THE CORONER'S RECOMMENDATION: FULFILLING ITS POTENTIAL? A PERSPECTIVE FROM THE ABORIGINAL LEGAL SERVICE (NSW/ACT)

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I The Coroner's Inquest

Coroners Acts in New South Wales ('NSW') and the Australian Capital Territory ('ACT') confer on coroners jurisdiction to conduct inquests into certain kinds of death.[1] As the outcome of a hearing, a coroner is tasked by their legislation to reach and record prescribed findings relating to the deceased, their death, and its manner and cause.[2] These determinations enable that death to be registered under the relevant Birth, Deaths and Marriages legislation.[3] If, though, this information can be established from preliminary investigations,[4] a coroner has the discretion to dispense with an inquest hearing, unless the death investigated is of a category for which the legislation specifically requires one to be held.[5] One such category is the death of a person in custody.[6]

In the course of an inquest, a coroner will receive a range of information relating to that death, its cause and the circumstances surrounding it.[7] A coroner's inquest may often not be the only investigation into a death, but a coroner brings to it the perspective of an independent officer[8] conducting an inquiry into the facts[9] in an open forum,[10] and has the opportunity to identify those factors which contributed to the death's occurrence and which could, in the future, be avoided. And while the determination of certain particulars may be the coroner's primary function,[11] other purposes have been recognised as valid to pursue.[12] Of these, the promotion of public health and safety and, specifically, the prevention of death may be the most vital.[13] Twenty years ago, the Royal Commission into Aboriginal Deaths in Custody ('RCIADC') noted this capability, observing that '[i]n the final analysis adequate post death investigations have the potential to save lives.'[14]

In contributing to the prevention of death, the principal strategy available to a coroner is their power to make recommendations at the conclusion of an inquest.[15] These recommendations 'represent the distillation of the preventive potential of the coronial process. The action taken in response to such recommendations carries the promise of lives saved and injury averted.'[16] Utilising the evidence as to the circumstances surrounding the death, the expertise of the coroner, and, perhaps, the submissions of those appearing at an inquest, such recommendations can offer possible 'remedies' to avoid future deaths.[17] It is this potential that underpins the frequently quoted motto of the coroner: 'We speak for the Dead to protect the Living.'[18]

II The Coroner's Recommendatory Power

A Common Law

As a part of English law in the late 18th century, the coronial jurisdiction was received by the colony of NSW upon its establishment.[19] At common law, a coroner – or the jury in a coroner's court – was entitled to attach a recommendation to their findings, although this was by way of a 'rider' only, and did not form a part of the record of their formal findings.[20]

B The Proposals of the Royal Commission

While the RCIADC identified the potential of the coroner's recommendatory power, it also recognised its vulnerability under common law.[21] In its *National Report*, the Commission proposed not only that coroners consistently be empowered to make recommendations, but that consideration be given to a more positive duty to do so.[22] Towards this, recommendation 13 proposed that all Coroners Acts be amended to *require* coroners to make recommendations

at inquests into a death in custody and, also, that they be enabled to make recommendations generally, on 'other matters'.[23]

To support a coroner's exercise of this power, the RCIADC also stressed the necessity of an effective process for the communication of any recommendation made to the relevant Minister or agency.[24] In addition, it proposed that governments and their departments be required to respond to these recommendations within an appropriate timeframe.[25]

III Implementing the Royal Commission's Proposals

A NSW and the ACT

In 1993, section 22A was inserted into the *Coroners Act 1980* (NSW), empowering coroners to make recommendations on 'any matter connected with the death' investigated.[26] However, no further provision was included requiring a coroner to make them at an inquest into a death in custody (or any other category of death). Nor was amendment made for their communication to the relevant authority[27] or their response.

In 1997, the ACT received a new *Coroners Act*, which does require a coroner conducting an inquest into a death in custody to record a finding on the 'quality of care, treatment and supervision of the deceased' that contributed to their death.[28] Importantly, it also makes provision both for the communication of these findings and for a response by agencies to whom such communications are directed.[29] The Act further empowers a coroner to make recommendations at any inquest, although no provision is included requiring a response.[30]

B Other Jurisdictions

This piecemeal and uneven approach to the RCIADIC's proposals regarding the coroner's recommendation has been replicated in other States. In all Australian jurisdictions, a coroner now has a statutory power to make recommendations on matters connected with the death at an inquest held into any category of death.[31]

But although coroners in each jurisdiction carry a statutory responsibility to reach certain findings relating to the specific death, they are not consistently under any statutory duty to identify those remedies as coronial recommendations to avoid future similar deaths. In 2011, with some exceptions, the exercise of this power remains, as the RCIADIC noted it to be in 1991, discretionary.[32]

State and territory coronial legislation has, until recently, afforded desultory support to any coroner in robust pursuit of the prevention of death. While empowering a coroner to comment or make recommendations, the legislation has offered little to either clarify or facilitate the effective exercise of this capability. Added to this lack of statutory direction, the relatively small number of appellate decisions on the coroner's recommendatory power provide limited guidance beyond establishing boundaries for its application, and offer scant encouragement of its potential.[33]

As a result, the impression conveyed to date by both the legislature and the judiciary is one that has effectively marginalised the coroner's recommendation, appearing to deprecate its use other than in narrowly defined, and occasional, circumstances.

IV The Exercise of the Recommendatory Power

A Current Provisions

Across jurisdictions, legislative provisions relating to the coroner's recommendatory power are marked by an inconsistency as to whether, and when, the coroner's use of it is mandatory or discretionary, together with an absence of direction as to the correct manner of its application. A resulting uncertainty is underscored by the lack of consistent statutory recognition of its use as a proper function of the coroner.[34]

In NSW, the ACT, the Northern Territory, Victoria and Western Australia, a coroner 'may' make recommendations on any matter connected with the death investigated.[35] Similarly, in South Australia, the Coroner's Court 'may' add to its findings any recommendation contributing to the prevention of a death similar to that investigated;[36] and in Queensland, a coroner 'may' comment on any matter connected with the death.[37] In Tasmania, however, a coroner is directed by legislation to exercise this power and 'must' make recommendations in every case, although only 'whenever appropriate'.[38]

B Inquests into Deaths 'In the Hands of the State'

Special provisions in some jurisdictions address the exercise of this power in the case of inquests into a death that has occurred in custody – 'in the hands of the state'.[39] In the Northern Territory, a coroner 'must' make recommendations towards the prevention of death if the death investigated occurred in custody.[40] In Tasmania and Western Australia, if the death being investigated occurred while in custody, a coroner 'must' report on the care, supervision or treatment of the deceased.[41] As already noted, in the ACT, a coroner conducting an inquest into a death in custody 'must' record findings on this issue as it contributed to the death of the deceased.[42] Under the Queensland *Coroners Act*, special provisions relate to the communication of any comments made by a coroner at an inquest into a death in custody, although there is no statutory direction to a coroner to make such comments.[43]

Imprisoned, acutely vulnerable, isolated from family and other supports and mostly invisible to the community, a person in custody has long been recognised as owed a special responsibility by the state while in its control.[44] These special provisions in some – if not all – jurisdictions continue to mark the impact and contribution of the RCIADIC.

V Responses to Coronial Recommendations

But, as the RCIADC noted, to realise any meaningful part of its potential a coronial recommendation must be considered and receive a response.[45] An appropriate response will not necessarily require full compliance with, or even partial implementation of, the measures proposed.[46] However, what is required is their proper consideration and a written response outlining what, if any, action is to be taken, and the reasons for it.

A NSW and the ACT

In NSW, the departmental review of the *Coroners Act 1980* (NSW) acknowledged that an adequate framework for both the communication of, and response to, coronial recommendations, was required.[47] But while the *Coroners Act 2009* (NSW) provided a process of communication for coronial recommendations, no provision was included for their response.[48] As set out above, the *Coroners Act 1997* (ACT) requires responses to be provided by government agencies only to comments made at an inquest into a death in custody.[49]

B Other Jurisdictions

In South Australia, the *Coroners Act 2003* (SA) requires responses only to recommendations made in inquests into deaths that occurred in custody.[50] At present, only the Northern Territory and the new Victorian Acts require responses to *all* recommendations made by a coroner.[51] All other Coroners Acts – those of NSW, Queensland, Tasmania and Western Australia – while empowering coroners to make recommendations, are silent on the issue of responses to them.

This chequered pattern of provisions only supports – if not encourages – an attitude that, in the absence of any legislative direction, a comment or recommendation by a coroner can be disregarded by the relevant agency.

VI Coroners' Use of their Recommendatory Power

In 1991, the RCIADIC also noted a general reluctance on the part of coroners to make recommendations, despite circumstances in some cases suggesting that a coronial recommendation – as a remedy to avoid future deaths – would be appropriate and beneficial.[52] Over the 20 years since the Commission, this pattern has persisted.

Recent studies have indicated that recommendations are made by coroners in a low proportion of inquests. In a survey of cases from 2000 to 2004 reported on the National Coroners Information System,[53] Bugeja has reported that only 1.4 per cent of coronial investigations in Victoria produced recommendations.[54] She identified a similar rate in other jurisdictions: for example, in Tasmania, where coroners are required, whenever appropriate, to make recommendations, they were produced in only 1.3 per cent of investigations.[55]

Charting inquests during the 2004 and 2005 calendar years, Watterson, Brown and McKenzie also noted a low number of inquests in which recommendations were made.[56] Similarly, in his report on coronial recommendations, the Queensland Ombudsman had only a relatively small amount of cases to consider.[57] And in Victoria, the Parliamentary Law Reform Committee, in its inquiry into the *Coroners Act 1985* (Vic), recorded evidence that some coroners do not consider making recommendations to be a part of their function.[58]

This cautious use of the recommendatory power has served to entrench current practice, rather than contributing to its development and a change in culture. A paucity and inconsistency of exercise by coroners of their power continues to marginalise the coronial recommendation and restrain its potential to contribute to the prevention of death. It promotes the above noted perception that recommendations are of lesser importance to the coroner's function, to be made sparingly, rather than as Waller – a former NSW State Coroner – has suggested 'fearlessly'.[59]

Such a view could be argued persuasively if it was dictated by the legislation or even accepted as good practice by coroners across jurisdictions. But Buegeja's study suggests that the formulation of recommendations in a particular case will be driven less by the circumstances of the death than by the identity of the coroner presiding.[60]

VII New Coroners Acts: A Shift in Coronial Law

The *Coroners Act 2008* (Vic) introduced significant reforms to the Victorian jurisdiction, in particular enhancing the coroner's role in the prevention of death. Both in a Preamble and an objects provision, the Act specifically recognises this potential contribution.[61] It not only restates the coroner's power to make recommendations,[62] but requires public authorities to respond to them in *all* cases.[63]

The following year, the NSW Parliament passed its *Coroners Act 2009* (NSW). This Act also includes an objects provision, identifying the enabling of coroners to make recommendations at an inquest as one of its purposes.[64] However, unlike the Victorian statute, it does not include a requirement for government agencies to submit a response.[65]

Whether other states and territories will introduce similar legislative reform is not known.[66] And whether a clear statutory recognition in these two jurisdictions of the coroner's recommendatory power as a legislative object results in its increased exercise can only be measured at a future date.[67]

VIII Conclusion

Over the past 20 years, the RCIADIC's proposals for the coroner's recommendation have received incomplete and disparate implementation. The current legislative framework surrounding the coroner's recommendatory power in each Australian jurisdiction contains important advances since 1991 and offers significant opportunities to coroners to contribute to the prevention of death. But the pursuit of this potential will continue to falter and be discounted while provisions across state and territory Coroners Acts regarding a coroner's duty to make recommendations and the responsibility of governments to respond to them remain inconsistent, disconnected and unclear.

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1 *Coroners Act 2009* (NSW) ss 21, 35; *Coroners Act 1997* (ACT) s 52. Both the NSW and the ACT Coroners Acts are silent on the issue of whether a coroner's common law powers are preserved, although *Coroners Act 1997* (ACT) s 12 confirms 'all the functions and jurisdiction' vested in the coroner immediately prior to the *Coroners Act 1956* (ACT). In South Australia, the *Coroners Act 2003* (SA) is also silent on the issue. In the Northern Territory, they are specifically preserved: *Coroners Act* 1993 (NT) s 6(2)(b). In other jurisdictions, coroners' common law powers are specifically abolished by legislation: *Coroners Act 2003* (Qld) s 104; *Coroners Act 1995* (Tas) s 4; *Coroners Act 1985* (Vic) s 4 (while under this provision, common law rules relating to the coroner ceased to have effect, the *Coroners Act 2008* (Vic) is silent on the subject of common law powers): *Coroners Act 1996* (WA) s 4. In his commentary on the *Coroners Act 2009* (NSW), Kevin Waller considered that in the absence of an express statutory removal, the coroner's common law powers remain: John Abernethy et al, *Waller's Coronial Law and Practice in New South Wales* (LexisNexis Butterworths, 4th ed, 2010) 13–14. Waller also refers to *Maksimovich v Walsh* [1983] 2 NSWLR 656, 662 in which Clarke J agreed with Waller's view in an earlier edition of the work (K Waller, *Coronial Law and Practice in New South Wales* (Law Book Co, 2nd ed, 1982)): John Abernethy et al, *Waller's Coronial Law and Practice in New South Wales* (LexisNexis Butterworths, 4th ed, 2010) 13.

2 *Coroners Act 2009* (NSW) s 81(1); *Coroners Act 1997* (ACT) s 52.

3 *Coroners Act 2009* (NSW) s 34: *Birth, Deaths and Marriages Registration Act 1995* (NSW); *Coroners Act 1997* (ACT) s 56: *Birth, Deaths and Marriages Registration Act 1997* (ACT).

4 In contrast to Coroners Acts in other jurisdictions, which specifically empower a coroner 'to investigate' a reportable death, Coroners Acts in New South Wales and the Australian Capital Territory provide coroners with jurisdiction 'to hold an inquest

into' a death: *Coroners Act 2009* (NSW) s 17(1); *Coroners Act 1997* (ACT) s 13. Coroners Acts in both jurisdictions, however, provide a coroner with powers of investigation: *Coroners Act 2009* (NSW) ch 6, pt 6.1; *Coroners Act 1997* (ACT) Part 5, Division 5.6. The NSW legislation also acknowledges that the investigation of deaths is one of the objects of the Act: *Coroners Act 2009* (NSW) s 3(c); and that ensuring that deaths are properly investigated is a function of the State Coroner: *Coroners Act 2009* (NSW) s 10(1)(b).

5 *Coroners Act 2009* (NSW) s 25(1); *Coroners Act 1997* (ACT) s 14.

6 *Coroners Act 2009* (NSW) ss 23, 27; *Coroners Act 1997* (ACT) s 14(2)(a).

7 The scope of the phrase 'manner of death' was considered by the Supreme Courts of NSW and the ACT: *Conway v Jerram* [2010] NSWSC 371, [52] (Barr AJ); *Coroner Doogan; Ex parte Lucas-Smith* (2005) 158 ACTR 1, 9–10 [28]–[29] (Higgins CJ, Crispin and Bennett JJ).

8 Under the *Coroners Act 2009* (NSW), a coroner is required to have legal qualifications (s 12(2)). and the State Coroner and a Deputy State Coroner must be a Magistrate (s 7(2)). Only the State Coroner or a Deputy State Coroner may conduct an inquest into a death in custody: *Coroners Act 2009* (NSW) s 22. Under the *Coroners Act 1997* (ACT), the Executive may appoint a person to be a Deputy Coroner (s 8(1)), but a Deputy Coroner is not permitted to conduct an inquest into a death in custody (s 9(2)).

9 Courts have stressed that a coroner's inquest is 'a fact finding exercise and not a method of apportioning guilt. … It is an inquisitorial process, a process of investigation quite unlike a trial': *R v South London Coroner; Ex parte Thompson* (1982) 126 Sol J 625 (Lord Lane CJ), cited in *Annetts v McCann* (1990) 170 CLR 596, 616 (Toohey J), referring to a citation of the case in *Jervis on the Office and Duties of Coroners* (10th ed) (Sweet & Maxwell, 1986) 6.

10 A coroner has the power to clear their court and prevent publication of evidence if in the public interest: *Coroners Act 2009* (NSW) s 74; *Coroners Act 1997* (ACT) s 40.

11 *Harmsworth v State Coroner* [1989] VR 989, 996 (Nathan J); *Conway v Jerram* [2010] NSWSC 371 [6] (Barr AJ).

12 John Norris, *The Coroners Act 1958: A General Review* (Law Department, 1981) 134, quoted in Law Reform Committee, Parliament of Victoria, *Coroners Act 1985: Final Report* (2006) 322. Objects provisions in the new NSW and Victorian Acts, as well as the Queensland Acts identify several further purposes: *Coroners Act 2009* (NSW) s 3; *Coroners Act 2008* (Vic) s 1; *Coroners Act 2003* (Qld) s 3.

13 New South Wales, *Parliamentary Debates,* Legislative Council, 4 June 2009, 6–7 (John Hatzistergos).

14 Commonwealth, Royal Commission into Aboriginal Deaths in Custody, *National Report* (1991) vol 1, 170 [4.7.4].

15 Lyndal Bugeja and David Ranson, 'Coroners' Recommendations: A Lost Opportunity' (2005) 13 *Journal of Law and Medicine* 173; see also Ian Freckelton and David Ranson, *Death Investigation and the Coroner's Inquest* (Oxford University Press, 2006) ch 18.

16 Boronia Halstead, 'Coroners Recommendations Following Deaths in Custody' in Hugh Selby (ed), *The Inquest Handbook* (Federation Press, 1998) 186, 187.

17 Bugeja and Ranson, above n 15, 174.

18 The words are attributed to Thomas D'arcy McGee, a 17th Century Irish-Canadian politician: see Law Reform Committee above n 12, 321. In his Second Reading Speech for the Coroners Bill 2009 (NSW), the then Attorney-General, while not quoting this motto specifically, acknowledged this duality of the coroner's function: New South Wales, *Parliamentary Debates*, Legislative Council, 4 June 2009, 6 (John Hatzistergos).

19 *Australian Courts Act 1828* (Imp) 9 Geo 4 c 83 was a declaratory Act. In *Mabo v Queensland (No 2)* (1992) 175 CLR 1, Deane and Gaudron JJ considered that the colony of NSW received English law, as far as it was applicable, on 7 February 1788, on the colony's establishment with the reading and publication by Captain Arthur Phillip of his second Commission as Governor of the new colony: at 78–9. In *Attorney-General v Maksimovich*, (1985) 4 NSWLR 300, Kirby P noted that the office of Coroner for NSW was created by Letters Patent of 1787: at 305.

20 *R v Harding* (1908) 1 Cr App R 219, 225 (Darling J). In England and Wales, the power of the coroner to add a rider was removed by the *Coroners Amendment Rules 1980* (UK) r 11. However, under the *Coroners Rules 1984* (UK) r 44, a coroner may announce their intention to report a matter to the relevant person or authority to take action.

21 The Commission noted that Coroners Acts in neither NSW nor Tasmania empowered a coroner to make recommendations: RCIADIC, above n 14, vol 1, 154 [4.5.86].

22 Ibid vol 1, 154 [4.5.89].

23 Ibid vol 1, 172 [4.7.4] (rec 13). The *Report* was referring to inquests into any category of death: at 153–4 [4.5.85]–[4.5.86].

24 Ibid 172 [4.7.4] (rec 14), 155–6 [4.5.92]–[4.5.94].

25 Ibid 172–3 [4.7.4] (rec 15).

26 *Coroners (Amendment) Act 1993* (NSW) sch 1(27). Section 22A is restated in the *Coroners Act 2009* (NSW) s 82(1).

27 This gap was only addressed in 2009 with the new *Coroners Act 2009* (NSW). A study by Ray Watterson, Penny Brown and John McKenzie identified that even in cases in which a coroner had made recommendations, many had not been communicated to the relevant Minister or government agency: Ray Watterson, Penny Brown and John McKenzie, 'Coronial Recommendations and the Prevention of Indigenous Death'

(2008) 12(2) *Australian Indigenous Law Review* 4. Referring to this report in his Second Reading Speech for the new Act, the then Attorney-General acknowledged this absence of an effective process of communication and stated that it received remedy in the new Act: New South Wales, *Parliamentary Debates,* Legislative Council, 4 June 2009, 6–7 (John Hatzistergos). Reporting on his investigation into practices surrounding coronial recommendations, the Queensland Ombudsman also identified serious systemic problems in this regard: David Bevan, 'The Coronial Recommendations Project: An Investigation into the Administrative Practice of Queensland Public Sector Agencies in Assisting Coronial Inquiries and Responding to Coronial Recommendations' (Report, Queensland Ombudsman, 19 December 2006) 21 <http://www.ombudsman.qld.gov.au/Portals/0/docs/Publications/Inv_reports/Coronial_Recommendations_Project.pdf>.

28 *Coroners Act 1997* (ACT) s 74.

29 *Coroners Act 1997* (ACT) ss 75–6.

30 *Coroners Act 1997* (ACT) s 57; such recommendations are made to the Attorney-General of the Australian Capital Territory.

31 *Coroners Act 1997* (ACT) s 57; *Coroners Act 2009* (NSW) s 82(1); *Coroners Act 1993* (NT) s 35(2); *Coroners Act 2003* (Qld) s 46(1) (the Queensland Act refers to 'comments' by a coroner); *Coroners Act 2003* (SA) s 25(2); *Coroners Act 1995* (Tas) s 28(2); *Coroners Act 2008* (Vic) s 72(2); *Coroners Act 1996* (WA) ss 25(2), 27(3) (under the Western Australian provisions, while 'comments' may be made by a coroner (under s 25(2)), 'recommendations' may be made by the State Coroner (s 27(3)).

32 RCIADIC, above n 14, vol 1, 154 [4.5.89]. Although in investigating certain categories of death, a coroner is required, in some jurisdictions, to make recommendations. These are further considered below: see text accompanying nn 39–44.

33 See eg, *Harmsworth v State Coroner* [1989] VR 989; *Coroner Doogan; Ex parte Lucas-Smith* [2005] ACTSC 74; *Keown v Khan* [1999] 1 VR 69; *Perre v Chivell* (2000) 77 SASR 282. Although *Doomadgee v Deputy State Coroner Clements* [2005] QSC 357 indicated a possible shift in judicial attitude, *Saraf v Johns* (2008) 101 SASR 87 has not continued an expansive reading of the power.

34 Only under the Queensland and the new Victorian and NSW Acts does it receive recognition as an object of each statute: *Coroners Act 2003* (Qld) s 3(d); *Coroners Act 2008* (Vic) s 1(c); *Coroners Act 2009* (NSW) s 3(e).

35 *Coroners Act 2009* (NSW) s 82(1); *Coroners Act 1997* (ACT) s 57(3); *Coroners Act 1993* (NT) s 35(2); *Coroners Act 2008* (Vic) s 72(2); *Coroners Act 1996* (WA) s 27(3). In addition, in the ACT, Northern Territory, Queensland, Tasmania, Victoria and Western Australia, a coroner 'may' comment on any matter connected with the death or event under investigation: *Coroners Act 1997* (ACT) s 52(4); *Coroners Act 1993* (NT) s 34(2); *Coroners Act 2003* (Qld) s 46(1); *Coroners Act 1995* (Tas) s 28(3); *Coroners Act 2008* (Vic) s 67(3); *Coroners Act 1996* (WA) s 25(2).

36 *Coroners Act 2003* (SA) s 25(2).

37 *Coroners Act 2003* (Qld) s 46(1).

38 *Coroners Act 1995* (Tas) s 28(2).

39 See Michael Hogan, Dave Brown and Russell Hogg, *Death in the Hands of the State* (Redfern Legal Centre Publishing, 1988).

40 *Coroners Act 1993* (NT) s 26(2).

41 *Coroners Act 1995* (Tas) s 28(5); *Coroners Act 1996* (WA) s 25(3).

42 *Coroners Act 1997* (ACT) s 74.

43 *Coroners Act 2003* (Qld) s 47.

44 This special responsibility to prisoners was recognised as a duty owed by the state as early as 1276 in the statute *De Officio Coronatoris*: Freckelton and Ranson, above n 15, 10; Waller, above n 1, 2.

45 RCIADIC, above n 14, vol 1, 155 [4.5.91], 157 [4.5.98].

46 Ibid vol 1, 156 [4.5.97].

47 New South Wales, *Parliamentary Debates,* Legislative Council, 4 June 2009, 6–7 (John Hatzistergos).

48 However, in his Second Reading Speech, the then Attorney-General announced that the Premier had issued a Memorandum to all Ministers and government agencies, directing them to provide responses to coronial recommendations within six months of their issue: Ibid 7; see also Nathan Rees, 'M2009-12 Responding to Coronial Recommendations' (Memo, NSW Department of Premier and Cabinet 4 June 2009) <http://www.dpc.nsw.gov.au/publications/memos_and_circulars/ministerial_memoranda/2009/m2009-12_responding_to_coronial_recommendations>.

49 *Coroners Act 1997* (ACT) s 76(1).

50 *Coroners Act 2003* (SA) s 25(5).

51 *Coroners Act 1993* (NT) s 46B; *Coroners Act 2008* (Vic) s 72(3)–(4).

52 RCIADIC*,* above n 14, vol 1, 154 [4.5.86]–[4.5.88].

53 A database established July 2000 and under the management of the Victorian Institute of Forensic Medicine since 2005: <http://www.vifp.monash.edu.au/ncis/web_pages/data_elements_coding_schemes_and_guidelines.htm>.

54 Bugeja and Ranson, above n 15, 174–5.

55 Ibid. However, Bugeja and Ranson refer to investigations, as opposed to inquests.

56 Watterson, Brown and McKenzie, above n 27. The focus of their study was the rate of response by government agencies to coronial recommendations, as opposed to coroners' use of the recommendatory power, and so the proportion of inquests in which recommendations were made was not recorded.

57 Bevan, above n 27, xi.

58 Law Reform Committee, above n 12, 377–80.

59 Kevin Waller, *Coronial Law and Practice in New South Wales* (Butterworths, 3rd ed, 1994) 95.

60 Bugeja and Ranson, above n 15, 174.

61 *Coroners Act 2008* (Vic) preamble, s 1.

62 *Coroners Act 2008* (Vic) s 72(2).

63 *Coroners Act 2008* (Vic) s 72(3)–(4). There was no provision requiring government agencies to respond to coronial recommendations under the previous *Coroners Act 1985* (Vic).

64 *Coroners Act 2009* (NSW) s 3(e).

65 In his Second Reading Speech to the *Coroners Bill 2009* (NSW), the then New South Wales Attorney-General advised that provisions under the new Act would ensure that such recommendations would reach the responsible Minister. His speech also referred to the New South Wales Premier's Memorandum (of 4 June 2009) requiring government agencies to respond to coronial recommendations and its aim of ensuring coronial recommendations receive serious consideration by Ministers: New South Wales, *Parliamentary Debates,* Legislative Council, 4 June 2009, 7 (John Hatzistergos); see also Rees, above n 48.

66 At present, the Western Australian Law Reform Commission is engaged in a Review of Coronial Practice (Project 100) and has released a Background Paper (September 2010) <http://www.lrc.justice.wa.gov.au/2publications/reports/P100-BP.pdf>, and a Discussion Paper (June 2011) <http://www.lrc.justice.wa.gov.au/2publications/reports/P100-DP.pdf>.

67 These two new pieces of legislation have been accompanied by a new initiative in the reporting of coroners' inquest reports and recommendations. In Victoria, the State Coroner's website now publishes all coroners' inquest reports, as required by the *Coroners Act 2008* (Vic) s 73. In NSW, the new *Coroners Act 2009* (NSW) does not require this publication, although the State Coroner's website publishes a selection of these reports: Coroner's Court, *Coronial Findings and Recommendations,* Lawlink: Attorney General and Justice <http://www.lawlink.nsw.gov.au/lawlink/coroners_court/ll_coroners.nsf/pages/coroners_findings>.