Implementing Coroners' Deaths in Custody Recommendations: a Victorian Case Study

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The critical role of the coroner in the prevention of deaths in custody was commented upon at length in the National Report of the Royal Commission into Aboriginal Deaths in Custody (RCIADIC). The Report specifically referred to the need to establish appropriate administrative machinery to ensure that coroners' recommendations received proper consideration and that accountability is attached to the implementation of these recommendations. This study examines the effectiveness of the administrative machinery in Victoria for processing coroners' recommendations after an inquest into a death in custody.

This article uses the administrative framework proposed by the RCIADIC in recommendations 14, 15, 16 and 17 as a model of best practice, and considers the extent to which this framework has been developed in Victoria. This framework has the potential to protect the public interest and secure accountability between the coroner and other agencies. It was also designed to ensure that this accountability operates in a transparent way, and that all relevant interests are informed about any remedial outcomes of the coronial process.

As will be shown, none of the RCIADIC recommendations relating to the pathway for implementation of coroners' recommendations has been fully implemented in Victoria. The Victorian Government stated in its 1993 Implementation Report that, of the four relevant RCIADIC recommendations (14, 15, 16 and 17), one has been implemented (14); two have been implemented in part (15 and 17) and one has not been implemented (16). It will be argued that the four relevant recommendations together comprise a step by step accountability circuit, and that only through full implementation of all four recommendations can a systematic framework of accountability which fully protects the public interest be achieved. To this extent, piecemeal implementation has very limited utility.

Victoria was selected as the site for this study because, at the time of the release of the National Report in 1991, the Victorian model of coronial process was acknowledged to be the "most innovative and efficient within Australia" and recommended as a model for adaptation in other Australian States.[1] The exemplary features included a centrally administered coronial service under the control of a State Coroner and a coronial service integrated with the Victorian Institute of Pathology. In the process of legislative reform sparked by the Royal Commission, the Victorian model has in fact been adapted or is being considered by many States, including Tasmania, the Northern Territory and Western Australia. Queensland is

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1 Royal Commission into Aboriginal Deaths in Custody, *National Report* (1991) Australian Government Publishing Service, Canberra at 136.

in the process of reviewing coronial legislation, but as yet, no Bill has been developed. While the Victorian model was comparatively superior at the time of the Royal Commission, the model has serious deficiencies and is particularly weak as a framework for securing accountability and transparency in agency responses to coroners' recommendations. In 1995, other legislatures have in fact gone further than that of Victoria in strengthening their legislation in this regard. Legislation enacted in the Australian Capital Territory in particularly notable.

The study investigated the pathway for implementation of coroners' recommendations in relation to case studies of deaths in custody for the years 1990, 1991 and 1992. Of the total of 36 cases of deaths in custody for this period, only five of the findings from inquests contained recommendations. Overall, a total of 11 recommendations resulted from these five findings, seven of which arose from two findings, both of which were made by one coroner. One other case, in which the person died from the aspiration of stomach contents, led to a finding containing a comment upon the vulnerability of intoxicated detainees. Many more of the cases referred to matters which could have been the subject of recommendations by coroners. The reasons why there may be some reluctance on the part of coroners to make recommendations at all have been discussed elsewhere.[2]

Table 1 (following page) sets out the number and types of recommendations made. Three of the five cases which contained recommendations were suicide cases and in the other two cases, the detainees died from head injuries and drug toxicity respectively. Findings from cases which involved lawful homicide (police shootings) or other homicide did not contain recommendations. The case in which an Aboriginal man died from self-inflicted hanging in police custody generated four recommendations, three of which were concerned with the need for greater awareness of the Aboriginal socio-cultural issues, and the other focussed upon the need to eliminate anchorage points from cells.

In the context of this study, the main elements of accountability are assumed to be transparency and public disclosure; clear and appropriate allocation of responsibility; clear and specific communication mechanisms; and public disclosure of failure to operate in an accountable way. These elements are reflected in the framework proposed by the Royal Commission in the four relevant recommendations. While this study focuses upon deaths in custody, the issues raised have general relevance to the implementation of coroners' recommendations.

Background

The preventive potential of the role of the coroner has been acknowledged for some time, although, in practice, many coroners appear reluctant to initiate remedial action. This preventive potential was recognised by the Royal Commission, and the relevant RCIADIC recommendations are intended to strengthen the capacity of the coronial jurisdiction to realise this potential and overcome apparent reluctance to make recommendations on the part of some coroners. For example, RCIADIC recommendation 13 proposed that the making of recommendations by coroners should be mandatory rather than discretionary where the facts of a case indicate a need for remedial action.[3]

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2 See Halstead, B A, "Coroners' Recommendations and the Prevention of Deaths in Custody: a Victorian Case Study" *Deaths in Custody Australia* series, Australian Institute of Criminology, (forthcoming).

3 Above n1 at 172.

Table 1: Communication Pathway Coroners' Recommendations

	Removal Anchorage Points J.W. 29/8/91 D.O.D. Coroner Wendy Wilmoth	**Medical Checklist Usage P.S. 2/11/92 D.O.D. Coroner Jacinta Heffey**	**Care of Intoxicated Persons (First aid only) R.C. 6/11/90 D.O.D. Coroner Barbara Cotterell (Comment Only)**	**Employ Nurse Watch-house Melbourne City Recs x 4 G.W. 1/12/91 D.O.D. Coroner Wendy Wilmoth**	**Emergency Communication Mechanisms D.S. 10/10/91 D.O.D. Coroner Wendy Wilmoth**	**Aboriginality Recs x 3 training/understanding J.W. 29/8/91 D.O.D. Coroner Wendy Wilmoth**	**Systemic Communicatio n of information D.T. 25/9/92 D.O.D. Coroner Tim McDonald**
From State Coroner ⇒ Attorney General	Yes 29/5/92	No	Yes 28/5/91	Yes 30/11/92	Yes 27/10/92	Yes 29/5/92	Yes
Reply Attorney General to State Coroner Office	Yes 22/6/92	No	Yes 21/6/91	Yes 20/1/93	Yes 27/11/92	Yes 22/6/92	Yes 19/11/93
Attorney General to Agency	Yes x 2 P.E.S. Ministry Chief Comm Police 22/6/92	No	Yes Chief Comm. Police 21/6/91	Yes x 2 20/1/93 Acting Dep Comm P.E.S. Dept. H C.S.	Yes 27/11/92	Yes x 2 P.E.S. Ministry Chief Comm. Police 22/6/92	Yes Attorney-General 27/10/93 Director O.O.C. 19/11/93
Agency to Attorney General	Yes x 2 Chief Comm. Police 24/6/92 Ministry P.E.S. 29/6/92 no info re action taken	No	Yes 4/9/91 Chief Comm. Police info re action taken	No	Yes info re action taken 25/1/93	Yes x 2 P.E.S. Ministry Chief Comm. Police no info re action taken	Yes x 2 from O.O.C. 14/2/93 23/2/94 Detailed info re action taken
Action taken	Yes - Cell assessment undertaken & removal of anchorage points	Not known	Yes - copy of prisoner medical checklist & Force Circ. Memo re care & welfare prisoners	Not known	Yes - alarms fitted new cells trial intercom system costing of fitting alarms other cells	Not known	Yes - improved communication with other custodial agencies - improved 'at risk' prisoner communication system

DOD - Date of Death; P.E.S. - Police and Emergency Services; H.C.S. - Health and Community Services; O.O.C. - Office of Corrections

The public interest in the coronial process has been generally described thus:

> The Coroner can and should enquire into the circumstances giving rise to the condition which caused the death, and ascertain whether they disclose a preventable hazard, or errors and weaknesses in systems or in administration affecting public safety.

Further:

> To place on record all relevant evidence as to the facts and circumstances of the death ... to inform the public through an impartial inquirer of the broad facts of the matter, and to inform all concerned, in appropriate cases, of the precautions desirable to avoid repetitions.[4]

A number of different views on the appropriateness of coroners taking an active role after an inquest in relation to remedying preventable hazards or errors and weaknesses in systems or in administration affecting public safety, have been expressed in reviews of the coronial process, both within Australia and in other common law jurisdictions. It is sometimes assumed that the facts of particular coronial findings should speak for themselves, and that there is no need for coroners to make explicit recommendations, or follow up matters raised during an inquest. However, it will be argued here that this approach institutionalises uncertainty in the practical outcome of the coronial process.

The Brodrick Report (commissioned by the Law Reform Commission, England in 1971) was very doubtful about the value of the coroner's power to make recommendations at all, arguing that the risk of the coroner making inappropriate or unfair comment outweighed any possible advantage that could arise, and that:

> When it appears to a coroner that there may have been some departure from proper standards which, if uncorrected, might result in further danger to individuals ... he should have a right to announce in public and in neutral terms that he is referring the circumstances of a death to an appropriate expert body or public authority for such enquiry and action as it may think fit.[5]

As a result, the power of coroners to make recommendations or attach riders to findings was removed in England and Wales following the release of the Report. Echoing these concerns, in relation to whether or not the relevant authority should be obliged to respond to the coroner with regard to matters raised in findings, the Report stated that:

> We have considered, whether, after a referral, the coroner should be empowered to call for a report from the authority concerned. While we have no doubt that, as a matter of courtesy, the authority would send him a reply in any event, we think it would be unwise for this to be made an obligatory procedure. The decision whether any further action is required may depend on many factors of which the coroner will know nothing and we think that these matters would best be left to the expert authorities concerned.[6]

On the other hand, the Norris Report (1980), which reviewed the operation of the Victorian *Coroners Act* 1958, endorsed a more active preventive role for the coroner. In considering overseas models, Norris drew attention to the capacity of the Ontario coronial system to take "direct action to implement jury recommendations when possible" by sending a copy of the verdict and recommendations "with a covering letter asking how it is intended to remedy the situation".[7]

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4 New South Wales Law Reform Commission, *Report of the Law Reform Commission on the Coroners Act, 1960* (1975) Goverment Printer, New South Wales at 98.

5 Law Reform Commission [England], *Report of the Committee on Death Certification and Coroners* (Brodrick Committee Report) (1971) CMND 4810 Home Office, United Kingdom para 16.52 at 193.

6 Ibid.

7 Norris, J, *The Coroners Act 1958 — A General Review* (1980) at 135.

To extract the full benefit from the disclosure of "hazards, or errors or weaknesses in systems or in administration affecting public safety" in a context in which the coroner has no lawful power to enforce recommendations requires some formal mechanism whereby the response of the agency associated with the existence of the hazard is also disclosed. Logically, this should be the case whether or not the agency complies with coroners' recommendations. The Royal Commission argued that:

> It is not a question of compelling the government or public authorities to act on recommendations, but rather to ensure that they have received proper consideration.[8]

Without some means of compelling "proper consideration", coroners' recommendations could well be ignored and lives placed at risk as a result. There is a strong public interest in strategic disclosure of the agencies' responses to coroners' recommendations, particularly when the agency is publicly funded and has great power over the individual, as is the case with custodial agencies.

The Royal Commission drew attention to the fact that not only were coroners' recommendations ignored in some cases, but:

> In several cases investigated by the Commission it was found that the recommendations had never come to the notice of the relevant authorities.[9]

The four Royal Commission recommendations proposed an explicit pathway for the communication of coronial recommendations, including feedback and public disclosure mechanisms for agency responses, in order to maximise accountability and transparency. This pathway would ensure that recommendations were reliably communicated; that they received reasonable consideration; and, that both the recommendations and agency responses were placed on the public record so that they would come to the attention of all interested parties. This pathway is illustrated in Figure 1 (p347). As can be seen, each step is a link in a chain, and each link is interdependent. Without full implementation of all four RCIADIC recommendations the chain of accountability would be incomplete and thus rendered impotent. There would be no certainty in the consideration of coroners' recommendations and no transparency in the response of agencies. The interested public would not be supplied with information from which to form a useful judgment about the efforts of custodial authorities to remedy deficiencies in custodial care.

The Victorian legislative framework

Sections 21(1) and 21(2) of the Victorian *Coroners Act* 1985 are the legislative provisions which relate to coroners' recommendations. They read as follows:

(1) A coroner may report to the Attorney General on a death which the coroner investigated.

(2) A coroner may make recommendations to the Attorney General on any matter connected with a death which the coroner investigated, including public health or safety or the administration of justice.

None of the four Royal Commission recommendations (14, 15, 16 and 17) is fully reflected in sections 21(1) and 21(2). There is no allocation of responsibility to respond to recommendations; no requirement for feedback to families or to the Attorney-General; no

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8 Above n1 at 156.
9 Ibid.

requirement even for the Attorney-General to forward recommendations on to the responsible agency.

It should be noted that the legislative provisions impart a discretionary rather than mandatory responsibility to the coroner to report recommendations to the Attorney-General. Moreover, the subsequent responsibility of the Attorney-General in relation to recommendations reported is not legislatively defined. The Attorney-General has the discretion to function as either a disinterested post-box which blindly forwards recommendations on to relevant agencies; as a proactive watch-dog to oversee the extent of compliance with coroners' recommendations; as a gate keeper to ensure the quality and consistency of coroners' recommendations, or all or none of the above. Significantly, there is no legislative provision for the return of information about responses to coroners' recommendations back to the Office of the State Coroner.

RCIADIC Recommendation 14 proposes that:

> copies of the findings and recommendations of the Coroner be provided by the Coroners Office to all parties who appeared at the inquest, to the Attorney-General or Minister for Justice of the State of Territory in which the inquest was conducted, to the Minister of the Crown with responsibility for the relevant custodial agency or department and to such other persons as the Coroner deems appropriate.[10]

To the extent that the coroner *may* make recommendations to the Attorney-General, the RCIADIC recommendation 14 is loosely implemented, though there is no legislative requirement for copies also to be sent to any other party. In particular, there is no requirement that copies of findings and recommendations "be provided ... to the Minister of the Crown with responsibility for the relevant custodial agency or department".[11]

Overall, the legislative provisions of the Victorian *Coroners Act* 1985 provide only a loose framework for the conveyance of coroners' recommendations to the Attorney-General. There is no provision for feedback from agencies to either the coroner, the Attorney-General or any other interested party. There is no certainty in the legislation that recommendations will be forwarded anywhere, and no transparency in relation to final outcomes in response to coroners' recommendations. In practice, the State Coroners Office does forward copies of findings to all parties who appeared at an inquest, although there is no legislative provision requiring this action. It was not the practice of the State Coroners Office to send copies of findings to the relevant Minister of the Crown.

The case studies

All of the five findings from coronial inquests into deaths in custody for the years 1990–92 which included recommendations were selected for this study. Also included was an additional case in which the coroner made a comment on the need for special care of heavily intoxicated persons. Inquests for these deaths were finalised between April 1991 and March 1993.

The inter-agency correspondence pathway for the communication and implementation of coroners' recommendations was investigated to determine the extent of compliance and feedback about action taken. Relevant agencies were asked to provide copies of all correspondence in relation to the particular recommendations and comment in each of the

10 Id at 172.
11 Ibid.

cases. The agencies asked were the Victorian Attorney-General's Department; the Victorian Police and the Victorian Office of Corrections. Initially, requests were made for copies of correspondence in relation to other cases of deaths in custody which occurred over this period. This had the potential to highlight risk factors in custodial care which may have led to remedial action, even though no specific recommendations were made, that is, cases in which the "facts spoke for themselves". Unfortunately, this request could not be fulfilled by the custodial agencies because of the excessive labour demands involved.

The only copies of correspondence which were made available to the author from the Department of Justice related to six cases out of the requested 15. These six cases were the only cases which contained recommendations or comments. Apparently, no other correspondence could be located. Presumably this is due to the fact that the Department of Justice was not sent copies of any findings which did not contain recommendations by the State Coroners Office.

The absence of records of correspondence on the Attorney-General's files relating to cases which did not contain recommendations suggests that coroners' findings alone are not formally viewed as spurs to remedial action. In other words, the text of the findings did not formally "speak for itself". Recommendations were required before findings could enter any formal channel which might initiate remedial action. Of course, it is possible that agencies informally initiated remedial action in response to coroners' findings. However, any such action would not be evident to other interested parties.

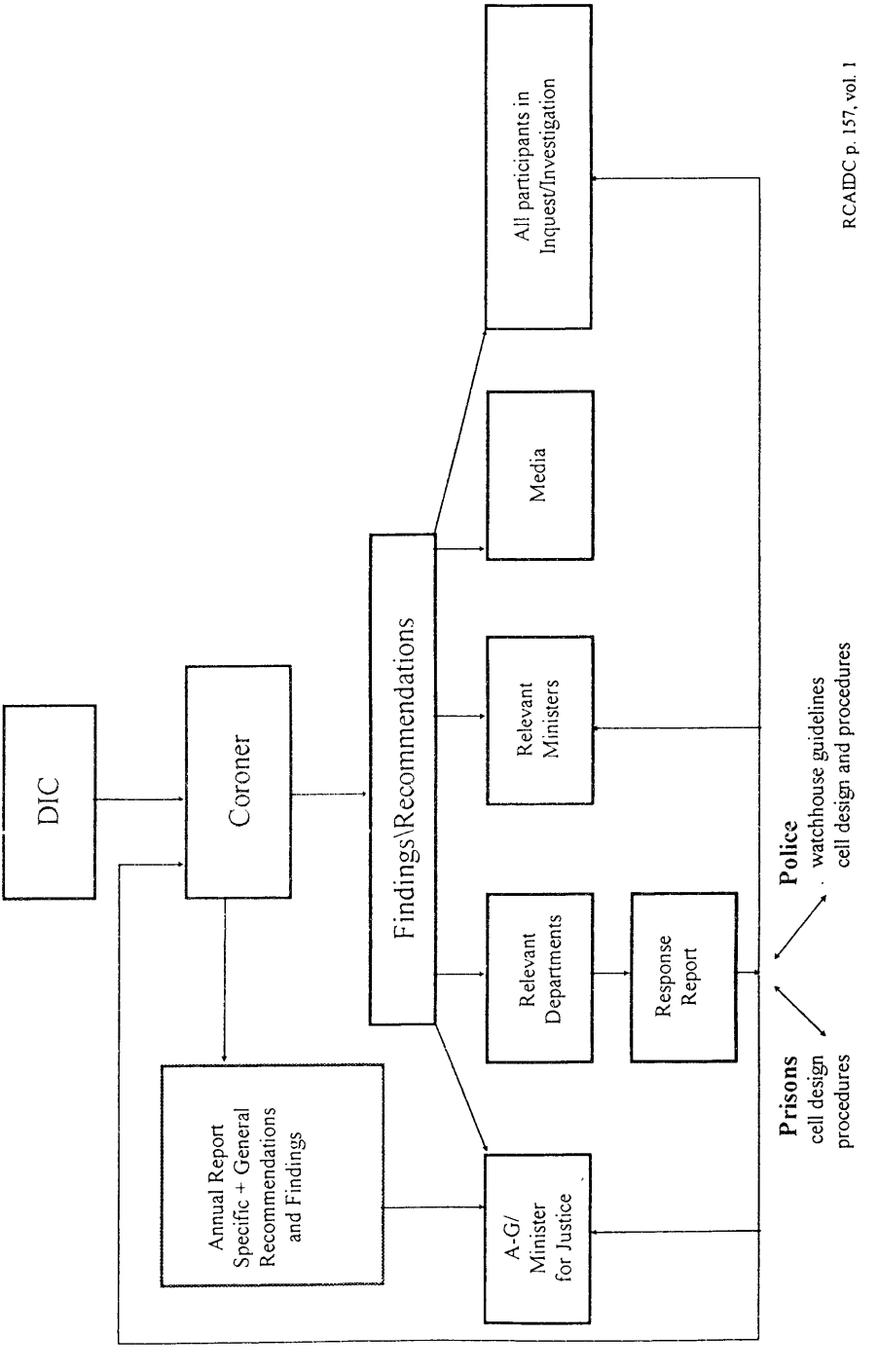
Figure 1 sets out the types of recommendations made and the flow of relevant information in each of the five cases under study. It can be seen that there was no systematic, failsafe mechanism which guaranteed that information would necessarily be conveyed to the relevant agency, or that feedback on action taken would be returned to any other relevant agency.

Considering the case studies in relation to recommendation 14, it would appear from discussions with the State Coroners Office staff and Attorney-Generals' staff that the protocol until quite recently was for the coroner to forward recommendations and findings to the Attorney-General, in accordance with the discretionary provisions of sections 21(1) and 21(2) of the *Coroners Act*. Apparently, this protocol was observed in four of the five inquests.

It should be noted that in one of the cases there was no record of any information sent or received by the Attorney-General, or any other agency in relation to the death, and hence the making of the recommendation about awareness of medical checklists in police custody in this case was apparently futile. The discretion provided by the legislation can lead to uncertainty which correspondingly blunts the preventive impact of the coronial process.

In all but one case, the Department of Justice identified which agency would have responsibility for the issues raised in coroners' recommendations and forwarded them on to the relevant agency. In this way, targeting of recommendations was enhanced, in that recommendations directed generally at police could be sent to the appropriate official, for example, either the Minister for Police and Emergency Services or the Police Commissioner, or both. To this extent, the involvement of the Department of Justice added value to the coroners' recommendations.

Figure 1: Suggested Reporting Procedure



RCIADIC Recommendation 15 proposed:

> That within three calendar months of publication of the findings and recommendations of the coroner as to any death in custody, any agency or department to which a copy of the Findings and recommendations has been delivered by the Coroner shall provide, in writing, to the Minister of the Crown with responsibility for that agency or department, its response to the Findings and recommendations, which should include a report as to whether any action has been taken or is proposed to be taken with respect to any person.[12]

In each of the case studies, the Attorney-General asked to be provided with information on any follow-up action taken as a result of the Coroner's recommendations. This request was open ended, with no expectation of a response within a certain time period. As can be seen from Table 1, agencies provided such information in response to only three of the twelve recommendations. For four other recommendations, the only response provided was acknowledgment of receipt of the findings and recommendations from the Attorney-General. For the remaining five recommendations, no response of any kind occurred from the agency, not even a letter acknowledging receipt of the findings. In none of the cases which did not elicit an action response was any follow-up action initiated by the Attorney-General.

No evidence of any correspondence between the agencies responsible for actioning coroners' recommendations and the relevant Minister of the Crown was found, nor was any request for such information located.

Curiously, in relation to the recommendation for an assessment of the feasibility of the removal of anchorage points from cells, Victoria Police expended large sums of money, not only assessing the feasibility but also carrying out the removal of anchorage points from watch-house cells. However, this action was apparently not communicated back to either the Attorney-General or the State Coroners Office, from the information available on file.

From this evidence, it can only be assumed that the Department of Justice, on behalf of the Attorney-General, functions as a disinterested post-box. The lack of follow-up suggests that it does not provide any monitoring of responses or operate as a watch-dog to ensure that risks to the lives of detainees are remedied. In effect, no accountability attaches to the recommendations made by coroners. If agencies choose to ignore recommendations completely, there will be no follow-up, and their inaction will not even be noted, let alone sanctioned.

In this context, it is worth reiterating the caveat of the Royal Commission that:

> It is not a question of compelling the government or public authorities to act on recommendations, but rather to ensure that they have received proper attention.[13]

In the Victorian Government 1993 Implementation Report, it was stated that Recommendation 15 has been "implemented in part". The partial implementation referred to the maintenance by the Department of Justice of a "register of reports which indicates to whom copies have been sent requesting information, and notes responses received. This register has been kept since 1989 and efforts are made to follow up agencies to ascertain when recommendations are to be implemented".[14]

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12 Id at 173.

13 Id at 156.

14 Victoria. Royal Commission into Aboriginal Deaths in Custody: Victorian Government 1993 Implementation Report (1994) at 58.

The author requested copies of any entries for the selected cases in the register which might indicate whether any follow up action had been taken. This request was refused, on the grounds that:

> It is not an official register and its readability is questionable. It only contains information which is reflected in the Coroner's letter or in our letters to the agencies referred to in the report — such as name, date received and agencies referred to.[15]

Clearly, the register does not function in any way as an accountability tool as is suggested in the Implementation Report. Indeed, it appears that the register does not contain information about coroners' recommendations per se at all. As previously stated, for the 1990–92 cases, there is no written evidence of any effort "to follow-up agencies to ascertain when recommendations are to be implemented".[16] From discussion and correspondence with officers in the Department, it would seem that the register simply documents the flow of correspondence and coronial reports in a reactive way, and does not function in any kind of proactive way, although it would appear that it possibly could.

It is clear that the intention behind Recommendation 15 is to institute a formal accountability mechanism, in which ultimate responsibility lies with the relevant Minister of the Crown, and thus the Parliament. The need for a formal accountability mechanism was highlighted by the Royal Commission, since it was noted with great concern that "in many cases investigated by the Commission in Western Australia, recommendations made by coroners had been effectively ignored".[17] This finding gave rise to the recognition of the public interest requirement that "some mechanism be established to ensure that the relevant authorities have received and considered those [coronial] recommendations".[18]

Recommendation 16 states:

> That the relevant Ministers of the Crown to whom responses are delivered by agencies or departments, as provided for in Recommendation 15, provide copies of each such response to all parties who appeared before the Coroner at the inquest, to the Coroner who conducted the inquest and to the State Coroner. That the State Coroner be empowered to call for such further explanations or information as he or she considers necessary, including reports as to further action taken in relation to the recommendations.

The Victorian Government 1993 Implementation Report states that this recommendation has not been implemented.[19] At present, the jurisdiction of the coroner over matters relating to a particular death ceases when a finding is handed down. He or she is not able to follow up issues which emerged in the course of the inquest, nor is there any jurisdiction to formally respond when it is apparent to the coroner that the responses to recommendations taken by a particular agency are unlikely to achieve the purpose intended or the response is likely to have an adverse effect. This short-circuits the preventive potential of the coronial process, and prevents the full harvest of benefits from an inquest. An intermediary agency could possibly take up such a post inquest role, but it is unlikely that an agency such as the Department of Justice, with the current level of resourcing to the follow-up of coronial recommendations, would have the familiarity with all of the risk factors

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15 Correspondence from the Department of Justice to the author dated 21 June 1995.
16 Above n13 at 58.
17 Above n1 at 156.
18 Ibid.
19 Above n13 at 58.

highlighted in inquests, to be fully alert to any counterproductive potential contained in agency responses to recommendations.

No documentary evidence was located from the case studies which would indicate that responses to coroners' recommendations were reliably communicated to anyone. Where such communication was made, it was made only to the Department of Justice. There is no indication that any of the other parties, including the coroner, were ever informed of the responses.

Without such information, there was no opportunity for the coroner or indeed any other party, apart from the Department of Justice, "to call for further explanations or information".[20] As previously stated, the Department of Justice did not take up this opportunity, even though it was the only agency occasionally provided with sufficient information from which to initiate such action.

At present, the only State or Territory which has enshrined RCIADIC recommendation 16 into coronial legislation is the Australian Capital Territory. The relevant section (13J) of the *Coroners (Amendment) (No 2) Act* 1994 (ACT) reads:

(1) The custodial agency to which a report is given under section 13H shall, not later than 3 months after the date of receipt of the report, give to the Minister responsible for the custodial agency a written response to the findings contained in the report.

(2) A written response under subsection (1) shall include a statement of the action (if any) which has been, or is being, taken with respect to any aspect of the findings contained in the report.

(3) The Minister to whom a copy of a response is given under subsection (2) shall give a copy of the response to the Coroner in respect of whose findings the report relates.

(4) The Coroner shall give a copy of the response to each person or agency to whom a copy of his or her report was given under section 13H.

Recommendation 17 provides:

> That the State Coroner be required to report annually in writing to the Attorney General or Minister for Justice, (such report to be tabled in Parliament), as to deaths in custody generally within the jurisdiction and, in particular, as to Findings and recommendations made by Coroners pursuant to the terms of Recommendation 13 above and as to the responses to such Findings and recommendations provided pursuant to the terms of Recommendation 16 above.

In the Victorian Government Implementation Report, it was stated that this recommendation had been implemented in part, stating that "a report by the State Coroner is included in the Annual Report of the Magistrates' Court, which is submitted to the Governor in Council and tabled in Parliament. However, the report is general in nature and does not deal with detailed responses provided by relevant agencies".[21] It was stated that discussions on this matter are continuing.

In fact, the entries in the 1994 Annual Report of the Magistrates' Court do not contain any information about recommendations made by coroners in deaths in custody cases, nor even about findings made, apart from a list of the names of the 23 shooting deaths which

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20 Above n1, Recommendation 16.

21 Id at 59.

occurred in Victoria between 1988 and 1994 and the Inquest dates for these cases.[22] In effect, the central thrust of Recommendation 17 has not been addressed.

While there remains hope that this recommendation may be more fully implemented in the future, it is clear that at present, the purpose behind Recommendation 17 has not been met at all. The purpose is presumably to create a mechanism which can strengthen accountability for the implementation of recommendations, and to place on the public record recommendations made and responses to the same. Ideally, Recommendation 17 would be interpreted as the final and critical link in a carefully crafted chain of accountability, tying together the responses of a range of agencies.

Section 12A of the *Coroners Act* 1980 (NSW), provides a useful example of an initiative in another State towards compliance with RCIADIC Recommendation 17. In accordance with this section, the New South Wales State Coroner presented a comprehensive annual report to the Attorney-General, summarising the details of all deaths in custody and police operations in 1994. Section 12A reads:

(4) The State Coroner is to make a written report to the Attorney-General containing a summary of the details of the deaths or suspected deaths of which the State Coroner has been informed under this section and which appear to the State Coroner to involve the death or suspected death of a person in circumstances referred to in Section 13A (Deaths in custody etc examinable only by State Coroner or Deputy State Coroner).

(5) A report under subsection (4) is to be made for the period of 12 months commencing on 1 January 1994 and for each subsequent period of 12 months. Each report is to be made within 2 months after the end of the period to which it relates.

(6) The Attorney General is to cause a copy of each report made to the Attorney General under subsection (4) to be tabled in each House of Parliament within 21 days after the report is made.

It should be noted that there is no specific reference to either coroners' recommendations or agency responses to recommendations in this section. Nevertheless, the 1994 Annual Report does contain details of recommendations made and extensive details of agency responses to most, but not all, recommendations.

The ACT *Coroners (Amendment) (No 2) Act* 1994 in section 44A contains a more comprehensive provision, which specifically requires that the annual report to the Attorney-General includes particulars of the responses of agencies to coronial findings (section 44A(3)(c)), as well as recommendations made (section 44A(3)(d)).

Why introduce an intermediary agent in the form of the Attorney-General?

Other States which have attempted to amend their legislation to accordance with RCIADIC recommendations over the last four years have also stipulated a role for the Attorney-General with regard to findings from deaths in custody cases. In some cases, this has mirrored the Victorian model, interposing the Attorney-General between the Coroner and agencies to whom findings and recommendations are addressed. This is reflected in section 13H(a) of

22 *Magistrates Court of Victoria Annual Report 1994* at 27.

the *Coroners (Amendment) (No 2) Act* 1994 (ACT), which also requires in section 13H(b) that copies of the findings and recommendation be reported by the Coroner directly to the custodial agency. Section 27 of the *Coroners Act* 1993 (NT) requires that the coroner send a copy of each finding and recommendation to the Attorney-General. In New South Wales the Coroner is required to compile an annual report on details of deaths in custody for the Attorney-General under section 12A of the *Coroners Act* 1980 (NSW), although there is no specific requirement for findings and recommendations to be sent to the Attorney-General.

It will be argued here that a passive and undefined role for the Attorney-General in this intermediary position has been counter-productive in Victoria, since it has blurred accountability and provided a false sense of security for the preventive functioning of the Coroner. Since other States have also chosen to adopt a similar modus operandi, it is worth exploring the positive and negative potentials of this intermediary role.

The initial purpose of engaging the Department of Justice/Attorney-General as an intermediary agency between the State Coroner and agencies responsible for implementing recommendations in Victoria is open to speculation, since there is no mention of the rationale for this step in either the Second Reading Speech for the Coroners Bill nor in the Norris Report 1980, which provided much of the impetus for the Victorian *Coroners Act* 1985. The Norris Report supported the establishment of a "system of assessing inquest verdicts and taking direct action to implement jury recommendations" as described in the Report of the Ontario Law Reform Commission.[23] Norris suggested the involvement of the Health Commission of Victoria in this context.[24] This suggestion was not accepted.

Possible explanations for interposing the Department of Justice between the State Coroner and agencies responsible for the implementation of recommendations can be suggested. The Royal Commission referred to submissions it received that "the coroner's investigatory role should remain distinct from the decision-making role of the government or public authorities".[25] The Department of Justice could function as such an intermediary agency through which to maintain the separation of roles.

Perhaps it was expected that an intermediary agency such as the Department of Justice could better provide a whole of government perspective on matters referred to in coronial findings. An agency such as the Department of Justice would possibly have more resources to engage in effective monitoring of the implementation of recommendations than the State Coroners Office, and have a wider understanding of the inter-agency implications of particular recommendations — for example, between the providers of health services and custodial services in relation to deaths in custody.

Another possible explanation is that the Attorney-General is to play a gate-keeper role. The gate-keeper could hone general recommendations into a more explicit directive, identifying specific action by whom and by when, thus enhancing the preventive potential and accountability of recommendations, and sieving out other recommendations which are too general to be effective. This role could be combined with a watch-dog role, whereby the Attorney-General could report annually to Parliament or to the relevant Minister on the extent to which agencies have implemented coronial recommendations. Failure to respond to recommendations could be followed up and inaction conveyed to relevant Ministers.

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23 Norris, J, *The Coroners Act 1958 — A General Review* (1980) at 135.

24 Id at para 188.

25 Above n1 at 156.

A non-interventionist post-box function, the role of the Department of Justice in the cases under review, does not function in any of these ways, and perhaps it was never planned that it should. In fact, the existence of a disinterested intermediary which has an unspecified purpose and no defined responsibilities is actually likely to blunt the remedial effectiveness of coronial recommendations. This worst of all possible worlds appears to describe the Victorian situation for 1990–92 cases of deaths in custody.

Without a direct relationship between the coroner and the targeted agency, there is no guarantee that information on whether or not implementation has taken place ever returns to the coroner. While there are arguments for and against direct involvement of the coroner in following-up compliance with recommendations, the preventive process will always benefit from feedback on progress towards the implementation of previous recommendations, since enhancing custodial health and safety is an incremental process. If previous recommendations on a particular issue have been ignored, the coroner should be aware of this and be able to find out why this was the case, to ensure that future recommendations have a better chance of implementation and achievement of custodial health and safety goals. Possibly the suggested reform did not have the desired effect. If so, coroners would wish to avoid making useless or counter-productive suggestions. Without feedback, they cannot enhance the reform process by taking this vital information into account in recommendations in future cases.

The only State which legislatively specifies the role of the Attorney-General is the Northern Territory, which requires in section 27(2) of the *Coroners Act* 1993 (NT) that:

> Where the Attorney General receives under subsection (1) a report or recommendation that contains comment relating to —
>
> (a) an Agency, within the meaning of the Public Sector Employment and Management Act, the Attorney-General shall, without delay, give to the Minister a copy of the report or recommendation;

and in Section 27(3) that:

> The Attorney General shall present a copy of each report or recommendation referred to in subsection (1) to the Legislative Assembly within 6 sitting days of the Assembly after receipt by the Attorney-General of the report or recommendation.

These provisions specify end points for the communication of findings and recommendations, but they do not identify the particular responsibilities of each agency in the chain of communication. Moreover, they do not include mechanisms for the provision of feedback about agency responses back to the Coroner, the relevant Minister of the Crown, other parties who appeared before the coroner at the inquest or the Attorney-General. The thrust of RCIADIC recommendations 15 and 16 is not met. Without specification of these issues, there is the risk that the process will amount to little more than a legislatively authorised one way game of "pass the parcel".

The Royal Commission framework as an implementation model

While the Royal Commission recommendations provide a practical framework for the consideration of coroners' recommendations, this framework should be embedded in an understanding of the nature of the implicit implementation model within which the framework must operate. Two key elements of this model are the nature of the relationship between the coroner and the implementation agency and the manner in which the coroners' recommendations fit within the existing agency policy context.

Within the broad conventional categorisation of implementation models — bottom-up versus top down — the relationship between the coroner and the target agency does not fit neatly. In many ways, the relationship is inherently problematic. Essentially, the coroner is an "outsider" making recommendations to the target agency. He or she is unlikely to have an in depth understanding of the full policy context of the agency within which his or her recommendations might be expected to fit. Inquests are essentially outcome focussed rather than process focussed, in that they examine the circumstances surrounding the worst of all possible outcomes — a death. Moreover, coroners are unlikely to have any understanding of the resource constraints pressing upon the agency. In this sense, coroners' recommendations are detached "good ideas". They are generated outside other policy making contexts and they are not designed to fit within existing policy contexts.

These relational difficulties may generate resistance to the achievement of a more accountable and transparent implementation framework. Agencies may well wish to preserve their current anonymous inertia, or to be able to choose which recommendations to implement and which to ignore without exposing such decisions to outside scrutiny.

Nevertheless, the preventive role of the coroner is as a kind of auditor, to the extent that it is focussed upon the bottom line of risks to life. It is this absolute that gives gravity to coroners' recommendations, which might otherwise be perceived to be lacking in policy relevance. In the case of deaths in custody, the Royal Commission provided a framework through which the authority of the coroner could be enhanced. Given the "outsider" status of the coroner as a source of policy comment, the need for a legislatively defined interagency relationship is all the more pronounced.

Conclusions

Recommendations 14 through to 17 from RCIADIC comprise a systematic approach to the problems of inter-agency accountability and communication in the implementation of coroners' recommendations. No doubt, individuals in such agencies can respond diligently and develop effective informal working relationships with other agencies to ensure that effective channels of communication operate for the implementation of recommendations. However, frequently, such informal protocols depend on the personal commitment of particular individuals and/or the quality of relationships between these individuals. Unfortunately, changes of personnel and inherent conflicts of interest between agencies can lead to the breakdown of such protocols or a piecemeal approach to systematic accountability. Such informal protocols are therefore inherently fragile.

This fragility in the relationship between the coroner and custodial agencies is potentially great in the context of deaths in custody. If a particular State has a high incidence of deaths in custody, from, say, police shootings, and the coroner is legitimately critical of custodial practices, informal relationships can rapidly deteriorate, and transparency and accountability can become casualties. There is thus a need for the enduring strength that a statutory base gives to the authority of coroners' recommendations, in terms of ensuring that they are properly considered and are also seen to be so considered.

While the Royal Commission recommendations identify systematically the linkage points in an effective chain of accountability, the Victorian example has shown that nominating such linkage agencies is not enough. The responsibilities attached to each link in the chain also need to be specified and clearly understood by each of the other links, to ensure that the "buck stops somewhere" and that each link performs a useful function. Loose assumptions about what those functions might be are sometimes not enough, particularly when resource constraints can make deaths in custody matters a lower order priority. Such

an approach does not compel compliance, but it would ideally compel agencies to provide a public account of their decision to comply or not to comply, and a public reassurance that conditions which lead to a death in custody have been or will be addressed and future deaths averted.

States which are in the process of amending legislation to conform with Royal Commission recommendations can learn valuable lessons from the successes and failures of the Victorian model. Already States like New South Wales, the Northern Territory and the Australian Capital Territory have enacted stronger provisions than the Victorian model. These would be usefully considered by other States with legislation at the drafting stage.

While this study did not set out to investigate the effectiveness of the reporting process of the States on the implementation of Royal Commission recommendations generally, it has demonstrated that there is significant looseness in the credibility of this reporting process, at least with regard to RCIADIC recommendations 14 to 17. The inaccuracies lend a veneer of respectability to a process whose many flaws dampen the momentum for necessary reform. Coroners recommendations are surely far too important to be cast adrift with no distress beacon and a sleepy coastguard, into a sea of uncertainty. Back at the bureaucracy, there are ticks in the distress beacon box and the coast guard is wide awake, on paper at least.