

15 November 2010

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RB;rp

The Honourable Stephen Wade MLC  
Shadow Attorney-General  
Parliament House  
North Terrace  
ADELAIDE SA 5000

Dear Mr Shadow Attorney

***Coroners (Recommendations) Amendment Bill 2010***

I refer to an email from your adviser, Mr Biars, received on 8 October 2010 and thank you for referring the above Bill to the Society for comment.

The Society's Criminal Law Committee has considered the Bill and accordingly I provide the following comments. We note your statement that the Bill seeks to bring South Australia "*into line with all other Australian jurisdictions*".

The equivalent provision in the respective *Coroners Acts* of each of the other Australian jurisdictions requires that the recommendation be in "*connection*" to the coronial event. The relevant portions of the sections are outlined below (with our emphasis).

***Victoria***

*s67(3) A coroner may comment on any matter connected with the death, including matters relating to public health and safety or the administration of justice.*

*s72(2) A coroner may make recommendations to any Minister, public statutory authority or entity on any matter **connected with** a death or fire which the coroner has investigated, including recommendations relating to public health and safety or the administration of justice.*

***New South Wales***

*s82(1) A coroner (whether or not there is a jury) or a jury may make such recommendations as the coroner or jury considers necessary or desirable to make in relation to any matter **connected with** the death, suspected death, fire or explosion with which an inquest or inquiry is concerned.*

- (2) Without limiting subsection (1), the following are matters that can be the subject of a recommendation:*
- (a) public health and safety,*
  - (b) that a matter be investigated or reviewed by a specified person or body.*

## Queensland

- s46(1) A coroner may, whenever appropriate, comment on anything **connected with** a death investigated at an inquest that relates to--
- (a) public health or safety; or
  - (b) the administration of justice; or
  - (c) ways to prevent deaths from happening in similar circumstances in the future.

## Western Australia

- s25(2) A coroner may comment on any matter **connected with** the death including public health or safety or the administration of justice.
- (3) Where the death is of a person held in care, a coroner must comment on the quality of the supervision, treatment and care of the person while in that care.

## Tasmania

- S28(2) A coroner must, whenever appropriate, make recommendations with respect to ways of preventing further deaths and on any other matter that the coroner considers appropriate.
- (3) A coroner may comment on any matter **connected with** the death including public health or safety or the administration of justice.
- (5) If a coroner holds an inquest into the death of a person who died whilst that person was a person held in custody or a person held in care or whilst that person was escaping or attempting to escape from prison, a secure mental health unit, a detention centre or police custody, the coroner must report on the care, supervision or treatment of that person while that person was a person held in custody or a person held in care.
- s45(2) A coroner may comment on any matter **connected with** the fire or explosion including public health or safety or the administration of justice.

## Australian Capital Territory

- s52(4) A coroner may comment on any matter **connected with** the death, fire or disaster including public health or safety or the administration of justice.

## Northern Territory

- s34(2) A coroner may comment on a matter, including public health or safety or the administration of justice, **connected with** the death or disaster being investigated.

It would therefore appear to us that your proposed amendments are wider than comparable provisions interstate.

Section 13 of the *Coroners Act 2003* vests the Coroner's Court with jurisdiction to hold inquests "in order to ascertain the cause of circumstances of the events prescribed under this Act.". The cause and circumstances are those set out in s21 of the Act.

The proposed amendment appears to vest the Court with the power to make a recommendation that is not confined to the event which conferred the jurisdiction. The proposed s25(2) provides as follows:

*The Court may add to its findings any recommendation that, in the opinion of the Court –*

- a) *might prevent, or reduce the likelihood of, a recurrence of an event similar to the event that was the subject of the inquest; or*
- b) *is appropriate in the circumstances (even if the recommendation relates to a matter that was not material to the event the subject of the inquest).*

Paragraph 25(2)(a) is the present s25(2). Paragraph 25(2)(b) is new and, we suggest, paves the way for the Coroners Court to make recommendations that are not connected to the event that confers jurisdiction or otherwise relevant to the inquest.

To date there have only been a limited number of reviews emanating from a Coroner's recommendation. This is because they are generally appropriate and predictable. If the amendment is enacted then there is the potential for the Coroner to make recommendations far beyond what was contemplated within the scope of the inquest. This will lead to an increase in the incidence of challenge to a Coroner's findings. This is an undesirable event.


The legislation should clearly and as unambiguously as possible, outline the Coroner's powers. To state that the Coroner may make a recommendation that "*is appropriate in the circumstances*" does not assist in defining the limits of the Coroner's power to do so. Indeed, read literally, the power is at large. That cannot be the case given the limited jurisdiction of the Coroner. By applying the usual principles of statutory construction the proposed s25(2)(b) will be read down (inevitably by the Supreme Court on appeal and more than likely on more than one occasion given the myriad of potential recommendations that may be made).

This exercise will be complicated by s25(2)(b) which, on its terms, suggests that the recommendation may relate to a matter that was not material to the coronial event. It begs the question, must there nevertheless be a connection to the event. This raises issues as to whether an immaterial matter can be connected. Ultimately, it leads to concerns that the Coroner may act beyond the power conferred on them.

Another amendment that we suggest should be considered is the equivalent of Western Australia's s25(3) and Tasmania's s28(5). This provision relates to deaths of people held in care. Where that occurs, the Coroner is required to comment on the quality of the supervision, treatment and care of the person while in care. This provision appears to expressly extend the matters upon which the coroner may comment. In our view, it would enable a Coroner to make recommendations on such matters raised by the Carter case (the young indigenous man who died in custody).

I trust this response is of assistance.

Yours sincerely



Ralph Bönig  
**PRESIDENT**