR 54, para 105-9; Leslie Thomas, Adam Straw and Danny Friedman, *Inquests: A Practitioner's Guide* (2nd Ed, 2008), 360-79.

⁸ *Royal Commission into Aboriginal Deaths in Custody (RCIADIC) National Report Vol 1* (1991), [4.7.4]; Graeme Johnstone, 'An Avenue for Death and Injury Prevention' in Hugh Selby (ed), *The Aftermath of Death* (1992) 140; James Reason, 'Human Error: Models and Management' (2000) 320 *British Medical Journal* 768; David Ranson, 'The Role of the Pathologist' in Hugh Selby (ed), *The Aftermath of Death* (1992) 80, 120-21; State Coroner of Western Australia, Findings and Recommendations of the Inquest into the Death of Mr Ward, 12 June 2009.

⁹ Article 2, Convention Against Torture and Other Forms of Cruel, Inhuman or Degrading Treatment or Punishment, opened for signature 4 February 1985, 1465 UNTS 85 (entered into force 26 June 1987); Article 7, International Covenant on Civil and Political Rights, opened for signature 16 December 1966, 999 UNTS 171 (entered into force 23 March 1976).

the right to equality before the law;¹¹ the right to protection of family;¹² the right to health;¹³ and the right to an effective remedy for rights violations.¹⁴

Need for a federal Human Rights Act

While we understand that the Australian Government will not consider the issue of comprehensive legislative human rights protection until at least 2014, we reiterate our strong support for a federal Human Rights Act. Such legislation was also overwhelmingly called for in public responses to the National Human Rights Consultation. The United Nations Human Rights Council, through the Universal Periodic Review (UPR) process (Recommendation 86.22), has recommended that Australia adopt such legislation.

Need for greater powers of Australian Human Rights Commission

The Australian Human Rights Commission has a limited role because it does not have authority to make enforceable determinations or to require the Australian Government to implement or respond to its recommendations. United Nations Committees have recommended that the Commission's mandate be strengthened and that its recommendations be given adequate follow-up.¹⁵ The UPR recommended (86.27) that the Commission should have adequate funding in order to be able to properly conduct its functions and activities.

Need to honour due diligence obligations

Human rights jurisprudence concerning the doctrine of 'due diligence' elaborates on Australia's obligations concerning the right to life. A due diligence standard

serves as a tool for rights-holders to hold duty-bearers accountable by providing an assessment framework for ascertaining what constitutes effective fulfillment of the obligation, and for analyzing the actions or omissions of the

¹⁰ See among other instruments, Article 26, International Covenant on Civil and Political Rights, opened for signature 16 December 1966, 999 UNTS 171 (entered into force 23 March 1976).

¹¹ See among other instruments, Article 26, International Covenant on Civil and Political Rights, opened for signature 16 December 1966, 999 UNTS 171 (entered into force 23 March 1976).

¹² Article 17, International Covenant on Civil and Political Rights, opened for signature 16 December 1966, 999 UNTS 171 (entered into force 23 March 1976); Article 10, International Covenant on Economic Social and Cultural Rights, opened for signature 16 December 1966, 999 UNTS 3 (entered into force 3 January 1976).

¹³ Article 12, International Covenant on Economic Social and Cultural Rights, opened for signature 16 December 1966, 999 UNTS 3 (entered into force 3 January 1976).

¹⁴ See among other instruments, Article 2, International Covenant on Civil and Political Rights, opened for signature 16 December 1966, 999 UNTS 171 (entered into force 23 March 1976).

¹⁵ Concluding Observations of the Committee against Torture, Australia, 40th Session, 22 May 2008, CRC/C/AUS/CO/3; Concluding Observations of the Committee on Economic, Social and Cultural Rights, Australia, 42nd Session, 12 June 2009, E/C.12/AUS/CO/4.

duty-bearer.¹⁶

Under international human rights law, Australia has an obligation to respect, protect and fulfil the human rights in the treaties to which it is a signatory. 'Respect' requires Australia to refrain from interfering directly or indirectly with human rights, while 'protect' includes the obligation to take measures to prevent third parties from interfering with human rights.

The obligation to 'fulfil' contains further obligations to facilitate, provide and promote human rights, and thus requires Australia to adopt appropriate legislative, administrative, budgetary, judicial and other measures towards the full realisation of human rights.¹⁷

Courts, police, social services, and any other agencies designated by the federal Government to have responsibility, are under a duty to ensure that all appropriate, reasonable steps are taken to protect individuals from threats to their life, threats of inhuman and degrading treatment or threats to their moral and physical integrity. The Commonwealth Government cannot delegate its ultimate responsibility to exercise this due diligence.¹⁸

Australia is therefore required to not only make legal avenues accessible for family members who have lost loved ones, but to take positive action – action necessary to protect the right to life of all persons. The focus of assessment of whether there has been sufficient due diligence is 'analysis of results and effectiveness'.¹⁹

As this submission focuses on the place of coronial systems in Australia's proposed National Human Rights Action Plan, we explain below how the role of coroners and the function of death prevention are relevant to Australia's human rights obligations.

Role of coroners

Coroners are required to discover the truth about a death, including not just its immediate but also its underlying causes.²⁰ In any best practice model, inquests, and particularly coronial recommendations, have a preventative role,²¹ in producing long-

¹⁶ Special Rapporteur on Violence Against Women, Its Causes and Consequences, *Summary Paper on the Due Diligence Standard for Violence Against Women* (2011)

<http://www2.ohchr.org/english/issues/women/rapporteur/vaw.htm> .

¹⁷ Committee on Economic, Social and Cultural Rights, General Comment 14, The Right to the Highest Attainable Standard of Health, UN Doc E/C 12/2000/4 (2000), para 33.

¹⁸ UN Committee on the Elimination of All Forms of Discrimination Against Women, General Recommendation No. 19 (11th session, 1992); *Velasquez-Rodriguez v Honduras*, judgment of 29 July, 1988, Inter-Am. Ct. H.R. (ser. C) No. 4, para 172; *Maria da Penha v Brazil*, Case 12.051, Report No. 54/01, Inter-Am. Ct. H.R., Annual Report 2000, OEA/Ser.L/V.II.111 Doc.20 rev. (2000).

¹⁹ Special Rapporteur on Violence Against Women, Its Causes and Consequences, *Summary Paper on the Due Diligence Standard for Violence Against Women* (2011)

<http://www2.ohchr.org/english/issues/women/rapporteur/vaw.htm> .

²⁰ Graeme Johnstone, 'An Avenue for Death and Injury Prevention' in Hugh Selby (ed), *The Aftermath of Death* (1992) 140, 145.

²¹ *Royal Commission into Aboriginal Deaths in Custody* ('RCIADIC') *National Report Vol 1* (1991), [4.7.4]; Graeme Johnstone, 'An Avenue for Death and Injury Prevention' in Hugh Selby (ed), *The*

term solutions to any systemic problems at the heart of the death.²² Systemic issues can arise from contexts as diverse as those involving the treatment of persons in custody and care, faulty products, medically related deaths, industrial accidents, or the way that the State responds to domestic/family violence.

The modern inquest's fundamental guiding principle should be respect for and protection of human life. This principle should guide a 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 requires inquiry into systemic failure, identification of institutional responsibility, and appropriately directed practical recommendations.

With respect to coronial investigations, the right to life has been interpreted as encompassing the following minimum requirements:

- the investigation must be independent;
- the investigation must be effective;
- the investigation must be reasonably prompt;
- there must be a sufficient element of public scrutiny;
- the next of kin must be involved to an appropriate extent; and
- the State must act of its own motion and cannot leave it to the next of kin to conduct any part of the investigation.²³

The inquest into Mr Ward's death conducted by the Western Australia State Coroner, Alistair Hope, provides a best practice example of modern coronial process.²⁴ The State Coroner's investigations, findings, wide-ranging 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.

Evidence of Australian human rights violations concerning the right to life

There is a wealth of published information that the Baseline Study should refer to in documenting Australia's human rights violations concerning the right to life. A small sample includes the following reports, which themselves also refer to a vast range of authoritative sources: *Freedom, Respect, Equality, Dignity: Action – NGO Submission to the Human Rights Committee* (September 2008);²⁵ the *National Report of the Royal Commission into Aboriginal Deaths in Custody* (1991); the Law

Aftermath of Death (1992) 140; James Reason, 'Human Error: Models and Management' (2000) 320 *British Medical Journal* 768.

²² David Ranson, 'The Role of the Pathologist' in Hugh Selby (ed), *The Aftermath of Death* (1992) 80, 120-21.

²³ *R on the Application of Amin v Secretary of State for the Home Department* [2004] 1 AC 653, 25, 43, 44, 50, 51; *R on the Application of D v Secretary of State for the Home Department* [2006] All ER 946, para 9(iii); *Jordan v United Kingdom* (2001) 37 EHRR 54, para 105-9; Leslie Thomas, Adam Straw and Danny Friedman, *Inquests: A Practitioner's Guide* (2nd Ed, 2008), 360-79.

²⁴ State Coroner of Western Australia, Findings and Recommendations of the Inquest into the Death of Mr Ward, 12 June 2009.

²⁵ <http://www.hrlrc.org.au/content/topics/civil-and-political-rights/un-human-rights-committee-review-of-australia-march-2009>, at 29 August 2011. See especially 64-66, 72-84.

Reform Commission of Western Australia Discussion Paper, *Review of Coronial Practice in Western Australia* (June 2011); the *Joint NGO Submission to the Universal Periodic Review of Australia* (July 2010, especially 4); and the *Joint Aboriginal and Torres Strait Islander Legal Services UPR Submission* (2011).²⁶

These reports document the ways in which forms of structural inequality and disadvantage contribute to a disproportionate number of deaths, including deaths of: people in police custody and prison; people with mental illness; women killed by male partners; migrants from CALD communities; asylum seekers and refugees; young people; and people with disabilities.

One example, out of many potential illustrations, demonstrates some of the human rights implications and their connection to the coronial system.

Example: The death of Paul Carter

Paul Carter was an Aboriginal man with a cognitive impairment and a history of mental illness and substance abuse. On 7 August 2006 he died after being hit by a truck on the Sturt Highway, 12 km out of Mildura. Earlier that day, Paul's brother had died unexpectedly from an epileptic seizure. Paul had spent much of the day with his family mourning his brother's death, and then went to his girlfriend's house where the police were called later in the night.

It was understood that the police were taking Paul to his father's house, but he was dropped off on the highway about 13 km away, where in the dark and cold, with no footpath and under the influence of grief and alcohol, he ran into the path of the truck. The Coroner found that it 'goes without saying that had Paul been delivered to his father's home that night, he would not have been at risk of running in front of a truck on the Sturt Highway.'²⁷

As part of our argument about what is needed for effective death prevention in order for the Australian Government to fulfil its obligations concerning the right to life, we also give examples of system failure in the last section of this submission.

Measures needed to address Australia's human rights obligations concerning the right to life

A raft of measures is necessary for Australia to genuinely respect, protect and promote the right to life. The Australian Government is obligated via due diligence to do all it reasonably can to prevent avoidable deaths. Action must include effective policy formulation based on an understanding of the demographics, patterns and risk

²⁶ http://vals.org.au/static/files/assets/41872791/ATSILS_UPR_Submission.pdf at 29 August 2011.

²⁷ State Coroner of Victoria, Inquest into the Death of Paul Wayne Carter, 13 May 2009, 40.

factors of particular types of deaths; and the translation of that policy into practical initiatives.

Systemic inequality is a key factor in many preventable deaths. This is evident in relation to the shamefully high number of deaths of Aboriginal and Torres Strait Islander peoples, particularly deaths in custody and, for women especially, deaths from family violence. Despite overwhelming evidence and practical recommendations on what is required from investigations such as the Royal Commission into Aboriginal Deaths in Custody, such deaths continue. This fact profoundly illustrates the present systemic failure to redress the ongoing impact of colonialism, racism, misogyny and economic and cultural dispossession on Australia's first peoples and other disadvantaged communities.

Our submission focuses on only one strategy, the need for effective and 'joined up' coronial systems and responses across Australia. This must be accompanied by best practice support and sensitively facilitated participation of families in investigations, inquests and all other aspects of the required systemic response.

Resourcing of coroners

A crucial factor in whether recommendations are made in a particular inquest is that while coroners are independent judicial officers who often have power to obtain documents and answers to questions about a death from governments, corporations and individuals; coroner's offices are usually under-resourced, with little assistance provided to help them compile their findings and recommendations.

The prevention goal would be met more effectively if coroners had access to more systematic training and resources to assist them with the formulation and distribution of recommendations, supported by systematic data and research able to be easily accessed across jurisdictions.

RECOMMENDATION 1

The Commonwealth Government should work with state and territory governments to enable each jurisdiction to effectively recognise the international human rights obligation to respect, protect and fulfil the right to life by introducing, as appropriate, amendments to coronial legislation so that coronial investigation is independent, appropriately and adequately resourced, and considers systemic issues.

As part of the recognition of the right to life, where the right to life is central to an inquest, family members must have genuine and effective access to legal aid at a level that is consistent with the level of legal representation accorded to government and other institutional parties in the inquest.

The need for effective death prevention

Coroners' recommendations can only save lives if they are responded to by the agencies and entities responsible. Effective death prevention also requires a system in which responses to coronial recommendations are tracked and changes are implemented which address the systemic factors identified by coroners to be at the heart of the death.

Families, advocates, researchers and others concerned with social justice also desire a publicly accountable coronial system that consistently produces comprehensive findings and appropriately targeted recommendations. They need to know that the goal of prevention is being served, and consequently need information about what recommendations have been made, the responses and associated reasoning of agencies and entities, how recommendations are being implemented, and how implementation will be monitored to ensure that avoidable deaths are prevented in the future.

As one bereaved family member has expressed it:

Put yourself into the situation of a family that has just lost someone. Why put ourselves through this anyway? . . . [I]t is a hardship reading through every detail in a coronial inquest, but if at the end of the day you know that, 'Such-and-such happened, that is why your son is dead', then all right. I knew three and a half years ago that the death should have been avoidable. There was no need for anyone to plough through 11 days of evidence for that. But if something else comes out of it, if systems can change, then yes, it is worth doing.²⁸

But how do family members, social justice advocates and the general public find out whether and when 'something else comes out of it'?

The National Coroners Information System (NCIS) is a very valuable tool and a significant step forward in the prevention of untimely death. Its primary role is to assist coroners by providing them with the ability to review similar previous coronial cases. However, NCIS data, including coronial findings and recommendations, is not publicly available. The NCIS also does not hold data about the implementation of coronial recommendations. This means that it is very difficult for researchers, let alone the general public, to assess the impact of coronial recommendations upon the prevention of deaths in the various Australian jurisdictions, either generally or in any particular kind of death.

The only research to date that has examined implementation of coronial recommendations in all Australian jurisdictions found that there were

²⁸ Mrs M. Kaufmann, mother of Mark who was fatally shot by police, *Minutes of Evidence*, 22 August 2005, 68-9, Law Reform Committee, Parliament of Victoria, *Inquiry into the Review of the Coroners Act 1985* <http://www.parliament.vic.gov.au/LAWREFORM/inquiries/Coroners%20Act/transcript.htm> at 9 September 2009.

recurring instances where coronial recommendations had not been communicated or had been miscommunicated, or were lost within bureaucratic processes.²⁹

A number of factors were significant in whether a recommendation was implemented:

- whether prior coronial recommendations arising from similar deaths were drawn to the attention of the relevant authorities;
- whether responses from targeted organisations were mandatory; and
- whether a proactive system for review of recommendations existed within the targeted organisation.³⁰

As the Australia-wide study found, within any particular jurisdiction, recommendations may not be implemented in time to prevent other similar deaths - or may never be implemented. The present patchwork system also means that government and other agencies in one jurisdiction are unlikely to learn effectively and in a timely way from a death, or even a pattern of deaths, in another jurisdiction.

Failure to bridge the gap between coronial recommendations and implementation, and to apply the lessons from recommendations concerning earlier deaths to similar subsequent situations, is evident even in contexts where there are clear national ramifications or where a national body is implicated in the recommendations.

This failure is best illustrated by the fate of many of the recommendations of the Royal Commission into Aboriginal Deaths in Custody.

Royal Commission into Aboriginal Deaths in Custody

The Royal Commission into Aboriginal Deaths in Custody was established in 1987 to address concerns about the numbers of Aboriginal and Torres Strait Islander peoples dying in prisons, police custody, and juvenile detention institutions. The Royal Commission's 1991 *National Report* concluded that the high death rate was due to the gross over-representation of Aboriginal and Torres Strait Islander peoples in custody.³¹ The Royal Commission therefore examined the underlying reasons for this, including profound social, economic and cultural disadvantage.

²⁹ Ray Watterson, Penny Brown and John McKenzie, 'Coronial Recommendations and the Prevention of Indigenous Death' (2008) 12 (6) *Australian Indigenous Law Review* 4, 5. The study tracked the response of government agencies to 484 coroners' recommendations in 185 inquests around Australia, mostly in 2004.

³⁰ Ray Watterson, Penny Brown and John McKenzie, 'Coronial Recommendations and the Prevention of Indigenous Death' (2008) 12 (6) *Australian Indigenous Law Review* 4, 12.

³¹ *RCIADIC National Report Vol 1* (1991).

As part of its investigation, the Royal Commission observed that there was a

pervasive and troubling failure of the coronial structure in every state and territory to supply the critical analysis needed to uncover the reasons for Aboriginal deaths in custody.³²

This was coupled with a failure of the coronial system as a whole to help prevent Aboriginal and Torres Strait Islander deaths.³³

The *National Report* offered practical suggestions to reduce the risk of Aboriginal and Torres Strait Islander incarceration and deaths in custody. 34 of the 339 recommendations concerned reform of the state and territorial coronial systems. In essence, they urged that the coronial system be strengthened so that coroners could be empowered to effectively address systemic prevention.

Five of the Royal Commission's recommendations specifically concerned the need for mandatory responses to coronial recommendations:

Recommendation 14

That copies of the findings and recommendations of the Coroner be provided by the Coroners Office to all parties who appeared at the inquest, to the Attorney-General or Minister of 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.³⁴

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.³⁵

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

³² Ray Watterson, Penny Brown and John McKenzie, 'Coronial Recommendations and the Prevention of Indigenous Death' (2008) 12 (6) *Australian Indigenous Law Review* 4, 6.

³³ Ray Watterson, Penny Brown and John McKenzie, 'Coronial Recommendations and the Prevention of Indigenous Death' (2008) 12 (6) *Australian Indigenous Law Review* 4, 6.

³⁴ *RCIADIC National Report Vol 1* (1991), 172.

³⁵ *RCIADIC National Report Vol 1* (1991), 172.

explanations or information as he or she considers necessary, including reports as to further action taken in relation to the recommendations.³⁶

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.³⁷

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.³⁸

While a number of the Royal Commission reforms have now been implemented, many have not. In relation to the coronial recommendation issues, the Commonwealth Government and all State and Territory governments supported Recommendations 14, 15, 17 and 18. Recommendation 16, essentially dealing with keeping the inquest parties 'in the loop' in relation to responses, and with coronial follow-up of responses, was not endorsed by South Australia, Tasmania or the Northern Territory.³⁹ Twenty years later, none of Recommendations 14-18 has been implemented in a systematic, nationwide manner.

The WA State Coroner, Alastair Hope, handing down his findings and recommendations in the inquest into the death of Mr Ward, has supported the continuing relevance of the Royal Commission's recommendations, drawing upon them to underpin his view of best practice coronial investigation and death prevention.⁴⁰

The findings from the national study examining implementation of coronial recommendations echo the Royal Commission in suggesting that mandatory responses would improve both the communication and implementation of coronial recommendations.⁴¹ Jurisdictions also need to have an effective system for monitoring recommendations, responses and appropriate implementation. Government agencies and other relevant entities must be encouraged to develop

³⁶ *RCIADIC National Report Vol 1* (1991), 173.

³⁷ *RCIADIC National Report Vol 1* (1991), 173. Recommendation 13: That a Coroner inquiring into a death in custody be required to make findings as to the matters which the Coroner is required to investigate and to make such recommendations as are deemed appropriate with a view to preventing further custodial deaths. The Coroner should be empowered, further, to make such recommendations on other matters as he or she deems appropriate (*RCIADIC National Report Vol 1* (1991), 172).

³⁸ *RCIADIC National Report Vol 1* (1991), 173.

³⁹ For more detail, see Ray Watterson, Penny Brown and John McKenzie, 'Coronial Recommendations and the Prevention of Indigenous Death' (2008) 12 (6) *Australian Indigenous Law Review* 4, 22.

⁴⁰ State Coroner of Western Australia, Findings and Recommendations of the Inquest into the Death of Mr Ward, 12 June 2009.

⁴¹ Ray Watterson, Penny Brown and John McKenzie, 'Coronial Recommendations and the Prevention of Indigenous Death' (2008) 12 (6) *Australian Indigenous Law Review* 4, 12.

their own internal systems for dealing with recommendations, that entail clear lines of responsibility.

Victoria has now mandated agency and other entity responses to coronial recommendations,⁴² making it only the third Australian jurisdiction to do so. Without mandatory responses, agencies can ignore or even lose recommendations without having to inform the court, the deceased's family or the public of their response.⁴³

RECOMMENDATION 2

The Commonwealth Government should work with state and territory governments to harmonise core best practice so that all pertinent State and Territory legislation is amended to require the relevant governments and other entities to respond to coronial recommendations within a set time frame.

Joined up justice

The systemic failure that led to the death is often perpetuated due to a second tier of systemic failure – an inability of governments and other entities to respond effectively. In these contexts, coronial recommendations concerning earlier deaths might have saved later lives if they had been implemented.

This second systemic failure is most clearly evidenced in responses to those deaths which continue to form a repeating pattern irrespective of state and territory boundaries, such as deaths associated with: the transportation of detained persons, the presence of hanging points in prisons, police shootings, or institutional failure to effectively intervene in family violence.

To more starkly highlight the present piecemeal approach to death prevention where lessons have often failed to be learned both within and across state and territory jurisdictions, we draw on a somewhat different but equally tragic pattern, of child deaths due to strangulation by blind cords.

Blind cord deaths perhaps best illustrate why reform of the broader system which analyses and responds to deaths is also necessary. The blind cord cases clearly show the gaps in the system that can perpetuate the pattern of deaths when responses to coronial recommendations are not only non-mandatory, but also are not part of a coordinated nationwide response.

⁴² *Coroners Act 2008 (Vic)* s 72.

⁴³ Ray Watterson, Penny Brown and John McKenzie, 'Coronial Recommendations and the Prevention of Indigenous Death' 2008 12(2) *Australian Indigenous Law Review* 4.

Blind cord deaths – examples of double system failure

On 28 July 2004, the Victorian State Coroner brought down his findings in relation to an infant who died when his neck became entangled in a looped blind cord. The Coroner adopted the recommendations of a Tasmanian inquest concerning another death in almost identical circumstances on 19 December 2003:

- a public education program should be implemented which highlights the risk and informs the community about methods to address the hazard;
- an effective approach should be adopted to render safe blinds and curtains which are already installed; and
- a mandatory safety standard should be implemented in [Victoria] with regard to the supply of window coverings with cords to address the risk of infant strangulation.

On 1 March 2007, 13-month-old Nicholas Esposito died in South Australia as a result of hanging.⁴⁴ The post-mortem report from forensic pathologist Professor Roger Byard said that hanging from cords is a recognised risk when cots are placed next to blinds. In his findings, the Deputy State Coroner (DSC) noted that Professor Byard had also given evidence at a previous South Australian inquest into the death of a 15-month-old toddler in November 1999 by hanging involving a blind cord.

As a result of the 1999 death, the former South Australian State Coroner, Wayne Chivell, had called for a public warning to be given to the parents of young children about the risks involved in allowing them to have access to ropes or cords which are long enough to go around the child's neck. He said that parents should ensure that curtain cords are kept out of the reach of small children and that they should be provided with advice and assistance about how to avoid these risks.

In Nicholas Esposito's inquest more than eight years later, the DSC said that child blind cord deaths were preventable. However he pointed out that over 2000-2008 there had been eight coronial reports from other States or Territories of infant blind cord deaths. Two of these deaths were the Tasmanian and Victorian deaths described above. The DSC noted that these two deaths were the subject of coronial findings and recommendations that were in the public domain and were very similar to those made in the present inquest into the death of Nicholas Esposito.

The DSC also found that while New South Wales, Queensland, Tasmania, Western Australia and the ACT now had blind cord regulations in place, South Australia and Victoria did not.⁴⁵ The difference between Tasmania and Victoria in relation to the legislation, despite two very similar deaths, appears largely due to the media

⁴⁴ SA Deputy State Coroner Anthony Schapel, Findings into the Death of Nicholas Esposito, 15 December 2007.

⁴⁵ The DSC noted that product safety regulators across Australia were undergoing a process of harmonising all applicable legislation, which had been agreed to by all State, Territory and Commonwealth Ministers and would include safety standards and bans. The nationwide system was expected to be in place by mid 2009.

coverage in Tasmania as the result of the activism of the mother of the child who died there.⁴⁶

The blind cord deaths starkly demonstrate the absence of clear recommendation and implementation pathways across states and territories. A general lack of systematic monitoring also makes it difficult to learn from patterns of deaths, particularly across Australian jurisdictions.⁴⁷ This situation creates a serious obstacle to consistent best practice in inquests, to public accountability, to attempts at systematic research, and ultimately to more effective death prevention across Australia.

Simply put, if states and territories have an effective response system and are able to learn from each other when similar deaths occur in different jurisdictions – whether those deaths occur in prison transport, are due to avoidable accidents, or take place in any other preventable context – people will not continue to die as a result of a failure to ‘join up’ justice.

In 2008, the then federal Minister for Home Affairs, the Honourable Bob Debus, expressed his hope that coronial recommendations and the prevention of avoidable deaths would be added to the agenda of the Standing Committee of Attorneys-General.⁴⁸

RECOMMENDATION 3

The Commonwealth Government should work with state and territory governments to achieve a uniform national coronial public reporting and review scheme for coronial findings and recommendations which:

guarantees that all coronial recommendations will be considered and responded to by the government agencies and any other entities or persons to whom they are directed;

provides ready public access to all coronial findings, recommendations and responses;

records and makes publicly available (including via a Coroners Annual Report to Parliament and on the Internet) whether or not coronial recommendations have been implemented by responsible government agencies and other entities;

enables evaluation of the impact of coronial recommendations upon the prevention of deaths;

adheres to timeliness at every step of the recommendations process; and

⁴⁶ Ray Watterson, Penny Brown and John McKenzie, ‘Coronial Recommendations and the Prevention of Indigenous Death’ (2008) 12 (6) *Australian Indigenous Law Review* 4, 17-18.

⁴⁷ Ray Watterson, Penny Brown and John McKenzie, ‘Coronial Recommendations and the Prevention of Indigenous Death’ 2008 12(2) *Australian Indigenous Law Review* 4.

⁴⁸ Hon Bob Debus, ‘Foreword’ (2008) 12 (6) *Australian Indigenous Law Review* 4, 1.

provides feedback to families (including a copy of recommendations and responses to families, other parties and legal representatives) at every step of the recommendations process.