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Public Interest Advocacy Centre

Emily Treeby
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Upper House Committees
Legislative Council
Parliament of New South Wales

By email: emily.treeby@parliament.nsw.gov.au

Dear Ms Treeby,

Response to questions on notice

I refer to my appearance before the Select Committee on the coronial jurisdiction in New South Wales on Tuesday 30 November.

In response to Mr Shoebridge's question as to where the power in s 28(2) of the Tasmanian *Coroners Act* has been useful, we refer the Committee to the following material from the *Tasmanian Coronial Practice Handbook*,[1] which includes a number of examples of recommendations that have been made to prevent death pursuant to this power:

> **What are coroners' recommendations?**
> Coronial recommendations have the potential to be a powerful force for the improvement of public health and safety. Investigating deaths is the vital primary function of the coronial process; however, recommendations allow the coroner to transcend this purpose and to actively work towards preventing similar deaths. The legislation states that if it is appropriate, a coroner must make recommendations with respect to ways of preventing further deaths (Act s 28(2)). The coroner also has the power to make recommendations on any other matter they consider appropriate. The recommendations can be directed towards any person or organisation. Examples of the organisations subject to recommendations are: hospitals, regulatory bodies, private companies and government departments.
>
> Examples of recommendations made by coroners to prevent deaths include:
> - enhancement of community education on sudden infant deaths and the dangers of co-sleeping
> - promotion of driver safety
> - the compulsory use of life jackets
> - a redesign of Risdon Prison to reduce hanging points (amongst other things)
> - changing medication dispensing regimes in hospitals
> - a dedicated mental health outreach and out-patient services for at-risk youth
> - strengthening pool fencing regulations (and increasing public awareness as to the application of these regulations to inflatable pools).
>
> Unlike some other jurisdictions, there are no legislative requirements in Tasmania for government entities to respond to, or actively implement, coronial recommendations. In 2009, the Premier of

[1] http://www.magistratescourt.tas.gov.au/__data/assets/word_doc/0007/358981/Tasmanian_Coronial_Practice_Handbook.docx, 100-1.

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New South Wales issued a Memorandum to ensure a consistent process across the New South Wales government to respond to coronial recommendations. In Tasmania, we rely on the good will and energy of individual government entities and private organisations to take on coronial recommendations and implement them (or the closest, most practicable alternative). In this way, we have seen significant reforms that have saved lives.

Recommendations aim to be positive and practical. Often interested persons will have valuable insight into the organisational structures and realities in which the incident occurred. Anyone with this knowledge has the potential to enhance and assist the coroner's preventative role by providing advice on what the most practical and effective changes may be. *Coroners welcome input into potential recommendations from interested persons.*

The best recommendations in matters involving systemic errors:

- **prevent**: other similar deaths. How can mistakes that may have contributed to the death be prevented?
- **anticipate and compensate**: if mistakes are not preventable, how can we ensure that they do not have tragic consequences?
- **detect and correct**: if mistakes are not preventable, how can we ensure that they are detected and remedied as soon as possible?
- **are likely to be implemented**: as they fit with current practice. They may be cost effective, and clarify and simplify procedures.

In the particular case of a person who dies in government care or custody, recommendations are important. The coroner may make comments and recommendations regarding improvements to any systemic issues that would enhance safety in the future. Independent and public scrutiny by the coroner of government practice and procedures encourages continual improvement in those procedures. This enhances accountability, transparency and responsible government. The making of recommendations directed to government practice and procedures creates a strong incentive to prevent future tragedies and related public criticism.

The Committee will see reference to the absence of legislative requirements in Tasmania for government entities to respond to, or actively implement, coronial recommendations and the parallel drawn to NSW. Although the Handbook notes that through the 'good will and energy of individual government entities and private organisations' lives have been saved, the most recent Magistrates Court of Tasmania Annual Report[2] is less sanguine and makes clear that this is a deficiency in the Tasmanian regime:

Responses to Coronial Recommendations

Recommendations are an important part of the coronial jurisdiction and pursuant to section 28(2) of the Act a coroner is required, whenever appropriate, to make recommendations to prevent future deaths. Unlike most other Australian coronial jurisdictions, Tasmania lacks either a statutory or policy-based mandatory response regime to coronial recommendations. Consequently, the status of coronial recommendations in Tasmania is perceived as unclear and there is scope for improvement in this area.

[2] https://www.magistratescourt.tas.gov.au/__data/assets/pdf_file/0010/640729/Magistrates-Court-Annual-Report-2020-to-2021.pdf, 32.

Nevertheless, over the course of the reporting period there were favourable responses from several government departments in response to some coronial recommendations. The Division has been working with government departments to put in place some voluntary guidelines about the provision of responses to coronial recommendations and has been pleased with the level of co-operation that has been forthcoming from many departments.

We thank the Committee for this opportunity to provide further evidence and hope it assists the Committee in its deliberations.

Yours sincerely

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