'WHY THIS LAW?': VAGARIES OF JURISDICTION IN CORONIAL REFORM AND INDIGENOUS DEATH PREVENTION

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I Introduction

[T]he claim of jurisdiction is never simply a claim of present authority but invokes with it a commitment of a justice to come.[1]

In considering the coronial role and its place in preventing Indigenous death, it is vital to reflect on jurisdictional matters that give coronial law its distinctive character. As Shaunnagh Dorsett and Shaun McVeigh outline, at play in jurisdictional questions is the very nature by which individuals become subject to a legal life and, importantly for this article, death.[2] They note that jurisdiction 'institutes a relation to life, place and event', where law becomes more than just an administrative or descriptive practice.[3] This is to say that jurisdictional practices have *very real effects*, bringing significant structure, meaning and expression to someone's life and death. Correspondingly, jurisdiction operates differently upon different bodies, including the dead. Due to their nature (as sudden, unexpected, 'reportable'), certain deaths become subject to coronial investigation and, in some cases, an inquest, and in this process are distinguished by a jurisdiction freighted with significant reform and evolution.[4]

In the recent past, amendments to the coronial legislation of Australian States and Territories have refined the coronial jurisdiction, as have appellate decisions. The courts have been concerned with matters of jurisdiction in many forms, such as the ambit of investigation[5] and inquest,[6] the power to make comments and recommendations,[7] and findings in relation to key issues such as causation and contribution to death.[8] Issues of jurisdiction, then, explicitly echo throughout common law decisions about the coronial role as do legislative amendments focused on honing the coronial purpose. Significantly, however, recent coronial reform has also been administrative in nature and not explicitly attached to legislative change or judicial interpretation. Folded within the boundaries of the juridical are innovative tools – tools Dorsett and McVeigh might term the 'technologies' of jurisdiction – which are beginning to enable systematic communication across Australian coronial jurisdictions, one of the most significant of these technologies being the National Coroners Information System ('NCIS').[9] Such technologies are considered internationally groundbreaking and have the capacity to help consolidate coronial practices into coherent systems of death prevention. Not only do they assist coroners to satisfy statutory obligations in 'fact-finding' regarding individual deaths; they also support the social relevance of the coronial role in death prevention.[10]

The coronial jurisdiction requires closer analysis if the future efficacy of Australian coronership is to be achieved, as tension exists between coronial jurisprudence, practice and possibility. As highlighted by commentators, in many senses the contemporary coronial jurisdiction is caught between the promising future of death investigation and the ad hoc trajectory of the past.[11] This tension is clearly articulated throughout coronial jurisprudence, reforms and public debate. Coronial law has attracted significant legislative adjustment and recent review,[12] which bespeaks a jurisdiction undergoing considerable, continuing development – one that realises death is an individual event that often raises public questions. Implicit within the public response to the jurisdiction, then, is an expectation of what coronial law can bring as distinct from the criminal process: a process of uncovering facts that is able to get to the heart of 'what happened'. This article examines the issues inherent in the settling of the coronial role throughout Australian jurisdictions and the implications of this for coronial reform in the 21st century, as seen through specific findings on Indigenous death.

The article begins by discussing the move towards prevention that dominates much commentary on the contemporary role and value of the coroner. It thereafter reviews the complexities of the coronial jurisdiction in light of this evolution, as highlighted by appellate decisions and consideration of a signal case: the death of Mulrunji Doomadgee in Queensland in 2004. The case received significant media attention[13] and the legal trajectories resulting from Mulrunji's death generated controversy following the decision by the Queensland Director of Public Prosecutions not to prosecute the police officer identified by the Acting State Coroner as causing the fatal injuries to Mulrunji. Eventually, the path this case took saw the officer become 'the only Queensland police officer who had to wait on a jury verdict on a death in custody'.[14] Accordingly, the case illustrates that the circumstances of death matter, and this capacity to account for context is precisely what the coronial focus on death offers the community. Nonetheless, it is also a role that is required to determine oftentimes problematic 'facts'. The article explores the Mulrunji case to highlight these issues.

The article then considers a key capacity of the coroner to contribute to preventing death in the community via inquests into multiple deaths. The article discusses how recent coronial inquests and subsequent findings into multiple Indigenous deaths in Aboriginal communities, in their capacity to contextualise individual deaths within a wider social and historical sphere, bring into sharp relief the systemic difficulties confronting some Indigenous communities. These recent findings in relation to multiple Indigenous deaths also reveal the frustrations of a jurisdiction increasingly seen as hamstrung in its capacity to fulfil its distinctive death prevention role. While the findings demonstrate the merits of the coronial jurisdiction, at times they also accentuate its inability to prevent further deaths occurring in similar circumstances. That this inability relates to death in Indigenous communities throughout Australia ignites some fundamental questions not only about the value of coronial law but also about larger socio-political commitments to public health in its broadest sense. These are also questions about the ways in which society institutes a response to that which often underscores preventable death: violence, poverty, mental health, safety, etc. To ask after this jurisdiction and its current effects more carefully is to approach the question 'why this law?'[15] so as to advance both its legal and extra-legal achievements in death investigation.[16] It is to fully recognise that a field of seeming 'narrow' compass (ie, death) is actually also about social life and activity, and to invest in it as such.

II The Coronial Evolution Towards Death Prevention: Trajectories of Reform

Coronial inquiries, as with criminal and civil trials, are retrospective exercises; they peer into the past to establish and adjudicate on the issues before them. Yet, unlike judgments of criminal or civil courts, coronial decisions have the unique potential to recalibrate social understanding about and responses to death and injury beyond a 'subsidiary' nature.[17] This potential is embedded within the authority of all Australian coroners, who have the power, statutorily defined, to make comments and recommendations to avoid preventable deaths in future.[18] This power takes similar form in State and Territory legislation, such as that stipulated in the *Coroners Act 1985* (Vic) where '[a] coroner may comment on any matter connected with the death including public health or safety or the administration of justice'.[19] And whilst not overtly espousing the preventive principle, it has been argued that such provisions provide a 'statutory base for prevention' and coroners have long interpreted it as such.[20] Increasingly, jurisdictions in Australia have taken this prevention principle further and statutorily expressed it. Most recently, Victoria's new Coroners Bill 2008, currently before Parliament, seeks to build upon the preventive focus by inserting clauses outlining the centrality of prevention to the jurisdiction.[21] Prevention will be legislatively enshrined as part of the role of the Coroner's Court and the core duties of coroners, including with regard to the appointment of coroners[22] and the functions of the proposed Coronial Council of Victoria – a council created and empowered by the Coroners Bill 2008 (Vic) to provide advice and make recommendations to the Attorney-General.[23] Both the Queensland and Tasmanian Coroners Acts have for some time symbolised the advancement of prevention as part of a coroner's chief responsibilities. The *Coroners Act 2003* (Qld) expressly provides for prevention by adding to comment provisions around public health, safety and the administration of justice[24] with s 46(1)(c), which provides the power to make comments that relate to 'ways to prevent deaths from happening in similar circumstances in the future'.[25] In Tasmania this power to make preventive recommendations is an obligation.[26]

Indeed, in overhauling and modernising Queensland coronial law, the Queensland Government noted the

importance of prevention across legislative provisions. Geraldine Mackenzie, Nigel Stobbs and Mark Thomas note that, when introducing the new *Coroners Act 2003* (Qld), the Queensland Attorney-General

> was at pains to explain that the amendments to the powers of the State Coroner were largely aimed at expanding the powers of the Coroner to obtain information and evidence, to 'find out what had really happened to cause the death and make meaningful recommendations to prevent it happening again.'[27]

The link between prevention principles and the practice of making recommendations is now well recognised in discussions on the coronial jurisdiction. Indeed, in relation to Indigenous deaths, the Royal Commission into Aboriginal Deaths in Custody ('RCIADIC') made note of the provision for prevention in the previous *Coroners Act 1958* (Qld), s 43(5), which, in limited circumstances, allowed coroners to make a 'rider' expressing their opinion so as 'to prevent the recurrence of similar occurrences'. However, the RCIADIC also noted that:

> Such a statutory provision tends to marginalise what ... should be a major consideration for all coroners on inquest. Far from requiring that recommendations be made, it tends to suggest that they will only be made in exceptional circumstances. The inhibition which some coroners have shown in cases examined by the Commission is reinforced by the provision of a power couched in such terms.[28]

The RCIADIC recommended a more 'positive duty' be imposed on coroners, which Queensland and Tasmania have clearly adopted. The Tasmanian and Queensland provisions mark a key development in contemporary coronial law: the legislative recognition of and expectations for the coroner's role in death prevention.[29] Unlike other legal jurisdictions that also might be said to 'weigh up' matters of death and injury (albeit with different focus and purpose), the coronial jurisdiction has a substantive remedial aspect that is forward looking. This is now firmly woven into the purpose and practice of coroners throughout Australia and contemporary declarations of 'prevention' as a chief pursuit are positioning the jurisdiction as proactive rather than reactive.[30] In this sense, the coronial jurisdiction fills

> a void left by deficits in both the civil and criminal law ... to address constructively scenarios in which members of the community meet their deaths unnecessarily and prematurely. In good part it is a public health issue.[31]

The principle of serving 'public health' is growing in coronial discourse, and is embodied in legislative and administrative changes to the jurisdiction. This is an important facet of the move towards ensuring that the coronial role is relevant in contemporary Australia, since not all communities experience a comparable status of 'health'. Indigenous people, it is frequently recognised, experience substantially lower levels of health than non-Indigenous Australians, including in relation to infant mortality, life expectancy, safety, the management of disease, mental health and overall wellbeing.[32] In light of these differences, the corollary of effectively serving 'public health' through coronial practice might, for Indigenous Australians, be a very real reduction in premature, preventable death. Higher rates of morbidity and mortality amongst Indigenous Australians compared with non-Indigenous Australians suggest that this is a matter of life and death, not to mention the critical 'public health' status of grieving communities following, for example, high levels of suicide and multiple deaths. Coronial recommendations, in their focus on public health and their capacity to prevent future deaths, have the potential to improve in some way the disadvantage experienced in many Indigenous communities. Recent coronial findings into multiple Indigenous deaths reiterate these public health principles, highlighting that issues of public health and individual death are inextricably linked and underwritten by social history. I take up these issues in the ensuing sections of this article.

Australian coroners have been consistently accommodating of the refinement of their tasks beyond fact-finding and towards a jurisdiction principled in how it responds to death in the community (and indeed some have strongly advocated for it).[33] This has been achieved through both extensive review and 'clause-by-clause' reform. In regard to the former, Victoria is widely recognised as a forerunner of progressive coronial practice following the recommendations of the 1981 Norris Report, which identified prevention as a key organising principle of modern coronial practice and which provided the foundations for the *Coroners Act 1985* (Vic).[34] More recently, extensive reform has been exhibited by Queensland, which overhauled its coronial system via the introduction of the *Coroners Act 2003* (Qld), following a path of reform initiated in the 1990s. The principle of prevention at the heart of the Queensland reforms signifies an impetus to more effectively tailor the jurisdiction to public needs.[35]

Most recently, however, Victoria has again conducted a sweeping review of its coronial jurisdiction, taking account of interstate and international jurisdictional practices. In 2006 the Victorian Parliamentary Law Reform Committee ('VPLRC') published its final report into the *Coroners Act 1985* (Vic), making 138 recommendations[36] to which the Victorian Government issued a response, supporting the majority of the recommendations.[37] This process has culminated in revised coronial legislation, in the form of the Coroners Bill 2008 (Vic). The Bill represents proposals to 'rejuvenate' the coronial system through reforms with a key aim being 'to reduce the number of preventable deaths in Victoria'.[38] Attorney-General Rob Hulls has noted that the provisions for prevention contained in the Bill will be supported by the establishment of a coroner's prevention unit assisting in the development and evaluation of recommendations.[39] On the wave of such significant reform, the Law Reform Commission of Western Australia has commenced its review of coronial practice in Western Australia, including reviewing the operation of the current Act.[40]

These more sizeable reforms around death prevention are occurring against the backdrop of clause-by-clause reform, which has generally been precipitated by the exposure of deaths that reveal the limitations of statutory frameworks.[41] Key examples of such reform in relation to Indigenous death are amendments made to Coroners Acts around Australia following the recommendations of the RCIADIC. Governments throughout Australia have variously implemented the RCIADIC recommendations with respect to coroners.[42] This genre of reform, as 'clause-by-clause', has brought about some significant developments, most particularly in relation to certain 'classes' of death, such as deaths in custody. Yet their status as 'clause-by-clause' reforms understates their importance, and also to some extent negates the impetus for more comprehensive and systematic reform. Therefore, while clause-by-clause reform has, to a degree, demonstrated responsiveness to preventing Indigenous death, and in this regard is positive, its piecemeal nature remains problematic. It has been argued, for example, that, with systematic implementation of key RCIADIC recommendations regarding accountability still largely elusive, the spirit and intention of clause reforms regarding deaths in custody are seriously undermined.[43] Coronial reform relating to deaths in custody was enacted to specifically recognise the special class of death that is a death in custody, addressing definitional issues in addition to investigation, inquiry, inquest[44] and, in some States and Territories, findings and recommendations and responses to them.[45] Such action greater illuminates the conditions under which people are subject to State custody and care. Yet the lack of systematic implementation of the RCIADIC recommendations might be said to generate a circularity of coronial responses to specific classes of death. As one example, where there is no accountability process (such as a requirement to respond to the work done by coroners to address a specific class of death, such as a death in custody) circularity may prevail.[46] This is an issue that clause-by-clause reform in relation to such deaths was arguably supposed to avoid.

At its most general level, capricious reform in relation to deaths that are inextricably connected to broader circumstances of life – including 'the economic status, health, education and culture of Aboriginal people in Australia'[47] – does little to avert future danger and results in the forfeiture of the steady reform agenda of prevention. Australian State and Territory government responses to the RCIADIC recommendations with respect to coroners demonstrate the ad hoc trajectory of reform following notable inquiries.[48] It could be argued that, in failing to systematically implement key recommendations relating to accountability mechanisms, governments have shied away from a valuable opportunity to give full effect to preventive aspirations contained in second reading speeches, coroners' opinions and case law throughout the history of Australian coronership. At best, this failure 'dampens the momentum for necessary reform',[49] and demonstrates that '[s]crutiny of the exercise of executive power by custodial agencies for the sake of democratic governance or human rights is not a high priority, *even where people are dying*'.[50] At worst, however, it further provides the preconditions for death upon death and evacuates 'prevention' to pure chance.[51]

It is important to note that, beyond the more tragic context and circumstances of the RCIADIC, an entire generation of 'piecemeal' reforms has steadily transformed the jurisdiction. For example, the changes heralded by the Norris reform agenda – a review of Victoria's coronial legislation,[52] the effects of which rippled throughout Australia in the 1980s – included the establishment of State or Chief Coroners, the abolition of coroners' power to commit for trial, an end to coroners' juries, and the enactment of provisions precluding coroners from making statements or suggesting that persons are criminally culpable.[53] This collection of reforms is responsible for steadily whittling the jurisdiction

down, away from its earlier conversations with the criminal jurisdiction, for example, towards the attitude of avoiding death – a characteristic of coronial law and practice that, whilst not confined to contemporary times, is now expressly articulated and legislatively recognised.[54] This attitude has shifted the coronial purview – and, importantly, its social and political dialogue – away from crime to public health (aided by medical expertise) and away from criminal concepts (culpability) to social purposes (death avoidance). Yet this honing of the coronial role has also seen a few cracks emerge, just as modern coronership gets down to the business of prevention (and perhaps because of it). At the heart of the coronial inquiry is issue of death itself: how and why it happened. And central to this is determining the cause and manner of death. The additional impetus – to look to avoid similar deaths in future, if that is appropriate – becomes tangled in the brute fact of individual death – the how and why of *this* person and the story of their fatality. The issue here is a tangle of legal and public health principles that have come to define Australian coronial law and practice; a tangle that other coronial jurisdictions with preventive principles do not necessarily experience (such as Ontario, Canada). It is this issue I now take up in relation to the history of causation and the coroner, thereafter discussing the death of Mulrunji in 2004 before turning to briefly consider recent coronial inquests and subsequent findings on multiple Indigenous death.

III The 'Nether World' of Coronial Law: Issues of Causation and Fact-Finding

> *Today the emphasis is upon making recommendations to help prevent injury and death as well as providing accurate statistical information as to causes of death. It is fair to say, however, that, throughout the evolution of modern coronership and coronial law, there has remained a tension between the coroner's duties of investigation into death and its causes as opposed to the criminal prosecution of those who cause death.*[55]

Nyland J's above comments in *Perre v Chivell*[56] were made in the context of a robust recount of the association between the coroner and the criminal jurisdiction, and the steady erasure of coronial powers around matters of liability. At issue in *Perre v Chivell* was whether the South Australian State Coroner had acted *ultra vires* in that he made findings or suggestions of criminal liability against the plaintiff Perre by attributing death to a bomb explosion and finding the plaintiff constructed and sent the bomb or arranged for someone else to send it. Nyland J took the issue of the State Coroner's determinations vis-à-vis causation and liability through its legislative life – that is, through to the prohibition against findings of guilt – and remarked on relevant jurisprudence that had boiled down the contemporary issue of causation and contribution to death in coronial law as one of 'fact' and 'common sense'.[57] Intrinsic to this distillation is that coroners are not to make conclusions of legal liability *nor* 'more indeterminate' conclusions of moral responsibility or blame, as espoused by Callaway JA in *Keown v Kahn*.[58] Nyland J cited the Victorian decisions of *Chief Commissioner of Police v Hallenstein*[59] and *Keown v Kahn*[60] at length and, in the process, succinctly referred to significant coronial reviews conducted by Sir John Norris and the Brodrick Committee in the UK. He also noted English authorities and the appeal to the 'facts' that are the duty of coroners to find. Following this excursion through history and issues of causation and contribution, Nyland J summarised it thus: '[i]t is clear therefore that the jurisdiction of the coroner is limited to making findings of fact. It is not his/her task to attribute or hint at blame.'[61] This is the accepted position in contemporary coronial law[62] and practice, and yet the issues of causation and contribution are peculiar ones in coronership, especially in relation to the drive towards, and debates surrounding, prevention-centred reform. At stake are a number of issues that recur in appellate decisions and which demonstrate uneasiness about the coroner's role and scope. This is not by any means a settled issue in coronial law, despite the cessation of many coronial powers with respect to the criminal jurisdiction, such as powers of committal.[63]

Freckelton notes that 'coronial law, while having its own identity and its own objectives, exists in a nether world between criminal law and civil law', and at its heart is the vexing issue of causation of death.[64] This is in part a problem of history and place: the coronial jurisdiction, despite the legacy of its cutting of ties with other jurisdictions (via the power to commit for trial, for instance), still seeks to stake a place amidst a chiefly adversarial legal terrain. All of this means that the coroner's inquisitorial functions are 'an anomaly on our courts' largely adversarial landscape'.[65] It is also an issue of the subject and scope of findings – the 'facts' coroners are required to determine. It is clear from the individual legislation which findings coroners must make in respect of deaths under their jurisdiction. Each State and Territory statute stipulates that coroners must find, typically, the identity of the deceased, when, where and how the death occurred, and the cause of death.[66] In Tasmania, the coroner must also find the identity of any

person who contributed to the death.[67] This provision was also a feature of the Victorian Act until its abolishment in 1999.[68] *Keown v Kahn* was important in this respect, critically commenting on the Victorian legislation in light of the Norris Report. Callaway JA was of the opinion that the provision requiring the identification of any person who contributed to the cause of a death adds nothing to coronial findings – such information would ordinarily be set out in the findings as to how the death occurred and cause of death.[69] Moreover, it might be thought that 'a finding of contribution is likely to cause injustice if its significance is misunderstood, [and so] s 19(1)(e) should be repealed'.[70] Clearly then, identifying contribution can be done via other means – that is, through findings about how death occurred and cause of death – and this raises the issue of what is being identified when coroners make findings as to causation or circumstances. That is, what might the 'facts' mean and what do they encompass? Most typically, and sometimes unavoidably, this steers the focus back to questions of culpability, which is to say that issues of liability ghost coronial law in the determination of the facts, problematising the proposition that 'the facts speak for themselves'.[71]

Returning to *Perre v Chivell*, Nyland J held that the 'jurisdiction of the coroner is limited to making findings of fact'[72] and in establishing this he noted that the 'factual findings of themselves cannot be said to be findings of criminal or civil liability.'[73] Nor do they 'suggest' as such, as '[t]he mere recital of relevant facts cannot truly be said, of itself, to hint at criminal or civil liability.'[74] The appeal to fact-finding is an interesting one as the courts have demonstrated a degree of uncertainty and debate on what constitutes the proper meaning and compass of the facts coroners are required to find, such as the relevant 'cause' of death,[75] the scope of 'how' in finding 'how the death occurred',[76] or the 'circumstances' of death.[77] While recent case law in both the UK and Australia demonstrates a relaxation on the interpretation of the meaning of 'how' in 'how the death occurred',[78] the meaning of 'cause' remains ambiguous as to multifactorial causes or indirect causes.[79] Yet, the depth and breadth of a coroner's inquiry into issues such as causation have implications beyond fact-finding, including the capacity to make targeted recommendations (that is, beyond the legal issues to wider issues of public health). As the VPLRC summarised in its 2006 review of the *Coroners Act 1985* (Vic):

> the power of a coroner to comment or make recommendations is limited to 'any matter connected with a death' which in general terms requires there to be a nexus between the comment and the recommendation and the circumstances surrounding the death which are investigated by a coroner. The cases have taken a narrow view of the requisite connection.[80]

Appellate decisions concerned with defining the parameters of coronial findings therefore bring important issues to bear on the jurisdiction of coroners in its widest sense – the proper scope and object of coroners' inquiries – and on their death-prevention capacities given the relationship of recommendations to the fact-finding task. For a jurisdiction both embracing, and being recognised for, its death-prevention role, this has significant implications. As Celia Wells asks (in the UK context), '[i]s the inquest a forum for answering the causal question at the furthest level of generality, or is the answer expected to be more specific? As the explanations become more specific, the causal explanations become more judgmental'.[81] Clearly, being 'judgmental' is not the same as identifying legal responsibility, but it is also important to acknowledge that 'facts' found by coroners are not unproblematic findings. The appellate decisions demonstrate as much. If we return to *Perre v Chivell* and Nyland J's consideration of the facts and his discussion of their meaning, this matter becomes clearer. In that case, Nyland J held that the South Australian State Coroner had not exceeded his jurisdiction in finding that Perre constructed and sent the bomb (or had someone else send the bomb on his behalf) that had killed the deceased. In setting out his reasoning, Nyland J cited Hedigan J's comments in *Chief Commissioner of Police v Hallenstein*[82] concerning the 'commonsense determination of contribution' as opposed to 'contribution as a philosophical or scientific abstraction'[83] and Callaway JA's determinations in *Keown v Kahn*[84] that 'the test of contribution is solely whether a person's conduct caused the death'.[85] Absent from a finding of contribution – a fact – then, is a determination of liability, as that is not the coroner's task. And in reciting such a 'fact', the coroner is neither stating nor suggesting criminal liability. The importance of avoiding findings of guilt has been repeatedly reiterated in reviews on the coronial jurisdiction, most recently in Victoria with the VPLRC.[86] An issue that emerges here is that 'blame' is not necessarily understood within a legal framework but as an extra-legal, often moral, responsibility. Callaway JA recognised this when he noted the importance of the evacuation of both legal *and* moral blame from the coronial context, the latter being vague with no possibility of vindication.[87]

The 2004 death of Mulrunji[88] demonstrates some of the key issues raised in this article. The case highlights the problems associated with the meaning of the 'facts' when those facts freight very specific histories of Indigenous death (ie, deaths in custody). Yet it also accentuates the possibilities for a jurisdiction embracing its role in avoidable death. It is widely known that Mulrunji died in police custody on Palm Island on 19 November 2004 after suffering fatal injuries sustained in custody at the police station during a tussle and fall involving Senior Sergeant Hurley. The Acting State Coroner found that, at the time of the fall, Senior Sergeant Hurley, who had earlier arrested Mulrunji after he swore at Hurley, was taking Mulrunji into the Palm Island watch-house. The findings of the Acting State Coroner included that Senior Sergeant Hurley caused the fatal injuries to Mulrunji.[89] Following the coronial findings, the Queensland Director of Public Prosecutions decided not to prosecute Senior Sergeant Hurley on the basis that the evidence was insufficient.[90] This decision was overridden by the Queensland Attorney-General following a review of the case by Sir Laurence Street (the 'Street Report').[91]

Essentially, the Street Report acknowledged the problematic conjunction of facts that, in this case, required explanation. Those facts included the nature of the medical injury and the circumstances of that injury, which meant that 'Senior Sergeant Hurley was the only other participant in the events in the police station immediately after that fall'.[92] The circumstances of this case were shorn down to specifics about the fatal injury and the tussle between Mulrunji and Hurley. On the facts before him, Sir Laurence Street determined that sufficient evidence did exist to prosecute Hurley and that there was reasonable prospect of conviction.[93] At trial Hurley was acquitted of manslaughter and assault[94] – so, the facts of the case were not attached to Hurley in a culpable sense. Yet in the coronial context, the 'circumstances' of the case – the 'how' of this Indigenous death – are wholly contextualised by the 'class' of this death that brought it to inquest in the first place: a death in custody.[95] The Street Report was not concerned with this key facet of the death, but it was appropriately of central concern to the Coroner, who found the arrest of Mulrunji unjustified and inappropriate,[96] and that the subsequent police investigation failed to meet the standards of deaths in custody investigations outlined in both the Queensland State Coroner's Guidelines and the National Report of the RCIADIC.[97]

The fact that this death was a death in custody brought a history of Indigenous life and relations with police to bear not only on the facts of this case but on the coronial recommendations. To this extent, the individual death of Mulrunji was also about the policing of Indigenous people and Queensland public nuisance laws, which have demonstrated a lack of social justice for Indigenous people,[98] just as the circumstances of his death again plotted a similar course to past deaths that were the subject of the RCIADIC. In this sense, the inquest can be said to have had a wide purview. The capacity for the coronial jurisdiction to account for the immediate and specific circumstances of individual death along these wider lines is important and is an issue I take up in the next section. But it is important here to reiterate that the key events (tussle, fall, death) and associated issues (police custody, policing) in this instance of Indigenous death contextualise and make meaning of the facts. Correspondingly, if, to paraphrase Callaway JA in *Keown v Kahn*, 'the facts speak for themselves',[99] it is the various ways in which facts are found and subsequently mobilised in law that problematises their brute 'factuality'. This means that we cannot regard coronial findings and their constituent statements of fact as if they have no consequence – as if they have no capacity for performance and effect throughout communities (and indeed we know they do as preventability vis-à-vis findings about death is a chief part of the coroner's focus). Whilst this might be unproblematic in the context of findings about identity, the issue becomes murkier than an appeal to facts might otherwise suggest when considering 'how' a death occurred.

Nor are questions of fact containable to 'legal' understandings or contexts, and this is where the evacuation of liability becomes thorny. This point is borne out by Nina Philadelphoff-Puren and Peter Rush, who highlight the productivity of judgment and the problems inherent in law's claims to determinacy. They note that, even as law writes events, it nonetheless 'believes it can control the contexts within which its texts emerge and take on meaning'.[100] Whilst coronial findings are not 'judgments', they are decisions with chief emphasis on fact-finding and recommendations. The point is that, if there is a nexus between points of inquiry, finding and recommendations (as established by coronial law), findings of fact are indeed full of possibility. Recent judicial decisions on the interpretation of 'how' in findings as to 'how death occurred' also acknowledge the fuller appreciation of the 'circumstances' of death required by coroners.[101] In a UK decision on the interpretation of 'how', the House of Lords

indicated that this change in coronial law 'would require a change of approach in some verdicts, on occasion a narrative form' – a form widely used in Australia.[102] The structure and narrative form of coronial findings in Australia is a strong feature of the jurisdiction, often weaving the findings of fact throughout discursive statements of circumstances.[103] This form reveals the extent to which interpretations of the circumstances of death that are brought to bear on the fact-finding exercise are far more 'subtle, contextualised and nuanced than if the court's decision has to be accommodated into predetermined words of a formal verdict'.[104] Coupled with the history that attaches to certain classes of death (such as deaths in custody), the 'how' of death that is borne out in the extra-legal world via coronial narratives has important implications for a coronial community invested in death prevention. It is a very real matter of grief, but it is also a matter of addressing the difference between the tasks of the criminal process and what the coronial process can offer in its more 'subtle, contextualised and nuanced' approach to accounting for death.[105]

The distinct ways in which facts are uncovered in coronial cases as opposed to criminal cases has been remarked upon.[106] Part of this jurisdictional difference lies in evidential matters; in undertaking inquests, coroners are not bound by the usual rules of evidence. The benefits of this are illustrated by comments made by the Queensland Attorney-General when introducing the new *Coroners Act 2003* (Qld). As noted earlier, he explained the importance of 'expanding the powers of the Coroner to obtain information and evidence, to "find out what had really happened to cause the death and make meaningful recommendations to prevent it happening again"'.[107] This notion of getting to the bottom of matters via extended powers says much about the expectation on coronial inquiries as truth-telling exercises – *'to find out what really happened'* – as distinct from processes concerned with charges of criminal liability. Yet the meaning of the facts cannot necessarily be confined to neat jurisdictional boundaries, not when 'truth' is on the line or when coronial findings resemble a composite of 'legal' and 'public health' principles.[108]

In this respect, the VPLRC review of the *Coroners Act 1985* (Vic) provides further evidence that causation and culpability are still difficult issues for a modern jurisdiction that espouses death prevention – and its 'public health' role – as a chief purpose. In considering the submission of the State Coroner's Office that a coroner investigating a death 'should be able to make a finding as to whether a death was "preventable"', thereafter having 'unfettered discretion to comment and make recommendations',[109] the Committee was reluctant to extend preventability to the status of a formal legal finding.[110] The VPLRC noted the 'important' requirement for a nexus between causation and recommendations, adding that 'the ability to make findings of preventability could feasibly reintroduce notions of culpability into coroner's findings',[111] not to mention blow the jurisdiction open by permitting coroners to 'embark on an infinite chain of inquiry'.[112] It appears then that, even in shedding questions of legal responsibility from the coronial task and declaring a preventive principle, the spectre of culpability remains.

IV Talk of Justice: Indigenous Death and the Promise of Coronial Law

> *The law speaks and the law gives; the law gives its talk and this law-talk is associated with justice.*[113]

In distinction to criminal courts, the uniqueness of the coronial jurisdiction lies in its focus on the death of individuals. As a 2002 UK Home Office study notes (following research into 'experiencing inquests'), '[i]t is only in the inquest that the deceased is the focus of the proceedings, rather than being a shadowy figure in somebody else's story'.[114] If we again take the example of the Queensland Attorney-General's emphasis on extending Queensland coronial powers so as to 'to find out what really happened', the implication is that the jurisdiction can access the 'truth' of a person's death, in distinction to other jurisdictions concerned with legal contest.[115] At the heart of this access also lies the principle of open justice and the possibilities for coronial law. To achieve this, the coroner has wide powers of investigation and inquiry – anomalous in our adversarial system – and presents factual findings in narrative form where the facts are routinely contextualised in broader circumstances of death. In some cases, such as inquests into multiple Indigenous deaths, the broadness of the inquiry's contextualisation of death enables significant insights into and attention towards life practices and experiences otherwise unacknowledged by law. The capacity for the coronial jurisdiction to account for the immediate and specific circumstances of individual death along these wider lines is important. It also means further accounting for specificities of Indigenous death beyond events such as Royal Commissions and recognising that this is in the public interest.

Central in this regard then is the place of the 'public interest'. Responding to the VPLRC's review of the *Coroners Act 1985* (Vic), the Victorian Government noted that '[t]he boundaries of the coroner's jurisdiction are defined by the public interest'.[116] This interest determines which deaths are investigated by the coroner and how. Writing in 1990, Michael Hogan noted that the public interest in the coronial sense is defined by both the open scrutiny of and accountability for deaths, and accountability of the coronial system itself.[117] Significantly, he added that this is also a question of 'both the substance and appearance of justice'.[118] In cases where specific classes of death in circumstances of state control and custody – such as deaths in custody – have disproportionately affected Indigenous communities,[119] or where multiple deaths leave communities 'paralysed by grief',[120] the call for 'justice' is weighted with legacies that carry broader criminological, socio-economic and socio-legal significance. As Jennifer Corrin and Heather Douglas note in relation to the death of Mulrunji in 2004:

> quite apart from the court and coronial proceedings, this case illustrates much broader issues, at the heart of which is the complex relationship between Aboriginal people and the criminal justice system.[121]

It is this relationship that plays out through coronial processes surrounding Indigenous deaths, not only in relation to the investigation, inquest findings and recommendations but also the concerns and expectations a community brings to the inquest. Coronial processes attaching to Indigenous deaths involve a complex feedback loop, where deaths both represent and reinforce the issues between Indigenous people and the authorities, such as the police. Elena Marchetti touches upon this feedback loop when she notes that 'the degree of suspicion surrounding the deaths of Thomas Hickey and Cameron Doomadgee indicates that Indigenous people still harbour feelings of distrust and animosity towards police.'[122] This is but one aspect of what constitutes 'justice' in relation to Indigenous death in Australia, as coroners place the death of Indigenous people in the context of their social life as a matter of public interest – most notably through inquests into multiple deaths.

The parameters of the 'public interest' in relation to Indigenous death appear to be on the coronial agenda in some Australian States and Territories through the practice of inquests into multiple deaths. In his October 2005 findings relating to the deaths in 2004 of Kumanjaya Presley, Kunmanara Coulthard and Kunmanara Brumby, Northern Territory Coroner Greg Cavanagh noted that he held an inquest into the deaths because it was

> in the public interest to reveal and highlight the extent of the sad and shocking petrol sniffing problems associated with these deaths and the many others that have occurred and are still occurring.[123]

Coroner Cavanagh continued his findings with an indictment of the Territory Government's inaction towards petrol sniffing in the Northern Territory, noting 'numerous' reviews, inquiries and reports concerning petrol sniffing and (with emphasis) the 1991 recommendations of the RCIADIC.[124] He also acknowledged the disappointing social effects of the failure to implement previous coronial findings, despite recent efforts by the Federal and Northern Territory governments to 'come to grips' with petrol sniffing in Indigenous communities.[125] Coroner Cavanagh noted that he could not disagree with a witness's 'use of the word "pathetic" to describe government responses to coronial recommendations in this area'[126] and set about reiterating previous recommendations made by 'coroners at least since 1998'.[127] In this sense, the 'public interest' around Indigenous death needs to shift so that the work of coroners has the constructive and productive effects that are signalled by preventive principles.

The work of some Australian coroners indicates active investigations in line with a 'public interest' that accounts for Indigenous death. Examples include the recent coronial findings by Western Australian State Coroner Alastair Hope (the 'Hope Report') into the deaths of 22 people who died between 2000 and 2007 in the Kimberley. Following a request from the Kimberley Aboriginal Law and Culture Centre ('KALACC'), the State Coroner held an inquest to explore the reasons for a high death rate amongst Aboriginal people in the Kimberley 'whose deaths appeared to have been caused or contributed to by alcohol abuse or cannabis use and also, if possible, to identify reasons for an alarming increase in suicide rates'.[128] The inquest was concerned with both the underlying reasons for the deaths and the appropriateness of any comments to assist in 'reducing the number of avoidable deaths'.[129] In that case the State Coroner produced a substantial report detailing the statutory findings and a broader exegesis of issues in the Kimberley, including living conditions, education, housing, alcohol and drug use, health, policing and child protection. The Western Australian

Government responded six weeks later, outlining services and commitments to addressing issues raised by the Hope Report.[130] The Chairman and Co-ordinator of the KALACC had written to the State Coroner believing that a coronial inquiry would illuminate root causes of the multiple deaths and 'jolt the systems of government, and some elements within the local community, into an appropriate level of response'.[131] As the Government response to the Hope Report indicates, the coronial inquest into multiple deaths in the Kimberly may have achieved, to some extent at least, the 'jolt' to government KALACC was hoping for.

The State Coroner again recently exercised his powers pursuant to s 40 of the *Coroners Act 1996* (WA) to conduct an inquest into more than one death when he held an inquest into the deaths of five people in the Aboriginal community of Oombulgurri. Following the inquest, on 21 July 2008 State Coroner Hope again made broad recommendations including that the State and Federal governments 'devise a plan to assess the sustainability of Indigenous communities in the Kimberley'.[132] The Federal Government response to State Coroner Hope's findings was an immediate announcement of income management rollout in five communities in the Kimberley, including Oombulgurri.[133] State Coroner Hope's findings on these two separate occasions is attracting attention, and there are calls to hold inquests into the deaths of people in Narrogin.[134]

The provision for coroners to hold inquests into multiple deaths, as occurred in the case of 22 people from the Kimberley, enables the 'circumstances' of death to be further contextualised in terms of community concerns and requests. This is not only a responsive death investigation system but also one that embodies public health principles. It further speaks to an additional accountability of the coronial system itself, given that a number of the deaths had been the subject of coronial investigations yet none were the subject of inquest proceedings.[135] The facilities are already in place to be able to identify these cases in the coronial system. Most of the deaths will have been entered onto the NCIS – an Australian database of coronial information (police reports, autopsy reports, etc) that is capable of practically responding to the preventive principles of the jurisdiction.[136]

Corresponding with greater attention towards coronial findings and recommendations (through, for example, their publicisation in the media, communication to the broader community and response from government) is the opportunity for a broadened and more effective conversation between the coroner and the community. It is this current deficit in conversation that coroners have themselves despaired at. For example, Coroner Cavanagh's findings into the 2004 deaths of Kumanjaya Presley, Kunmanara Coulthard and Kunmanara Brumby[137] clearly articulate the frustrations of making recommendations in respect of preventable Indigenous deaths that pass unnoticed or unresponded to, save for the repeated participation of witnesses in inquests and their attempts at publicity and dissemination of recommendations. In his 2004 findings, Coroner Cavanagh reiterated findings he made in earlier inquests and went so far as to quote South Australian State Coroner Chivell's 2002 findings in outlining recommendations regarding the deaths before him. In other words, it appears that some coroners are frustrated with what they identify as a relatively internal coronial dialogue about remedial action that finds little external traction. Coroner Cavanagh's 2004 findings illustrate that coroners are well aware of the issues facing Indigenous communities through both their own repeated investigations into preventable deaths and the investigations and insights of other coroners. That is, they are developing individual and collective expertise with respect to these deaths. And, in each instance, in investigating deaths, holding inquests and making findings, those coroners draw on the expertise and experience of witnesses. This is a devastating amount of expertise to be stockpiling without consequence throughout Australian States and Territories.

Clearly, it is the shift towards an accountable conversation between the coronial jurisdiction and the community that will increase the capacity of coroners throughout Australian States and Territories to bring effect to the spirit of prevention increasingly and explicitly enshrined in Coroners Acts. How this is best managed – and what form 'accountability' takes – is the subject of debate.[138] However, the honing of the coronial role, the development of administrative mechanisms (such as the NCIS) and the expectations regarding death prevention woven throughout recent coronial reform proposals (such as Victoria's Coroners Bill 2008) all symbolise the realisation and expectation that, in accounting for individual deaths, coroners have the capacity for and access to the expertise required to contribute to death prevention.[139] As demonstrated by the case of Victoria, support for this expertise is finding purchase in innovative approaches without recourse to mandatory responses to coronial recommendations. Such approaches include the proposal to establish a coroner's prevention unit to assist in the targeted development and evaluation

of coronial recommendations, coupled with effective distribution of findings and public availability via internet publication.[140] This signifies an alternative path to prevention and accountability, one that calls upon different parts of the community to participate in the outcomes following death.

V Conclusion

Amendments to Coroners Acts have, over the years, increasingly distinguished deaths of people in specific situations – most notably, deaths in custody – and have recognised ways to embody preventive principles, such as through the holding of inquests into multiple deaths. If we disentangle the lament for the possibilities of the RCIADIC from the debates about its capacity for change or the measure of its effectiveness, what emerges is the call for a greater response to the specificities of Indigenous death *in context*. Whilst proaction in relation to preventable injury comes in many forms, including through data- and information-sharing,[141] recent coronial findings on Indigenous death warn that understanding and responding to Indigenous death may require a broader scope than the law has otherwise supported in appreciating and accounting for the circumstances of death. For many Indigenous Australians, issues of 'public health' require a broad and appropriately contextual vision.[142] This means, therefore, that, if Indigenous deaths are not to be treated as isolated, de-contextualised events, inquests will continue to ignite fundamental questions about larger socio-political commitments to public health in its broadest sense. These are also questions about the ways in which society responds to issues that often underwrite preventable death, such as violence, poverty, mental health, safety, etc. In the aftermath of another Aboriginal death in custody, the entire legacy of Indigenous life in Australia will be brought to the fore.

Inquests provide the capacity to understand individual death in the wider context of community life. While Indigenous Australians experience lower life expectancy and higher mortality rates than non-Indigenous Australians,[143] examining the circumstances of death will continue to uncover that the 'how' of 'how death occurred' relates to government legacies for Indigenous life and may witness coronial recommendations 'trespassing' on issues of social policy. The current promise for the possibilities of coronial law embedded in death prevention principles seems to be premised on the idea that law speaks not into a vacuum but to a community that both listens and responds. Much has been written about the impossibility of progress without mandatory responses to recommendations, calls which represent the desperate need for a conversation that is inclusive of the community and Indigenous history. Despite these calls, as recently as October 2008 the Victorian Government has manifested its rejection of this option in presenting the new Coroners Bill, opting instead for a response to recommendations centred on greater distribution of coronial findings, public access to findings and the augmentation of internal coronial expertise.[144] This may not represent the mandatory response so often called for in the face of death, but it does hold out hope for a wider and more honed dialogue about death. Without this wider dialogue and attention towards coronial recommendations, with the attendant opportunities for assessing and changing services, policies and practices, aspirations for effective death prevention will continue to be frustrated. Where such a dialogue is absent, the promise signalled by the ongoing refinement and improvement of coronial practice is destined to remain largely unfulfilled. This means it is indeed possible that the greater the coronial expertise and the more refined the coronial role, the more deleterious the 'facts' of death may actually be for Australian society.

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1 Shaunnagh Dorsett and Shaun McVeigh, 'Questions of Jurisdiction' in Shaun McVeigh (ed), *Jurisprudence of Jurisdiction* (2007) 3, 8.

2 Dorsett and McVeigh, above n 1. See also Shaun McVeigh, 'Subjects of Jurisdiction: The Dying, Northern Territory, Australia, 1995–1997' in Shaun McVeigh (ed), *Jurisprudence of Jurisdiction* (2007) 202, 204.

3 Dorsett and McVeigh, above n 1, 5.

4 Ian Freckelton and David Ranson, 'The Evolving Institution of the Coroner' in Ian Freckelton and Kerry Peterson (eds), *Disputes and Dilemmas in Health Law* (2006) 296.

5 *Grace v Saines* [2004] VSC 229.

6 *Fire Rescue Authority (Qld) v Hall* [1998] 2 Qd R 162; *Atkinson v*

Morrow [2005] QCA 353; *R v Coroner Doogan; Ex parte Lucas-Smith* (2005) 158 ACTR 1.

7 *Harmsworth v State Coroner* [1989] VR 989; *Chief Commissioner of Police v Hallenstein* [1996] 2 VR 1; *Grace v Saines* [2004] VSC 229; *R v Coroner Doogan; Ex parte Lucas-Smith* (2005) 158 ACTR 1; *Doomadgee v Deputy State Coroner Clements* [2006] 2 Qd R 352.

8 *Anderson v Blashki* [1993] 2 VR 89; *Keown v Kahn* [1999] 1 VR 69; *Chief Commissioner of Police v Hallenstein* [1996] 2 VR 1; *Secretary, Department of Health and Community Services v Gurvich* [1995] 2 VR 69; *Perre v Chivell* (2000) 77 SASR 282; *R v Coroner Doogan; Ex parte Lucas-Smith* (2005) 158 ACTR 1.

9 Dorsett and McVeigh, above n 1, 5. The NCIS is a national Australian database of coronial information which provides access to coronial data and 'contributes to a reduction in preventable death and injury in Australia': Jessica Pearse and Leanne Daking, 'The National Coroners Information System: Contributing to Death and Injury Prevention' (2007) 36(2) *Health Information Management Journal* 54, 54. See also the NCIS website: NCIS <http://www.ncis.org.au> at 21 November 2008.

10 See, eg, Freckelton and Ranson, 'The Evolving Institution of the Coroner', above n 4, 296; Ian Freckelton, 'The Myers Oration 2005: Untimely Death, Law and Suicidality' (2005) 12(2) *Psychiatry, Psychology and Law* 265.

11 See, eg, Freckelton and Ranson, 'The Evolving Institution of the Coroner', above n 4, 296; Ian Freckelton, 'Causation in Coronial Law' in Ian Freckelton and Danuta Mendleson (eds), *Causation in Law and Medicine* (2002) 331; Ian Freckelton, 'Death Investigation, the Coroner and Therapeutic Jurisprudence' (2007) 15 *Journal of Law and Medicine* 242.

12 See, eg, Law Reform Committee, Parliament of Victoria, *Coroners Act 1985: Report* (2006) <http://www.parliament.vic.gov.au/LAWREFORM/inquiries/Coroners%20Act/final%20report.pdf> at 21 November 2008.

13 Australian writer Chloe Hooper received a Walkley Award for her coverage of the inquest into the death of Mulrunji in *The Monthly*, and has subsequently published a book about the inquest and the trial of Senior Sergeant Hurley. See Chloe Hooper, *The Tall Man: Death and Life on Palm Island* (2008).

14 Jennifer Corrin and Heather Douglas, 'Another Aboriginal Death in Custody: Uneasy Alliances and Tensions in the Mulrunji Case' (2008) 28(4) *Legal Studies* 531, 531. Briefly, the trajectory was as follows: at the conclusion of the inquest, the Queensland Acting State Coroner referred the case to the Director of Public Prosecutions, who decided against prosecution. This decision was subject to independent review, following which the Queensland police officer whom the Acting State Coroner found had caused the fatal injuries was charged with manslaughter and assault and subsequently acquitted. See Corrin and Douglas for a comprehensive discussion of this case, its trajectory across jurisdictions and the attendant issues with jurisdictional differences.

15 Dorsett and McVeigh, above n 1, 4.

16 See, eg, Dorsett and McVeigh, above n 1, 6, where they write '[q]uestions of jurisdiction address the relation ... between the legal and the social domains'.

17 Justin Malbon, 'Institutional Responses to Coronial Recommendations' (1998) 6 *Journal of Law and Medicine* 35, 39. See also Freckelton, 'Death Investigation, the Coroner and Therapeutic Jurisprudence' above n 11; Lyndal Bugeja and David Ranson, 'Coroners' Recommendations: A Lost Opportunity' (2005) 13 *Journal of Law and Medicine* 173. This is not to discount the importance of attending to the ways in which law reads and writes fatal events via judgment. Such exercises offer not only recognition of law's bias but also impetus for reform. My point here is about a chief jurisdictional purpose. On judgment and criminal law, see further Nina Philadelphoff-Puren and Peter Rush, 'Fatal (F)laws: Law, Literature and Writing' (2003) 14 *Law and Critique* 191.

18 See, eg, *Coroners Act 1985* (Vic), s 19(2). The jurisdictional differences do not end there of course, and extend to differences in rules of evidence, etc. I will not comment on those other differences here. For an excellent summary, see Ian Freckelton and David Ranson, *Death Investigation and the Coroner's Inquest* (2006).

19 *Coroners Act 1985* (Vic), s 19(2). It must be noted that, following the Victorian Parliamentary Law Reform Committee's ('VPLRC') review of the *Coroners Act 1985* (Vic), the new Coroners Bill 2008 (Vic) was drafted, and it is currently before the Victorian Parliament. This wording is retained in the Bill at s 67(3) in relation to findings of a coroner, and is reiterated at s 72(2) regarding recommendations.

20 Graeme Johnstone, 'A Coroner's Perspective on Death and Injury Prevention' (1992) 66 *Law Institute Journal* 705, 705. See also Malbon, above n 17, 38. Ian Freckelton has distinguished the focus on the preventive role of the coroner as a defining characteristic of the evolution of coronial law: see Malbon, above n 17, 39 (note 34).

21 See the Coroners Bill 2008 (Vic) preamble, s 1(c); Explanatory Memorandum, Coroners Bill 2008 (Vic) 1. See also Victorian Attorney-General Rob Hulls' second reading speech, where he outlined the issue of prevention as one of two key themes emerging from the VPLRC Report. He noted the VPLRC Report's acknowledgment of the 'need to strengthen the prevention role of the coroner. Whilst the Victorian coronial system has an impressive history in the area of prevention ... the committee

recognised that the role could be further supported. The bill addresses this issue and is supported by the establishment of the first coroner's prevention unit, which will assist the coroner in relation to the formulation of appropriate prevention recommendations as well as help monitor and evaluate the effectiveness of those recommendations.' Victoria, *Parliamentary Debates*, Legislative Assembly, 9 October 2008, 4035 (Rob Hulls, Attorney-General). See also 4037 where the Attorney-General outlines reduction of preventable death through coronial findings as a key purpose of the Bill.

22 Coroners Bill 2008 (Vic), s 93(2).

23 Coroners Bill 2008 (Vic), s 110(2)(b) specifically notes that advice and recommendations must be in respect of 'matters relating to the preventive role played by the Coroners Court'.

24 *Coroners Act 2003* (Qld), ss 46(1)(a)–(b).

25 *Coroners Act 2003* (Qld), s 46(1)(c).

26 *Coroners Act 1995* (Tas), s 28(2). For comment powers regarding health, etc, see s 28(3).

27 Geraldine Mackenzie, Nigel Stobbs and Mark Thomas, '"What Really Happened" Versus "What We Can Prove": Tension Between the Roles of Coroner and DPP in Queensland' (2007) 6(24) *Indigenous Law Bulletin* 6, 7 (citations omitted).

28 Commonwealth, Royal Commission into Aboriginal Deaths in Custody ('RCIADIC'), *National Report* (1991) vol 1 [4.5.87]–[4.5.89].

29 Mackenzie, Stobbs and Thomas, above n 27, 7.

30 See Freckelton and Ranson, *Death Investigation and the Coroner's Inquest*, above n 18, 762.

31 Ian Freckelton, 'Causation in Coronial Law', above n 11, 339.

32 See Karen Andreasyan, Wendy E Hoy and Srinivas Kondalsamy-Chennakesavan, 'Indigenous Mortality in Remote Queensland, Australia' (2007) *Australian and New Zealand Journal of Public Health* 31(5) 422; C Jane Freemantle et al, 'Patterns, Trends, and Increasing Disparities in Mortality for Aboriginal and Non-Aboriginal Infants Born in Western Australia, 1980–2001: Population Database Study' (2006) 367(9524) *The Lancet* 1758; R W Edwards, *Australian Social Trends 2002*, Australian Bureau of Statistics 4102.0 (2002) 86–90; Rex Wilde and Pat Anderson, *Ampe Akelyernemane Meke Mekarle 'Little Children are Sacred': Report of the Northern Territory Board of Inquiry into the Protection of Aboriginal Children from Sexual Abuse* (2007); Janet Stanley et al, *Child Abuse and Family Violence in Aboriginal Communities – Exploring Child Sexual Abuse in Western Australia*, Australian Institute of Family Studies (2002); Brian Pink and Penny Allbon, *The Health and Welfare of Australia's Aboriginal and Torres Strait Islander Peoples*, Australian Bureau of Statistics and Australian Institute of Health and Welfare (2008) 151ff.

33 Coroners such as Hal Hallenstein and Graeme Johnstone are regarded as instrumental in shaping the coronial role along more preventive lines. See Johnstone, above n 20; Malbon, above n 17, 39 (note 34); Law Reform Committee, Parliament of Victoria, above n 12, 2.

34 John Gerald Norris, *The Coroners Act 1958: A General Review* (1981) 4. Despite Norris' positioning of prevention, it was not specified in the Act. See also Malbon, above n 17, 38; Ian Freckelton, 'Coronial Law Reform: The New Wave' (2006) 14 *Journal of Law and Medicine* 151, 151.

35 On the Queensland reform, see Justin Malbon, Geoff Airo-Farulla and Cate Banks, *Review of Queensland Coronial Laws: Final Report*, Indigenous Advisory Council (1997); Glenn Cranny, 'Coronial Inquests: Some Recent Lessons' (2006) 26(5) *Proctor* 24; W Jarred, *The Coroners Bill 2002 (Qld): Highlighting the Important Role of Coroners in Accident Prevention*, Research Brief No 2003/04, Queensland Parliamentary Library (2003) 7; Queensland, *Parliamentary Debates*, Legislative Assembly, 3 December 2002, 5220–22 (Rod Welford, Attorney-General and Minister for Justice). To illustrate ongoing issues with recent reform, see reports regarding limitations and inadequacies of the new Act, including that of the Queensland Ombudsman, which speaks to the issues around recommendations that plague other jurisdictions despite extensive reform: Queensland Ombudsman, *Report of the Queensland Ombudsman: The Coronial Recommendations Project* (2006); Queensland, Commission of Inquiry into Queensland Public Hospitals, *Queensland Public Hospitals Commission of Inquiry: Report* (2005) ch 7, 521–6 <http://www.qphci.qld.gov.au/final_report/Final_Report.pdf> at 21 November 2008.

36 Law Reform Committee, Parliament of Victoria, above n 12. For a cogent summary for the review recommendations, see Freckelton, 'Coronial Law Reform: The New Wave', above n 34.

37 Victorian Government, *Government Response to the Victorian Parliament Law Reform Committee's Coroners Act 1985 – Final Report* <http://www.parliament.vic.gov.au/LAWREFORM/inquiries/Coroners%20Act/> at 21 November 2008.

38 Rob Hulls (Victorian Attorney-General), 'Coroner Gets New Powers to Keep Victorians Safe' (Press Release, 9 October 2008) <http://www.premier.vic.gov.au/attorney-general/coroner-gets-new-powers-to-keep-victorians-safe.html> at 21 November 2008

39 Victoria, *Parliamentary Debates*, Legislative Assembly, 9 October 2008, 4035 (Rob Hulls, Attorney-General); Hulls, 'Coroner Gets New Powers to Keep Victorians Safe', above n 38.

40 The Commission is currently undertaking preliminary consultation prior to releasing a Discussion Paper in 2009. See the terms of reference at Law Reform Commission of Western Australia, *Review of the Coronial Practice of Western Australia* <http://

www.lrc.justice.wa.gov.au/3_coronial.html> at 21 November 2008. This level of coronial reform is not restricted to Australia. New Zealand recently overhauled its coronial legislation and practice, developing the *Coroners Act 2006* (NZ). This comprehensive piece of legislation is a result of a lengthy process of review (following a Law Commission Report in 2000) and attempts to address public confidence in the coronial system, centralise the system and recognise cultural and spiritual beliefs and values of families. See New Zealand Law Commission, *Coroners*, Report 62 (2000) <http://www.lawcom.govt.nz/UploadFiles/Publications/Publication_70_139_R62.pdf> at 21 November 2008; *Coroners Act 2006* (NZ).

41 A recent example is that of proposed amendments to the *Coroners Act 2003* (Qld) following the report of the Commission of Inquiry into Queensland Public Hospitals (the Davies Report), held following complaints relating to the conduct of Dr Jayant Patel at the Bundaberg Base Hospital. Commissioner Davies noted the issue of under-reporting of reportable deaths, identifying among the issues the ambiguity of s 8(3)(d) and its meaning with respect to the reporting of a death 'if it was not reasonably expected to be the outcome of a health procedure'. See Queensland, Commission of Inquiry into Queensland Public Hospitals, above n 35, ch 7, 521–6. The Queensland Government has introduced the Coroners and Other Acts Amendment Bill 2008 to address the issues identified by Commissioner Davies. See Coroners and Other Acts Amendment Bill 2008 (Qld); Explanatory Memorandum, Coroners and Other Acts Amendment Bill 2008 (Qld); Queensland, *Parliamentary Debates*, Legislative Assembly, 7 October 2008, 2845–6 (Kerry Shine, Attorney-General and Minister for Justice and Minister Assisting the Premier in Western Queensland). An additional example is the coronial reform enacted in Victoria following the exposure of multiple child deaths in one family. In Victoria in 2003, further coronial reform was enacted in response to multiple child deaths in one family that had gone unnoticed. Amidst intense media scrutiny and the spectre of undetected homicide, then Premier Steve Bracks sought a report outlining the system for dealing with multiple deaths, which detailed a number of inadequacies with regards to information-sharing with respect to child deaths (attention which echoed UK concerns). See Victoria, Department of Premier and Cabinet, *Report into the System for Dealing with Multiple Child Deaths* (2003); Victoria, *Parliamentary Debates*, Legislative Assembly, 6 May 2004, 1052 (Rob Hulls, Attorney-General). This case demonstrates that media, too, has had a part to play in clause-by-clause change. To address the inadequacies, the Victorian Parliament promptly passed the *Death Notification Legislation (Amendment) Act 2004* (Vic), which included the relaxation of privacy provisions around information pertaining to child deaths and created the category of 'reviewable death' to be reported to and investigated by the coroner. This category provides for investigation into the second or subsequent child death within one family: see *Death Notification Legislation (Amendment) Act 2004* (Vic), s 9; *Coroners Act 1985* (Vic), s 15A; see also David Ranson, 'Multiple Child Deaths: A New Direction in Death Notification Legislation' (2004) 12 *Journal of Law and Medicine* 156. The Coroners Bill 2008 (Vic) is subsequently dealing with the inadequacies of this clause reform, which inappropriately captured child deaths that bore no risk indicators for child protection. See Victoria, *Parliamentary Debates*, Legislative Assembly, 9 October 2008, 4036 (Rob Hulls, Attorney-General); Victoria, *Parliamentary Debates*, Legislative Assembly, 6 May 2004, 1052–54 (Rob Hulls, Attorney-General).

42 See Prue Vines and Olivia McFarlane, 'Investigating to Save Lives: Coroners and Aboriginal Deaths in Custody' (2000) 4(27) *Indigenous Law Bulletin* 8; Chris Cunneen and David McDonald, *Keeping Aboriginal and Torres Strait Islander People Out of Custody: An Evaluation of the Implementation of the Recommendations of the Royal Commission into Aboriginal Deaths in Custody* (1997).

43 See Vines and McFarlane, above n 42; Boronia Halstead, 'Coroners' Recommendations Following Deaths in Custody' in Hugh Selby (ed) *The Inquest Handbook* (1998) 186.

44 See Vines and McFarlane, above n 42.

45 See recommendations 12–18 of the RCIADIC: Commonwealth, RCIADIC, above n 28, vol 1, [4.7.4]. See also *Coroners Act 1997* (ACT), ss 75(1), 76; *Coroners Act* (NT), ss 26(1)(a), 26(2), 27(1), 35, 46A, 46B; *Coroners Act 2003* (SA), s 25. See also below n 139.

46 See Corrin and Douglas, above n 14, for an analysis of the Mulrunji case and the resemblance of some coronial recommendations to the RCIADIC recommendations.

47 Vines and McFarlane, above n 42, 12.

48 The RCIADIC was one of the 'largest Royal Commissions in the history of Australia' with 339 recommendations, not to forget the subject matter of the Commission: Aboriginal people losing their lives in police and prison custody. Chris Cunneen, 'Assessing the Outcomes of the Royal Commission into Aboriginal Deaths in Custody' (2001) 10(2) *Health Sociology Review* 53, 53.

49 Boronia Halstead, 'Implementing Coroners' Deaths in Custody Recommendations: A Victorian Case Study' (1996) 7(3) *Current Issues in Criminal Justice* 340, 354.

50 Vines and McFarlane, above n 42, 12 (emphasis added).

51 The Coroners Bill 2008 (Vic) further addresses outstanding recommendations of the RCIADIC. To the extent that 'outstanding RCIADIC recommendations' have become a hallmark of the reform agenda and a measure of its success or failure, it is important to note the criticisms, as Elena Marchetti does, of

the RCIADIC as an entity that was 'constrained by its powers and mandate and it could therefore never have achieved the reforms required to change the marginalisation of Indigenous people': Elena Marchetti, 'Critical Reflections upon Australia's Royal Commission into Aboriginal Deaths in Custody' (2005) 5 *Macquarie Law Journal* 103, 111.

52 Norris, above n 34.

53 See Freckelton, 'Coronial Law Reform: The New Wave', above n 34, 151.

54 For a discussion of early coronership, see Jill McKeough, 'Origins of the Coronial Jurisdiction' (1983) 6 *University of New South Wales Law Journal* 191; for a full view of history in England and Australia until contemporary times, see Freckelton and Ranson, *Death Investigation and the Coroner's Inquest*, above n 18, ch 1. On the kernel of 'prevention' long at the heart of the jurisdiction, see Johnstone, above n 20.

55 *Perre v Chivell* (2000) 77 SASR 282, [24].

56 (2000) 77 SASR 282.

57 Ibid [49].

58 [1999] 1 VR 69, 76; *Perre v Chivell* (2000) 77 SASR 282, [51]ff.

59 [1996] 2 VR 1.

60 [1999] 1 VR 69.

61 *Perre v Chivell* (2000) 77 SASR 282, [54].

62 The prohibition on findings or comments of guilt are outlined in Coroners Acts throughout Australia: *Coroners Act 1996* (WA), s 25(5); *Coroners Act 2003* (Qld), s 45(5); *Coroners Act 1980* (NSW), s 22(3); *Coroners Act 1985* (Vic), s 19(3); Coroners Bill 2008 (Vic), s 69(1); *Coroners Act 2003* (SA), s 25(3); *Coroners Act 1995* (Tas), s 28(4); *Coroners Act* (NT), s 34(3). In the ACT a coroner must not include an adverse comment against a person in a finding unless first giving them notice: see *Coroners Act 1997* (ACT), s 55.

63 See Freckelton, 'Causation in Coronial Law,' above n 11, 332. In cases where coroners believe a person has committed an offence they must report to the appropriate authority. In most jurisdictions (save for Western Australia) this is mandatory. See *Coroners Act 1985* (Vic), s 21(3); *Coroners Act 1980* (NSW), s 19; *Coroners Act 1997* (ACT), s 58; *Coroners Act* (NT), s 35; *Coroners Act 2003* (Qld), s 48; *Coroners Act 1995* (Tas), s 30(3); *Coroners Act 1996* (WA), s 27(5).

64 Freckelton, 'Causation in Coronial Law', above n 11, 340.

65 Freckelton and Ranson, 'The Evolving Institution of the Coroner', above n 4, 297.

66 *Coroners Act 2003* (Qld), s 45(2); *Coroners Act* (NT), s 34(1); *Coroners Act 1980* (NSW), s 22; *Coroners Act 2003* (SA), s 13; *Coroners Act 1997* (ACT), s 52(1); *Coroners Act 1985* (Vic), s 19(1); *Coroners Act 1995* (Tas), s 28(1); *Coroners Act 1996* (WA), s 25(1).

67 *Coroners Act 1995* (Tas), s 28(1)(f).

68 *Coroners (Amendment) Act 1999* (Vic).

69 *Keown v Kahn* [1999] 1 VR 69, 76.

70 Ibid 77 (Callaway JA).

71 This statement is paraphrased from Callaway JA (in ibid 76–7), who held: 'A coroner ... will ordinarily set out the relevant facts in the course of finding how death occurred and the cause of death. *The facts will then speak for themselves*, leaving readers of the record of investigation to make up their own minds about lawful self-defence or any similar issue.' (emphasis added)

72 *Perre v Chivell* (2000) 77 SASR 282, [54].

73 Ibid [56].

74 Ibid [57] (Nyland J). For further discussion of the case, see Freckelton and Ranson, *Death Investigation and the Coroner's Inquest*, above n 18, 649–50.

75 *Harmsworth v State Coroner* [1989] VR 989; See Freckelton, 'Causation in Coronial Law', above n 11; Freckelton and Ranson, *Death Investigation and the Coroner's Inquest*, above n 18, 636–50.

76 *Atkinson v Morrow* [2005] QSC 92.

77 *Atkinson v Morrow* [2005] QSC 92; *Queensland Fire and Rescue Authority v Hall* [1998] 2 QdR 162.

78 'How' in 'how the death occurred' has been interpreted as 'by what means and in what circumstances', rather than the more restrictive 'by what means'. See *Atkinson v Morrow* [2005] QSC 92, [32] (Mullins J); *R (Middleton) v West Somerset Coroner* [2004] 2 AC 182, 200.

79 See Freckelton, 'Causation in Coronial Law', above n 11, 331; Freckelton and Ranson, *Death Investigation and the Coroner's Inquest*, above n 18, 638–42.

80 Law Reform Committee, Parliament of Victoria, above n 12, 362 (citations omitted). See also *Harmsworth v State Coroner* [1989] VR 989.

81 Celia Wells, 'Disasters: The Role of Institutional Responses in Shaping Public Perceptions of Death' in Robert Lee and Derek Morgan (eds), *Death Rites: Law and Ethics at the End of Life* (1996) 196, 202.

82 [1996] 2 VR 1.

83 *Perre v Chivell* (2000) 77 SASR 282, [50].

84 [1999] 1 VR 69.

85 *Perre v Chivell* (2000) 77 SASR 282, [51].

86 The VPLRC stated that '[a]voiding issues of blame is important, since the coronial jurisdiction aims to make inquisitorial determinations of fact rather than judicial determinations of legal responsibility'. See Law Reform Committee, Parliament of Victoria, above n 12, 367.

87 *Keown v Kahn* [1999] 1 VR 69, 76.

88 Paula Morreau notes that, whilst the name 'Mulrunji' was used

in the inquest, the spelling is 'Moordinyi'. See Paula Morreau, 'Policing Public Nuisance: The Legacy of Recent Events on Palm Island' (2006) 6(28) *Indigenous Law Bulletin* 9, 12 (note 1).

89 *Inquest into the Death of Mulrunji* (Unreported, Queensland Coroner's Court, Acting State Coroner Clements, 27 September 2006) 27 <http://www.courts.qld.gov.au/mulrunji270906.pdf> at 21 November 2008. For discussion, see further Corrin and Douglas, above n 14. Hurley is appealing against the 2006 coronial findings by Acting State Coroner Clements: see 'Coroner Erred in Hurley Case: Court', *The Sydney Morning Herald* (online), 9 September 2008 <http://news.smh.com.au/national/coroner-erred-in-hurley-case-court-20080909-4cct.html> at 21 November 2008.

90 For discussion see Mackenzie, Stobbs and Thomas, above n 27; Corrin and Douglas, above n 14.

91 Sir Laurence Street, *Palm Island Death in Custody: Cameron Doomadgee* (2007) <http://www.justice.qld.gov.au/files/AboutUs/StreetReport_PalmIsland.pdf> at 21 November 2008.

92 Ibid 10, [12].

93 Ibid 12.

94 'Hurley Not Guilty On Both Counts', *ABC News* (online), 20 June 2007 <http://www.abc.net.au/news/stories/2007/06/20/1956821.htm> at 21 November 2008.

95 See *Coroners Act 2003* (Qld), s 27(1)(a)(i) which provides that: 'The coroner investigating a death must hold an inquest if the coroner considers the death is a death in custody'.

96 *Inquest into the Death of Mulrunji* (Unreported, Queensland Coroner's Court, Acting State Coroner Clements, 27 September 2006) 3, 28.

97 Ibid 9.

98 See Morreau, above n 88, 11. See also Leanne Weber, 'Bridges or Bandaids? Another Aboriginal Death in Police Custody Reveals Fatal Flaws in the Aboriginal Liaison Officer Concept' (2007) 19(2) *Current Issues in Criminal Justice* 235.

99 *Keown v Kahn* [1999] 1 VR 69, 76. See also above n 71.

100 Philadelphoff-Puren and Rush, above n 17, 201–2.

101 *Atkinson v Morrow* [2005] QSC 92.

102 *R (Middleton) v West Somerset Coroner* [2004] 2 AC 182. See Freckelton and Ranson, *Death Investigation and the Coroner's Inquest*, above n 18, 637.

103 Freckelton and Ranson, *Death Investigation and the Coroner's Inquest*, above n 18, 618.

104 Ibid.

105 Ibid.

106 Mackenzie, Stobbs and Thomas, above n 27; Corrin and Douglas, above n 14.

107 Mackenzie, Stobbs and Thomas, above n 27, 7.

108 Of course the 'truth' is a sticky issue. On the contingencies involved in accessing 'truth' in official discourses, see Marchetti, above n 51; see also Michael Wearing, 'Legal-Administrative Repertoires: Official Accounts of Black Deaths in Custody' (1991) 4 *Journal for Social Justice Studies* 133; Kerry Carrington, 'The Death of Mark Quayle: Normalising Racial Horror in Country Towns and Hospitals' (1991) 4 *Journal for Social Justice Studies* 161.

109 Law Reform Committee, Parliament of Victoria, above n 12, 366–7.

110 Ibid, 382–383.

111 Ibid, 382.

112 Ibid.

113 Costas Douzinas, 'The Metaphysics of Jurisdiction' in Shaun McVeigh (ed), *Jurisprudence of Jurisdiction* (2007) 21, 23.

114 Gwynn Davis et al, *Experiencing Inquests*, UK Home Office Research Study 241(2002) ix <http://www.homeoffice.gov.uk/rds/pdfs2/hors241.pdf> at 21 November 2008.

115 Mackenzie, Stobbs and Thomas, above n 27, 8.

116 Victorian Government, above n 37.

117 Michael Hogan, 'Towards a New South Wales Coronial System for the Nineties' (1991) 2(3) *Current Issues in Criminal Justice* 75, 77–8.

118 Ibid 78.

119 The RCIADIC asked 'why do Aboriginal people, who form about 1.5% of the Australian population, have twenty times the risk of dying in police custody and ten times the risk of dying in prisons?'. See Commonwealth, RCIADIC, above n 28, vol 1, [3.5.3].

120 This is a statement by Western Australian State Coroner Alistair Hope. See *Inquest into the Deaths of E J Riley, R Henry, C Atkins, T Beharral, M Brown, J Dick, L Dawson, B Dickens, I B Gepp, O G J Hale, E J Laurel, J Middleton, W R Miller, G Oscar, C A Shaw, S Surprise, D K Edwards, N M Cox, D Sampi, L Sampi, T J O'Sullivan, Z Yamera* (Unreported, WA Coroner's Court, State Coroner Hope, 25 February 2008) 17 <http://www.safetyandquality.health.wa.gov.au/docs/mortality_review/inquest_finding/Kimberley_Coronial_Report_Findings.pdf> at 21 November 2008 ('*WA Inquest*').

121 Corrin and Douglas, above n 14, 557.

122 Marchetti, above n 51, 110–11. Thomas Hickey was 17 when he died on 15 February 2004 after falling from his bicycle in Waterloo, NSW. Hickey allegedly fell from his bike and was impaled on a fence during a police chase, which the police denied.

123 *Inquest into the Deaths of Kumanjaya Presley, Kunmanara Coulthard and Kunmanara Brumby* [2005] NTMC 034 (Unreported, NT Coroner's Court, Coroner Cavanagh, 10 October 2005) 2.

124 Ibid 5-7.

125 Ibid 17. Coroner Cavanagh repeatedly made reference to South Australian Coroner Wayne Chivell's 2002 findings into the deaths of Kunmanara Ken, Kunmanara Hunt and Kunmanara Thompson: *Inquest into the Deaths of Kunmanara Ken, Kunmanara Hunt and Kunmanara Thompson* (Unreported, SA Coroner's Court, Coroner Chivell, 6 September 2002) <http://www.courts.sa.gov.au/courts/coroner/findings/findings_2002/kunmanara_hunt.finding.htm> at 21 November 2008. Coroner Cavanagh also referred to Northern Territory Coroner Warren Donald's 1998 recommendations in the case of Esky Muller and Coroner Chivell's 2005 findings into the deaths of Kunmanara Ward, Kunmanara Ken, Kunmanara Ryan and Kunmanara Cooper to illustrate the repeated frustrations of coroners on the issue of petrol sniffing in Indigenous communities. See ibid, [68]; *Inquest into the Death of Esky Muller* A82/94 (Unreported, NT Coroner's Court, Coroner Donald, 2 September 1998); *Inquest into the Deaths of Kunmanara Ken, Kunmanara Hunt and Kunmanara Thompson* (Unreported, SA Coroner's Court, Coroner Chivell, 6 September 2002). All these findings (and more), including references to the Gordon Inquiry and the RCIADIC, have been referred to in the Senate Community Affairs Committee, Parliament of Australia, *Beyond Petrol Sniffing: Renewing Hope for Indigenous Communities* (2006) [1.1]–[1.73].

126 *Inquest into the Deaths of Kumanjaya Presley, Kunmanara Coulthard and Kunmanara Brumby* [2005] NTMC 034 (Unreported, NT Coroner's Court, Coroner Cavanagh, 10 October 2005) 17.

127 Ibid 35–6.

128 *WA Inquest* (Unreported, WA Coroner's Court, State Coroner Hope, 25 February 2008) Executive Summary.

129 Ibid 9.

130 Western Australian Government, Department of Indigenous Affairs, *WA State Government Response to the Hope Report* (2008) <http://www.dia.wa.gov.au/Documents/ReportsPublications/WAStateGovtResponsetoHopeReprtFinalVersionPublic8April08.pdf> at 21 November 2008.

131 *WA Inquest* (Unreported, WA Coroner's Court, State Coroner Hope, 25 February 2008) 2.

132 Andrea Hayward, 'Oombulgurri Should be Closed, Lawyer', *WA Today* (online), 25 July 2008 <http://www.watoday.com.au/wa-news/oombulgurri-should-be-closed-lawyer-20080725-3ksq.html> at 21 November 2008.

133 Jenny Macklin (Federal Minister for Families, Housing, Community Services and Indigenous Affairs), 'Income Management Rollout in Oombulgurri' (Press Release, 21 July 2008) <http://www.jennymacklin.fahcsia.gov.au/internet/jennymacklin.nsf/print/oombulgurri_21jul08.htm> at 21 November 2008.

134 Andrea Hayward, 'Probe Narrogin Deaths, Health Group', *WA Today* (online), 25 July 2008 <http://www.watoday.com.au/wa-news/probe-narrogin-deaths-health-group-20080725-3ksb.html > at 21 November 2008.

135 *WA Inquest* (Unreported, WA Coroner's Court, State Coroner Hope, 25 February 2008) 3. The investigations into a number of the deaths were 'completed administratively by coroners pursuant to section 25 of the *Coroners Act 1996*'.

136 On the NCIS see Pearse and Daking, above n 9. See also the NCIS website: NCIS <http://www.ncis.org.au> at 21 November 2008.

137 See above n 123.

138 For example, some jurisdictions have legislatively mandated a response to coronial recommendations in relation to death. The *Coroners Act 1997* (ACT) imposes an obligation on a coroner to report findings following an inquest into a death in custody to the Attorney-General, the custodial agency, the Australian Institute of Criminology, and, if the deceased was Aboriginal or Torres Strait Islander, to the appropriate local Aboriginal legal service (see s 75(1)). The custodial agency then has three months to respond to the findings (s 76). The *Coroners Act* (NT) similarly places an obligation on a coroner to: investigate and report on the care, supervision and treatment of the person while being held in custody or caused or contributed to by injuries sustained while being held in custody (s 26(1)(a)); make recommendations with respect to the prevention of future deaths in similar circumstances (s 26(2)); and report these to the Attorney-General (s 27(1)). Under s 35 of the Act the coroner may also report or make recommendations to the Attorney-General. See s 46A which provides for the obligations imposed on the Attorney-General for forwarding reports received under ss 27 and 35 to the appropriate authorities, and see s 46B which outlines the obligations on those authorities to respond to the coroner's report or recommendations. The *Coroners Act 2003* (SA) provides (at s 25) for the making of recommendations with respect to preventing death. The Act provides for the dissemination of findings (s 25(4)) and, for deaths in custody, requires the provision of findings to specific agencies, parties and witnesses (s 25(4)(b)). Section 25(5) of the Act places an obligation on the responsible Minister to report to Parliament on a response to the coronial recommendations and forward a copy of that report to the State Coroner.

139 A significant declaration of this is the announcement that the new Coroners Bill 2008 (Vic) will be supported by the establishment of a coroner's prevention unit to assist coroners in formulating and evaluating recommendations. See Hulls, 'Coroner Gets New Powers to Keep Victorians Safe', above n 38.

140 See Victorian Government, above n 37. See also Coroners Bill 2008 (Vic) s 73(1). On the coroner's prevention unit see Victoria,

Parliamentary Debates, Legislative Assembly, 9 October 2008, 4035 (Rob Hulls, Attorney-General); Hulls, 'Coroner Gets New Powers to Keep Victorians Safe', above n 38.

141 See the VPLRC discussion of the NCIS: Law Reform Committee, Parliament of Victoria, above n 12, 338–46.

142 See Mary-Anne L Measey et al, 'Suicide in the Northern Territory, 1981–2002' (2006) 185(6) *Medical Journal of Australia* 315; Ernest Hunter and Desley Harvey, 'Indigenous Suicide in Australia, New Zealand, Canada and the United States' (2002) 14(1) *Emergency Medicine* 14; David P Thomas et al, 'Long-term Trends in Indigenous Deaths from Chronic Diseases in the Northern Territory: A Foot on the Brake, a Foot on the Accelerator' (2006) 185(3) *Medical Journal of Australia* 145. See also above n 32.

143 Pink and Allbon, above n 32.

144 This approach therefore recognises the importance of appropriate, tailored recommendations. For a pointed discussion of coronial evolution, see Freckelton and Ranson, 'The Evolving Institution of the Coroner', above n 4.