Coronial Council of Victoria – Reference 4 – November 2017

Coronial Council Appeals Review

Coronial Council of Victoria

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29 November 2017

The Hon. Martin Pakula MP
Attorney-General
121 Exhibition Street
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Dear Attorney-General

Coronial Appeals Review Reference Report

On behalf of the Coronial Council of Victoria, I present to you the Council's report and recommendations regarding the Coronial Appeals Reference pursuant to the terms of reference. This report is submitted under s 110 of the *Coroners Act 2008*.

In preparing this report we have received submissions from families, the Coroners Court, the Supreme Court and other legal institutions and relevant organisations. On behalf of the Coronial Council, I would like to express our gratitude to all those who made time to prepare submissions and attend interviews.

Our report has identified a number of ways in which to improve the appeals process. In addition, we have addressed ways to improve access for families to the initial coronial investigation and findings that will assist in avoiding the need for appeal.

On behalf of the Council, I thank you for your consideration of this matter and look forward to your response.

Yours sincerely

Professor Katherine McGrath MB BS, FRCPA FAICD
Chairperson, Coronial Council of Victoria

Contents

Executive summary

This review of the rights to re-open a coronial investigation or appeal coronial findings was prompted by concerns raised by a number of families who have engaged with the coronial system in recent years. For some families, the coronial process left unanswered questions and did not allow them to find closure. Others were not satisfied with the investigation, or disagreed with the conclusions reached by the coroner.

Under the *Coroners Act 2008*, an application to re-open an investigation within the Coroners Court is available if there are new facts and circumstances, and the Court considers it appropriate to re-open the investigation. An appeal against the finding of a coroner to the Supreme Court must be on a question of law. In 2014, a new ground of appeal 'in the interests of justice' was added to the Coroners Act, but this only applies to a refusal to re-open a case or a decision not to hold an inquest.

In contrast, grounds of appeal under the previous Act, the *Coroners Act 1985* included fraud, consideration of evidence, failure to consider evidence, irregularity of proceedings or insufficiency of inquiry, mistake in the record of findings, the emergence of new facts, and evidence or findings found to be against the weight of evidence. These are still the current grounds of appeal against the findings of an inquest in most other Australian states.

In undertaking this review, the Council sought and received submissions from families with experience of the coronial system, the Coroners Court, the Supreme Court, legal institutions such as the Law Institute of Victoria, the Victorian Bar Association and Victoria Legal Aid, as well other institutions, individual lawyers and community legal centres. The Council also interviewed many of the parties who made submissions to clarify details and to test the assumptions and options proposed by this review. Further, the Council talked to the staff at the Coroners Court, who provided valuable information on their role in advancing the Court's objectives in the provision of coronial services, supporting the administration of justice, reducing preventable deaths, and promoting public health and safety for the Victorian community. The recommendations included here are supported unanimously by the Coronial Council of Victoria.

There are important principles that underpin our legal system, such as fairness, justice for all, independence of the judiciary and the critical issue of timely justice. These principles seek to engender an efficient system that brings a just finality to all parties. If there are grounds to believe there has been an error of judgement in reaching the findings in an individual case, then families and other interested parties need to be able to appeal the decision. In our system, that is by means of appeal to a higher court.

All parties should have the opportunity to be heard where they have a sufficient interest in the matter, and to be able to understand why the final decision was reached. Family members in particular bring important knowledge in the pursuit of the truth in relation to the death of their loved one. While the Coroners Court already recognises the contribution of families, more formal mechanisms for engagement would help to ensure these voices are effectively heard.

The Coroners Court has a number of unique features that distinguish it from other courts in our system. It is an inquisitorial court, not an adversarial one. This means the Coroners Court

determines what evidence will be considered, rather than hearing evidence presented by opposing parties. The focus of a coronial investigation is to determine what happened, rather than to ascribe guilt. While Counsel Assisting may help families, this is not a formal part of their work. The main task of Counsel Assisting is to support the coroner to explore and define the relevant issues, and to help the coroner to make accurate and appropriate findings.

Given that the coroner's role is limited to identifying the deceased and the cause and circumstances of death, and identifying any measures that would prevent such deaths in the future, families can find it distressing that evidence they consider relevant may not necessarily be aired. In engaging with the coronial process, families often seek to defend the legacy of their loved one, and it can be difficult for them to accept that the limited role of the Coroners Court may not allow for this, or indeed, may hinder it.

In undertaking its role, the Coroners Court is required to take into account that the death of a loved one is distressing for the family, and that the family or senior next-of-kin should be kept informed of the investigation. Often, family members who wished to appeal the coroner's findings felt that key issues had been overlooked, or that the findings were not sufficiently supported by the evidence presented. Some family members told the Council it was difficult for them to raise issues they considered important because there was no clear mechanism to do so during the coronial investigation. If an inquest was held, the family's ability to put their views was often limited by lack of independent legal representation, in the face of one or more barristers representing the other interested parties.

Family members who did have the resources to engage legal expertise, as well as some of the lawyers they engaged, told the Council that the grounds of appeal only on an error of law were too restrictive. In examining a number of these cases, the Council found that there was a reasonable case to be made for the coroner's findings, but that the families felt the process had not allowed them to raise their concerns. In addition, it did not provide an explanation as to why the findings were made, and why other options were excluded. In some cases, this led to a deep sense of injustice, particularly for the legacy of their loved one's reputation. This was very distressing, and at times even disabling, for multiple family members.

In some cases, the wording of the findings or errors of fact in the findings were sources of unintended grief for families. To address this, the Council is of the view that the opportunity to request the original coroner to revise the findings without re-opening a case is a simple proposal that would help to meet some families' needs. This may help to resolve issues where the difficulties relate more to commentary on the circumstances surrounding the death, rather than the factual findings.

The Council does not support the return to the former system of review by the State Coroner. The Council heard from former State Coroners that this was not an efficient system, and led to a large backlog of cases for review. It also took significant time from the State Coroner's role as the senior coroner in the Court. Further, the Council does not accept that an alternative pathway for appeal to an independent panel or other independent process should replace the well-established and fundamental role of the Supreme Court in the current legal system.

The Council considers that there are many steps that could be better designed within the initial coronial process that would reduce this sense of helplessness and frustration experienced by some families, and reduce the need to seek redress by appeal. Throughout the review, the

Council was conscious of the difficult balance that the coronial system attempts to maintain. The coronial process must identify the cause of death and opportunities for prevention, as well as ensuring justice and finality for all parties involved. It must also provide for the needs of families, as well as other interested parties, to understand the circumstances of the death.

The Coroners Court is very aware of this difficult balance, and is continually reviewing its processes and improving its systems. However, communicating with grieving families requires special expertise, and there is no longer a dedicated resource available in the court system to support this need. The Council therefore recommends that a Client Advocacy Office be established to bring senior expertise in house to assist the court in developing more effective communication strategies to meet families' needs.

In addition, in a relatively small number of cases, families' ongoing grief would have been reduced if they had been given opportunities to understand better why findings were made, why certain factors were not considered, and to meet with other interested parties to understand what went wrong. This would also reduce the demand for broader appeal processes.

The Council also heard that processes within the court may depend on the practices of individual coroners, and therefore varies accordingly. There is a strong case for standardising the way in which families and other interested parties are informed of investigative progress, allowed to raise their concerns during an inquiry, and advised of expected timeframes. The development of a standard approach, which should be proactive and not simply reactive, would be informed by the Client Advocacy Office.

In relation to the grounds of appeal to the Supreme Court to set aside findings, several families strongly argued that in their cases, the coroner's findings exceeded the evidence. They and their legal advisers wanted to appeal, but did not because of the restriction of grounds of appeal to errors of law and the significant risk of costs being awarded against them.

The legal profession expressed divided opinions on the grounds of appeal. Some experts stated that the restriction to 'error of law' grounds created a higher barrier to appeal than existed in the *Coroners Act 1985*. Some of those who represented families argued for a return to the grounds in the previous Act, which are similar to those in other jurisdictions such as New South Wales and Queensland. Other senior members of the legal profession contended that an error of law includes circumstances where the finding of a coroner is against the evidence, and therefore there is no need to broaden the grounds for an appeal to the Supreme Court.

In the Council's view, this is best resolved by adding the grounds that the findings are 'against the evidence or weight of evidence' as an explicit statement in addition to the current error of law grounds. This would clearly allow for appeals on this particular component of the former Act. Some will argue this is a duplication, but after careful consideration and consultation with the Chief Parliamentary Counsel, the Council considers that clarifying this as a ground of appeal will address the concerns of families and their legal representatives, while allowing case law to determine the boundaries of this approach. This is very unlikely to increase the number of appeals significantly.

The Council was unable to address the concerns families often had about the cost of appeals, especially where third parties may seek costs against the family if the appeal fails. This is true in all courts, and there is no easy solution. However, the Council recommends the

establishment of a specialised, centralised unit within Victoria Legal Aid to give advice to families involved in coronial processes, both in the initial inquiry and if they consider an appeal. This would not mean representation in the normal course of events, although it may in exceptional circumstances, such as public interest cases. Such a service would provide expert advice to families that cannot afford their own representation, and the Council is of the view that this is important to help families understand how to navigate the system. This type of unit works well in New South Wales, and a variant is currently being trialed in Queensland.

To further meet the needs of families and other interested parties engaged with the coronial process, the Council recommends establishing a restorative justice program. Other courts use these processes to bring affected parties together in a carefully facilitated and guided process. The Council considers that a formal restorative justice process could be a powerful tool to allow some families the opportunity to have their questions answered after coronial findings have been made, and to address their sense of frustration with the outcomes. It would allow people affected by the death to discuss what happened from a range of perspectives, and provide the chance for an apology to be made if this is appropriate. A Court representative (not the coroner involved, but, for example, an officer from the Client Advocacy Office) would also attend to explain the coronial process.

Finally, the Council was surprised by the lack of readily accessible data and performance information for the Court. Transparency needs to be a feature of all public institutions, and there should be accessible information about court processes as well as outcomes. All data currently reside in individual case files, and it is not possible to undertake a survey of recent participants, or to know how many appeals occur each year. The Council is of the view that in order to assess the efficacy of court processes over time, system-level data profiles should be developed in line with the recommendations in the International Framework for Court Excellence.

Recommendations

Recommendation 1: The Coronial Council considers that the operation of s 77 of the Coroners Act is appropriate. However, the Victorian Government should seek to amend the Coroners Act to clarify that the findings of inquests made under the 1985 Coroners Act may be reviewed by the State Coroner as provided for by that Act.

Recommendation 2: The Victorian Government should seek to amend the Coroners Act to allow the Coroners Court to separately consider an application to:

a. set aside a finding if the Coroners Court considers it appropriate, and it is not necessary to re-open the investigation to do so; or

b. revise the wording in any part of a decision if the Coroners Court considers it appropriate, and it is not necessary to re-open the investigation to do so.

Consistent with s 77(4) of the Coroners Act, the Coroners Court should be constituted by the coroner who conducted the original investigation unless they no longer hold the office of coroner, or there are special circumstances.

An application for review on the proposed grounds should be subject to a three-month time limit from the day on which the finding of the coroner is made.

In order to achieve greater clarity of review opportunities within the Coroners Court, consideration should be given to linking ss 76 and 77 more closely in the Coroners Act.

Recommendation 3: The Coroners Court should adopt appropriate measures to facilitate greater engagement and understanding of court processes by families with the advice of the Client Advocacy Office (see Recommendation 4). In particular, the Coroners Court should work together with the Victorian Institute of Forensic Medicine to:

a. develop standardised court processes to provide regular and accessible information to families on the role and work of the Coroners Court;

b. better manage expectations of the timeline and scope for the coronial investigation, and advise families of significant milestones in the process;

c. provide regular updates on the progress of the coronial investigation, including when significant milestones have been reached, and the reasons for any delays; and

d. advise families on opportunities to make a submission on issues they consider relevant to the investigation.

Recommendation 4: The Victorian Government should fund the establishment of a Client Advocacy Office within the Coroners Court. The Client Advocacy Office should have a high level of expertise in grief counselling, so they can provide sophisticated guidance and advice to the Coroners Court and the Victorian Institute of Forensic Medicine on best practice in assisting families and other interested parties engaging in the coronial system.

Recommendation 5: The Coroners Court should develop appropriate guidelines and templates to ensure that, to the extent that it is consistent with the judicial independence of coroners, coronial findings:

a. follow a clear and consistent style;

b. clearly identify 'findings', 'commentary' and 'recommendations';

c. that are made in respect of the circumstances in which the death occurred, must confine those circumstances to matters which are proximate and causally relevant to the death; and/or underpin matters which relate to the preventative role of the Coroners Court;

d. advise how submissions from families and other interested parties have been considered; and

e. explain the rationale for making certain findings or recommendations (and not others) in sensitive or contentious cases.

Recommendation 6: The Victorian Government should fund a centralised Coronial Legal Advice Service, through Victoria Legal Aid, to provide legal advice to interested parties relating to the coronial process.

Recommendation 7: The Coroners Court should work with Victoria Legal Aid, the Victorian Bar and the Law Institute of Victoria to develop appropriate arrangements to assist families to access legal representation to enable them to effectively participate in the coronial process, particularly in circumstances where there is a significant power imbalance between parties, or there is a significant public interest issue at stake.

Recommendation 8: The Victorian Government should seek to amend the Coroners Act to make it clear that an appeal against a coronial finding in s 83 is available on a question of law; and where the finding is 'against the evidence or the weight of the evidence'.

Recommendation 9: The Victorian Government should seek to amend the time limit for commencing an appeal against a refusal by the Coroners Court to re-open an investigation in s 84 of the Coroners Act from 28 days to three months.

Recommendation 10: The Victorian Government should fund a restorative justice program to enable families to resolve outstanding issues and questions following the conclusion of a coronial investigation. The referral of cases considered suitable for a restorative justice process should be managed by the Client Advocacy Office within the Coroners Court.

Recommendation 11: The Coroners Court should take steps to better understand and respond to systemic issues that may arise during coronial processes. In particular, the Coroners Court should:

a. establish mechanisms to collect and analyse systemic data on court performance;

b. undertake periodic client feedback surveys; and

c. become a party to the International Framework for Court Excellence.

1. Introduction

Terms of reference

1.1 On 15 December 2016, the Victorian Attorney-General, the Hon. Martin Pakula MP, asked the Coronial Council of Victoria (the Council) to conduct a review of the provisions under the *Coroners Act 2008* (Vic) (the Coroners Act) that allow for appeals against, and the re-opening of, coronial investigations.

1.2 A formal reference was issued to the Council pursuant to s 110 of the Coroners Act in the following terms:

> The Coronial Council of Victoria is asked to review the existing rights, under sections 77 and 83 of the Coroners Act 2008 (Act), to re-open an investigation or appeal coronial findings and to provide advice on:
>
> - whether there is a need to amend section 77 or 83 (and sections 87 and 87A, to the extent that they are related to section 77 or 83); and
> - if there is a need to make amendments, the nature of those amendments.
>
> In formulating its advice, the Coronial Council should have regard to:
>
> - the existing operation of the appeal and re-opening provisions in the Act;
> - the historical development of appeal and re-opening provisions in the Victorian coronial jurisdiction, including changes made by the *Courts Legislation Miscellaneous Amendments Act 2014* (Vic);
> - analogous appeal and re-opening provisions in other Victorian legislation;
> - appeal and re-opening provisions in other Australian coronial legislation;
> - the interests of families, the interests of justice, the interests of maintaining finality of decision-making, and the efficiency of the court system;
> - the impact of any proposed changes to the appeal and re-opening provisions on costs and resourcing for the Coroners Court and the appellate jurisdiction;
> - any other impact of any proposed changes to the appeal and re-opening provisions on the coronial system and the wider appeals system.

The role of the Coronial Council of Victoria

1.3 The Council is independent of the Coroners Court and Government. The Coronial Council was established under s 109 of the Coroners Act to provide advice to the Attorney-General in respect of:

- issues of importance to the coronial system in Victoria;
- matters relating to the preventative role played by the Coroners Court;
- the way in which the coronial system engages with families and respects the cultural diversity of families;
- any other matters relating to the coronial system that are referred to the Council by the Attorney-General.

1.4 Matters of importance for the coronial system to be considered by the Council may include:

- the identification of themes, trends and patterns that are seen to emerge;
- legislative issues; and
- proposed law reform.

1.5 The membership of the Council is set out in **Appendix A**.

Conduct of the review

1.6 Following the request made by the Attorney-General, the Council undertook detailed research and consultation on the reasons and circumstances that lead individuals to appeal or seek internal review of coronial decisions, and the potential barriers to doing so. Apart from considering how the provisions in the Coroners Act relating to appeals and re-opening investigations could be improved, the review has also examined other non-legal barriers to appealing findings.

1.7 The findings and recommendations presented in this report have been informed by:

- analysis of relevant Victorian legislation on coronial processes;
- comparable legislation from other jurisdiction in Australia;
- consideration of information provided by the Coroners Court on the current processes for the conduct of coronial investigations and inquests;
- direct consultation and feedback from –
    - families who have been involved in the coronial process;
    - the Supreme Court of Victoria (Supreme Court) and the Coroners Court;
    - current and past State Coroners;
    - legal practitioners experienced in the Victorian coronial jurisdiction;
    - peak bodies and service providers, including the Victorian Bar, Law Institute of Victoria, Victoria Legal Aid, the Flemington and Kensington Community Legal Centre, Office of the Victims of Crime Commissioner, the RMIT Centre for Innovative Justice, and Medical Insurance Australia; and
    - other coronial jurisdictions in Australia;
- a literature review of coronial law and practice in Victoria and other Australian jurisdictions;
- information relating to the management of grief and bereavement issues arising in the coronial context; and
- examination of the data and records provided by the Coroners Court and the Supreme Court relating to applications for review and appeals under the current regime.

1.8 As part of the review, the Council sought submissions from interested individuals and organisations through direct correspondence from the Council, print media advertisements, and online through the Engage Victoria website.

1.9 In addition to considering submissions, the Council also held meetings with individual families to discuss their experiences of the Coroners Court. This engagement has been highly valuable in understanding the concerns of families involved in the coronial process, and identifying areas where improvements could be made to better recognise and accommodate their needs. While the review does not address or attempt to resolve individual cases, the contributions made by families have been valuable in helping to identify systemic issues and inform the Council's recommendations.

1.10 The Council acknowledges that families are more likely to attend meetings or prepare submissions to the Review if they have had a negative experience with the coronial system. However, family members who found some aspects of the process challenging or unsatisfactory sometimes also reported on positive elements of their engagement with the Coroners Court. For example, while some families were dissatisfied with the findings made, they could at the same time recognise and express appreciation for the help and assistance they received from staff at the Coroners Court during the coronial process.

1.11 The Council also held meetings with a range of stakeholders, including members of the legal profession, peak bodies and service providers, as well as staff at the Coroners Court, to obtain a first-hand account of the experiences of those engaging with the coronial system. Further detail relating to submissions and meetings is set out in **Appendix B**.

1.12 In this report, the Council makes a range of recommendations to ensure that the appeal mechanisms under the Coroners Act are working effectively and fairly to deliver justice to all users of the system. In making these recommendations, the Council is conscious of the need to balance a range of competing interests, acknowledging, in particular, that different individuals and organisations engaging with the coronial system may have disparate perspectives on optimal outcomes. The interests of justice, the independence of the judiciary, the importance of maintaining finality in decision making, and the critical issue of timely justice and the efficiency of the court system in Victoria more broadly have also been important guiding principles in undertaking this review.

1.13 The Council has reflected on the range of issues raised by families and organisations, and interpreted the terms of reference for this review broadly. Accordingly, the Council's recommendations encompass not only the coronial appeals process, but also additional measures that will provide better support for families and other interested parties who engage with the coronial process. These steps are intended to meet the justice needs of families and others, and reduce the likelihood that formal appeal processes will be pursued through the Victorian legal system.

Limitations of the review

1.14 The Review sought to examine data on the number of applications to review or appeal coronial findings in Victoria and other Australian jurisdictions. Due to the Council's reliance on external data sources, analysis was limited by the accuracy, completeness and availability of data. The evaluation was prepared using publicly available information, or information provided to the Council by key stakeholders including Victorian and interstate courts.

1.15 The Council has been advised that some of the data relating to appeals may be incomplete, as cases can be incorrectly coded in court databases, and therefore may not appear when searches are performed. The Review also sought to obtain data on the number of coronial cases that are appealed in other Australian jurisdictions, but found that this information was often not readily available.

1.16 The Council's research was also limited by the absence of regular and methodical feedback mechanisms within the Coroners Court, which could have shed light on families' experience of the coronial system regarding a broad set of issues over a period of time. The Council was keen to undertake a broader survey of families engaging with the Coroners Court, but time and data access issues ultimately prevented this.

Acknowledgments

1.17 This inquiry has benefited from the input and experience of a broad range of people. The Council is particularly grateful to the families who shared their experiences of engaging with the Coroners Court. They explained what works well and what could be done better to assist those who, through the loss of a loved one, find themselves involved in the Victorian coronial jurisdiction.

1.18 The Council also thanks the dedicated staff at the Coroners Court who provided valuable information on their role in advancing the Court's objectives to continue to be a world leader in the provision of coronial services, supporting the administration of justice, reducing preventable deaths and promoting public health and safety for the Victorian community.

1.19 This review also benefits from the insights of Victorian State Coroners past and present, and members of the Victorian legal profession. Discussions with the current State Coroner of New South Wales were also valuable in gaining a comparative perspective on key issues. The contribution of all of these experts greatly enhanced the Council's understanding of the issues explored in this review.

1.20 The Council is grateful to all those who shared their experience and perspective throughout this review, either in person or through written submissions.

2. Background

The role of the Coroners Court of Victoria

2.1 The role of the coroner is to preside over the independent investigation of deaths and fires reported to the Coroners Court. The Coroners Court is an inquisitorial court established by the Coroners Act.[1] Accordingly, the focus of a coronial investigation is to determine what happened, rather than to ascribe guilt, attribute blame or apportion liability.[2]

2.2 The main purpose of a coronial investigation into a death is to make a finding, if possible, as to the:

- identity of the deceased person;
- cause of death; and
- circumstances in which the death occurred.[3]

2.3 All coronial findings must be made on the balance of probabilities with reference to the evidence before the court. Further, any adverse findings or comments about individuals relating to a death are subject to the *Briginshaw* principle, which provides that the more serious the matter at issue, the stricter the standard of proof.[4] A coroner therefore needs to have a comfortable level of satisfaction that an individual caused or contributed to a death before making a finding to that effect. Where the coroner investigating a death believes an indictable offence may have occurred in connection with the death, the Director of Public Prosecutions must be notified.[5]

2.4 More generally, under the Coroners Act, the role of the Coroners Court is to contribute to the reduction of preventable deaths and to promote public health and safety in the Victorian community.[6] To this end, coroners are empowered to comment on matters relating to health and safety connected with the death they have investigated.[7] They may also make recommendations to any Minister or public statutory authority on any matter connected with the death.[8]

2.5 The Victorian Institute of Forensic Medicine works in close partnership with the Coroners Court to prepare reports about the medical causes of deaths investigated under the Coroners Act; and provide information to, and obtain information from, family members of a deceased person for the purposes of a medical examination and the coronial process generally.[9]

1 *Coroners Act 2008* (Vic) ss 89(1) and (4).
2 Ibid s 69(1).
3 Ibid s 67(1).
4 *Briginshaw v Briginshaw* (1938) 60 CLR 336.
5 *Coroners Act 2008* (Vic) s 49.
6 Ibid Preamble.
7 Ibid s 67(3).
8 Ibid s 72.
9 *Victorian Institute of Forensic Medicine Act 1985* (Vic) s 66.

2.6 The Coroners Court has a heavy workload, handling approximately 6,500 cases a year.[10] Each coroner is supported in their work by a registrar who assists in the case management of the coronial files, and an in-house legal services team. Family liaison officers provide further assistance to coroners by supporting families during court proceedings. In the vast majority of cases, findings are made by the coroner undertaking an investigation in chambers, rather than hearing evidence and submissions in open court.

2.7 Where circumstances require, a coroner may also hold a public inquest into any death the coroner is investigating.[11] While inquests are held at the discretion of the coroner,[12] the Coroners Court publishes guidelines setting out the considerations a coroner will use to decide whether to hold an inquest.[13] There are also certain limited categories of deaths where an inquest is mandatory.[14] Public inquests are only a small part of coronial investigations, and account for approximately five per cent of deaths reported in Victoria each year.[15] If a coroner decides not to hold an inquest into a death, the person who made the request to hold an inquest may appeal against the coroner's determination to the Supreme Court.[16]

2.8 The Coroners Act makes it clear that coroners must ensure the coronial system operates fairly and efficiently.[17] To this end, when exercising a function under the Coroners Act, coroners should, as far as possible in the circumstances, take into account that:

- the death of a family member, friend or community member is profoundly distressing, and that people in distress may need professional support or other support;
- unnecessarily long or protracted coronial investigations can exacerbate the distress of family, friends and others affected by the death;
- different cultures have different beliefs and practices surrounding death that should, where appropriate, be respected;
- family members affected by a death being investigated should, where appropriate, be kept informed about the investigation;
- there is a need to balance the public interest in protecting a living or deceased person's personal or health information with the public interest in the legitimate use of that information; and
- it is desirable to promote public health and safety and the administration of justice.[18]

10 Coroners Court of Victoria, *Annual report 2016*, p. 37.
11 *Coroners Act 2008* (Vic) s 52(1).
12 *Bourke v Coroners Court of Victoria* [2015] VSC 418, [7].
13 Coroners Court of Victoria, *Guidance on when inquests are held*, March 2015, www.coronerscourt.vic.gov.au/find/publications/guidance+on+when+inquests+are+held.
14 *Coroners Act 2008* s 52(2).
15 Coroners Court of Victoria, *Guidance on when inquests are held*, March 2015.
16 *Coroners Act 2008* (Vic) s 82(1).
17 Ibid s 9.
18 Ibid s 8.

2.9 Further, if an inquest is held, the Coroners Act provides that it should be conducted with as little formality and technicality as the interests of justice permit, and that it should be comprehensible to interested parties and family members who are present.[19] A person who wishes to appear as an interested party at an inquest may be granted approval to do so, if they have a sufficient interest in the matter and the coroner considers it appropriate.[20]

2.10 Once a coroner has completed their investigation, they must deliver a written finding as to the identity of the deceased and the cause and circumstances of the death. Findings are normally expressed in narrative language by a coroner. The legislation does not codify categories of available findings, but they usually fall within the general categories of homicide, suicide, misadventure, accident, natural causes or, if there is inadequate evidence to satisfy the criteria of any other verdict, an open finding.[21]

2.11 A coroner can also make any recommendations they think necessary in fulfilling their preventative role. The findings, comments and recommendations made after a public inquest, or which result from a coronial investigation without a public inquest and include recommendations, are published online unless otherwise ordered by the coroner.[22] Copies of the findings are usually provided to the senior next-of-kin, as well as any person or organisation the coroner has determined is an interested party, or has a sufficient interest in the investigation.

Relevant provisions of the *Coroners Act*

2.12 Section 77 of the Coroners Act provides that a person may apply to the Coroners Court for an order that some or all of the findings be set aside, or that the investigations be re-opened, if new facts and circumstances come to light in a matter and the Coroners Court considers it appropriate to re-open the investigation:

> **77 Re-opening an investigation**
>
> (1) A person may apply to the Coroners Court for an order that some or all of the findings of a coroner after an investigation (whether or not an inquest has been held) should be set aside.
>
> (2) Subject to subsection (3), the Coroners Court may order that—
>
> (a) some or all of the findings be set aside; and
>
> (b) if the Court considers it appropriate, that the investigation be re-opened.
>
> (3) The Coroners Court may only make an order under subsection (2) if it is satisfied that—
>
> (a) there are new facts and circumstances; and
>
> (b) it is appropriate to re-open the investigation.

19 *Coroners Act 2008* (Vic) s 65.
20 Ibid s 56.
21 Ian Freckelton and David Ranson, *Death investigation and the coroner's inquest* (Oxford University Press, 2006), p. 629.
22 *Coroners Act 2008* (Vic) s 73.

> (4) For the purposes of an application made under this section, the Coroners Court must be constituted by the coroner who conducted the original investigation unless—
>
> (a) the coroner who conducted the original investigation no longer holds the office of coroner; or
>
> (b) there are special circumstances.

2.13 An application to the Coroners Court to re-open or set aside a finding is considered by the coroner who conducted the original investigation or inquest, unless that coroner no longer holds the office of coroner, or there are special circumstances.[23] There is no time limit for commencing such an application. See Chapter 3 for more detail about the operation of s 77 to re-open or set aside a coronial finding.

2.14 In addition, under s 83 of the Coroners Act, findings of a coroner are open to challenge in the Supreme Court of Victoria within six months after the day on which the decision of the coroner was made:

> **83 Appeal against findings of coroner**
>
> (1) A person with a sufficient interest in an investigation may appeal against the findings of a coroner in respect of a death or fire after an investigation to the Trial Division of the Supreme Court constituted by a single judge.
>
> (2) An interested party may appeal against the findings of a coroner in respect of a death or fire after an inquest to the Trial Division of the Supreme Court constituted by a single judge.
>
> (3) Subject to section 86, an appeal under this section must be made within 6 months after the day on which the determination of the coroner is made.

2.15 An appeal against the refusal to re-open an investigation is also available under the Coroners Act. The appeal must be commenced within 28 days after the refusal, by the person who made the original application to the coroner:

> **84 Appeal against refusal by coroner to re-open investigation**
>
> (1) If the Coroners Court refuses to re-open an investigation under section 77, a person who requested the Coroners Court to set aside some or all of the findings of the coroner may appeal against the Court's determination to the Trial Division of the Supreme Court constituted by a single judge.
>
> (2) Subject to section 86, an appeal under this section must be made within 28 days after the refusal by the Coroners Court.

2.16 The Coroners Act provides that an appeal must be on a question of law, and be brought in accordance with the rules of the Supreme Court. The Supreme Court may make any order in relation to an appeal, including an order remitting the matter for re-hearing to the Coroners Court with or without any direction in law:

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23 *Coroners Act 2008* (Vic) s 77(4).

87 Appeal to Supreme Court

(1) Subject to section 87A, an appeal to the Supreme Court under this Part is an appeal on a question of law.

(2) Subject to this Part, an appeal under this Part must be brought in accordance with the rules of the Supreme Court.

(3) The Supreme Court may make an order staying the operation of a determination that is the subject of an appeal under this Part.

(4) Subject to section 88, after hearing and determining the appeal, the Supreme Court may make any order that it thinks appropriate, including an order remitting the matter for re-hearing to the Coroners Court with or without any direction in law.

(5) An order made by the Supreme Court on an appeal under this Part, other than an order remitting the matter for re-hearing to the Coroners Court, may be enforced as an order of the Supreme Court.

2.17 Appeals relating to a refusal to re-open an investigation may also be available in circumstances where the application is brought by the senior next-of-kin of the deceased or a person with sufficient interest in the case, and the Supreme Court is satisfied that it is necessary or desirable in the interests of justice to allow the appeal:

87A Appeal to Supreme Court in the interests of justice

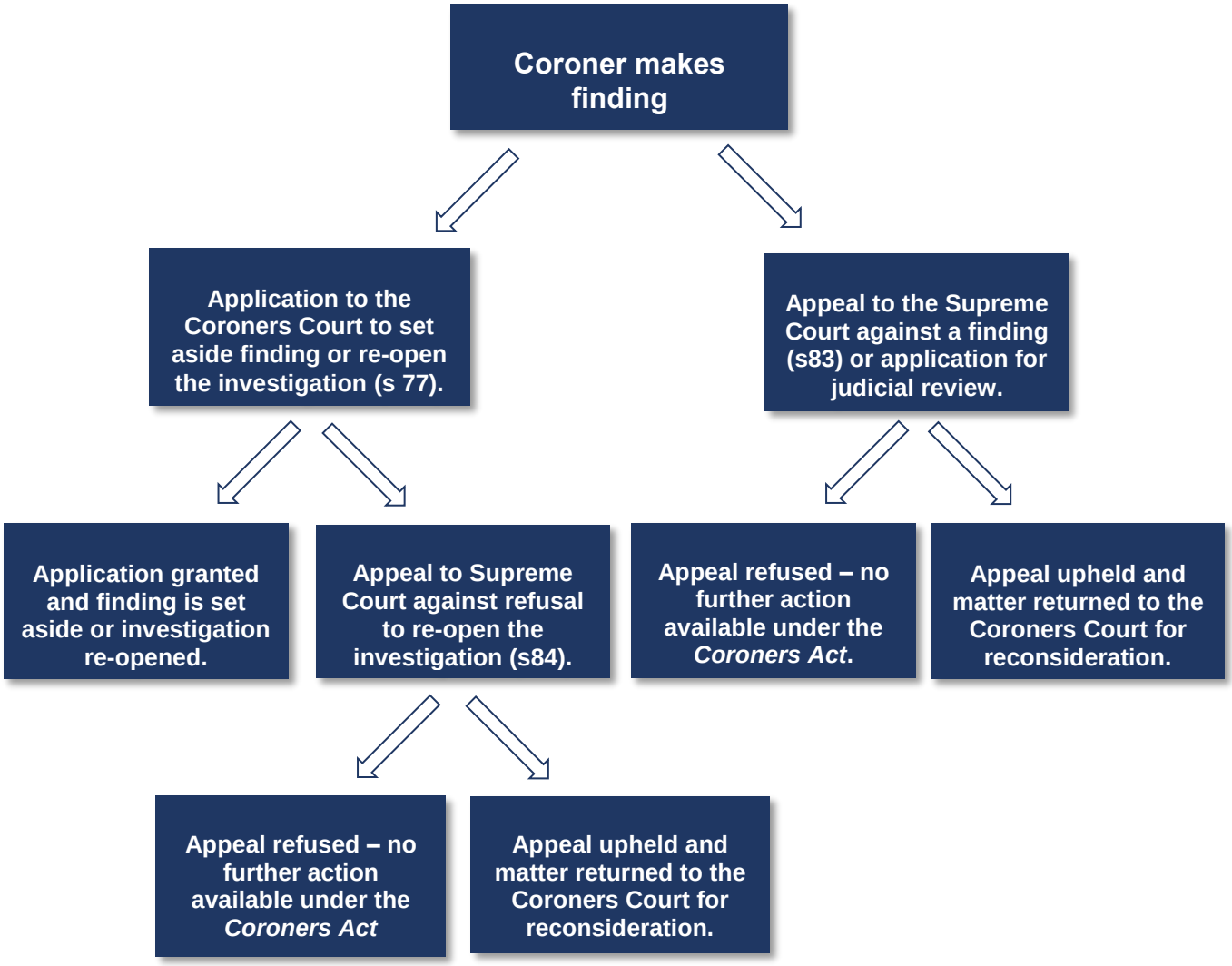
(1) An appeal to the Supreme Court other than on a question of law may be made under section 82(1) in respect of a decision by a coroner to not hold an inquest into a death, or section 84(1) in respect of a refusal by the Coroners Court to re-open an investigation into a death, if the appeal is made by—

(a) the senior next of kin of the deceased; or
(b) a person with sufficient interest.

(2) The Supreme Court may allow an appeal under subsection (1) if it is satisfied that it is necessary or desirable in the interests of justice to do so.

2.18 Chapter 6 examines the available appeal grounds.

Figure 1: Overview of review and appeal options under the Coroners Act



The historical development of the review and appeal provisions in the Victorian coronial jurisdiction

Operation of the Coroners Act 1985

2.19 In undertaking this review, the Council has considered the comparable provisions for review appeal of coronial findings available under the *Coroners Act 1985*, which was the legislation that preceded the *Coroners Act 2008*.

2.20 The *Coroners Act 1985* limited review to inquest findings only, both for review by the Coroners Court and appeals to the Supreme Court. In the first instance, a person could apply to the State Coroner for an order that some or all of the findings of the inquest were void.[24] In order to make a successful application, the State Coroner had to be satisfied that:

- there was a mistake in the record of the findings; or
- review was desirable because of new facts or evidence.[25]

2.21 If one of these conditions were satisfied, the State Coroner had the discretion to declare that some or all of the findings on an inquest were void and re-open, or direct another coroner to re-open, the inquest and re-examine any finding.[26]

2.22 Further, any person could appeal directly to the Supreme Court against some or all of the findings of a coroner's inquest.[27] The Supreme Court could make an order that some or all of the findings of the inquest were void if:

- it [was] necessary or desirable because of fraud, consideration of evidence, failure to consider evidence, irregularity of proceedings or insufficiency of inquiry; or
- there [was] a mistake in the record of the findings; or
- it [was] desirable because of new facts or evidence; or
- the findings [were] against the evidence and the weight of the evidence.[28]

2.23 If one of these grounds were satisfied, the Supreme Court could order the State Coroner to hold a new inquest, or direct any coroner other than the coroner who held the first inquest to hold a new inquest. The Supreme Court could also order the State Coroner to re-open (or direct another coroner to re-open) the inquest and to re-examine any finding.[29] A refusal by the State Coroner to make an order to re-open an inquest or re-examine any finding could also be appealed to the Supreme Court.[30]

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24 *Coroners Act 1985* (Vic) s 59A(1).
25 Ibid s 59A(3).
26 Ibid s 59A(2).
27 Ibid s 59(1).
28 Ibid s 59(3).
29 Ibid s 59(2).
30 Ibid s 59B(1).

2.24 Applications for appeal under the *Coroners Act 1985* generally focused on whether there was an 'insufficiency of inquiry' or 'consideration of evidence' by the Coroners Court, or whether the findings were 'against the evidence and the weight of the evidence'. Review of a finding based on the 'consideration of evidence' was interpreted to mean the coroner had considered evidence that should not have been considered, or failed to consider evidence that should have been considered.[31] A ruling that the finding of a coroner was void on the basis of an 'insufficiency of inquiry' addressed situations where a coroner failed to carry out an inquiry necessary for the purposes of investigating a death and making the findings required by the Act.[32]

2.25 The ground of review where the finding was said to be 'against the evidence and the weight of the evidence' was originally the subject of judicial criticism for imposing a 'heavy burden on the court since it involves the court in reviewing the whole of the evidence and examining for itself all issues of fact, including inferences from the evidence'.[33] However, the Court of Appeal clarified in a 1998 judgment that '[a]ll that was intended [by s 59(3)(d)] was that perverse findings might be set aside, i.e. findings for which there was no evidence or that no reasonable coroner could make.'[34]

Implementation of the Coroners Act 2008

2.26 The *Victorian Parliament Law Reform Committee Inquiry into the Review of the* Coroner's Act 1985 prompted significant reforms to the coronial system in Victoria in 2006, including through the introduction of the *Coroners Act 2008*.[35] The new Act established the Coroners Court as a specialised inquisitorial court, and gave its findings the status of decisions of a court.[36] It also sought to improve services for families, and to strengthen the preventative role of the coroner.

2.27 In particular, family members told the Parliamentary Committee that they needed to have increased access to information about the coronial process and be informed about their rights and key events.[37] They also highlighted a need for sensitive contact from staff and better information on the availability of counselling and services.[38] The *Coroners Act 2008* was accordingly drafted to address these issues and introduced objectives that acknowledged and strengthened the position of families.[39]

31 *Keown v Khan* [1998] VSC 297.
32 *Plover v McIndoe* [2000] VSC 475.
33 *Anderson v Blashki* [1993] 2 VR 89.
34 *Keown v Khan* [1998] VSC 297.
35 Victorian Parliament Law Reform Committee Inquiry into the Review of the *Coroner's Act 1985*, Parliamentary Paper No 229 of Session 2003-06, September 2006.
36 *Coroners Act 2008* (Vic) s 89.
37 Parliamentary Debates (Hansard), Parliament of Victoria Legislative Assembly, Thursday, 9 October 2008, *Coroners Bill 2008*, p. 4035.
38 Ibid.
39 Ibid.

2.28 The *Coroners Act 2008* expanded the range of appeal rights to the Supreme Court, including an appeal against a decision of a coroner that a death is not a reportable death, the findings of a coroner made in respect of a death or a fire after an investigation or an inquest as well as an order to release a body and the terms of that release.[40] It also significantly broadened the class of cases eligible for review by the Coroners Court or appeal to the Supreme Court, to include all findings resulting either from an inquest or investigation conducted in chambers.

2.29 In order to make this work more manageable, the new legislation provided that an application to the Coroners Court to re-open an investigation would be considered by the original coroner, rather than the State Coroner. Similar to the appeal grounds available with respect to the civil judgments of other lower courts, the new Coroners Act stated that appeals against coronial findings would be available on a question of law.

2.30 The reforms do not appear to have been in response to any specific concerns relating to the appeal provisions contained in the earlier legislation; nor are they an attempt to limit or modify the number of cases progressing to the Supreme Court on appeal. The numbers of appeals before 2008 and following the introduction of the new Coroners Act are few and substantially unchanged.

2.31 In 2014, the grounds of appeal available against a refusal to re-open an investigation under s 84 of the Coroners Act was broadened to allow an appeal by a senior next-of-kin of the deceased or a person with sufficient interest in circumstances where the Supreme Court is satisfied that it is necessary or desirable in the interest of justice to do so.[41]

2.32 The inclusion of this further ground for review in 2014 was designed to restore aspects of the pre-2008 appeals provisions relating to the re-opening of an inquest.[42] The stated objective of the amendment was to increase the capacity for senior next-of-kin and other persons with a sufficient interest to appeal significant decisions regarding coronial investigations and inquests.[43]

40 Parliamentary Debates (Hansard), Parliament of Victoria Legislative Assembly, Thursday, 9 October 2008, *Coroners Bill 2008*, p. 4037.

41 *Coroners Act 2008* (Vic) s 87A (came into force on 1 January, 2015 following commencement of the *Courts Legislation Miscellaneous Amendments Act 2014*).

42 Parliamentary Debates (Hansard), Parliament of Victoria Legislative Assembly, Wednesday, 25 June 2014, *Courts Legislation Miscellaneous Amendments Bill 2014*, Second reading speech, p. 2289.

43 Ibid.

3. Re-opening a coronial investigation in the Coroners Court

Overview

3.1 In most cases, coronial investigations provide valuable information to families, interested parties and the community about the cause and circumstances of a death. In some situations, however, the coronial process cannot give all the answers that families and others seek. In others, family members or interested parties are unhappy with the investigation, or disagree with the coroner's conclusions.

3.2 The re-opening provision in s 77 of the Coroners Act ensures that new information or evidence can be considered if it might alter the original findings. This is not intended as a mechanism by which the original decision can be reconsidered. The question for the Council is whether the existing grounds to re-open an investigation or set aside a finding are appropriate, and whether they provide enough flexibility to consider new evidence that may affect the outcome of a coronial decision.

Current law and practice

3.3 Section 77 of the Coroners Act provides an opportunity for a coroner to re-open an investigation or set aside a finding if new evidence has come to light. In order for an application to be successful, the Coroners Court must be satisfied that:

- there are new facts and circumstances; *and*
- that it is appropriate to re-open the investigation.[44]

3.4 New facts and circumstances encompass 'facts and circumstances that are new to the investigation. These facts may have been known to people during the investigation, but they were not known to the coroner conducting the investigation.'[45] Guidance on this provision indicates that the Coroners Court should consider all relevant factors when deciding whether to re-open an investigation. This includes the need to promote the finality of decisions in the Coroners Court, and the fair and efficient operation of the coronial system.[46]

3.5 Accordingly, the Coroners Court should not exercise its power to re-open an investigation in a manner that would encourage a person to negligently or intentionally withhold information and then subsequently seek a re-opening of the investigation by claiming that there were facts and circumstances that were 'new' to the investigation.[47] However, the Supreme Court has also noted that the coroner must not import any additional conditions to narrow the scope of the test, which the legislature has not imposed.[48]

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44 *Coroners Act 2008* (Vic) s 77(2).
45 *Hecht v Coroners Court of Victoria* [2016] VSC 635 [43].
46 Explanatory Memorandum, *Coroners Bill 2008*, Clause 77.
47 Ibid.
48 *Hecht v Coroners Court of Victoria* [2016] VSC 635 [46].

3.6 The second limb of the test considers whether, notwithstanding the existence of new facts and circumstances, it is appropriate to re-open the investigation. The Supreme Court has noted that 'it would be unusual if a new fact that entirely supported and reinforced the original finding could be a ground to set aside the finding and re-open the investigation … even if a new fact had a potential to bear upon the original finding, the extent of that impact could be anywhere on the scale between negligible and overwhelming'.[49] Accordingly, the likely impact of the new fact and circumstance on the original finding is a relevant consideration in determining whether it is appropriate for an investigation to be re-opened.

3.7 The legislation does not define what is 'appropriate', but this should be understood in the context of the nature and purposes of the coroner's powers and functions as defined in the Coroners Act.[50] The application of the test to the relevant issues is deliberately left to the judgment of the coroner, given their specialist knowledge and experience in determining how an investigation should achieve the purposes of the legislation.[51]

3.8 The rules of the Coroners Court state that the party seeking review of the original findings must complete an application to set aside findings. This must identify the specific orders sought and the reason(s) for the application.[52] There are no restrictions on who can bring the application for review, and there is no time limit for bringing an application. A successful application for review could result in the re-opening of the investigation, and/or an order that some or all of the original findings be set aside.

Review rights in other Australian jurisdictions

3.9 In evaluating the existing opportunities to review coronial findings in Victoria, it is useful to consider analogous provisions in coronial legislation in other Australian jurisdictions. The options for review of coronial findings within the Coroners Court are not harmonised, and vary considerably between jurisdictions. For example, some jurisdictions, such as New South Wales and Western Australia, do not allow a dissatisfied party to re-open a case once it has been finalised by a coroner.

3.10 All other jurisdictions in Australia offer review of findings within the Coroners Court, but the approach varies considerably. Victoria, Queensland and Tasmania allow for the reconsideration of all investigations by the Coroners Court if certain conditions are satisfied, while the remaining jurisdictions only allow for review of findings made in the course of an inquest. Victoria and Tasmania allow a person to appeal to the Supreme Court if the Coroners Court refuses an application to re-open an investigation. Queensland allows similar appeals to its District Court, but only for findings relating to inquests. Further details are set out in **Appendix D**.

49 *Mortimer v West* [2017] VSC 293 [47].
50 Ibid [50].
51 Ibid [49].
52 Coroners Court Form 43 Rule 65(1): Application to set aside a finding: www.coronerscourt.vic.gov.au/home/in+the+courtroom/form+43+application+to+set+aside+findings.

Victorian statistics on applications to review coronial decisions

3.11 There are approximately 6,500 cases notified to the Coroners Court each year. Once a matter is finalised, the Coroners Court receives only a handful of applications each year seeking an order that some or all of the findings be set aside, or that the investigation be re-opened, on the basis that new facts and circumstances have come to light. The available data indicate that there are fewer than a dozen applications annually for review within the Coroners Court. Approximately one-third of such applications result in an investigation being re-opened, or a finding set aside. A breakdown of applications by year from 2012–2017 is set out in **Appendix E**.

What the Council heard

Grounds to re-open a coronial investigation or set aside a finding

3.12 During meetings with families and organisations, the Council had valuable discussions about the opportunities currently available to re-open an investigation or set aside findings within the Coroners Court. Family members generally thought that the existing model for seeking review was overly restrictive, and should be expanded to include circumstances where the family does not agree with the conclusions reached by the coroner. It was proposed that a broader set of review grounds could include:

> *[T]here are reasonable grounds that the coronial process may have been significantly flawed; there is significant issue with the Findings; an "Interested Party" may have been denied natural justice or procedural fairness; and upon an official instruction of the State Coroner.*[53]

3.13 Another proposal from a family suggested that review of a matter could take place within the Coroners Court if:

> *[I]t is apparent that the finding or any part of the findings contains, prima facie, deficiencies or errors which if corrected would be likely to justify alterations to the original finding or findings.*[54]

3.14 The requirement for 'new facts and circumstances' to be present in order to justify re-opening an investigation was considered a difficult threshold to satisfy. Some families described their experience seeking to re-open an investigation within the Coroners Court as follows:

> *When I had recovered enough to mount an appeal I was told I had to obtain new evidence to have the file opened and any chance of having the case investigated.*[55]

53 Submission 8.
54 Submission 9.
55 Submission 17.

> *I submitted further evidence following my son's inquest, and received a response saying the coroner has read and reviewed the material and is not satisfied that the cause of death should be altered at this time.*[56]

3.15 While a number of family members thought that the re-opening provision of the Coroners Act should be broadened, the general view from key institutional stakeholders and experts was that the current laws are appropriate for reviewing coronial findings. For example, the Supreme Court stated that:

> *As the cases now establish, there is broad scope for the reopening of investigations under s 77 and scope for the Supreme Court to allow an appeal in appropriate circumstances, ensuring the legislation is correctly applied and providing guidance for the future.*[57]

3.16 The Coroners Court also indicated that the current opportunities to seek review were appropriate. Relevant to this issue, the State Coroner indicated in the Coroners Court's submission that:

> *[T]he Victorian public's review rights under the present provisions of the Act are very broad.*[58]

3.17 The Law Institute of Victoria and the Victims of Crime Commissioner also noted that the current review provisions were appropriate:

> *The LIV submits that the existing reopening provisions in the Coroners Act 2008 should remain, as they are consistent with other Australian legislation allowing coronial investigations to be reopened where significant new information comes to light.*[59]

> *I fully support the ability and right of a person affected by a death to request that findings of a Coroner be set aside and an investigation into a death be re-opened, on the basis that new facts and circumstances have become known.*[60]

3.18 The Victorian Bar and other legal experts were also broadly comfortable with the opportunity to seek review of a finding within the Coroners Court, but identified areas where greater clarity would improve the operation of the Coroners Act.

56 Submission 23.
57 Submission – Supreme Court of Victoria.
58 Submission – Coroners Court of Victoria.
59 Submission – Law Institute of Victoria.
60 Submission – Victims of Crime Commissioner.

3.19 There was also a view among some legal professionals that coronial findings could follow a standard template to facilitate greater consistency in the presentation of findings, commentary and recommendations. It was felt that it would also be useful for findings to outline correspondence with families and the issues that had been considered. To the extent appropriate, it was suggested that the findings could also state the reasons why certain lines of inquiry were not pursued, or why particular arguments were found to be unsupported by the evidence.

Appropriateness of the original coroner undertaking review

3.20 In discussions, a number of family members made it clear that they would prefer that the review of a coronial matter be conducted by the State Coroner or an independent person or panel, rather than by the original coroner who handled the investigation as is currently the case. Some families perceived that the original coroner, while having the benefit of familiarity with the matter, might lack impartiality, or be reluctant to re-open an investigation or review findings. Comments on this point noted that:

> *Section 77 only permits a coronial inquest be reopened if there are new facts and circumstances. If the coroner showed bias or impropriety or failed to act reasonably you are left without a remedy. An appeal does not assist because you are not necessarily appealing the outcome.*[61]

> *If the disputed questions are substantial and are sent back to the originating coroner, they have the obvious potential to produce resentment and biased opposition on the part of that coroner.*[62]

> *There is an imperative need for oversight by an independent body of the Coroner's Court, its processes and practices and the performance of the individual Coroners and the decisions they are handing down.*[63]

> *[Seeking review] was a very frustrating experience and we feel it would be improved by allowing families to have another coroner / person view the cases where conflicts seem to occur.*[64]

> *Coroners are not infallible; but it is difficult to imagine any coroner would come forward with a different finding following the re-opening of an investigation … that would be admitting that he/she got it wrong in the first place.*[65]

3.21 A number of submissions provided proposals about how review of coronial findings might occur. One suggested that the decision to re-open an investigation, or set aside a finding, be undertaken by a different coroner than the one who conducted the original investigation:

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61 Submission 20.
62 Submission 9.
63 Submission 16.
64 Submission 21.
65 Submission 23.

> *I am definitely of the opinion that if it is deemed appropriate the investigation be re-opened, then the Coroners Court must be constituted by a coroner other than the coroner who constituted the original investigation.*[66]

3.22 Another proposed that a panel of coroners could undertake the review function, with or without the involvement of the original coroner:

> *[T]he original findings [could] be reviewed by a panel comprising two or more coroners including or excluding, in accordance with the State Coroner's direction, the coroner who issued the original findings.*[67]

3.23 Other family members similarly emphasized the potential benefits of review undertaken by a panel, but also highlighted the possible advantages of involving community representatives in the process:

> *[The review could be undertaken by] independent personnel comprising 3 people with authority and specialist expertise - a presiding Judge (or equivalent), an assisting Solicitor, and an assisting Psychological / Social Worker.*[68]

> *[It would be useful to have] an independent Review Panel with community and Coronial Council representation and the power to alter the Finding or direct the Coroners Court to amend, correct or re-open a case with an alternate Coroner.*[69]

3.24 Finally, a further option proposed the creation of an Ombudsman-style position to consider applications for review in coronial matters, noting that:

> *This person would need to be highly qualified and perhaps based within the Department of Justice. This person could act as a bridge between the court and the public, but also as a check-and-balance on the court. In certain cases, it might be that this person has the authority to review a case … and advise the State Coroner that he or she ought to have it reviewed.*[70]

66 Submission 23.
67 Submission 9.
68 Submission 8.
69 Submission 16.
70 Submission 11.

Clarity of the re-opening provision

3.25 With respect to bringing greater clarity to the re-opening provision in the Coroners Act, the Victorian Bar noted that it would be useful to 're-draft s77 for clarity to allow an application to set aside findings or re-open an investigation, and to allow an appeal from the entirety of the exercise of the coroner's discretion in respect of such an application'.[71]

3.26 One barrister who is familiar with coronial inquests and applications for review suggested that this clarity could be achieved by amending the Coroners Act to distinguish between requests to re-open an investigation, and more modest applications to set aside some of the findings. This would establish a new separate ground to set aside some findings, where there is otherwise no need to re-open the investigation. This discussion also canvassed the suggestion that the amendment could also provide guidance on what is meant by 'appropriate' in an application to re-open an investigation; and a 'finding', as opposed to commentary, for the purposes of an application to set aside a coroner's finding.

3.27 More generally, the Victims of Crime Commissioner observed that the review and appeal provisions of the legislation can be difficult to navigate, particularly for families, and could be improved by structural amendments aimed at providing greater overall clarity and consistency:

> *The Act is somewhat "clunky" and difficult to follow and there are some inconsistencies as to who can make certain applications [and] could be improved through a better sequential order. For example, all procedures relating to appeals against orders and findings made in investigations and inquests could be completely contained within one Part.*[72]

3.28 A further issue raised by the Flemington and Kensington Community Legal Centre concerned the current definition of 'coroner' in the Coroners Act. The Centre indicated that this definition creates practical difficulties in seeking to re-open some historical cases if new facts and circumstances came to light, where the original finding pre-dated the current legislation:

> *The key issue with [the review grounds] is the narrow definition of who is a coroner. [The current] definition excludes any person who held the office of coroner at a time not immediately preceding the introduction of the Act, and was not appointed to the office of coroner under the Act. Thus, a person who held the office of coroner prior to, but not immediately preceding, the Act coming into effect is not a coroner for the purposes of the appeal and reopening provisions in the Act.*[73]

71 Submission – Victorian Bar.
72 Submission – Victims of Crime Commissioner.
73 Submission – Flemington and Kensington Community Legal Centre.

3.29 The Victoria Police submission stated it would be appropriate to limit standing to seek review of a coronial finding under the Coroners Act. Specifically, Victoria Police proposed that 'only a "person with sufficient interest" should have the option to apply to have findings set aside or an investigation to be re-reopened, and the section should be amended to reflect this'.[74]

Correcting errors or revising findings

3.30 A number of families raised concerns about incorrect descriptions of facts or circumstances in coronial decisions they have not been able to satisfactorily resolve. Submissions expressed a strong view that the coronial system should provide an opportunity to correct factual errors in findings through a quick and straightforward process.

> *We have now disputed [the] Coroner's findings with three successive State Coroners on the basis of his failure to consider all of the available evidence, in support of our request we have prepared and submitted a schedule detailing some 50 errors in fact and conflicting evidence and have requested of the State Coroner that the investigation be reopened by an alternative Coroner, to review and correct those errors in the Finding, but these have all been refused.*[75]

> *There was evidence aplenty at my son's inquest … but for whatever reason, much of that evidence (including material in hospital records) was ignored.*[76]

3.31 A further source of dissatisfaction for families related to comments made by coroners in the course of their findings, which can be perceived as unnecessary or hurtful by the family of the deceased.

> *[The coroner] commented on things entirely unrelated to the death and he is not allowed to do this.*[77]

3.32 Some families indicated that they were not interested in re-opening an investigation, but had sought to set aside a finding or to revise a paragraph or sentence in commentary to the decision that was particularly upsetting or distressing.

74 Submission – Victoria Police.
75 Submission 16.
76 Submission 23.
77 Submission 10.

The Council's conclusions

Suitability of s 77 to re-open investigations

3.33 The Council has given careful consideration to the submissions made by families and organisations on the issues raised in relation to s 77 of the Coroners Act. It is important to recall that the re-opening provision in the Coroners Act operates as a safeguard to ensure that any new information or evidence can be considered following the conclusion of a matter, if it might alter the original findings. It is not intended to allow reconsideration of matters and findings simply because a party is dissatisfied with the decision of a coroner.

3.34 Having reviewed the relevant legislation, the Council considers that the approach to re-opening investigations in Victoria is consistent with, if not more generous, than the provisions authorising the review of coronial decisions in most other Australian jurisdictions. Apart from Queensland and Tasmania, Victoria is the only jurisdiction in Australia that allows for a review of coronial findings in respect of all coronial investigations.

3.35 In contrast, jurisdictions such as New South Wales and Western Australia do not allow for any review of a coronial finding without the intervention of a superior court. The other jurisdictions where review is available within the Coroners Court generally take a similar approach to Victoria, and require new evidence that casts doubt on the finding of the coroner to justify re-opening an investigation. The Council is not aware of any other court within Victoria that allows for the review of a decision by way of a comparable re-opening provision, which appears to be unique to the Coroners Court.

3.36 On a practical level, while discussions with families highlighted various sources of dissatisfaction with coronial findings, to an independent observer, the coroners' findings in those matters generally seemed sensible and logical. The Council is of the view that in the majority of these cases, requests by family members to pursue other lines of investigation or consider alternative causes of death would be very unlikely to change the fundamental conclusions reached by the coroner.

3.37 The Council is therefore comfortable that the current legislative policy reflected in s 77 of the Coroners Act is appropriate, and strikes the right balance between promoting finality and efficiency in the court system, and ensuring there are appropriate avenues to review a finding where new evidence becomes available. The policy also makes sense in light of the significant time and resource implications of re-opening a coronial investigation for a court that is already managing a large caseload.

3.38 Further to this issue, the Council has reflected on the relative merits of seeking review from the original coroner who has a high degree of familiarity with the matter, as against the fresh perspective that may be brought by a different coroner or outside party. While families seeking to re-open an investigation often state a preference for the review to be undertaken by a new coroner or independent person or panel, none of the key legal organisations or experts raised concerns about the current arrangement.

3.39 The Council does not perceive a conflict that would prevent the original coroner from undertaking the review function required by the Coroners Act. Given their familiarity with the case, the Council considers the original coroner is best placed to consider an application for review, if new facts and circumstances come to light. Practical considerations also weigh in favour of this conclusion, given the time required to review a matter to decide whether there is sufficient new evidence to justify re-opening an investigation.

3.40 As head of jurisdiction, the Council considers that the State Coroner's time should be dedicated to considering the most complex coronial matters and managing court business. Accordingly, the Council is of the view that it is not necessary or appropriate for the State Coroner or another coroner to undertake a review of a case where a finding has already been made. Further, the Council does not support the establishment of a review panel or ombudsman function to consider applications to re-open an investigation or set aside a finding, as this would require lay people to review the decisions of expert judicial officers.

3.41 Although the general policy approach to the review of coronial findings is appropriate, the opportunity to seek review in historical cases is currently ambiguous and should be clarified. The Council considers that s 77 is limited to investigations under the 2008 Coroners Act, and would not provide for re-opening investigations under the 1985 Coroners Act.

3.42 However, under the *Interpretation of Legislation Act 1984* (Vic), where an Act is repealed, amended, or otherwise ceases to have effect, the right and privileges accrued under that Act are not affected, unless the contrary intention expressly appears.[78] Accordingly, notwithstanding the repeal of the 1985 Coroners Act, it appears that s59A of that Act is likely to remain in operation with respect to the review of findings made in an inquest under the 1985 Act. In order to put the matter beyond doubt, the Council considers that it would be desirable to amend the Coroners Act to confirm that this is the case. As a matter of policy, the Council is of the view that it is appropriate that the grounds of review which existed under the 1985 Coroners Act continue to apply to findings which were made in the course of inquests conducted under that Act.

3.43 The Council is not persuaded that standing to seek review of a coronial finding under the Coroners Act should be limited. The Council considers it appropriate that any person who has new evidence in relation to a coronial investigation can come forward, potentially many years after the original decision was finalised, to seek a review of the original decision. The requirement that the court be satisfied that it is 'appropriate to re-open the investigation' provides an adequate safeguard against misuse of this provision.

3.44 For the reasons outlined, the Council does not consider that broadening the scope for re-opening a coronial investigation, or requiring review by a person other than the original coroner, is necessary or desirable. Accordingly, the Council does not propose an amendment to s 77 of the Coroners Act. However, the Council recommends that the Coroners Act clarify that an inquest may be reviewed in historical cases as provided for in the 1985 Coroners Act.

78 *Interpretation of Legislation Act 1984* (Vic), s 14(2).

Recommendation 1: The Coronial Council considers that the operation of s 77 of the Coroners Act is appropriate. However, the Victorian Government should seek to amend the Coroners Act to clarify that the findings of inquests made under the 1985 Coroners Act may be reviewed by the State Coroner as provided for by that Act.

Opportunities to improve resolution of complaints within the Coroners Court

3.45 The frustration experienced by families in their efforts to correct errors in coronial findings left a strong impression on the Council. While most of the errors identified were unlikely to affect the conclusions reached, the Council accepts that, in some cases, they undermined the confidence of families in Court processes and decisions, and caused considerable distress.

3.46 The Council notes that the Coroners Act already provides for the correction of clerical mistakes and factual errors.[79] However, discussion with families indicates that this provision is not well known, and some families sought to resolve their concerns through the more complex re-opening provision of the Act. The Council considers that the Coroners Court could provide guidance to families and other interested parties through a factsheet which could accompany coronial findings.

3.47 The Council also considers that there are opportunities to improve resolution of complaints about findings or the wording of coronial decisions that are not material to the ultimate conclusions reached, and do not require the Coroners Court to re-open an investigation. While the requirement for 'new facts and circumstances' provides appropriate parameters for re-opening an investigation in the Coroners Court, applications for review of the wording of a finding should turn on whether the Coroners Court considers it appropriate to make the amendments sought, having regard to the interests of all parties concerned.

3.48 Accordingly, the Council recommends that the Coroners Act be amended to make it clear that, upon the application of an interested party, the Coroners Court may set aside a finding that is not material to the ultimate conclusions reached, or revise any part of a decision, if it is appropriate to do so, having regard to the interests of all parties affected by the finding. The Council does not expect that applications of this type would result in the consideration of new evidence, or fresh findings being made by a coroner.

3.49 Consistent with s 77(4) of the Coroners Act, the Coroners Court should be constituted by the coroner who conducted the original investigation unless they no longer hold the office of coroner, or there are special circumstances. If the original coroner is not available, the State Coroner would consider the application. In the interest of achieving finality in a case, an application under this proposed new ground to review a coronial finding should be subject to a three-month time limit from the day on which the finding of the coroner is made.

79 *Coroners Act 2008* (Vic) s 76.

3.50 As a further practical matter, the Council suggests that coroners may wish to consider sharing draft copies of a finding with interested parties in sensitive cases, to allow for corrections or revisions to take place before a finding is finalised.

3.51 In order to address concerns that the review provisions within the Coroners Act are 'clunky' and difficult to follow, the Council recommends that consideration be given to linking ss 76 and 77 of the Act more closely.

Recommendation 2: The Victorian Government should seek to amend the Coroners Act to allow the Coroners Court to separately consider an application to:

a. set aside a finding if the Coroners Court considers it appropriate, and it is not necessary to re-open the investigation to do so; or

b. revise the wording in any part of a decision if the Coroners Court considers it appropriate, and it is not necessary to re-open the investigation to do so.

Consistent with s 77(4) of the Coroners Act, the Coroners Court should be constituted by the coroner who conducted the original investigation unless they no longer hold the office of coroner, or there are special circumstances.

An application for review on the proposed grounds should be subject to a three-month time limit from the day on which the finding of the coroner is made.

In order to achieve greater clarity of review opportunities within the Coroners Court, consideration should be given to linking ss 76 and 77 more closely in the Coroners Act.

4. Experience of families engaging in the coronial process

Overview

4.1 While the terms of reference did not specifically call for feedback on the original coronial investigation itself, the Council considers that there are important opportunities to improve the experience of families engaging with the Coroners Court, which if available would significantly reduce the need or desire to pursue further legal remedies. The Council recognises that in many instances, family dissatisfaction with the coronial findings appears to stem from the unmet justice needs of families. Accordingly, many of the reforms recommended in this review focus on empowering families to better understand and engage in the coronial process, and enhancing the human dimension of coronial investigations to achieve more positive outcomes for families.

4.2 The Council is of the view that, at its best, the coronial system can facilitate understanding of the circumstances of the death, and make recommendations for better and safer processes that may avoid similar deaths occurring.[80] However, the coronial process can be daunting and difficult for people who have lost their loved ones. Experts have noted that, among other factors, delays to the coronial finding relating to the cause of death, a lack of information concerning the process, and the confronting nature of the evidence at an inquest can cause the family significant distress.[81]

4.3 It is also clear there is a tension between the coronial process required for proper and impartial investigations that benefit the community as a whole, and the needs of families who are experiencing grief as a result of the loss of a loved one. In particular, families may arrive at the inquest with their own version of events, and can feel upset if others 'get the story wrong' in the official record of the case.[82] Moreover, families may see a coronial investigation as an opportunity to set the record straight, and they may hope that those whom they feel contributed to the death be publicly identified or reprimanded.[83] Families can experience distress and dissatisfaction if the coroner's findings and recommendations do not reflect these expectations.

4.4 Many of the submissions received, as well as the Council's discussions with families, confirm the potential for coronial processes to help or hinder the way families resolve their grief and accept the circumstances of a death. The key theme to emerge from talking to families about their experiences of the original coronial investigation is that there is, in some cases at least, a significant need for greater access and participation by families in the coronial process. The feedback from families focused on several important elements that are necessary to facilitate more meaningful engagement with the Coroners Court, namely:

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80 Ian Freckelton, *Minimising the Counter-Therapeutic Effects of Coronial Investigations: In Search of Balance*, (2016) 16(3) QUT Law Review 22.

81 Michael S King, *Non-adversarial justice and the coroner's court: A proposed therapeutic, restorative, problem-solving model* (2008) 16 JLM 442, 444.

82 Alison Wertheimer, *A Special Scar: The Experiences of People Bereaved by Suicide* (Routledge, 2014), pp. 85–86.

83 Ibid p. 85.

- timely and efficient access to information necessary to fully engage in the coronial process;
- the opportunity for families to participate, and have their views heard and questions answered during the coronial investigation; and
- better understanding of the findings ultimately made by a coroner.

4.5 Each of these themes will be discussed in turn in this Chapter. The Council considers that giving families more opportunities to be heard and have their experiences acknowledged during the coronial process is likely to better meet families justice needs, as well as reducing demand to re-open investigations within the Coroners Court, or appeal findings to the Supreme Court.

What the Council heard

Access to relevant information

4.6 A number of families highlighted the importance of clear communication regarding the role and processes of the Coroners Court, and indicated they would have liked more focused and tailored information at significant milestones during the coronial process. The Council heard that the *ad hoc* process for relaying information to families can also be very damaging. One observer familiar with a number of recent coronial cases summarised this issue as follows:

> *In general, I have noticed a degree of frustration in many families when it comes to understanding the role of the Coroners Court, its limitations and legal formalities which often act as a barrier to comprehension and acceptance of outcomes.*[84]

4.7 This was a theme that came up on a number of occasions in discussions. In particular, families said that prior to the commencement of the investigation, they would have appreciated:

- a clearer understating of the role of the coroner and the operation of an inquisitorial court system;
- a better explanation of processes, and the rights of the family;
- an indication of likely timeframes for various aspects of the investigation, and the reason for delays when they occur;
- an overview of available outcomes or findings in the case; and
- more pro-active approach to providing information during the case.

4.8 Once a coronial investigation is underway, families stated they wanted regular and structured updates on the progress of the case during the coronial investigation. They would have also welcomed more timely and reliable communication from the Coroners Court about practical aspects of the investigation.

[84] Submission 11.

4.9 In some cases, family members submitted that their participation in an inquest was hindered by the fact they were not given a full investigation brief, or that it took significant time and effort to obtain all the information relating to the case.

4.10 A final important theme that emerged from meetings with families concerned the recognition of significant relationships other than senior next-of-kin prescribed by the legislation. In particular, the parents and siblings of a person who has died wanted to be kept better informed of coronial processes and outcomes in circumstances where they were estranged from the domestic partner identified as senior next-of-kin in the case.

4.11 The submission received from the Centre for Innovative Justice also reflected on the importance of families accessing appropriate information and support to engage fully in coronial processes concerning their loved ones.

> *When the* Coroners Act 2008 *was introduced, a central concern was to strengthen the response to the needs of families by improving their access to information and involvement in the coronial process. These reforms were driven by the recognition that there was a greater need for families to be involved and informed about their rights and of key events throughout the coronial process.*[85]

4.12 Legal experts reported that while coronial processes are generally open and facilitative, it can be difficult for families to engage with an unfamiliar system. Some experts also indicated that there were opportunities for greater standardisation to provide better outcomes for families and others involved in the coronial process, including through better training of coroners and the development of practice guidelines. In this respect, it was suggested that greater hands-on case management would help families, particularly in cases heading to inquest. Experts also stated that more and better processes and policies for engaging with families would be useful.

4.13 Discussions with staff in key roles at the Coroners Court highlighted that the Coroners Court makes considerable efforts to provide information to families at key stages of the coronial process. For example, the Registrars and Family Liaison Officers at the Coroners Court contact families, and give them general information on the purpose of a coronial investigation, how the court undertakes its work, the role of specific officers in the court, and significant milestones in the coronial process.

4.14 The Coroners Court also communicates with families by phone or letter to provide information on the progress of their matter; how they can apply to access documents in a brief of evidence; what they can expect in the course of an inquest; and where they can seek further information if required. Additionally, the Coroners Court website contains a range of publications which set out information about coronial processes, practice directions, the relevant legislation and answers to frequently asked questions.

85 Submission – Centre for Innovative Justice.

Opportunities for families to be heard

4.15 Submissions indicated that there are a range of barriers that can prevent families participating fully and effectively in the coronial processes, including a lack of understanding of the scope and method of the investigation to be undertaken by the coroner. Families also noted that they would have liked to have more opportunities to make submissions or ask questions during an investigation or inquest. Some of the feedback on this point noted the following:

> *Often I wasn't allowed to speak at the inquest, often my questions were cut off, I was told it wasn't relevant no one had to answer, and sometimes whole hours of my evidence were lost.*[86]

> *[There was a] lack of opportunity to present information to the Coroner during the inquest (in addition to material contained in our statements).*[87]

> *I told [the coroner] my concerns and she said she would take them into account when handing down her decision. It was clear she didn't.*[88]

> *As far as I'm aware, no person was concerned enough to obtain the total medical documentation of my daughter, or investigate her treatment by her psychiatrist.*[89]

4.16 Families also felt that the coronial process could have been more inclusive and open to contributions made by those closest to the deceased. The inability to speak directly to the coroner, or have their positions acknowledged, has been a source of frustration for a number of families:

> *I feel the affected families would at least feel that their loved one was being considered as a worthwhile human being … if they were able to have more input into recommendations to make the workplace safer for everyone. … [I]f there was an opportunity for the deceased['s] family to speak directly to the Coroner or his / her assistant regarding their thoughts, opinions as to how / why this tragedy occurred they might get some sense of closure.*[90]

4.17 A number of families also commented on the time and cost of attending coronial inquiries, and the perception that this was not appropriately considered in the course of scheduling and conducting coronial inquests. They felt that more awareness of the practical needs of families was required to better facilitate their attendance and engagement in coronial processes.

86 Submission 20.
87 Submission 16.
88 Submission 2.
89 Submission 14.
90 Submission 18.

> *We were ready to go with substantial submissions and … gave up three days' work. [The coroner] said he was not going to hear any submissions that day and gave the participants until a specified date to deliver their submissions in writing. The hearing occupied about fifteen minutes and everything transacted could have been dealt with by mail or on the telephone. We submit that in circumstances like these, more consideration should be shown by the Court to minimise inconvenience, which in our case was considerable, and to us as low income people, expensive.*[91]

> *Requests were repeatedly made to the police and to the court at the directions day to list the proceedings at a time when I could attend without leaving my children alone … The court did not care.*[92]

4.18 Discussions with families highlighted more generally that their experience of the coronial process, and their opportunities to engage effectively with it, was determined significantly by the conduct of individual coroners. To this end, families wanted the Coroners Court to ensure that all coronial processes are, for example, undertaken in a 'sensitive, courteous and professional manner'.[93]

4.19 Families highlighted that appropriate support during the coronial process could improve their engagement with the coronial system. For example, families said that having a dedicated support or case officer throughout their case would have been valuable.

> *We recommend that a Case Manager be allocated to any family of a deceased where the process may, or does, involve a Directions Hearing and/or Public Inquest. This Case Manager would be the contact and communication person for all matters pertaining to this particular Inquest. [Similarly], a Pastoral Officer could provide appropriate personal support to the family of the deceased throughout the coronial process.*[94]

4.20 The Coroner's Court stopped engaging specialist grief counsellors to assist families in 2013, but families who talked to counsellors prior to this time reported that they benefited from the service. Family members noted the counsellors' specialty in grief issues, their compassion, and the help they provided during a difficult time.[95] There were some families who spoke highly of the support they received during their engagement with the Coroners Court, while others observed that more could be done to meet the needs of families coping with grief.

> *Despite being extremely traumatised following [the] death we had only brief contact with the Family Liaison Officer at the Coroner's Court and at her suggestion we subsequently engaged legal representation.*[96]

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91 Submission 9.
92 Submission 20.
93 Submission 8.
94 Submission 8.
95 Sweeney Research, *Families Information Needs and Experiences of the Victorian Coronial System*, October 2008, p19.
96 Submission 16.

4.21 Legal experts familiar with coronial matters indicated that unrealistic expectations of the coronial system could lead to family frustration with the process. There was a view that early and appropriate information could help to manage family expectations of timeframes, processes and outcomes. The Council's discussions with the Coroners Court also touched on opportunities to meet families' needs by scoping out key issues and timelines for a coronial investigation.

Understanding findings made by a coroner

4.22 In the course of this review, a number of families noted their frustration that not all issues of importance to them were explored during the original coronial investigation, or that the coroner did not obtain and consider all information the family considered relevant. In some cases, families also raised concerns regarding perceived gaps in police or other external investigations, which they thought adversely affected the quality of findings reached by the Coroners Court. Some of the feedback the Council heard on this issue includes the following observations:

> *[T]he lack of scope, limited witness list and duration of the inquest did not allow all issues to be canvassed.*[97]

> *I received the brief and realised how poorly the matter had been investigated and my concern at that time was that you get in effect one chance at a coronial investigation and that is it. There were so many lines of inquiry that were ignored.*[98]

> *More investigation should be made into ALL the circumstances as to how this tragic work death occurred, and not just take the written report of police and witnesses as regularities can and do happen.*[99]

> *The analysis [of police] results presented in evidence at the inquest were confused, inconclusive and incomplete.*[100]

4.23 It is clear that lack of opportunities to be heard in a coronial investigation can be a significant source of frustration for families, and can lead to dissatisfaction with the coronial process and outcomes. Furthermore, when the findings do not match family expectations or make the recommendations families sought, families can experience significant dissatisfaction and frustration with coronial outcomes. A number of family members indicated in the course of this review that they were dissatisfied with a coronial finding because they thought that the conclusions reached exceeded the evidence available to the coroner.

> *On the basis of the 'circumstances' listed in the Coroner's final report, I cannot agree with the finding … Related to this is the seemingly*

97 Submission 16.
98 Submission 20.
99 Submission 18.
100 Submission 9.

> *insignificant emphasis that the coroner has given to the statements of three independent witnesses.*[101]

4.24 In some cases, families believed that reaching a definitive conclusion as to the cause and circumstances of a death was prioritised even when there were gaps in the evidence, and that finality in the matter came at the cost of the deceased's reputation. Families found this upsetting because they often perceive a coroner's findings as an important part of their loved one's legacy.

4.25 Families also commented on instances where a coroner failed to make recommendations the family sought. For some families at least, there was a clear link between a recommendation by the Coroners Court, and publicly holding an individual or organisation accountable for a death. For example, we heard that:

> *[The] Coroner made various remarks … but there were no Recommendations made. We do not accept that [the] Coroner's conduct in [the] case contributed in any way to a reduction in similar preventable deaths, the promotion of public health and safety or the administration of justice.*[102]

4.26 A related issue can arise if families are not advised of adverse comments in findings before the investigation is finalised, nor given an opportunity to provide submissions on the issues in contention. For example, we heard that:

> *I was not aware the Findings were made or given a chance to comment before they were released.*[103]

4.27 Finally, families also noted that they were not able to seek clarification about a finding after the investigation had concluded, and that this was sometimes a source of dissatisfaction and frustration.

> *At the handing down of the coroner's decision … we were advised by [the coroner] that we were not permitted to ask any questions.*[104]

4.28 After the investigation, some family members would have welcomed the opportunity to discuss the findings with the coroner or a senior officer at the Coroners Court to understand better why certain conclusions were reached.

101 Submission 7.
102 Submission 16.
103 Submission 10.
104 Submission 2.

The Council's conclusions

4.29 One purpose of the coronial process is to understand the circumstances of a death, and allow families and other interested parties to focus on constructive outcomes, including measures to prevent future deaths in comparable situations. In this way, the coronial process can have therapeutic effects by allowing families to come to terms with what has happened, and find closure through their engagement with the coronial system. At the same time, it is clear from families' submissions that coronial processes can also exacerbate feelings of grief, loss and anger associated with a death.

4.30 The Council recognises that while in the vast majority of cases the coronial system works effectively and produces appropriate outcomes, sometimes families' dissatisfaction with coronial processes and findings leads to deep grief and prolonged and destructive effects. In order to ensure that families experience the coronial process as fair and beneficial, the Council is of the view that there are significant opportunities improve the provision of information to families, enhance family engagement at key stages in a coronial investigation, and make the content of findings clearer and more accessible for those who are not familiar with legal processes or language.

4.31 Further, this type of assistance could also be valuable for other interested parties involved in the coronial process, such as individuals instrumentally involved in a death. The Council recognises that they too can experience considerable anxiety, concern and trauma when they do not adequately understand what is taking place in a coronial investigation.

Opportunities to improve information provided to families and other interested parties

4.32 The Council considers that families and other interested parties need to have a clear understanding of the role of the Coroners Court and the key steps in a coronial investigation, and that this will help to ensure they have realistic expectations of the coronial system and can engage meaningfully in the process. While the Coroners Court makes a considerable amount of general information available to families and other interested parties, the Council recognises families can find it difficult to absorb complex or detailed material soon after the death of a loved one. Some families have stated in their feedback that they found navigating the coronial process overwhelming and confusing, and felt that the Coroners Court could improve the quality and presentation of the information it provides.

4.33 The Coroners Court provides families with information about their matter during the coronial process in a range of ways, including through letters and phone contact with the senior next-of-kin. This approach appears to work well in many cases. However, families who provided feedback stated that the process for communication could be *ad hoc*, and that they had to repeatedly contact the Coroners Court for updates on their matter. The Council found that processes within the court varied depending on the practices of individual coroners. The Council considers that the Coroners Court must take into account that the death of a loved one is profoundly distressing for the family, and that the family or senior next-of-kin should be kept informed of key stages and developments in the coronial investigation.

4.34 There are many steps in the initial coronial process that could be improved to mitigate this sense of helplessness and frustration in families, and reduce the need to seek redress by appeal. For example, the Council is of the view that developing standardised and sophisticated processes for communicating key information about a case could overcome some of the distress families experience when engaging with the Coroners Court. These communication processes would include likely timeframes for specific aspects of the investigation and the reasons for any delays. The Council recognises that the Coroners Court must balance different perspectives that exist among court users, and that the court is continually reviewing its processes to improve its systems. However, communicating with grieving families requires special expertise, and this is no longer available in the court system.

4.35 The Council recommends that the Coroners Court and the Victorian Institute of Forensic Medicine undertake a review of current processes with the assistance of a grief counselling expert, and develop better communication strategies to meet the needs of families. In addition to revising the content of the material currently provided to court users, it may be appropriate to break down the information into more manageable parts; and to continue to offer relevant information at key stages of the coronial process. The information on the Coroners Court website could also be improved to ensure that families can learn about key topics and issues relevant to their situation.

4.36 The Council considers that clearly setting the scope and parameters for an investigation, for example during a directions hearing or by other means of communication, is likely to be very valuable in managing expectations regarding the role of the Coroners Court and the kinds of issues that can be appropriately explored and resolved by a coroner. Mapping out an expected timeline for key milestones in the case, such as the collection of evidence, hearing dates and expected finalisation of a decision would also give families a clearer sense of the various stages and duration of coronial processes. The Council recommends that the Coroners Court develop guidelines for coroners to do so.

4.37 The Council further recommends that the Coroners Court and the Victorian Institute of Forensic Medicine develop guidelines to help ensure that interested parties are provided with regular, proactive updates on the progress of the coronial investigation, including when significant milestones have been reached, as well as the reasons for any delays. Further, the Court could provide information about individual cases through an online portal, which may be a further step to help families and other interested parties access up-to-date information about their matter.

Enhancing family engagement in court processes

4.38 A further important theme in the feedback families provided was that they were not able to have their concerns heard or satisfactorily resolved by the Coroners Court. The Council considers that family members bring important knowledge in the pursuit of the truth in relation to the death of their loved one. While the Coroners Court already recognises the contribution of families, the processes for doing so are relatively informal. The Council is of the view that the use of formal mechanisms may be more effective to allow families to contribute to investigations.

4.39 The Council heard that some families had contemplated appealing the findings of the coroner because they felt key issues had been overlooked, or that the findings were not sufficiently supported by the evidence presented. Families reported it was difficult for them to raise issues they considered important because there was no clear mechanism to do so during the coronial investigation. If an inquest was held, the family's ability to put their views was often limited because they did not have independent legal representation, in the face of one or more barristers representing the other interested parties.

4.40 Through a desktop review of findings relating to a number of these cases, the Council formed the view that there was a reasonable case to be made for the coroner's findings. However, it was also clear from the Council's meetings with families that in some cases they felt the process had not allowed them to raise their concerns. In addition, families wanted an explanation as to why the findings were made, and why other options were excluded. This often led to a deep sense of injustice, particularly for the legacy of the loved one's reputation. This was very distressing, and at times even disabling, for multiple family members.

4.41 The Council is of the view that all parties involved in a coronial inquiry should have the opportunity to make submissions on matters they think are relevant to a coronial investigation. However, it is currently difficult for families to raise such issues because there is no clear mechanism to do so in the normal course of a coronial investigation. The Council recommends that the Coroners Court develop clear guidelines to ensure that all families are advised at an early stage of a coronial investigation about how and when they can make a submission to the coroner responsible for their matter.

Recommendation 3: The Coroners Court should adopt appropriate measures to facilitate greater engagement and understanding of court processes by families with the advice of the Client Advocacy Office (see Recommendation 4). In particular, the Coroners Court should work together with the Victorian Institute of Forensic Medicine to:

a. develop standardised court processes to provide regular and accessible information to families on the role and work of the Coroners Court;

b. better manage expectations of the timeline and scope for the coronial investigation, and advise families of significant milestones in the process;

c. provide regular updates on the progress of the coronial investigation, including when significant milestones have been reached, and the reasons for any delays; and

d. advise families on opportunities to make a submission on issues they consider relevant to the investigation.

Establishment of a Client Advocacy Office within the Coroners Court

4.42 The coronial process must identify the cause of death and opportunities for prevention, as well as ensuring justice and finality for all parties involved. It should also provide for the needs of families to understand the circumstances of the death, and protect their loved one's legacy. Further, a range of interested parties, as well as the community more generally, have a significant interest in the accurate explanation of what happened leading to a death. The Council recognises that the Coroners Court is aware of this difficult balance, and that it is continually reviewing its processes and improving its systems. However, communicating with grieving families requires special expertise, and there is no longer a dedicated resource available in the court system to support this need.

4.43 In order to further address some of the issues raised regarding more targeted support for families, the Council recommends the establishment of a Client Advocacy Office, to bring senior expertise in house to provide advice to the Coroners Court and the Victorian Institute of Forensic Medicine on best practice for engaging with grieving families. One of the key functions of the Client Advocacy Office would be to oversee an ongoing systemic review of Coroners Court policies and practices, and implement appropriate reforms to better manage engagement with families and others interacting with the Coroners Court. The Office would also lead and coordinate the work of the existing team of Family Liaison Officers within the Coroners Court to ensure that communication is pro-active, sensitive and appropriately tailored to meet the needs of court users.

4.44 It is envisaged that the Client Advocacy Office would be filled by a senior person with expertise and experience in grief counselling, as well as a strong background in law and organisation management. They would need to have sufficient seniority to undertake the important advocacy work proposed by the Council. A suitable candidate would also have a good understanding of legal processes and counselling to help lead the work of the existing team of Family Liaison Officers, and be able to develop strong relationships with community counselling services to ensure that the needs of families and others engaging with the Coroners Court are met appropriately.

Recommendation 4: The Victorian Government should fund the establishment of a Client Advocacy Office within the Coroners Court. The Client Advocacy Office should have a high level of expertise in grief counselling, so they can provide sophisticated guidance and advice to the Coroners Court and the Victorian Institute of Forensic Medicine on best practice in assisting families and other interested parties engaging in the coronial system.

Making coronial findings more accessible

4.45 Some of the key sources of frustration or dissatisfaction with coronial findings for families relate to concerns that not all issues of importance to the family were adequately explored by the Coroners Court, and a sense that the voices of families were lost in the coronial process. While accepting there will be differing views on optimal outcomes in a matter under investigation in the Coroners Court, the Council considers that more could be done to ensure families, as well as other interested parties involved in a coronial investigation, feel they have been heard, and can understand the rationale for the conclusions reached in a coronial investigation.

4.46 The Council considers that it would be beneficial to develop guidelines and templates within the Coroners Court that would make findings more accessible for those engaging in the coronial process. To the extent possible and consistent with the judicial independence of coroners, the Council recommends that coronial findings follow a clear and consistent template that readily identifies and separates 'findings', 'commentary' and 'recommendations' in a coronial decision. This approach would not only be valuable for the purposes of any subsequent review of a matter, but would significantly assist families and other interested parties who lack familiarity with legal processes and language.

4.47 Further, the Council is of the view that some of the family distress caused by the observations or commentary in a coronial finding could be reduced by ensuring that there are clearer parameters for the types of issues a coroner should comment on in the course of their decision. In order to ensure that commentary does not stray into an unnecessary exposition on circumstances that may have only a limited connection to a death, and which may cause distress to the family, the Council recommends that guidelines be developed on this issue. If it is determined to make a finding as to the circumstances of the death in the course of a coronial investigation, those circumstances should be confined to matters which are proximate and causally relevant to the death; and/or underpin matters which relate to the preventative role of the Coroners Court. Focusing the obligation of a coroner in this way may address some of the concerns raised by families about unnecessary or distressing analysis of personal matters concerning the deceased in circumstances where they have no bearing on the ultimate conclusions reached.

4.48 Families indicated that a decision not to undertake certain lines of inquiry or make recommendations sought in a case could be confusing and distressing. To address this issue, the Council recommends that findings specifically outline how family submissions and concerns have been considered or addressed in the course of the coroner's investigation of a matter. Other interested parties involved in a coronial investigation are also likely to welcome a more detailed explanation of how their submissions have been considered by the Coroners Court in forming its findings. The Council also recommends that coroners provide more detailed guidance in their findings on the scope of the inquiry undertaken, and the rationale for why certain findings or recommendations may or may not be appropriate or necessary in a particular case. While this approach is desirable in all findings, the Council considers it particularly important in sensitive or contentious coronial investigations.

Recommendation 5: The Coroners Court should develop appropriate guidelines and templates to ensure that, to the extent that it is consistent with the judicial independence of coroners, coronial findings:

a. follow a clear and consistent style;

b. clearly identify 'findings', 'commentary' and 'recommendations';

c. that are made in respect of the circumstances in which the death occurred, must confine those circumstances to matters which are proximate and causally relevant to the death; and/or underpin matters which relate to the preventative role of the Coroners Court;

d. advise how submissions from families and other interested parties have been considered; and

e. explain the rationale for making certain findings or recommendations (and not others) in sensitive or contentious cases.

5. Access to legal advice and representation for families engaging in coronial processes

Overview

5.1 One of the key themes to emerge during the review was the significant need for legal advice among families who engage in the coronial process. While demand for advice is high among those who find themselves involved in a coronial matter, the opportunities to obtain legal advice and representation in coronial investigations is currently limited in Victoria. The Council is of the view that better access to legal advice and representation during coronial investigations could improve families' experience of court processes, and help to alleviate key sources of dissatisfaction with outcomes.

5.2 While Victoria Legal Aid can offer some support in coronial matters, legal assistance for a coronial inquest is generally only available if it is reasonably likely the person will be charged with a serious offence, or it is in the public interest that the person be legally represented.[105] Public interest is defined narrowly, and must, for example, clarify or test the scope of existing legal rights and duties or improve administrative decision making, and the efficiency and fairness of the justice system.[106] In addition, legal aid in Victoria is subject to a means test that assesses the income and assets of a person applying for a grant of legal assistance.

5.3 Victoria Legal Aid indicated that they receive more than 1,000 calls a year to their Legal Help phone line seeking information on coronial inquests and other matters following a death. Given the limited resources available, only a very small number of matters are referred to full phone advice or casework assistance. Most people who seek assistance from Victoria Legal Aid are referred by friends and relatives, community legal centres, social welfare services or police, rather than by a court.

5.4 Victoria Legal Aid's capacity to assist in coronial matters includes several Public Defenders in Chambers who have significant experience in appearing in Coroners Court matters, as well as a small group of staff who have run inquest matters. In addition, there is a larger number of lawyers who have some familiarity with the Coroners Act and have provided advice in relation to inquests and related issues. Other relevant experience at Victoria Legal Aid exists in the Equality Law program, which oversees the victims of crime work, and in the Mental Health and Disability Advocacy program, which provides procedural justice to people involved in proceedings before the Mental Health Tribunal.

5.5 Addition legal advice or representation which may be available to families include the limited assistance offered by community legal centres in certain public interest cases, and *pro bono* legal aid provided by solicitors or barristers. Apart from these avenues, families are generally left to organise their own legal representation for coronial inquests, even in highly complex cases. The Council was not able to obtain data on the percentage of families who access legal advice or representation in respect of coronial investigations.

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105 VLA Handbook for Lawyers, *Guideline 4 (Coronial Inquests)*, Victoria Legal Aid https://handbook.vla.vic.gov.au/handbook/7-state-civil-law-guidelines/guideline-4-coronial-inquests.

106 VLA Handbook for Lawyers, *Guideline 8 (Public Interest and Strategic Litigation)*, Victoria Legal Aid https://handbook.vla.vic.gov.au/handbook/8-public-interest-and-strategic-litigation.

5.6 The Council has previously highlighted the need for better access to legal assistance in Victoria. In particular, the Council recommended to the Victorian Government in 2014 that the State Coroner be given legislative discretion to identify the need for legal aid to be granted to families in certain circumstances, but the recommendation was not adopted.[107] At the time, the Council noted that unrepresented families were particularly disadvantaged in complex investigations where the conduct of a large, well-funded organisation was in question.

5.7 While the Federation of Community Legal Centres Victoria did not provide a submission for this review, they shared similar concerns in their 2013 issues paper on coronial processes in Australia:

> *Despite the therapeutic ideal, many families and communities experience the coronial process and its aftermath as neither fair nor healing. Exacerbation of the family's trauma often begins with lack of access to free legal representation. Families commonly experience additional suffering and frustration during the investigation and, if it takes place, the inquest.*[108]

5.8 The Department of Justice and Regulation's Access to Justice Review in 2016 also considered the issue of legal representation for families in coronial inquests.[109] The review recommended that:

> *The Coroners Court consider establishing a relationship with relevant pro bono schemes to provide it with an opportunity to make referrals in relation to contested autopsy applications.*
>
> *In addition, the Government should work together with the Coroners Court to identify a suitable referral pathway for bereaved families at the Coroners Court. Once a suitable court support mechanism or services has been identified, the Government should assist to fund the service.* [110]

5.9 In making these recommendations, the Access to Justice Review recognised the particular vulnerabilities of bereaved family members, and the many challenges they can face when engaging with the coronial system.[111] The review also stated that improved support for families would support community perceptions of fair and balanced coronial processes, particularly when the coroner is examining the actions of state authorities, who are often legally represented.[112] This recommendation is yet to be accepted by the Victorian Government.[113]

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107 Coronial Council of Victoria, *Annual Report 2014-15*, p. 8.
108 Federation of Community Legal Centres Victoria, *Saving lives by joining up justice: why Australia needs coronial reform and how to achieve it* (2013), p. 16.
109 Access to Justice Review, *Volume 2 Reports and Recommendations* (2016), p. 503.
110 Ibid p. 504, Recommendation 8.6.
111 Ibid p. 505.
112 Ibid p. 505.
113 Access to Justice Review – Government Response, engage.vic.gov.au

5.10 Several interstate jurisdictions offer centralised support for families engaging in the coronial system. For example, the New South Wales Coronial Inquest Unit is a statewide specialist service of Legal Aid NSW that provides free legal advice and assistance to families involved in coronial inquests.[114] For matters of public interest, such as a death in custody, psychiatric hospital or state care, the Coronial Inquest Unit may also provide legal representation to a family member or next-of-kin involved in the inquest. In addition to providing this valuable service to families, the unit assists the Coroners Court in its preventative function through recommendations to government agencies and regulatory bodies in matters of public interest.

5.11 Similarly, in Queensland, the Attorney-General recently approved funding for a centralised coronial assistance legal service, provided by Caxton Legal Centre and Townsville Community Legal Service. The service was established in mid-2017 to respond to a gap in the availability of services for bereaved families involved in the coronial process. The Coronial Assistance Legal Service provides legal advice about any aspect of the coronial process and associated issues. It can provide representation for bereaved family members appearing in some inquests when the matter fits within casework guidelines. The service also works with other service providers, and can help families connect with social work, counselling and other support services.[115]

What the Council heard

5.12 Families indicated that coronial inquests can feel adversarial rather than inquisitorial, and commented that in some cases the inquest was run like a trial. Furthermore, submissions made it clear that it can be difficult to for families to receive appropriate legal advice in relation to coronial matters. For example, one submission noted that:

> *I was clearly told be [sic] the coroner's office that legal representation at the Inquest would not be necessary. However, given what transpired at the inquest and the manner in which [the Coroner] conducted the inquest, we feel that we've been prejudiced by this advice.*[116]

5.13 During consultations, some families stated they had obtained some form of legal assistance during the original coronial process, either by engaging a solicitor or seeking out *pro bono* legal representation. Nevertheless, many observed that they felt at a significant disadvantage compared to well-resourced hospitals, corporations or government entities. In circumstances where families had obtained free legal representation, some felt they could not pursue all lines of inquiry they were interested in exploring, for fear that they would be imposing on the goodwill of those acting on their behalf.

5.14 A number of families also specifically commented on the real or perceived power imbalance between families and well-resourced third parties involved in inquests, including hospitals, corporations or government entities.

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114 Legal Aid NSW, Coronial Inquest Unit, https://www.legalaid.nsw.gov.au/what-we-do/civil-law/coronial-inquest-matters.

115 Caxton Legal Centre Inc, https://caxton.org.au/coronial_assistance.html.

116 Submission 2.

> *At the Coronial Inquest there were some 20 legal and insurance representatives as well as representatives from various departments [of the hospital].*[117]

5.15 Families also observed that following the conclusion of the coronial investigation, they found it difficult to access the necessary information and legal advice they needed in order to make a determination about further legal action. For example, one family said:

> *[T]he complexity of bringing an appeal in the Supreme Court and a lack of understanding of processes is another barrier to families appealing findings in the Supreme Court.*[118]

5.16 Several submissions from organisations also highlighted the importance of appropriate legal representation for families during the original coronial inquest. For example, the Flemington and Kensington Community Legal Centre was critical that many families who have lost a loved one do not obtain effective, adequately funded legal representation. It noted in particular:

> *[M]any families who have lost a loved one do not obtain effective, adequately funded legal representation. At a time when they are struggling to comprehend the death, they are also encountering a world of legal jargon and processes that is unfamiliar to most people.*[119]

5.17 The centre furthermore argued that funding should be available for legal aid, at least in police contact cases. It noted that this funding would improve the investigative process, and may help to lessen the need for appeals.

> *We nevertheless urge the Coronial Council to consider the lack of [a] dedicated funding stream to provide families with legal representation at police contact death inquests. Decisions under the European Court of Human Rights have made clear that the right to life encompasses the right to representation where the State has taken life. Beyond the issue of human rights compliance and ensuring equality in representation, the funding of families aids the investigative process and in turn, may reduce the need for appeals.*[120]

5.18 Barristers familiar with coronial processes stated that the Victorian Bar has a *pro bono* scheme to assist families in complex coronial inquests. They felt that most families involved in such cases can get legal representation. In circumstances where a family did not have legal representation, some legal experts felt that a fair and thorough hearing of family concerns largely depended on the individual coroner handling the investigation and the efforts of Counsel Assisting in the case.

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117 Submission 16.
118 Submission 16.
119 Federation of Community Legal Centres Victoria, *Saving lives by joining up justice: why Australia needs coronial reform and how to achieve it* (2013), http://www.fclc.org.au/lrs.php, p. 60.
120 Submission – Flemington and Kensington Community Legal Centre.

5.19 Further, the Victorian Bar stated that it was important that families contemplating an appeal to the Supreme Court against a coronial decision were able to obtain appropriate legal advice before deciding whether to proceed with an appeal, and to be legally represented in the appeal.[121]

The Council's conclusions

Improving access to legal advice relating to coronial matters

5.20 The Council accepts that families may find it difficult to understand and participate in the coronial process, and that they would benefit from better access to independent legal advice. This would help families to engage at all stages of the coronial process, and ensure that they have all the necessary legal assistance and guidance to make informed decisions about their case. While families can access legal advice in some coronial cases, the Council is of the view that the current situation in Victoria is *ad hoc* and lacks clarity and coordination.

5.21 The Council considers that the New South Wales Legal Aid Coronial Inquest Unit is a valuable model for a suitable framework to provide accessible legal support for families navigating the coronial process in Victoria. The Council anticipates that a centralised approach to coronial legal advice would also develop legal expertise within a specialised coronial legal service, and improve links between key organisational stakeholders.

5.22 To address the current gap in legal services available to provide advice on coronial matters, the Council therefore recommends the establishment of a dedicated Coronial Legal Advice Service in Victoria, through Victoria Legal Aid, to provide centralised legal assistance and support for bereaved families during the coronial process. Given the coronial expertise that already exists within Victoria Legal Aid, the Council considers that the organisation is well placed to undertake this function.

5.23 The Council envisages that the Coronial Legal Advice Service would be responsible predominantly for providing legal advice and referrals in appropriate coronial matters, with some direct involvement in casework and legal representation of families where capacity allows. The Council considers that the best approach in the coronial context is to provide legal advice that helps people to help themselves. This would allow for higher intensity services such as full representation to be provided in cases where they are really needed. The Coronial Legal Advice Service should reflect this underlying principle in its work by undertaking some community engagement and education to raise awareness of rights in relation to coronial inquests, and developing self-help kits for families with a higher level of legal capability.

121 Submission – Victorian Bar.

5.24 The Council anticipates that casework would be provided in a smaller number of cases, which may range from preparing written submissions on a particular issue for filing with the Coroners Court, to limited appearance work for oral submissions at an inquest, to full representation for an inquest. The criteria for undertaking casework would include the existing 'public interest' basis specified for legal assistance by Victoria Legal Aid, but would also extend to cases where representation of family interests would highlight perspectives on the death that would not otherwise be brought to the Court's attention. The Council envisages that the Coronial Legal Advice Service would develop appropriate guidelines around the conditions for legal aid, following consultation with the Coroners Court and other key stakeholders.

5.25 In addition to providing legal advice before and during a coronial investigation, the Council anticipates that the Coronial Legal Advice Service could also play an important role following the conclusion of a coronial case by helping families understand findings, providing guidance on the prospects of further legal action in a matter, and offering advice on opportunities to resolve residual concerns outside formal legal settings.

Recommendation 6: The Victorian Government should fund a centralised Coronial Legal Advice Service, through Victoria Legal Aid, to provide legal advice to interested parties relating to the coronial process.

Developing arrangements to help families access legal representation

5.26 The Council is of the view that in most cases, families do not need legal representation during coronial cases due to the role of Counsel Assisting the Coroner. However, there are rare occasions in complex cases, especially if large, well-funded and sometimes multiple organisations are involved, when families should be legally represented in order to have a fair balance in the views put forward for the coroner's consideration.

5.27 The Council is aware the Coroners Court is working closely with the Victorian Bar to develop appropriate mechanisms for a *pro bono* assistance scheme. This is a very worthwhile initiative, and the Council urges the Coroners Court and the Victorian Bar to formalise measures to ensure that legal representation is available for families in complex cases, and particularly in circumstances where there is a significant power imbalance between parties, or there is a significant public interest issue at stake.

5.28 The Council furthermore recommends that the Coroners Court work with the Law Institute of Victoria to identify similar opportunities for developing appropriate referral pathways for families in need of legal representation.

Recommendation 7: The Coroners Court should work with Victoria Legal Aid, the Victorian Bar and the Law Institute of Victoria to develop appropriate arrangements to assist families to access legal representation to enable them to effectively participate in the coronial process, particularly in circumstances where there is a significant power imbalance between parties, or there is a significant public interest issue at stake.

6. Appealing a decision of the Coroners Court

Overview

6.1 Appeals provide a framework to ensure that courts make decisions in accordance with the law, and apply laws consistently across the court system. Further, appeals to the Supreme Court can provide valuable guidance on the interpretation of legislation and good practice in the lower courts.

> *The justice system exists to conclusively determine legal rights according to law. Appeals are designed as a check within that system to ensure correct and consistent application of the law.*[122]

6.2 Appeal mechanisms are not uniform and reflect the degree of supervision of lower courts that is considered appropriate by Parliament for specific types of decisions. The nature of the available review in any legal proceeding is determined by legislative policy, and can vary considerably in terms of its scope, requirements and outcomes. Developing a principled appeals regime requires an inquiry into the level of judicial oversight considered appropriate for the proper administration of justice in the type of judgment at hand. This process must take into account the interests of individuals affected by the decision, the gravity of the legal consequences flowing from the decision, and the proper allocation of finite resources available for the review.

6.3 The form of an appeal generally reflects a necessary compromise between the desirability of correcting error or other injustice, and the need for finality in resolving cases.[123] Finality is closely related to accessibility, because a relentless pursuit of perfection at all cost would cause the system to collapse under its own weight.[124] The degree of finality in a matter is, among other things, a conscious rationing of judicial resources, and an acknowledgement of the necessary limitations on the capacity to uncover the ultimate reality in every case.[125]

6.4 An appeal regime can give effect to a desired policy position on the appropriate oversight for certain types of decisions by setting clear parameters around the subject matter that can give rise to an appeal. The scope of appeals that may be conferred by statute can broadly be categorised as an appeal on a question of law; an appeal on a question of fact; and/or an appeal on the proper exercise of discretion.[126] Whereas appeals on a question of law focus on ensuring that the primary decision maker acted in accordance with the law, appeals on a question of fact or the exercise of discretion involve a review of the evidence and reasoning that led to the finding or conclusion.

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122 Submission – Supreme Court of Victoria.
123 The Hon AM Gleeson AC QC, *Finality*, Sir Maurice Byers Lecture, Bar News, Winter 2013, p. 35.
124 Ibid p. 41.
125 Ibid p. 37.
126 MJ Beazley, PT Vout and SE Fitzgerald, *Appeals and Appellate Courts in Australia and New Zealand* (LexisNexis Butterworths, 2014), p. 101.

6.5 In Victoria, civil appeals from the decisions of the Coroners Court, Magistrates' Court, the Children's Court and the Victorian Civil and Administrative Tribunal are limited to appeals to the Supreme Court on a question of law. This means that an appeal is generally available if:

- the primary decision maker applied the wrong legal rule, principle or test to the facts;
- failed to draw the proper inference from the primary facts;
- made findings of fact without supporting evidence, or failed to give proper weight to certain evidence where to do so would have affected the decision; or
- failed to accord procedural fairness to the appellant; or where evidence arises that the original judgment is tainted by fraud.[127]

The scope of such review does not, however, extend to a reconsideration of findings of fact made by the original decision maker.

6.6 The judicial review of a decision of the Victorian Ombudsman, Auditor-General and Royal Commissions is similarly confined to circumstances where the authority has made an error of law, for example, by exceeding its statutory jurisdiction, or where there has been a denial of natural justice in the process of making a decision or finding.

6.7 Where legislation permits an appeal on a question of fact, the appellate court is permitted to make its own findings of fact upon the evidence given during the original hearing, and substitute an alternative judgment for the original decision.[128] An appeal against a discretionary judgment, such as a sentence, must establish error in the exercise of discretion by showing that the judge acted upon the wrong principle, gave weight to irrelevant matters, or failed to give weight or sufficient weight to relevant considerations.[129] Appeals of a question of fact or the exercise of judicial discretion are usually limited to the criminal jurisdiction of lower courts, where a higher level of scrutiny is desirable to ensure fair and consistent decisions relating to convictions and sentences.[130]

6.8 The approach to the scope of appeal generally available for civil judgements in the lower courts of Victoria, including findings of the Coroners Court, reflects a clear policy intention that decisions of this type should only be disturbed in rare circumstances where judicial oversight is necessary to ensure that the court or tribunal below exercised its powers according to law. This process for review serves the interests of maintaining the integrity of the legal process, while ensuring the finality of proceedings and the efficient administration of justice.[131]

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127 MJ Beazley, PT Vout and SE Fitzgerald, *Appeals and Appellate Courts in Australia and New Zealand* (LexisNexis Butterworths, 2014), pp.105-109.

128 Ibid p. 102.

129 *House v R* [1936] HCA 40; (1936) 55 CLR 499 (17 August 1936), p. 505.

130 For example, in Victoria, appeals against conviction and/or sentence in criminal matters considered by the Magistrates' Court are available by way of a fresh hearing to the County Court, which is an exceptionally broad ground of review that does not require the existence of any error in the original decision. Otherwise, a party to a criminal proceeding in the Magistrates' Court may appeal to the Supreme Court on a question of law.

131 Submission – Supreme Court of Victoria.

> *Appeal structures should be designed mindful of the function they serve and advance the interests of justice. It is not the function of the Supreme Court to provide, in effect, a second hearing of a factual issue determined by a specialist magistrate and substitute their own view. It does not advance the interests of justice to have these decisions simply remade in a higher court.*[132]

6.9 Further, appeals on a question of law are often found where the original decision maker exercised a specialist jurisdiction with particular factual expertise. In the coronial context, the Supreme Court has stated that where legislation entrusts judgment of particular matters to a specialist court, an appellate court 'would be very slow to find that a judgment so made constitutes an error of law'.[133]

6.10 The Council considers that the potential benefits of a successful appeal to the Supreme Court would generally include:

- correcting significant errors to achieve justice in individual cases;
- maintaining accurate and complete public records relating to the cause and circumstances of deaths in Victoria, to facilitate the preventative function of the Coroners Court;
- ensuring that legal processes are fair and equal, and that comparable cases produce consistent outcomes;
- promoting high-quality decisions in the Coroners Court; and
- clarifying and developing laws or policies regarding coronial decision making where necessary and appropriate.

6.11 As elsewhere in the legal system, appeals in coronial matters inevitably have substantial social costs. These include the significant time and resource implications of appeals for courts that already have a demanding workload, and the diversion of attention and effort from other cases that need resolution. There are also cost implications for families and other parties, as well as the emotional toll on those affected, and who may need to give evidence more than once. In addition, there is the potential to undermine confidence in the original proceeding and the finality of that decision, and the possibility of delays to the implementation of recommendations that could bring about important systemic changes to protect the community.

132 Submission – Supreme Court of Victoria.
133 *Mortimer v West* [2017] VSC 293 [51].

Current law and practice

Appeal to the Supreme Court against a coronial finding

6.12 Section 83 of the Coroners Act allows a person with sufficient interest in an investigation, or an interested party, to appeal directly to the Supreme Court against a coroner's findings[134] on a question of law.[135] Appeals are generally limited to findings, as opposed to recommendations or comments, which are not formally binding on any person and have no legal consequences.[136] An application for appeal under this provision must be brought within six months of the coroner's determination, subject to a grant of extension by the Supreme Court in exceptional circumstances.[137]

6.13 The Supreme Court has noted that: 'The existence of a question of law is not only a precondition of the right to appeal under the *Coroners Act 2008*, but forms the subject matter of the appeal itself.'[138] Further, a decision by a court 'does not "involve" an error of law unless the error is material to the decision in the sense that it contributes to it so that, but for that error, the decision would have been, or might have been, different'.[139]

6.14 With respect to the relevant threshold for commencing an appeal, the Supreme Court has held that a factual finding made without any evidence may give rise to a question of law.[140] At the same time, the Supreme Court has been careful to point out that reasonable minds might come to different conclusions, and it is the responsibility of the coroner to make findings in relation to a matter having weighed all the evidence.[141] Accordingly, 'a finding by the Coroner that is not supported by evidence is not necessarily to be elevated to a question of law'.[142] Provided there is some evidence to support a coronial finding, the weighing of that evidence is a matter for the coroner and cannot form the basis of an appeal against a finding on a question of law.

> *A Coroner may not make findings that are not open on the evidence. However, where there is evidence before a Coroner, the weighing of that evidence is a matter for the Coroner.*[143]

6.15 The Supreme Court has warned against attempts to 'inflate' questions of fact into questions of law in order to seek review of a decision by the Supreme Court.

> *[A] question of law is not involved in the decision simply because a tribunal or court makes one or more findings of fact that are not*

134 *Coroners Act 2008* (Vic) s 83(1) and (2).
135 Ibid s 87.
136 Ian Freckelton and David Ranson, *Death Investigation and the Coroner's Inquest* (Oxford University Press, 2006), p. 691.
137 *Coroners Act 2008* (Vic) s 83(3) and s 86.
138 *Bourke v Coroners Court of Victoria* [2015] VSC 418 [21].
139 *Australian Broadcasting Tribunal v Bond* (1990) 170 CLR 321 [353], cited in *Mortimer v West* [2017] VSC 293 [61].
140 *Somerville v Coroners Court of Victoria* [2016] VSC 543 [66].
141 *Thales Australia Limited v Coroners Court of Victoria & Ors* [2011] VSC 133 [59].
142 *Mortimer v West* [2015] VSC 150 [21].
143 *Somerville v Coroners Court of Victoria* [2016] VSC 543 [66].

> *supported by evidence, nor is it sufficient that the reasoning whereby a conclusion of fact is reached is demonstrably unsound.*[144]

6.16 In relation to the question of when the denial of procedural fairness or natural justice may give rise to an appeal on a question of law, the Supreme Court has noted that coroners must conduct investigations in a fair and efficient manner, comply with the rules of natural justice, and act judicially.[145]

> *A fundamental element of procedural fairness is the hearing rule or the 'right to be heard'. The elements of the right will vary in particular cases but will generally include some or all of the following: a reasonable opportunity to make submissions; notice of various matters; the subject matter and adverse consequences of the decision, … disclosure of any adverse conclusions not obviously open on the known material.*[146]

6.17 However, the Supreme Court indicated that it is sufficient that a person with an interest in the case is given the opportunity to put submissions or matters to the coroner.

> *The obligation to provide natural justice does not require the Coroner to give 'a running commentary' on his or her assessment of the evidence or the findings he or she is considering making. Natural justice for a person subject to the risk of an adverse finding requires the Coroner to give that person an opportunity to make submissions. It does not require the Coroner to warn the person that a specific adverse finding is under contemplation and to invite a response.*[147]

6.18 The Supreme Court observed that the need to identify a question of law serves as a criterion upon which several policy objectives are fulfilled through the Coroners Act, noting that: 'It is essential that the question of law which has been erroneously decided by a coroner must be identified exactly. It is the means by which finality of the coronial process is achieved as well as the trigger by which the statutory jurisdiction of the Supreme Court may be enlivened.'[148] Related to this point, the Supreme Court noted that 'A factor to consider in exercising a function under the Act is that unnecessarily lengthy or protracted coronial investigations may exacerbate the distress of families, friends and others affected by the death. '[149]

144 *Thales Australia Limited v Coroners Court of Victoria & Ors* [2011] VSC 133 [60].
145 *Mortimer v West* [2016] VSC 11 [26].
146 *Hall v University of New South Wales* [2003] NSWSC 669, cited in *Mortimer v West* [2015] VSC 150 [36].
147 *Mortimer v West* [2015] VSC 150 [37].
148 *Bourke v Coroners Court of Victoria* [2015] VSC 418 [21].
149 *Somerville v Coroners Court of Victoria* [2016] VSC 543 [91].

Appeal to the Supreme Court against a refusal to re-open an investigation

6.19 Section 84 of the Coroners Act allows appeals against the refusal by a coroner to re-open an investigation,[150] either on a question of law or, for a limited class of persons, if the Supreme Court is satisfied that it is necessary or desirable in the interests of justice.[151] An appeal must be brought within 28 days after the refusal by the Coroners Court, by the person who made the original application for review.[152]

6.20 The Supreme Court indicated that, provided the coroner applied the correct test in considering an application to review a finding, it would be unlikely to over-rule a discretionary decision.[153]

> *A decision whether to re-open the investigation is governed by the particular set of considerations specified in s 77(3). It follows that any 'question of law' on which [the] appeal can be based must be a question of law in connection with the refusal to re-open [the matter].*[154]

6.21 If the appeal is brought by a senior next-of-kin of the deceased or a person with sufficient interest, an appeal may be allowed if the Supreme Court is satisfied it is necessary or desirable in the interests of justice to do so.[155] The phrase is to be interpreted by reference to the guiding principles on factors to consider in exercising a function under the Coroners Act,[156] as well as the general objective to promote the fairness and efficiency of the coronial system.[157] In interpreting the operation of this provision, the Supreme Court has held that:

> *Read with s 87 which provides for an appeal only on a question of law, s 87A appears to allow for an appeal that extends to reconsidering the findings of fact and the conclusion to be drawn from them. … Taken together, the whole section empowers the appellate court to overturn or vary a coroner's decision based on factual findings if satisfied that the interests of justice require it or make it desirable to do so.*[158]

6.22 Given that the subject of the appeal is the refusal to re-open a coronial investigation, 'the scope for examining factual error is confined to the decision whether new facts and circumstances existed and any findings of fact upon which the coroner concluded it was not appropriate to re-open the investigation.'[159] Further, it has been judicially found that the 'Supreme Court should exercise the appellate power in s 87A sparingly, acknowledging the particular advantages a coroner has over a non-specialist court in determining when it is "appropriate" to re-open an investigation.'[160]

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150 *Coroners Act 2008* (Vic) s 84.
151 Ibid ss 87 and 87A.
152 *Coroners Act 2008* (Vic) s 84(2).
153 *Mortimer v West* [2017] VSC 293 [51].
154 *Mortimer v West* [2017] VSC 293 [38].
155 *Coroners Act 2008* (Vic) s 87A (came into force on 1 January, 2015 following commencement of the *Courts Legislation Miscellaneous Amendments Act 2014*).
156 *Coroners Act 2008* (Vic) s 8.
157 Ibid s 9.
158 *Mortimer v West* [2017] VSC 293 [66]-[67].
159 Ibid [67].
160 Ibid [70].

6.23 The Supreme Court articulated a number of considerations that are relevant to the question of whether an appeal should be allowed under the 'interests of justice' provision. In a recent decision, the Supreme Court allowed an appeal against the refusal of a coroner to re-open an investigation on the basis that the coroner:

- relied on an incorrect test to determine whether the grounds for review had been satisfied;
- accepted untested evidence as fact, thereby giving rise to a new circumstance that justified re-opening the investigation to allow the family to present further evidence in relation to those matters; and
- denied the family procedural fairness by failing to advise them as to the possibility of adverse findings, and not inviting further submissions to address the relevant issues before delivering the ruling.[161]

6.24 Conversely, the Supreme Court found in another case that it would not be in the 'interests of justice' to allow the appeal in question, given the significant time that had passed since the original inquiry, the difficulty in obtaining fresh witness testimonies, and the potential for a new investigation to exacerbate the distress of family, friends and others affected by the death.[162]

6.25 In applying this test, the Supreme Court has cautioned that 'the interests of justice are not the same as the interests of one party or even all the parties to the proceeding – they extend beyond the private interests concerned'.[163] Among other things, those interests would 'take into account the desirability of finality in investigations, the extent to which an issue of public health and safety is engaged and … the particular interests of next of kin being heard'.[164]

161 *Hecht v Coroners Court of Victoria* [2016] VSC 635 [47]-[51].
162 *Somerville v Coroners Court of Victoria* [2016] VSC 543 [90]-[92].
163 *Mortimer v West* [2017] VSC 293 [72].
164 Ibid [72].

Application for judicial review of a coronial decision

6.26 In addition to the grounds of appeal set out in the Coroners Act, under the common law jurisdiction of the Supreme Court, an aggrieved person can apply for judicial review of decisions and orders of a coroner, subject to the procedures set out under the Supreme Court Rules.[165] An application for judicial review seeks a reconsideration of a lower court's decision, and is a function of the Supreme Court's supervisory jurisdiction of other courts in Victoria.[166]

6.27 The jurisdiction is limited to considering the legality of the original decision, and does not entitle the Supreme Court to consider the merits of the finding under review. The Supreme Court has observed that '[w]hen exercising this limited jurisdiction, this Court is not entitled to examine whether in fact the Coroner made the right decision, or whether it is fair or reasonable, but is concerned instead with ensuring that he acted within jurisdiction and that in performing his decision making process, he complied with the law'.[167]

6.28 Common grounds for judicial review include jurisdictional error, failing to observe some applicable requirement of procedural fairness, fraud, and error of law on the face of the record.[168] An application for judicial review of a coronial finding, or decision not to re-open an investigation, would need to show that one of these grounds was satisfied. An application for judicial review must be filed in the Supreme Court within 60 days of the date of the judgment or decision in contention.[169] If the Court determines that the decision was not lawful, it can remit the matter back to the original decision maker.

6.29 An application for judicial review provides comparable grounds of review to those available to a person currently seeking an appeal of a coronial finding under the Coroners Act on an error of law, with slightly longer timeframes for an appeal against a refusal to re-open a coronial investigation.

Award of costs of an appeal from the Coroners Court

6.30 Generally, the costs of a civil proceeding 'follow the event', which means that the successful party is entitled to recover their costs from the losing side. Unless expressly provided by legislation, the Victorian Supreme Court can exercise full discretion in relation to the awarding of costs, and may determine by whom and to what extent the relevant costs will be paid.[170] As a general rule, however, where appeals against the findings of a Coroner's Court are successful, the practice of the Supreme Court is to make no order as to costs.[171] This means that successful appellants may not be able to recover costs to cover their own legal expenses.

165 *Supreme Court (General Civil Procedure) Rules 2015* (Vic) – Order 56 (Judicial Review).
166 Graeme Blank and Hugh Selby (eds), *Appellate Practice* (Federation Press, 2008), p. 16.
167 *Korp and Korp v Deputy State Coroner* [2006] VSC 282 [31].
168 *Craig v South Australia* [1995] HCA 58 [8].
169 *Supreme Court (General Civil Procedure) Rules 2015* (Vic) – Order 56 (Judicial Review).
170 *Supreme Court Act 1986* (Vic) s 24(1).
171 Ian Freckelton and David Ranson, *Death Investigation and the Coroner's Inquest* (Oxford University Press, 2006), p. 703.

6.31 In civil matters, indemnity certificates for reimbursement of certain costs from the Appeal Costs Board can be made by a successful appellant in the Supreme Court on a question of law, if they are granted a costs order and cannot recover costs from the other party.[172] This may be relevant where a family successfully appeals a coronial finding in the Supreme Court, but it would not assist if the original coronial decision was upheld. A civil appeal under the *Appeal Costs Act 1998* (Vic) may be indemnified up to $50,000 (inclusive of appellant and respondent costs) and would depend on the relevant certification being issued by the court or tribunal. The ability of the Appeals Costs Board to make an allowance depends on a variety of factors relating to eligibility.

Appeal rights in other Australian jurisdictions

6.32 All Australian jurisdictions allow for some form of appeal directly to the Supreme Court, or the District Court in Queensland. A person seeking to appeal in other Australian jurisdictions can generally rely on the existence of factors such as:

- fraud;
- rejection of evidence;
- irregularity of proceedings;
- an insufficiency of inquiry;
- mistake in the record of the findings;
- the existence of new facts or evidence; or
- other compelling reasons to re-open the investigation.

6.33 Details of the grounds of appeal available in other Australian jurisdictions are set out in **Appendix E**. The right to appeal to a superior court is limited to findings resulting from a coronial inquest in all states and territories apart from Victoria, where findings from all investigations are eligible for appeal. This means that a significantly broader class of coronial decisions can be appealed in Victoria than in any other jurisdiction.

6.34 The Council sought to find out whether appeal provisions relating to coronial findings in other jurisdictions led to higher numbers of appeals in those jurisdictions. The available data do not appear to show this. Data provided by the Supreme Courts of South Australia and the Northern Territory indicate there have been no appeals against the finding of a coroner in the past five years in those jurisdictions. The Council's own research indicates that, in the same time period, there were two appeals against a coronial finding in Queensland, with both applications dismissed;[173] one appeal against a coronial finding in New South Wales, with the proceedings dismissed;[174] and one appeal against a coronial finding in Western Australia, with the appeal upheld and findings against the applicant declared void.[175]

172 *Appeal Costs Act 1998* (Vic) s 4.
173 *Gentner v Callaghan & Ors* [2014] QDC 123 (11/0203); *Isles v State of Queensland* [2015] QDC 335 (15/3855).
174 *Mauceri v Deputy State Coroner MacMahon and Ors* [2017] NSWSC 545.
175 *Mead v Mulligan* [2013] WASC 460.

Victorian statistics on applications to review or appeal coronial decisions

6.35 Coroners' findings in Victoria are rarely appealed to the Supreme Court. Since the commencement of the *Coroners Act 2008*, there has been one appeal to the Supreme Court under the Act against the finding of a coroner,[176] and five appeals against the decision of a coroner not to re-open an investigation.[177] Of these appeals, one application was upheld relating to a refusal to re-open an investigation, and the remaining applications were dismissed by the Supreme Court.

6.36 In the appeal that was upheld, the Supreme Court found it was in the interests of justice that certain findings be set aside.[178] The cases that were dismissed failed in their application because none of the grounds for complaint identified an error of law by the original coroner, or persuaded the Supreme Court that it was otherwise necessary or desirable in the interests of justice to allow the appeal (where available as a result of the post-2014 amendment to the legislation). A breakdown of applications to appeal Coroners Court decisions to the Supreme Court of Victoria is set out in **Appendix F**. Further, there was also one application for judicial review by the Supreme Court during this time, relating to a coronial finding made under the *Coroners Act 1985*, which led to a declaration that a finding was wrong and constituted an error of law on the face of the record.[179]

6.37 The Council also considered the number of applications to appeal a coronial finding on the grounds available under the earlier *Coroners Act 1985*, to get a comparative perspective on appeals prior to and following the legislative reforms in 2008. A breakdown of applications to appeal Coroners Court decisions to the Supreme Court under the previous legislation is set out in **Appendix G**. The available information shows that appeals from the Coroners Court to the Supreme Court have always been rare, averaging fewer than one case a year. There has been no change to the volume of appeals since the enactment of the *Coroners Act 2008*.

6.38 For a variety of reasons, some families may not seek formal review or appeal in their matter. It is difficult to estimate how many families contemplated taking action but did not. However, the Council is aware that in the past five years, approximately 20 families have written letters either to the Department of Justice and Regulation or the Attorney-General of Victoria to raise concerns about coronial review and appeal mechanisms in Victoria.[180] While the volume of correspondence indicates there is a certain level of dissatisfaction, these numbers are not high as a proportion of the overall caseload of the Coroners Court, which would equate to around 35,000 cases during the same time period.

176 *Thales Australia Limited v Coroners Court of Victoria & Ors* [2011] VSC 133.

177 *Mortimer v West* [2017] VSC 293; *Hecht v Coroners Court of Victoria* [2016] VSC 635; *Somerville v Coroners Court of Victoria* [2016] VSC 543 (also appealed against finding under s 83 of the Act but was out of time); *Mortimer v West* [2016] VSC 11 (appeal against findings of a Supreme Court Associate Justice) and *Mortimer v West* [2015] VSC 150.

178 *Hecht v Coroners Court of Victoria* [2016] VSC 635.

179 *Cahir v Jamieson and Ors* [2010] VSC 285.

180 In circumstances where families wrote several letters in relation to the same matter, the correspondence has been counted once. Letters from concerned members of the public with no direct connection to a case have not been included.

What the Council heard

Grounds of appeal under the Coroners Act

6.39 In the coronial context, parties have a particular interest in the outcome of findings and recommendations made by a coroner, and may pursue an appeal if they think the original investigation did not resolve certain issues, or if they believe there has been some miscarriage of justice.

6.40 Discussions with families highlighted that they considered the prospect of appealing a coronial finding to the Supreme Court to be complex, time consuming and expensive. While a number of families said they seriously contemplated bringing an appeal in the Supreme Court, none had ultimately done so. One of the main reasons they gave was that they believed the current ground of appeal on an error of law was overly restrictive, and created a very limited avenue to seek redress from the Supreme Court. For example, families said that:

> *[W]e consider the present review and appeal provisions under the* Coroners Act 2008 *(the Act) to be too restrictive and, in the case of Appeals to the Supreme Court, financially oppressive and intimidating.*[181]

> *Appeals should not be restricted to a point of law, new information could change the outcome.*[182]

6.41 The Law Institute of Victoria and the Flemington and Kensington Community Legal Centre also indicated in their submissions that the current grounds of appeal to the Supreme Court were not sufficiently broad to provide justice to Victorian families.

> *The LIV recognises that the 2008 amendments, which significantly narrowed the available grounds of appeal against coronial findings, were made in order to increase the efficiency of the Coronial appellate system by preventing baseless appeals that would unnecessarily prolong an already stressful process for families of the deceased. However, LIV members report that the 2008 amendments have made the grounds of appeal unduly restrictive, as evidenced by the fact that there has only been one appeal against a Coroner's finding in Victoria since the 2008 amendments were implemented.*[183]

> *FKCLC acknowledges the pressures placed on the appellate jurisdiction. However, the added burden that may be created by expanding s87 [limiting appeals to an error of law] is greatly outweighed by the necessity of upholding the principles of fairness and consistency with respect to access to justice across all Australian jurisdictions.*[184]

181 Submission 9.
182 Submission 15.
183 Submission – Law Institute of Victoria.
184 Submission – Flemington and Kensington Community Legal Centre.

6.42 The Law Institute of Victoria's main concern was the lack of opportunity to appeal findings where the conclusions reached by a coroner exceeded the evidence available in the matter. On this issue, the submission observed that there may be merit in broadening grounds of appeal to include the weight given to particular evidence during the original inquiry, or other questions of evidentiary interpretation.[185]

6.43 More broadly, the submission of the Law Institute of Victoria also reflected the importance of ensuring that the public sees the coronial system operating in a way that prioritises the promotion of justice as its primary aim.

> *Fact-finding is at the centre of the coronial process; as such, judicial supervision of this process is the only meaningful way to ensure the evidentiary process is operating correctly to ensure fair outcomes for families. To prevent appeals on any grounds other than questions of law denies families recourse to challenge the most central function of the coronial jurisdiction; that is, to make an assessment of cause of death based on available evidence.*[186]

6.44 The submissions of the Law Institute of Victoria and the Flemington and Kensington Community Legal Centre further stated that the approach in Victoria is out of step with the opportunities to seek appeal of coronial findings in other Australian jurisdictions.[187] In particular, the Law Institute of Victoria observed that the right to appeal against findings based on how a coroner has interpreted evidence or given weight to certain evidence is recognised in other Australian coronial jurisdictions and should be considered in Victoria in the interests of pursuing a just outcome for families and others affected by a death.[188]

6.45 In order to address these concerns, the Law Institute of Victoria and the Flemington and Kensington Community Legal Centre recommended in their submissions that the grounds of appeal be amended, similarly to New South Wales and Australian Capital Territory legislation, to state that the Supreme Court may grant an appeal against a coronial finding if it is satisfied that appeal is required in the interests of justice because of fraud, rejection of evidence, irregularity of proceedings, insufficiency of an inquiry, the discovery of new evidence or facts, or for any other reason.[189]

6.46 The Law Institute of Victoria noted that a matter should not be open to appeal unless necessary to do so in the interests of justice. It noted that a prolonged process of appeals and reviews of decisions is not only costly and inefficient, but creates the perception that coroners and the Coroners Court are incompetent and largely incapable of robust decision making without supervision from superior judicial bodies.[190]

> *As a matter of efficient and fair judicial administration, the LIV considers it important to maintain the perception and reality that, as a general rule, the*

185 Submission – Law Institute of Victoria.
186 Submission – Law Institute of Victoria.
187 Submissions – Law Institute of Victoria and Flemington and Kensington Community Legal Centre.
188 Submission – Law Institute of Victoria.
189 Submissions – Law Institute of Victoria and Flemington and Kensington Community Legal Centre.
190 Submission – Law Institute of Victoria.

> *decision of any court or judicial body is final and matters are not open to appeal unless necessary in the interests of justice.*[191]

6.47 At the same time, the Law Institute noted that the need for finality needs to be balanced against the appropriate administration of justice.

> *[I]f findings are not supported by the facts, or evidence has been interpreted incorrectly and in a way that would have a significant impact on the outcome of a case, finality in decision-making must come second to the administration of justice.*[192]

6.48 The Flemington and Kensington Community Legal Centre similarly observed that the principles of fairness should be paramount in developing an appropriate appeals regime. The submission stated that the added burden created by expanding grounds of appeal is greatly outweighed by the principles of fairness, consistency and access to justice in all Australian jurisdictions.[193]

6.49 In contrast to these arguments for change, a number of key legal bodies, including the Supreme Court, Coroners Court and the Victorian Bar, were of the view that the current appeals system is working well. The Coroners Court observed that the current options available to the Victorian public, as contained in the Coroners Act, are appropriate, and arguably even wider than the appeal rights from other tribunals in Victoria.[194] As a practical matter, the Coroners Court also noted that legislative reform was unnecessary because coroners' findings are rarely appealed, despite there being a six-month appeal period from the date that the finding is made.[195]

6.50 The Supreme Court's submission highlighted that appeals cannot be a mechanism for resolving dissatisfaction with coronial findings. While appeal structures are an important safeguard, they are not a suitable way to resolve the inevitable limitations of the coronial process to provide outcomes that satisfy families deeply affected by a death in tragic circumstances.[196]

6.51 The submission of the Victorian Bar similarly supported the current grounds for coronial appeals. It notes that limiting appeals to a question of law strikes an appropriate balance between fairness and efficiency in the system, as required by the Coroners Act.[197]

191 Submission – Law Institute of Victoria.
192 Submission – Law Institute of Victoria.
193 Submission – Flemington and Kensington Community Legal Centre.
194 Submission – Coroners Court of Victoria.
195 Submission – Coroners Court of Victoria.
196 Submission – Supreme Court of Victoria.
197 Submission – Victorian Bar.

6.52 Medical Insurance Australia also supported the current opportunities to appeal coronial findings. In particular, the submission stated that a multiplicity of processes relating to a coronial matter would be undesirable, given the range of forums available for interested parties to explore concerns they have with coronial investigations and findings.[198] The submission further noted that offering broader grounds for review or appeal would only extend the already lengthy timeframe it takes to resolve a matter.[199] It also stated that finality is essential to ensure families and other interested parties can find closure.[200]

> *It is imperative that there be finality in coronial processes, so that families and other loved ones of the deceased, and health practitioners involved in their care, can have closure. Coronial processes can also have very significant effects on health practitioners involved. In [our] experience, practitioners will often feel that their clinical judgment is to be critiqued, and that this could have significant effects on their ongoing practice.*[201]

6.53 The submission of Medical Insurance Australia also noted that finality is essential to ensure the timely and appropriate implementation of coronial recommendations, to allow 'those bodies who receive recommendations on how to improve health care can consider and, if appropriate, implement them in an orderly manner.'[202]

Standing to commence an appeal

6.54 Several submissions indicated that it would be useful to improve consistency across appeal provisions in the Coroners Act regarding standing to commence an appeal in the Supreme Court. For example, the Victims of Crime Commissioner stated that it was problematic that:

> *There are also inconsistencies as to who can make applications.*[203]

6.55 Victoria Police similarly observed that there was an inconsistency in approach, noting that those who have rights of application for a re-opening of an inquest or appeal of a Coroner's decision fall into three different categories: 'a person', 'a person with sufficient interest' and 'an interested party'.[204]

6.56 While the Flemington and Kensington Community Legal Centre did not raise concerns with the operation of the current provisions *per se*, it did recommend that the meaning of 'sufficient interest' be defined to provide greater clarity in the legislation. To this end, it proposed adopting the definition in the South Australian *Coroners Act 2003*:

> *A person has a sufficient interest in a finding made on an inquest if—*

198 Submission – Medical Insurance Australia.
199 Submission – Medical Insurance Australia.
200 Submission – Medical Insurance Australia.
201 Submission – Medical Insurance Australia.
202 Submission – Medical Insurance Australia.
203 Submission – Victims of Crime Commissioner.
204 Submission – Victoria Police.

> a) *the finding affects or may affect that person's pecuniary interests; or*
>
> b) *the finding reflects adversely on that person's competence in his or her trade, profession or occupation; or*
>
> c) *the person has, in the opinion of the Supreme Court, some other interest sufficient to ground an application under this section.*[205]

6.57 The Victorian Bar observed that the current arrangements with respect to standing are appropriate, noting that:

> *Only a person with a sufficient interest in an investigation may appeal the findings after an investigation. [Further] only a person who has already been given leave to appear at the inquest as an interested party may appeal the findings after an inquest. This invests the Supreme Court with an appropriate discretion to promote the interests of fairness and efficiency in the coronial system.*[206]

6.58 The Victorian Bar also noted it would be desirable to be able to appeal the decision of a coroner to grant or refuse leave to appear as an interested party at an inquest. It stated that there should be a statutory right of appeal (modelled on s. 84) against a decision to refuse leave under s 56 to appear as an interested party at an inquest.[207]

Costs associated with an appeal

6.59 Families noted the significant costs involved in appealing to the Supreme Court, particularly in terms of retaining appropriate legal representation. A number of submissions addressed this issue, noting that:

> *Money is the main barrier. … In my case I spent $20,000 on solicitors advice I stopped short of selling my home, which is what I would have to do to fund an Appeal.*[208]
>
> *[T]he cost of appealing the matter was prohibitive and a significant deterrent in filing an appeal. We have received cost estimates for this type of action from $35,000 to $90,000 which for us was cost prohibitive.*[209]
>
> *Had we known we had a right to appeal to the Supreme Court, I have no doubt the cost would have been prohibitive.*[210]

205 *Coroners Act 2003* (SA) s. 27(7).
206 Submission – Victorian Bar.
207 Submission – Victorian Bar.
208 Submission 15.
209 Submission 16.
210 Submission 23.

6.60 Some families also noted the risk that the costs of other parties with an interest in the matter could be awarded against them if the appeal was unsuccessful. For example, one submission stated:

> *We submit that bona fide contentious issues should be capable of satisfactory resolution without the need for applicants or appellants to either risk financial ruin (resulting from Supreme Court costs orders), or face the alternative of abandoning what may well be legitimate, soundly based quests for justice.*[211]

6.61 Organisations widely acknowledged that the cost of appeal proceedings in the Supreme Court could be a deterrent to families seeking an appeal. For example, the Victims of Crime Commissioner observed on this issue that:

> *[T]he costs involved to appeal to the Supreme Court for members of the public is significant, to the point, realistically, of being prohibitive for most of the community.*[212]

6.62 The submissions of families makes it clear that the cost of an appeal was a significant deterrent to pursuing further action if they were dissatisfied with a coronial finding. Most legal organisations and experts agreed that the cost of an appeal could be significant, but they generally viewed this as an appropriate mechanism to prevent litigation in the Supreme Court that had little or no prospect of success.

Time limitations for commencing an appeal against a refusal to re-open an investigation

6.63 A number of families noted that the current time limitations for bringing an appeal against the refusal of a coroner to re-open an investigation under s 84 of the Coroners Act should be increased. Submissions stated that most families had limited experience with the legal system, and their engagement with the coronial process came at a particularly vulnerable time. They needed more time to consider their options and seek appropriate legal advice.

> *Not enough time is allowed for the grieving families to come to terms with their loss, and to try and seek answers as to how this tragedy could have happened, it takes many months even years to understand.*[213]

> *[Time frames for review] should be a minimum of 6 months taking into account the emotional fragility of senior next-of-kin at this time.*[214]

> *There should be no statute of limitations, or time constraints, on any appeal/re-opening issue. Investigations should be re-activated upon new facts and information that has the capacity to bring about a just outcome.*[215]

211 Submission 9.
212 Submission – Victims of Crime Commissioner.
213 Submission 18.
214 Submission 15.
215 Submission 8.

6.64 Several submissions from organisations also commented on the time limits prescribed in the Coroners Act to appeal coronial decisions in the Supreme Court. There was a general view that the timeframes for commencing an appeal were inconsistent between various provisions of the legislation, and that this was confusing and undesirable. For example, the Victims of Crime Commissioner observed that, currently, families might find it difficult to understand their appeal rights, given there are different timeframes specified for different types of appeals.[216]

6.65 More particularly, submissions stated that the 28-day time limit prescribed for commencing an appeal against a refusal by a coroner to re-open an investigation in the legislation[217] did not allow families enough time to seek appropriate legal advice and consider their options for appeal. For example, the Law Institute of Victoria noted that:

> *The 28 day time limit under s84 [to appeal against a refusal by a coroner to re-open an investigation] may not afford families sufficient opportunity to obtain legal advice.*[218]

6.66 Similarly, the Victorian Bar expressed the view that the 28-day limit arguably sacrifices fairness for efficiency, particularly taking given the desirability of encouraging potential appellants to seek legal advice and to be legally represented in the appeal.[219] The Flemington and Kensington Community Legal Centre was also of the view that 28 days was not enough time for families to decide whether to pursue an appeal following a decision not to re-open an investigation. While a family can seek an extension to appeal, this was seen as undesirable:

> *Currently, grieving families who do not appeal within 28 days must satisfy the requirements of s 86 to be granted an extension of time.*[220]

6.67 There were a range of suggestions for remedying the inconsistencies. Both the Victorian Bar and Flemington and Kensington Community Legal Centre recommended that the time limit for commencing an appeal be extended to six months. Conversely, the time limit of six months available for seeking an appeal against the findings of a coroner was seen as overly generous by some organisations.[221] The Law Institute of Victoria indicated that a three-month time period for appeals strikes the correct balance between court efficiency and allowing grieving families sufficient time for to seek legal advice and lodge an appeal.[222]

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216 Submission – Victims of Crime Commissioner.
217 *Coroners Act 2008* (Vic) s 84.
218 Submission – Flemington and Kensington Community Legal Centre.
219 Submission – Victorian Bar.
220 Submission – Flemington and Kensington Community Legal Centre.
221 *Coroners Act 2008* (Vic) s 83.
222 Submission – Law Institute of Victoria.

The Council's conclusions

Clarifying the grounds of appeal against a coronial finding

6.68 It is clear from the submissions that some families consider the current grounds for appealing a coronial finding too restrictive. The most common reason for families to contemplate an appeal was because they believed the finding exceeded the evidence. In some cases, legal experts advised families that the *Coroners Act 2008* created a higher barrier to appeal than the grounds available under the previous legislation, and that an unsuccessful appeal could result in substantial legal costs being awarded against them. Some members of the legal profession who have represented families in coronial matters also felt there was room for improvement or clarification of appeal rights, and argued for the adoption of broader grounds similar to those that exist in other Australian coronial jurisdictions.

6.69 At the same time, the Council recognises that key legal bodies and prominent experts in Victoria consider that the current grounds of appeal to the Supreme Court are appropriate. This group emphasized that an important aspect of justice is reasonable finality, which reflects the public interest in resolving cases quickly and effectively. It also underpins fair and efficient judicial administration and appropriate use of available court resources, as well as supporting the authority of the Coroners Court as a capable and robust decision-making body.

6.70 Those in favour of maintaining the existing appeals framework also pointed out that the grounds of appeal in the Coroners Act are consistent with existing appeal rights available to challenge decisions in other civil jurisdictions in Victoria. They made the case that the current level of judicial oversight of coronial findings is appropriate. They further noted that the appeal regime in the Coroners Act should recognise the Coroners Court as a specialist jurisdiction with particular factual expertise that should be respected.

6.71 In considering the best way forward, the Council has reflected on the most appropriate use of the Supreme Court's time, resources and expertise, and accepts that it is not the function of a superior court to provide a second hearing of factual matters determined by a specialist magistrate in the Coroners Court. The Council accepts that a superior court cannot resolve the inevitable limitations of the coronial process to satisfy all individuals. In the vast majority of cases where families or others are dissatisfied with a coronial finding, an appeal to the Supreme Court is unlikely to produce a different outcome, irrespective of the scope of the appeal grounds available.

6.72 The Council also recognises the enormous emotional toll the coronial process and any subsequent legal action can have on families as they struggle to come to terms with the loss of a loved one. Further, members of the same family may engage with the coronial process in different ways, and can have different views and expectations about optimal outcomes. While acknowledging the importance of ensuring just outcomes for families, the Council must also take into account the fair treatment of third parties engaging in coronial processes, and the overarching need to preserve the proper administration of justice by the Coroners Court.

6.73 Accordingly, the Council is not persuaded that a return to the grounds of appeal that existed under the *Coroners Act 1985*, or comparable review grounds in other jurisdictions, is necessary or desirable. However, several families strongly argued that in their cases, the coroner's findings exceeded the evidence. The Council considers that in rare circumstances where the finding of a coroner clearly exceeds the evidence in the case, the legislation should make it clear that an appeal to the Supreme Court is available.

6.74 While some senior members of the legal profession argued that an appeal on a 'question of law' already includes circumstances where findings were against the evidence, other experts consider that the operation of this ground is narrower. The Council is of the view that different interpretations of what is meant by a 'question of law' in the Coroners Act is at the heart of much of the disagreement about the current scope to appeal coronial decisions.

6.75 Upon reflection on these issues, the Council considers that this disagreement is best resolved by amending the Coroners Act to state that an appeal against a coronial finding is available on a question of law and in circumstances where the finding is 'against the evidence or the weight of the evidence'. The proposed amendment would allow for appeals on this particular component of the former Coroners Act.

6.76 This phrase was the subject of judicial interpretation when it formed part of the appeals framework available under s 59(3) of the *Coroners Act 1985*. The Court of Appeal clarified that the provision was intended to ensure that findings for which there was no evidence, or that no reasonable coroner could make, would be eligible for review by the Supreme Court.[223]

6.77 The Council is of the view that it is necessary to clarify that an appeal to the Supreme Court is available in circumstances where there is no evidence to support a coroner's finding, or no reasonable coroner could have made the decision on the evidence available. The Council therefore recommends that the Coroners Act be amended to state that an appeal against the finding of a coroner in s 83 of the Coroners Act is available on a question of law, and where the finding is 'against the evidence or the weight of the evidence'.

6.78 While some will argue this is a duplication, after careful consideration and consultation with the Chief Parliamentary Counsel, the Council is of the view that clarifying this as a ground for appeal will address the concerns of families and their legal representatives, while allowing case law, consistent with the approach applied by the Court of Appeal under the corresponding provision of the 1985 Coroners Act,[224] to determine the boundaries of this approach.

6.79 The Council considers it very unlikely that the proposed amendment would significantly increase the number of appeals. In all but the most exceptional cases, families are likely to benefit far more from enhanced opportunities to engage in the original coronial investigation, and from expert support provided during and following the conclusion of the case, than seeking an alternative finding through formal legal review. The Council's recommendations to better support families are set out in Chapters 4 and 7 of this report.

223 *Keown v Khan* [1998] VSC 297.
224 Ibid.

Recommendation 8: The Victorian Government should seek to amend the Coroners Act to make it clear that an appeal against a coronial finding in s 83 is available on a question of law; and where the finding is 'against the evidence or the weight of the evidence'.

Standing and costs issues

6.80 The Council has considered the submissions made by organisations on the issue of standing, but does not consider that there is sufficient evidence to warrant amending the standing provisions in respect of an appeal against the findings of a coroner or against refusal to re-open an investigation.

6.81 The Council has also given careful consideration to the issue of costs in the context of coronial appeals. While appeals to the Supreme Court are undoubtedly costly for families, they also create significant expense for other parties with an interest in the outcome. More broadly, appeals to the Supreme Court come at a substantial financial cost to the community, and may divert attention and effort from other cases in the Victorian justice system. The issue of costs is not unique to the Coroners Court, and the Council is not able to make a recommendation on this issue as part of this review.

6.82 However, the Council recommends the establishment of a centralised Coronial Legal Advice Service through Victoria Legal Aid, to give advice to families about both the original coronial investigation and the possibility of an appeal. This service would provide expert legal advice to help families better understand the original coronial process, and assist them to better understand the content and rationale for coronial findings. It would also give them an indication of the prospects for success in pursuing further legal action. Details of this recommendation are set out in Chapter 5 of this report.

Increasing the time limit for commencing an appeal

6.83 The Council recognises that all legal systems need to place suitably tailored scope and time limitations on appeals. Based on the feedback received from families and legal organisations, including the Law Institute of Victoria and the Victorian Bar, the Council is of the view that 28 days is not a realistic timeframe for families to commence an appeal against a refusal to re-open an investigation under s 77 of the Coroners Act.

6.84 The Council considers that a time limit of three months to seek such an appeal would strike an appropriate balance between resolving a case in a timely manner, and allowing families sufficient opportunity to seek legal advice and consider their options for commencing an appeal in the Supreme Court. The Council therefore recommends that the time limit for appealing the finding of a coroner in s 84 of the *Coroners Act 2008* should be extended from 28 days to three months. In considering the proposed amendment, it may be appropriate to give further consideration to harmonising the time limit for commencing appeals under Part 7 of the Coroners Act more generally.

Recommendation 9: The Victorian Government should seek to amend the time limit for commencing an appeal against a refusal by the Coroners Court to re-open an investigation in s 84 of the Coroners Act from 28 days to three months.

7. Addressing the needs of families through a restorative justice process

Overview

7.1 The Council recognises that the Coroners Court cannot necessarily provide all of the answers or solutions sought by families following the death of a loved one. It has become clear in the course of this review that some families have not been able to accept the outcomes of the coronial process, and this has had a profoundly debilitating effect on their lives. The Council is of the view that in many of these cases, families are seeking outcomes that cannot be provided by the legal system. This includes, for example, an apology or acknowledgement of the harm caused, validation of their interests and concerns, or evidence of change in practices and procedures to prevent future deaths.

7.2 The Council's observations are consistent with research which indicates that litigants are frequently motivated to take legal action to obtain an apology, an acknowledgement of having been wronged, preventing the same misfortune from occurring to another, a proper investigation, or making sure people observe their legal obligations in the future.[225] The desire to punish and be publicly vindicated can also be key motivators to pursue legal action.[226] Experts note that the power of apologies or expressions of regret can be significant, and there is evidence to suggest that they are a meaningful means of redress, as well as reducing the desire of parties to litigate.[227]

7.3 Restorative justice has been used successfully in a range of systems in Australia and around the world. It is generally understood to be a process that involves those who have a stake in a specific matter collectively identifying and addressing harms, needs and obligations, in order to heal and put things as right as possible.[228] The restorative justice process can be flexible and responsive to the needs of participants, and aims to promote healing among individuals affected by a particular event. A restorative justice conference can include:

- the person harmed telling the person responsible for the harm how their life has been affected;
- the person responsible for the harm acknowledging their responsibility;
- the person harmed hearing from the person who caused the harm, and having the opportunity to ask questions, such as what the person was thinking or why the person committed the offence;
- the person responsible for the harm offering an apology;
- the person harmed and the person responsible for the harm reaching an agreement for the person responsible to do specific things aimed at addressing the harm.[229]

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225 Hazel Genn, *Understanding Civil Justice*, (1997) 50 *Current Legal Problems* 155, p. 175.
226 Ibid.
227 Prue Vines, *Apologising to Avoid Liability: Cynical Civility or Practical Morality?* (2005) 27 *Sydney Law Review* 483, p. 483.
228 Howard Zehr, *The Little Book of Restorative Justice* (Skyhorse Publishing, 2002), p. 37.
229 RMIT Restorative Justice Conferencing Pilot Program, *Restorative justice for people affected by a serious motor vehicle collision* (2017), https://www.rmit.edu.au, p. 2.

7.4 A restorative justice process can have numerous benefits in allowing the victim's personal experience to be heard, and for the person responsible for the harm to acknowledge the effects of their actions. It has been said that 'reclaiming voice for families, friends and victims in justice processes is an important democratic project'.[230] Experts have observed that restorative justice can meet the needs of victims in ways that the traditional justice system cannot, by bringing attention to the interests and needs of victims, creating an environment where the voice of victims can be heard, and by recognising victims' agency and helping to restore their dignity.[231] Studies of victims who attend restorative justice conferences indicate that they are glad they participated in the program. Victims report a range of positive outcomes, including reductions in their post-traumatic stress symptoms, a greater ability to return to work, to resume normal daily activities and sleep better at night.[232]

7.5 The availability of restorative justice conferencing in appropriate circumstances should complement existing legal processes. It should not prevent an individual or family from seeking redress through the court system. A further important consideration is that restorative options may not be appropriate in every case. Experts have made it clear that a successful restorative process relies, among other factors, on proper screening of parties and cases to determine suitability, voluntary participation, proper preparation, the availability of a trained mediator.[233] Indeed, failure to undertake such precautions can present a significant risk of re-traumatisation of the parties, a lack of protection of their procedural rights and their loss of faith in the integrity of the coronial process.[234]

7.6 Restorative justice is commonly found in the criminal justice system, where the emphasis is on repairing the harm caused by criminal behavior. In recent years, restorative justice practices have become mainstream in Australian juvenile justice, and have also been extended for use with adult offenders in some jurisdictions.[235] For example, restorative justice conferencing is currently available in Victoria for young offenders through the Youth Justice Group Conferencing program under the *Children, Youth and Families Act 2005* (Vic), which is coordinated by the Department of Health and Human Services and run by multiple community service organisations.[236]

230 John Braithwaite, *Restorative Justice and Responsive Regulation: The Question of Evidence* (2014) ANU RegNet Research Paper No 2014/51, p. 8.

231 Victorian Law Reform Commission, *Alternative Criminal Justice Models* (2015), http://www.lawreform.vic.gov.au.

232 Lawrence W Sherman and Heather Strang, *Restorative Justice: The Evidence* (2007) The Smith Institute, https://www.iirp.edu, p. 24.

233 Michael S King, *Non-adversarial justice and the coroner's court: A proposed therapeutic, restorative, problem-solving model* (2008) 16 JLM 442, p. 452.

234 Ibid.

235 Jacqueline Joudo Larsen, *Restorative Justice in the Australian Criminal Justice System* (2014) Australian Institute of Criminology Reports Research and Public Policy Series No 127, http://www.aic.gov.au, p. 5.

236 Penny Armytage and Professor James Ogloff AM, *Youth Justice Review and Strategy, Meeting needs and reducing offending – Part 1* (2017) Victorian Department of Justice, http://www.justice.vic.gov.au, p. 97.

7.7 The Youth Justice Group Conferencing program facilitates a meeting between the child and other interested parties with a view to increase the child's understanding of the effect of their offending on the victim and the community. It also seeks to reduce the likelihood of the child re-offending, and to negotiate an outcome plan that is agreed to by the child.[237] Evaluation of these types of restorative justice programs highlights the positive impact for both victims and offenders, which can include victim satisfaction, as well as diversion of offenders from supervisory orders and future contact with the criminal justice system.[238]

7.8 More recently, the RMIT Centre for Innovative Justice has developed a pilot program through its Culpable Driving and Restorative Justice project in Victoria, to bring together people affected by a serious motor vehicle collision, including victims, the person responsible for the harm, support people and other family or community members.[239] Participation in the program is voluntary, free and confidential for people who meet the eligibility requirements of the program. Moreover, the restorative justice conferences are led by professionally trained conveners who work to ensure that the process is safe for everyone involved. The program is designed to expand the options available to victims, including the possibility of an acknowledgment of the harm done, an apology direct from the offender and other opportunities to help victims find closure.[240]

7.9 The Victorian Royal Commission into Family Violence has also recognised that restorative justice processes can meet a broad range of victim needs that might not always be available through the courts, and may assist victims of family violence to recover from the impact of the abuse they have suffered.[241] The Commission accordingly recommended the development of a framework and pilot program for the delivery of restorative justice options for victims of family violence that are victim-driven and incorporate robust safeguards.[242] The Victorian Government has committed to implementing all Royal Commission recommendations. The Department of Justice and Regulation is leading work on developing a restorative justice framework based on close consultation with experts and victim survivor representatives and international best practice.[243]

What the Council heard

7.10 The Centre for Innovative Justice prepared a valuable submission on the possible role that restorative justice conferencing opportunities could play to meet the needs and interests of families and other parties engaging in the coronial system. This submission noted that opportunities to appeal coronial findings cannot be considered in isolation, and should instead be examined through a broader lens of the justice needs and experiences of families and others engaging with the coronial system:

237 *Children, Youth and Families Act 2005* (Vic) s 415.
238 Jacqueline Joudo Larsen, *Restorative Justice in the Australian Criminal Justice System* (2014), Australian Institute of Criminology Reports Research and Public Policy Series No 127, http://www.aic.gov.au, p. 10.
239 RMIT Restorative Justice Conferencing Pilot Program, *Restorative justice for people affected by a serious motor vehicle collision* (2017), https://www.rmit.edu.au, p. 3.
240 RMIT Centre for Innovative Justice, Annual Review 2016, p. 11.
241 Victorian Royal Commission into Family Violence: Report and Recommendations, p. 135.
242 Ibid Recommendation 122.
243 Victorian Government Response, Ending Family Violence: Delivering Change, https://www.vic.gov.au/familyviolence/recommendations/

> *The effective operation of appeal provisions cannot be considered meaningfully in isolation from the coronial system as a whole, or in isolation from the proceedings from which appeals emanate. This review must also consider the circumstances in which appeals arise and the factors that contribute to them. Among these factors, the review must ask whether the needs of families are being met, and if they are not being met, the extent to which this failure drives dissatisfaction and appeals.*[244]

7.11 The submission of the Centre for Innovative Justice explained the meaning of restorative justice in the following terms:

> *The term 'restorative justice' refers to a broad range of practices which attempt to repair the harm caused by collectively including those affected, in its resolution. Restorative justice involves a process where parties can 'meet together to discuss what happened, why it happened and how to make things right'. ... [I]ts 'needs-based' approach is focused on healing, accountability, community restoration, and redress for harm and loss caused.*[245]

7.12 The submission highlighted that restorative justice researchers have identified that those involved in justice processes often have unmet 'justice needs', meaning a need for 'participation, voice, validation, vindication, and accountability'. The submission observed that:

> *Restorative justice provides a useful framework for identifying the needs of families. A negative experience of the coronial process may be an indication that a particular justice need has not been met. [In the coronial context] restorative justice processes may provide families and non-family members with the opportunity to have their needs met in ways that traditional justice processes, including appeals and reviews, cannot.*[246]

7.13 The Centre for Innovative Justice also pointed out that improving access to justice goes beyond improving appeal rights, or providing greater access to affordable legal representation:

> *It is also about ensuring that proceedings are more meaningful - and therefore more effective – and deliver better outcomes for all participants and the community. When the justice system fails to meet people's needs, people will continue to look to other avenues for redress, such as appeal and review processes, to try to have these needs met. When those avenues are closed to them or are not able to properly meet their needs, people can feel frustrated, disempowered and increasingly dissatisfied with the legal process. Dissatisfaction is likely to drive a sense of injustice. This is a feature of the coronial system."*[247]

244 Submission – Centre for Innovative Justice.
245 Submission – Centre for Innovative Justice
246 Submission – Centre for Innovative Justice
247 Submission – Centre for Innovative Justice

7.14 The submission made a compelling case for developing opportunities for families to find more meaningful outcomes through restorative processes, while maintaining the institutional integrity, purpose and functions of the coroner and safeguarding procedural rights. This is particularly important and relevant because people who feel they have been heard and had experiences acknowledged are much less likely to seek redress through other avenues such as appeal or review.[248]

7.15 The submission proposed that restorative justice processes such as conferencing are well-suited to addressing the needs of parties involved in the coronial system. The submission noted that the inquisitorial nature of coronial investigations is particularly amenable to restorative justice principles. Indeed, the Centre for Innovative Justice points out that the Coroners Act already contains a number of inherently restorative practices, such as the recognition of the value of an apology and the need to provide support and information to family members, friends, community members and other distressed people.[249]

7.16 The submission draws on the work of Michael S King, a retired Western Australian coroner and strong proponent of the role of restorative justice as a component of an effective coronial process. King has highlighted that restorative justice processes can offer families:

> *the opportunity of meeting in a safe, non-adversarial environment, of listening to other people's experience of how the situation has affected them, of telling their own story and expressing their own feelings about this situation that may well have affected them deeply on different levels of their life, and, where possible, of reaching an agreement as to any remedial measures to be taken. As in other restorative justice conferences, it offers the possibility of healing and closure to the parties.*[250]

7.17 The approach proposed by King, and endorsed by the Centre for Innovative Justice, is that the Coroners Court could discuss with the parties the possibility of a restorative justice conference after handing down a decision. This would be done on the basis that the facts of the case were not in dispute, and issues of responsibility for the death had been settled, in order to avoid the possibility of confusion or trauma for the parties.[251]

7.18 The Centre for Innovative Justice proposed that screening could occur following:

- the handing down of a coroner's findings after an investigation or inquest;
- a coroner's determination not to hold an inquest; or
- a coroner's refusal to re-open an investigation.[252]

248 Submission – Centre for Innovative Justice.
249 Submission – Centre for Innovative Justice
250 Michael S King, *Non-adversarial justice and the coroner's court: A proposed therapeutic, restorative, problem-solving model* (2008) 16 JLM 442, p. 452.
251 Submission – Centre for Innovative Justice.
252 Submission – Centre for Innovative Justice.

7.19 The Centre for Innovative Justice observed that the dissatisfaction of families with the coronial process can be understood as a consequence its failure to meet their justice needs, and that formal appeal or review processes may not resolve the sense of injustice experienced. However, restorative justice principles can influence practices and approaches without undermining the integrity of the coronial and appeal processes, and without tilting the balance of proceedings in favour of particular parties.

7.20 The submission noted that appropriate restorative justice measures can alleviate the need for further legal action by families. In particular, it observed that the availability of an alternative, complementary forum may also help to reduce appeals, preserving the finality of coronial findings and improving efficiency, while serving to protect the integrity of the conventional coronial processes, functions and purposes.[253]

The Council's conclusions

7.21 The Council has reflected on the concerns raised by families engaging in coronial processes and the submission made by the Centre for Innovative Justice. It agrees that restorative justice conferencing could provide solutions that are not available through the Coroners Court, and that a carefully developed restorative justice program could provide a valuable complementary process to help meet the justice needs of families.

7.22 The Council considers that in appropriate cases, it would be beneficial for families and other interested parties involved in a coronial investigation to have the opportunity to discuss the outcomes of a case with the assistance of an expert facilitator. It is envisaged that the restorative justice process would allow families to ask questions or explain how the loss of their loved one has affected them. It would also allow individuals and organisations to answer questions, explain changes in procedures or policies, or offer an apology if appropriate. The Council does not expect that the individual coroner involved in an investigation would participate in the restorative justice conference, but in some circumstances it may be valuable for a senior representative of the Coroners Court to be in attendance at a conference.

7.23 The Council therefore recommends that the Victorian Government provide funding for the establishment of a restorative justice program to enable families involved in complex or sensitive cases to participate in a process to resolve outstanding issues following the conclusion of a coronial investigation. The referral of cases deemed suitable for a restorative justice process should be managed by the Client Advocacy Office within the Coroners Court.

7.24 The Council considers that the development of the model for the restorative justice program should consider a range of matters including timing and points of intervention; overcoming possible barriers to participation; and the specific mode and delivery of the program. Careful consideration will also need to be given to the types of matters that may be referred to the program; eligibility and suitability criteria for program participants; timing of the restorative justice process in relation to coronial processes; and clarifying the role of any restorative justice process in the context of related legal proceedings. Participation in any restorative justice process should be voluntary.

253 Submission – Centre for Innovative Justice.

7.25 The ideal restorative justice model for coronial matters should have a strong capacity for responsiveness and flexibility, as the needs of participants are likely to be diverse, and every case will be different. The Council recommends substantial consultation with families, the Coroners Court and other stakeholders as part of the development of the program, to ensure that it is tailored to the needs of participants.

Recommendation 10: The Victorian Government should fund a restorative justice program to enable families to resolve outstanding issues and questions following the conclusion of a coronial investigation. The referral of cases considered suitable for a restorative justice process should be managed by the Client Advocacy Office within the Coroners Court.

8. Information management within the Coroners Court

Overview

8.1 The Council considers that openness to feedback from court users through surveys and other similar methods can have a range of benefits within the Coroners Court, including more innovative and responsive court processes, better management of court user expectations and ongoing improvements to the delivery of court services.

8.2 One widely recognised process for improving court performance is the International Framework for Court Excellence, which offers an internationally recognised management system designed to help courts improve their performance.[254] The Framework provides a clear statement of the core values of court excellence, including optimal internal organisation of the court, strong leadership, clear court policies, quality resource management, effective and efficient court operations, high quality and reliable court performance data and a high level of public respect.[255]

8.3 The former Chief Justice of the Supreme Court, the Hon Marilyn Warren AC, observed that the Supreme Court of Victoria has already embraced the Framework as part of the Court's ongoing improvement of its transparency and accountability.[256] Specifically, under the rubric of the Framework, the Supreme Court has developed a strategic statement focused on:

- safe-guarding and maintaining the rule of law, and ensuring equal access to justice;
- fairness, impartiality and independence in decision making;
- processes that are transparent, timely and certain;
- accountability for the court's use of public resources; and
- the highest standards of competence and personal integrity.[257]

8.4 The Victorian County Court and Magistrates' Court are also parties to the Framework.

8.5 The Council considers that adoption of the Framework by the Coroners Court warrants careful consideration as a valuable means by which court values and policies can be clearly articulated, and ongoing performance can be measured and evaluated to ensure the needs of court users are met.

254 The International Framework for Court Excellence, 2nd Edition, March 2013, http://www.courtexcellence.com.
255 Ibid.
256 The Hon Marilyn Warren AC, Chief Justice of Victoria, *The Aspiration of Excellence; Judiciary of the Future – International Conference on Court Excellence*, Singapore 28-29 January 2016.
257 Ibid.

The Council's conclusions

8.6 The lack of court data on a system level restricted the Council's ability to identify the level of concern regarding the appeals process. All data currently resides in individual case files, and it was not possible to undertake a survey of recent participants or know how many appeals occur each year. In order to assess the efficacy of court processes over time, these system-level data profiles need to be developed further.

8.7 The Council is of the view that data on the number of applications seeking review within the Coroners Court, or appeal applications to the Supreme Court, can be valuable in monitoring key trends. Accordingly, the Council recommends that the Coroners Court develop its capacity to capture and evaluate accurate, comprehensive and reliable data regarding court statistics. This may require updating Coroners Court processes and information technology capabilities, so that data can be easily captured and interrogated.

8.8 The Council considers that the ongoing collection and evaluation of information about the experience of court users is vital to ensure the Coroners Court understands common concerns or systemic issues, and can respond to them effectively. The Coroners Court needs to monitor how its policies and procedures operate in practice in order to determine whether they are achieving their objectives. Accordingly, the Council recommends that the Coroners Court undertake regular surveys of all court users, to examine the level of satisfaction with coronial processes, services and outcomes. The findings of such surveys should lead the Coroners Court to consider ways to implement necessary changes identified by court users, and report publicly on its response to feedback received, including through the court's website and annual report.

8.9 The Council anticipates that the Client Advocacy Office could play a leading role in helping the Coroners Court develop and implement appropriate surveys and other feedback mechanisms to evaluate the experience of court users, as well as appropriate data collection and analysis processes.

8.10 The Council is also of the view that it would be valuable for the Coroners Court to become a party to the International Framework for Court Excellence, which offers a valuable set of concepts and tools by which courts can voluntarily assess and improve their performance against specified justice and court administration measures. The framework builds on a range of recognised organisational improvement methodologies, while reflecting the special needs and issues specific to courts, and it has already been successfully implemented by a number of other courts in Victoria. The Council considers that adopting the Framework help to ensure the Coroners Court can deliver the highest quality court services essential to fulfilling its critical role, and recommends that the Coroners Court take the necessary steps towards membership in this International Consortium.

Recommendation 11: The Coroners Court should take steps to better understand and respond to systemic issues that may arise during coronial processes. In particular, the Coroners Court should:

a. establish mechanisms to collect and analyse systemic data on court performance;

b. undertake periodic client feedback surveys; and

c. become a party to the International Framework for Court Excellence.

Appendix A: Coronial Council members

Current Council members

- Professor Katherine McGrath (Chair)
- Judge Sara Hinchey (*ex officio*)
- Deputy Commissioner Shane Patton APM (*ex officio*)
- Professor Noel Woodford (*ex officio*)
- Dr Ian Freckelton QC
- Mr Christopher Hall
- Dr Robert Roseby
- Ms Maryjane Crabtree
- Ms Maria Dimopoulos
- Ms Michele Lewis

Appendix B – Consultation

Submissions

The Coronial Council received 22 submissions from families who have engaged with the Victorian coronial system and interested members of the public.

The Council also received submissions from the following organisations:

- Victorian Coroners Court
- Supreme Court of Victoria
- Victorian Bar
- Law Institute of Victoria
- Victorian Police
- Flemington and Kensington Community Legal Centre
- Medical Insurance Australia
- Office of the Victims of Crime Commissioner
- Centre for Innovative Justice.

The Council's report has also been informed by the valuable insights gained in the course of meeting with families, legal experts and barristers, the Victorian State Coroner and staff at the Coroners Court, and a range of professionals with strong expertise in the workings of the coronial system in Victoria.

The Council is grateful for all who contributed their time and efforts to this report.

Appendix C: Applications for review within the Coroners Court from 2012–2017

Year	Applications	Refused	Accepted
2017	10	7	3
2016	9	5	4
2015	11	9	2
2014	3	3	0
2013	4	3	1
2012	2	2	0
Total	**39**	**29**	**10**

Appendix D: Comparative table of review options in Australian jurisdictions

Jurisdiction	Re-opening of investigation available in the Coroners Court	Cases eligible for re-opening	Grounds for re-opening a matter	Who undertakes review
Victoria	Yes	All coronial investigations	New facts and circumstances required	Coroners Court
New South Wales	No	N/A	N/A	N/A
Western Australia	No	N/A	N/A	N/A
Northern Territory[258]	Yes	Inquests only	New facts and circumstances required	Coroner
Queensland[259]	Yes	All coronial investigations	New evidence casts doubt on the finding or it is otherwise in the public interest	Coroner who held inquest or State Coroner
South Australia[260]	Yes	Inquests only	Not limited to any specified legal grounds for review	Coroners Court
Australian Capital Territory[261]	Yes	Inquest or inquiry	Discovery of new facts or evidence of material significance	Chief Coroner
Tasmania[262]	Yes	All coronial investigations	Range of grounds including fraud, mistake of evidence, new facts or evidence affecting the findings	Chief Magistrate

258 *Coroners Act 1993* (NT) s 44A.
259 *Coroners Act 2003* (QLD) ss 50, 50A and 50B.
260 *Coroners Act 2003* (SA) s 26.
261 *Coroners Act 1997* (ACT) s 68.
262 *Coroners Act 1995* (Tas) s 58.

Appendix E: Comparative table of appeal options in Australian jurisdictions

Jurisdiction	Appeal to superior court on outcome of review	Appeal to superior court on findings	Grounds of appeal
Victoria	Yes (All decisions)	All investigations	Appeal on a question of law (or interests of justice test for appeal against refusal to re-open an investigation).
New South Wales[263]	N/A	Inquests only	If necessary or desirable in the interests of justice because of fraud, rejection of evidence, irregularity of proceedings, an insufficiency of inquiry, discovery of new evidence or facts or for any other reason.
Western Australia[264]	N/A	Inquests only	If necessary or desirable in the interests of justice because of fraud, rejection of evidence, irregularity of proceedings, an insufficiency of inquiry; mistake in the record of the findings; new facts or evidence; findings are against the evidence or the weight of the evidence.
Northern Territory[265]	No	Inquests only	If necessary or desirable in the interests of justice because of fraud, rejection of evidence, irregularity of proceedings, an insufficiency of inquiry; mistake in the record of the findings; new facts or evidence; findings are against the evidence or the weight of the evidence.
Queensland[266]	Yes (Decisions on inquests only)	Inquests only	If new evidence casts doubt on the finding; or the finding was not correctly recorded; or there was no evidence to support the finding; or the finding could not be reasonably supported by the evidence.
South Australia[267]	No	Inquests only	Not specified.
Australian Capital Territory[268]	No	Inquests only	If necessary or desirable in the public interest or the interests of justice because of fraud, rejection of evidence, irregularity of proceedings, insufficiency of inquiry, discovery of new facts or evidence or otherwise.
Tasmania[269]	Yes (All decisions)	Inquests only	If the inquest may have been tainted by fraud; the investigation was not sufficiently thorough or was compromised by evidentiary or procedural irregularity; or there are mistakes in the record of the findings; or new facts or evidence affecting the findings have come to light; or the findings were not supported by the evidence; or there is another compelling reason to reopen the investigation.

263 *Coroners Act 2009* (NSW) s 85.
264 *Coroners Act 1996* (WA) s 52.
265 *Coroners Act 1993* (NT) s 44.
266 *Coroners Act 2003* (QLD) s 50.
267 *Coroners Act 2003* (SA) s 27.
268 *Coroners Act 1997* (ACT) s 93.
269 *Coroners Act 1995* (Tas) s 58A.

Appendix F: Relevant appeals to the Supreme Court under the *Coroners Act 2008*

Year	Case No	Name	Appeal Type	Outcome
2017	[2017] VSC 293	*Mortimer v West*	*Coroners Act 2008* s 84 (refusal to re-open investigation)	Appeal dismissed.
2016	[2016] VSC 543	*Somerville v Coroners Court of Victoria*	*Coroners Act 2008* s 83 (appeal against finding – out of time); *Coroners Act 2008* s 84 (refusal to re-open investigation)	Appeal dismissed.
2016	[2016] VSC 635	*Hecht v Coroners Court of Victoria*	*Coroners Act 2008* s 84 (refusal to re-open investigation)	Appeal upheld and application to set aside relevant finding granted.
2015 / 2016	[2015] VSC 150; [2016] VSC 11	*Mortimer v West*	*Coroners Act 2008* s 84 (refusal to re-open investigation)	Appeal dismissed and further appeal dismissed.
2011	[2011] VSC 133	*Thales Australia Ltd v Coroners Court of Victoria & Ors*	*Coroners Act 2008* s 83 (appeal against finding)	Appeal dismissed.

Appendix G: Relevant appeals to the Supreme Court under the *Coroners Act 1985*

Year	Case No	Name	Appeal Type	Outcome
2002	[2002] VSC 227	*Khan v West (Coroner)*	*Coroners Act 1985* s 59; Application that findings of the Coroner were void (against the evidence and the weight of the evidence ground).	Appeal upheld (declaration that some findings were void; and order that Coroner re-open inquest).
2000	[2000] VSC 475	*Plover v McIndoe (Coroner)*	*Coroners Act 1985* s 59; Application that findings of the Coroner were void (insufficiency of inquiry and findings were against the evidence and the weight of the evidence ground).	Appeal dismissed.
1999	[1999] VSC 530	*Kahn v West (Coroner)*	*Coroners Act 1985* s 59; Application that findings of the Coroner were void (against the evidence and the weight of the evidence ground).	Appeal upheld (declaration that one finding was void; and order that Coroner re-open inquest).
1997	No.7038 of 1996 Dated: 11/09/1997	*Khan v West (Coroner)*	*Coroners Act 1985* s 59; Application that findings of the Coroner were void (against the evidence and the weight of the evidence ground).	Appeal upheld (declaration that finding was void, on the basis that the evidence and processes of reasoning supporting the finding were not open to the Coroner – direction that inquest be reopened).
1997	No.7153 of 1996 Dated: 7/02/1997	*Munro v West (Coroner)*	*Coroners Act 1985* s 59; Application that findings of the Coroner were void (against the evidence and the weight of the evidence ground).	Appeal upheld (declaration that findings were void – direction that inquest be reopened).

1995	[1996] 2 VR 1	*The Chief Commissioner of Police v Hallenstein*	*Coroners Act 1985* s 59; Application that certain of the coroner's findings were void (consideration of evidence and against the evidence and the weight of the evidence grounds).	Appeal upheld (declaration that relevant findings were void).
1994	[1995] 2 VR 69	*The Secretary to the Department of Health and Community Services v Gurvich*	*Coroners Act 1985* s 59; Application that certain of the coroner's findings are void (findings against the evidence and the weight of the evidence).	Appeal upheld (declaration that relevant findings were void).
1993	[1993] 2 VR 89	*Anderson v Blashki (Coroner)*	*Coroners Act 1985* s 59; Application that certain of the coroner's findings are void (findings against the evidence and the weight of the evidence).	Appeal upheld (declaration that relevant findings were void).
1991	[1991] VSC 289	*Taylor v Coroners Court of Victoria*	*Coroners Act 1985* s 59; Application that certain of the coroner's findings are void (evidence withheld from coroner that ought to have been made available at the inquest).	Appeal dismissed.