

Coronial Assistance  
Legal Service



Coronial Investigation  
in Queensland:  
(Counter)-Therapeutic Effects

## ABOUT THE AUTHORS

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## DISCLAIMER

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## ABOUT CAXTON LEGAL CENTRE

Caxton Legal Centre (Caxton) has more than 40 years of experience representing the interests of people who are disadvantaged or on a low income when they come into contact with the law. Strategic advocacy, the provision of legal advice and social work services, and community legal education are key components of Caxton's service.

Caxton has a strong reputation for achieving outcomes for vulnerable people through high-quality legal advice across a range of areas including coronial law, civil law, family law, employment law, elder abuse law, retirement village and manufactured home park law and criminal law. A leader in the field of multidisciplinary service delivery, Caxton has refined the co-working relationship between lawyers and social workers to bring the strengths of each profession to the fore.

Caxton's respected reputation attracts universities, government and the community sector to form ongoing partnerships that enable the delivery of a diverse suite of services, from duty law services to student clinics each working towards Caxton's vision of a just and inclusive Queensland.

## CORONIAL ASSISTANCE LEGAL SERVICE

The Coronial Assistance Legal Service (Coronial Service) is operated by Caxton and Townsville Community Legal Service. The Coronial Service is funded by the Department of Justice and Attorney-General to provide legal advice and representation to bereaved families in contact with the coronial system.

The Coronial Service aims to ensure that families are able to participate in the coronial process in a way that responds to the needs of each individual family.

The Coronial Service does this by ensuring that families have access to legal advice, representation and social work support about all aspects of the coronial process and associated legal matters.

The Coronial Service:

- represents families in inquests
- provides advice where there is a dispute between family members about who should make decisions about the burial or cremation of a deceased person or where a funeral service should be held
- represents family members in mediations to resolve burial disputes
- prepares applications to the Supreme Court for the court to determine contested burial matters if matters cannot be resolved by mediation

- assists family members to make applications for burial assistance grants
- explains the coronial process and what bereaved families can expect
- requests information from coroners to assist families to understand how their loved one died
- makes submissions to coroners arguing that deaths are reportable deaths under the *Coroners Act 2003* (Qld) (Coroners Act)
- makes requests to coroners that inquests be held
- applies to the State Coroner seeking review of findings of other coroners
- provides advice about seeking review of decisions of coroners in the District Court
- communicates with organisations associated with the coronial process such as, Queensland Health, Office of Industrial Relations and Workplace Health and Safety prosecutor.

One third of all families who have accessed the Coronial Service have also received support from Caxton's social worker. The support Caxton's social worker provides includes:

- support in court at inquests
- grief and bereavement counselling
- applications to benevolent institutions to secure grants for travel and accommodation for family members to attend inquests
- referrals to suitable longer-term counselling services.

Caxton Legal Centre has now developed significant expertise in the coronial jurisdiction. The experiences of our clients identified through our work in the Coronial Service indicate that there are a number of improvements that could be made to coronial processes and practices to enhance the therapeutic benefits of the coronial system to assist families, witnesses and communities to heal.

## WHAT IS THERAPEUTIC JURISPRUDENCE?

Therapeutic jurisprudence is the study of the use of the law as a therapeutic agent.<sup>1</sup> It recognises that the law can have consequences that are therapeutic, and others that are counter-therapeutic.<sup>2</sup>

<sup>1</sup> Richardson, E., Spencer, P. and D. Wexler (2016). The International Framework for Court Excellence and Therapeutic Jurisprudence: Creating Excellent Courts and Enhancing Wellbeing. *Journal of Judicial Administration*, vol. 25, p. 153.

<sup>2</sup> Roper, I. and V. Holmes (2016). Therapeutic Jurisprudence in the Coronial Jurisdiction. *Journal of Judicial Administration*, vol. 25, p. 134.

Given that the coronial jurisdiction is required to investigate sudden and unexpected deaths, those drawn into the jurisdiction are typically experiencing significant grief, trauma and stress.<sup>3</sup>

The concept of therapeutic jurisprudence within the coronial system has attracted scholarly attention. Tait and Carpenter (2015) aptly note that the law is not simply a set of codes to be followed without reflection, for these codes have consequences on all involved in the proceedings.<sup>4</sup> As such, ‘... legal institutions, and those charged with making them work, are now deemed to have responsibility for the mental and emotional well-being of all participants.’<sup>5</sup>

The Coroners Act and the State Coroner’s Guidelines<sup>6</sup> explicitly give families a role in the coronial process and recognise the rights of families to:

... have their views considered when issues arise such as the extent of autopsy and to be informed of the coroner’s decision to retain organs/tissues for further investigation. They are deemed to have sufficient interest in information and documents pertaining to the investigation of their relative’s death, and to be given leave to appear at inquest into the death. They have a right to receive copies of the coroner’s findings and comments.<sup>7</sup>

In Queensland, coroners cannot investigate deaths without regard to the views or interests of family members of the deceased. The coronial process can either exacerbate or mitigate the grief and trauma of a sudden death<sup>8</sup> and, given that a coroner’s work is intimately connected with wellbeing,<sup>9</sup> coroners should be mindful of this. If coroners take a therapeutic approach towards the coronial process, it can help to reduce feelings of distress and trauma.<sup>10</sup> ‘What occurs after death, including how it is investigated and portrayed, can impact upon the grief process, potentially either distorting it or bringing it to resolution.’<sup>11</sup>

<sup>3</sup> Ibid, p. 136.

<sup>4</sup> Tait, G. and B. Carpenter (2015). Suicide, Statistics and the Coroner: A Comparative Study of Death Investigations. *Journal of Sociology*, vol. 51(3), p. 563.

<sup>5</sup> Ibid.

<sup>6</sup> *State Coroner’s Guidelines 2013*. Ch. 2.

<sup>7</sup> Ibid.

<sup>8</sup> Tait, G., Carpenter, B., Quadrelli, C. and M. Barnes (2016). Decision-making in a Death Investigation: Emotions, Families and the Coroner. *Journal of Law and Medicine*, vol. 23(3), p. 571.

<sup>9</sup> King, M. (2009). Non-adversarial Justice and the Coroners Court: A Proposed Therapeutic, Restorative, Problem-solving Model. *Journal of Law and Medicine*, p. 442.

<sup>10</sup> Roper, I. and V. Holmes (no. 2), p. 136.

<sup>11</sup> Freckelton, I. QC (2016). Minimising the Counter-therapeutic Effects of Coronial Investigations: In Search of Balance. *QUT Law Review*, vol. 16(3), pp. 4, 6.

## EXPERIENCE OF FAMILY MEMBERS

### Confusion and lack of ‘an equal voice’

Families are thrust into the coronial process because of the sudden, unexpected death of a loved one. The great majority of these families will not have any real knowledge or understanding of the coronial process. Families often ‘... hold misconceptions about the purpose and function of coroners courts. A common and potentially damaging misunderstanding is that the coroner’s role is to apportion blame or responsibility for a death.’<sup>12</sup>

Early and thorough explanation of the purpose, role and the scope of the coronial process can minimise the potential for misunderstanding.

Some families find the idea of a coronial investigation confronting, however, others find that it provides much needed answers about the death of their loved one.<sup>13</sup>

Despite the inquisitorial nature of the coronial process and inquests, families also feel that they struggle to get an equal voice in the coronial process, particularly in inquests.<sup>14</sup> Government and institutional bodies that participate in inquests are usually legally represented to ensure that their interests are protected. Families can feel that they are left to fend for themselves and rarely feel at the centre of the process.<sup>15</sup>

### Time delays in coronial processes

Time delays and lack of communication with bereaved families has highlighted the need for reform in the coronial jurisdiction. Prolonged investigations and delayed inquests can re-traumatise those close to the deceased and exacerbate their grieving process, as well as increase the risk of losing records and a decline in the reliability of witness’s memories.<sup>16</sup> It is also distressing for families that delays may mean that recommendations that coroners make at inquest are not timely and ‘... that other lives are endangered or lost in the intervening period when matters of public safety are not remedied.’<sup>17</sup>

Coroners strive to resolve inquests in a fast and efficient manner to minimise the risks of delay to parties involved, working in conjunction with agencies such as the Queensland Police Service, Department of Health and Department of Justice and Attorney-General.<sup>18</sup>

<sup>12</sup> Roper, I. and V. Holmes (no. 2), p. 142.

<sup>13</sup> Queensland Audit Office (2018). *Delivering Coronial Service*. Report, p. 4.

<sup>14</sup> Coronial Reform Group (2019). *Submission from the Coronial Reform Group (CRG) to the Productivity Commission Inquiry into the Social and Economic Benefits of Improving Mental Health* 39, p. 3.

<sup>15</sup> Ibid.

<sup>16</sup> Ibid.

<sup>17</sup> Ibid.

<sup>18</sup> Queensland Audit Office (no. 13), p. 37.

However, the timeliness of the finalisation of coronial investigations depends on a number of factors including the complexity of the case, the circumstances of the death, whether criminal proceedings are instituted, reliance on expert evidence and whether an inquest is held.<sup>19</sup>

The time that it takes for information to pass through the requisite channels can cause significant harm to the affected families.

Further to the prolonged grief and re-traumatisation, delayed coronial investigations and inquests can result in those involved doubting the ability and authenticity of the coroner, as well as increasing the risks of families making allegations that are based on suspicion alone.<sup>20</sup>

## Lack of Communication to Bereaved Families During Coronial Investigations

The coronial system must strike a delicate balance regarding communication with families. Too little or no communication received by families is frustrating and can cause distrust or suspicion, while too much may be upsetting and re-traumatising.<sup>21</sup> However, anecdotally as identified through our practice, it is the lack of communication that causes the greatest concern for families in the coronial jurisdiction.

Initial contact with family is usually made by police who first respond to the scene, they deliver brochures to the families that explain the process of a coronial investigation. The family will then also receive a letter from the Coroners Court at the start of the investigation, which contains further information. If forensic services are required, the family will also receive information from a coronial counsellor.<sup>22</sup>

After these letters have been received, little communication is directed to the families about the progress of the investigation. The *Delivering Coronial Services Report* by the Queensland Audit Office found that the lack of communication is due to a variety of factors including:

- no single point of contact. Agencies do not appoint a case manager with responsibility for the file across the duration of the investigation
- workload of agency staff. High workloads and backlogs mean that staff do not have time to proactively communicate with families
- lack of procedures, processes, or systems for sharing information across agencies and prompting staff to update families

- inadequate staffing and structures in some areas. This can mean that when staff take leave there is limited or no coverage of their roles by other staff. As a result, actions such as communicating with families are often delayed until the staff member returns.<sup>23</sup>

Procedural reform to improve communication with bereaved families is needed to better support and inform them during this difficult time.

Candid and constant communication to the next of kin should be paramount in a coronial investigation. Families should have timely access to investigation materials including autopsy reports, police investigation reports and other relevant investigation material. Families should be supported to understand that material. The appointment of a case manager has been recommended to assist coroners with this task.<sup>24</sup>

## ENHANCING THE THERAPEUTIC BENEFITS OF THE CORONIAL PROCESS

### Legal and advocacy services

Families can find it very helpful to receive legal advice about the coronial process and how to obtain information throughout an investigation or how to request an inquest.<sup>25</sup> Many families find inquest proceedings formal and intimidating. This is especially the case where there are government departments or corporations involved whose interests are often advanced through legal representatives in an adversarial manner.<sup>26</sup> Where families are not legally represented in inquests, they often rely on counsel assisting the coroner to explain processes and convey questions to witnesses. This can cause a conflict for counsel assisting whose role requires that they impartially and fairly present evidence to the coroner.<sup>27</sup>

Of the 107 families that Caxton assisted through the Coronial Service from June 2017 until November 2019, 90 families identified as being financially disadvantaged and being unable to afford to pay for legal advice or representation in relation to their coronial matter.

The ACT Coronial Reform Group recommend that government ensure that proper financial, legal and other support is provided to bereaved families to participate in the coronial process.<sup>28</sup>

<sup>23</sup> Ibid, p. 38.

<sup>24</sup> Sweeney Research (no. 21).

<sup>25</sup> Australian Inquest Alliance (2011). *Submission to Productivity Commission Inquiry into Access to Justice Arrangements*, p. 7. <https://www.pc.gov.au/inquiries/completed/access-justice/submissions/submissions-test/submission-counter/sub062-access-justice.pdf>. Accessed 14 November 2019.

<sup>26</sup> Ibid.

<sup>27</sup> *State Coroners Guidelines 2013*. Ch. 9, p. 9.

<sup>28</sup> Coronial Reform Group (no. 14), p. 3.

<sup>19</sup> Ibid, p. 29.

<sup>20</sup> Freckelton, I. QC (no. 11).

<sup>21</sup> Sweeney Research (2008). *Families, Information Needs and Experiences of the Victorian Coronial System*. Report, Victorian Department of Justice quoted in Freckelton, I. (no. 11).

<sup>22</sup> Queensland Audit Office (no. 13), p. 37.

## Counselling and support services

There is currently limited counselling and support services available for bereaved families throughout the coronial process in Queensland. Families are currently being referred to the Queensland Health Forensic and Scientific Services (QHFS) for support immediately after death, mainly with decisions around autopsy,<sup>29</sup> however, resources are limited as QHFS only has five counsellors.<sup>30</sup> This service cannot provide ongoing support to families and limited to no support is offered to witnesses.<sup>31</sup> The Office of Industrial Relations currently provides grief and trauma counselling services to individuals, families and witnesses affected by a workplace death or serious injury.<sup>32</sup> The Queensland Audit Office has stated that the support given to witnesses by the Coroners Court needs to be improved.<sup>33</sup>

In the inquest into the death of Marcia Anne Kathleen Maynard, Deputy State Coroner Lock recommended that the Queensland Government facilitate and fund a program that provides counselling for families and witnesses or others who may be involved in, and impacted by, a coronial investigation and/or inquest.<sup>34</sup>

In May 2019, the Queensland Government responded to the recommendation made in the Maynard inquest indicating that implementation of the recommendation was under consideration.<sup>35</sup> The Attorney-General and Minister for Justice further responded on 3 September 2019 and stated:

In acknowledging that families and witnesses have a diversity of support needs, a series of consultation sessions will be held in 2019 to bring together those who play a role in supporting people bereaved or otherwise affected by a death reported to a coroner ...

Agencies are also continuing their focus on improving the case management and legal assistance they provide to coroners and the counselling support provided to families, through the allocation of additional temporary staff within the Coroners Court of Queensland and additional coronial counsellors within Queensland Health.<sup>36</sup>

One third of families who accessed Caxton's Coronial Service also accessed Caxton's social worker. Caxton does not currently receive funding for a coronial social work service

but has identified a need for coronial clients to receive such support. Dr John Drayton has identified that '... [s]ocial work assists bereaved people most directly by maintaining a space for reflection within the confusion and demands of the coronial jurisdiction, enabling and validating insights unavailable to the microscope or the legislature.'<sup>37</sup>

## Allowing families to provide information about the deceased person during an investigation or at inquest

Understandably, family members often want to be able to tell their story '... to have it taken into account by the court and to be treated with respect, with an ethic of care.'<sup>38</sup> It is important for family that the court acknowledge that the inquest is about the death of a particular deceased person, who lived a unique and valuable life and whose loss is deeply felt by the family.<sup>39</sup>

King recounts how therapeutic jurisprudence influenced the way the Geraldton coroner wrote his decisions:

Previously, he had always referred to the dead person as the 'deceased', and their background was only referred to in so far as it related to the cause of death. Now, he always refers to the person by their formal title and begins with a short paragraph containing personal details placing the person in a social and family context. The thinking behind the change was that the family would better appreciate the reasons that acknowledged the humanity of their loved one rather than those that appeared to reduce the person to an object.<sup>40</sup>

Queensland coroners have allowed family members to read statements about their loved one into the record at the close of evidence, explaining to the court who the deceased was as a person and setting out the impact that the death has had on the family.<sup>41</sup> Less commonly, coroners have allowed family members to play video presentations or show photographs in court.<sup>42</sup>

While there is contention as to whether this practice appropriately maintains the fact-finding objectivity of the court,<sup>43</sup> the practice is very much appreciated by our client family members and, managed appropriately, does not impact on the objectivity or impartiality of the coroner.<sup>44</sup>

<sup>29</sup> Queensland Audit Office (no. 13), p. 40.

<sup>30</sup> Ibid.

<sup>31</sup> Ibid.

<sup>32</sup> <https://www.worksafe.qld.gov.au/injury-prevention-safety/incidents-and-notifications/in-an-emergency>. Accessed 14 November 2019.

<sup>33</sup> Queensland Audit Office (no. 13), p. 40.

<sup>34</sup> Lock, J., Deputy State Coroner (2018). *Findings of Inquest into the death of Marcia Anne Kathleen Maynard*, 22 September 2018, p. 22.

<sup>35</sup> Queensland Government *Response to Recommendations made in the Findings in the Inquest into the Death of Marcia Anne Kathleen Maynard*. [https://www.justice.qld.gov.au/\\_data/assets/pdf\\_file/0009/614583/qgr-maynard-ma-20190909.pdf](https://www.justice.qld.gov.au/_data/assets/pdf_file/0009/614583/qgr-maynard-ma-20190909.pdf). Accessed 11 November 2019.

<sup>36</sup> Ibid.

<sup>37</sup> Drayton, J. (2013). Bodies-in-Life/Bodies-in-Death: Social Work, Coronial Autopsies and the Bonds of Identity. *The British Journal of Social Work*, vol. 42(2), pp. 264, 279.

<sup>38</sup> King, M. (no. 9), p. 457.

<sup>39</sup> Freckelton, I. QC (no. 11), p. 26.

<sup>40</sup> King, M. (no. 9), p. 446.

<sup>41</sup> State Coroner Ryan; *Findings in the Inquest into the Death of Russell Winks*, 12 December 2018, p. 5; Deputy State Coroner Lock; *Findings in the Inquest into the Death of Stephen Leonard Viner*, 8 August 2019, p. 4.

<sup>42</sup> Coroner Wilson; *Findings in the Inquest into the Death of Holly Winta Brown*, 12 June 2019, p. 5.

<sup>43</sup> Freckelton, I. QC (no. 11), p. 26.

<sup>44</sup> Ibid, p. 27.



The process provides the court an opportunity to express empathy. The coroner can also acknowledge what the family has said concerning the effect of the death in the reasons for the decision.<sup>45</sup>

## Therapeutic benefits of coronial comment and recommendations

Coroners are required to make findings as to the identity of the deceased, the place, time, manner and cause of death.<sup>46</sup> If an inquest is held, the coroner may also make a comment about anything connected with a death that relates to public health or safety, or the administration of justice or ways to prevent deaths from happening in similar circumstances in the future.<sup>47</sup>

The Coroners Act does not require government to respond to recommendations made by coroners, however, the State Government has implemented an administrative arrangement whereby government agencies are required to report publicly on their response to recommendations directed to them.<sup>48</sup> These responses to recommendations are published on the State Coroners website with inquest findings.<sup>49</sup>

Timely and thoughtfully devised coronial recommendations can strengthen the therapeutic benefit of the coronial jurisdiction for families,<sup>50</sup> particularly where government responds and/or implements those recommendations, and families can see a community benefit obtained from the death of their loved one.<sup>51</sup>

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<sup>45</sup> King, M. (no. 9), p. 457.

<sup>46</sup> s 45(2) *Coroners Act 2003* (Qld) (Coroners Act).

<sup>47</sup> s 46(1) Coroners Act.

<sup>48</sup> *State Coroner's Guidelines 2013*. Ch. 9, p. 22.

<sup>49</sup> <https://www.courts.qld.gov.au/courts/coroners-court/findings>.

Accessed 14 November 2019.

<sup>50</sup> Roper, I. and V. Holmes (no. 2), p. 146.

<sup>51</sup> Coronial Reform Group (no. 14), p. 4.