ATTACHMENT A

KEY ISSUES FOR CORONIAL REFORM IN THE ACT

In the table below, we have outlined our groups key concerns with the ACT coronial process. We also provide brief notes suggesting reforms that could be undertaken to improve the system. These key points could provide an ideal starting point for restorative inquiries relating to coronial processes.

ISSUE	COMMENTS	SUGGESTED REFORM
a) Families need to be supported and guided through the coronial process and its aftermath.	Counsel Assisting the Coroner's role is to assist the coroner, not the family. In our experience this person is usually appointed just before the inquest so is not on hand to support and guide the family through the inquest process and its aftermath. Counselling services do not provide guidance or advice through legal procedures and the coronial process overall. They are often short term and do not assist families to navigate the process nor its impacts.	A family liaison person, with a background in the coronial process and bereavement support, needs to be available to support the family from soon after the death, to after the implementation (or otherwise) of the recommendations arising from the inquest. A restorative approach would support this.
b) Unacceptable time gap between the death and the coronial.	Families can wait for 3 years or more, for a coronial inquest to be held. This is unacceptable. Families are left in limbo, and mostly in the dark about where the investigation is up to. Also witnesses often say they cannot remember what happened and documents are lost after such a lengthy delay. Any action arising from the inquest does not occur in a timely manner, putting more lives at risk. This is particularly important in regards to matters of public safety.	A dedicated coroner needs to be appointed in the ACT which should shorten wait times for coronial inquests. Coronial inquests also need to be given a higher priority. Round table restorative discussions could be held prior to the commencement of formal coronial processes to determine if a particular case needs to go through a formal coronial inquest.

c) Prohibitive cost of coronial inquests for families	For families to be fairly represented at coronial inquests in the ACT they need to get independent legal representation. The process is completely new for most families, often adversarial, certainly intimidating and time consuming. Written documents need to be produced, medical records often up to 3,000 pages need to be read and understood and often complicated family stories/ opinions need to be clearly presented in court. The usual cost from our experience is $30,000 and up. Many families feel that the onus falls primarily on them to 'come up with evidence', produce documents, find witnesses, make the case and follow the process through.	The ACT Government needs to fully fund the costs of independent legal representation for those involved in coronial inquests. *Funding needs to be provided at a level that is consistent with the level of legal representation accorded to government and other institutional parties*. (ref p.70 *Saving Lives by Joining Up Justice*, March 2013, Australian Inquest Alliance). Restorative reform processes should explore how to achieve the key objectives of the Corner's ACT whilst defraying costs for all involved.
d) The coroner needs to have the power to investigate cases fully. At present he/she only can look at events 'proximate' to the death.	In mental health cases, this can mean that the full story is not investigated.	Broaden the ACT Coroners Act to allow the Coroner to make comments on any matter relating to the death and not just those relevant to public safety.
e) There needs to be more pressure on the government to act on coronial recommendations.	Coroners in the ACT are very reluctant to make recommendations. When they do, they are often not implemented and no explanations are provided to families or the community about why this decision was taken.	Change to ACT Coroners ACT required. When recommendations are not accepted by the minister, information explaining this decision should be formally provided by the government to all parties involved and should be publicly available. When recommendations are approved, families/ interested parties should be regularly informed of the progress of implementation. *Families and Australian communities need to see the preventative system actually working, and so*

		must be kept informed about what recommendations have been made, how those recommendations are being implemented and how implementation will be monitored. (p21. *Saving Lives by Joining Up Justice*. March 2013, Australian Inquest Alliance).
f) Factually incorrect information has been included in coronial findings in the ACT that is damaging or distressing to families and errors have been published in the local media.	The Coroners ACT 1997 says *55.1 A coroner must not include in a finding or report under this Act (including an annual report) a comment adverse to a person identifiable from the finding or report unless the coroner has, making the finding or report, taken all reasonable steps to give to the person a copy of the proposed comment and a written notice advising the person that, within a specified period (being not more than 28 days and not less than 14 days after the date of the notice), the person may—* *(a) make a submission to the coroner in relation to the proposed comment; or* *(b) give to the coroner a written statement in relation to it.* Families have no similar opportunity to comment on incorrect information that will be published in coronial findings. In the ACT there is no right to appeal to findings other than going to the Supreme Court. This situation is inequitable and breaches Australia's international treaty arrangements and the ACT Human Rights ACT 2004.	Families need to be provided with the opportunity to comment on / correct inaccuracies in coronial findings before they are published. A restorative approach would support this. Families/interested parties should have the right to appeal against inaccuracies in the coronial findings without needing to go to the Supreme Court. A restorative approach would support this. There should be a formal process by which families/other interested parties have the right to make a formal complaint about a coroner.

g) **The Coronial Process can expose families and the lives of the deceased person to an exceptional degree of scrutiny and this can result in findings that are lengthy and detailed. Families may be given very little explanation as to why this is required. As is noted above the difficulty for families is compounded when findings contain errors and where the only option to correct this is for families to take further lengthy and expensive legal action.** **Families and the deceased person's right to privacy need to be balanced with the public interest particularly in matters where organisational or institutional failing may have contributed to the person's death. Consideration should be given to not unnecessarily exposing the deceased person and their family's private and confidential information except where this is relevant to achieving necessary reform.** **Some findings are made available online and others are not. It is not always clear what criteria are used to determine whether an online version is published.**		Findings need to be carefully scrutinised to ensure that what ever information is included has a clearly defined and accepted purpose and does not infringe unnecessarily on the confidentiality and privacy of the deceased person and their family. If confidential/private information is to be published then explanations and discussions need to take place so everyone - including the deceased person's family - is aware of why this decision has been made. A restorative coronial process could allow for the timely correction of errors and facilitate a clear understanding of the family's concerns regarding confidentiality and privacy. A restorative coronial process could also support the development of an agreed set of findings that balance the deceased person and their family's privacy with the public interest. Criteria need to be developed to determine which findings need to be published online.
h) Opportunities for real systemic change are lost when a coroner is reluctant (unable?) to make adverse comments against individual	It is evident from the coronial findings in our cases that there is an unwillingness to make adverse comments about the practices of government agencies and the	The adversarial system needs to be dispensed with. A coronial inquest should be an open process with all parties working together to see what changes need to be implemented to avoid further deaths.

professionals and government systems when there is clearly evidence that there are issues of public safety. **It seems that the same concerns do not apply when making adverse comments about the deceased person.**	staff working in them. Teams of lawyers work to shield government agencies from censure of any kind. The ACT Health Directorate and other agencies are only mandated to respond to the formal recommendations. Contributing factors to the death identified during the inquest are rarely addressed and valuable information that may prevent further loss of life is missed. Family members who have died are dehumanised in the coronial process and there is a culture of blame the victim rather than looking at how to improve practices and systems to prevent further deaths. This lack of empathy causes further grief to families.	A restorative approach would support this. (In the UK many coronial inquests are now conducted in a 'round table' environment not a traditional court room setting.) A process should be established whereby 'contributing factors' arising during coronial inquests are seriously considered and acted upon (i.e. not just formal recommendations). A restorative approach would support this. NSW Coronial findings/reports are documented in a more considerate and respectful way. At the beginning of the findings the deceased is 'introduced' so there is some understanding of the background and life of the person who has died. The ACT Coronial system should adopt a similar approach. A restorative approach would support this.
i) There is no effective oversight of recommendations that are being made by coroners across the nation. Key recommendations often languish on a shelf and are not acted upon. No specific body is tasked with the responsibility to oversee similarities in causes of deaths.		A national **public** register of all coronial recommendations should be kept and where governments or others have declined to implement those recommendations a clear explanation must be provided as to the reasons why. A national research body needs to be established to examine recommendations, and look for patterns of deaths across Australia and ensure those recommendations are given high priority for action.