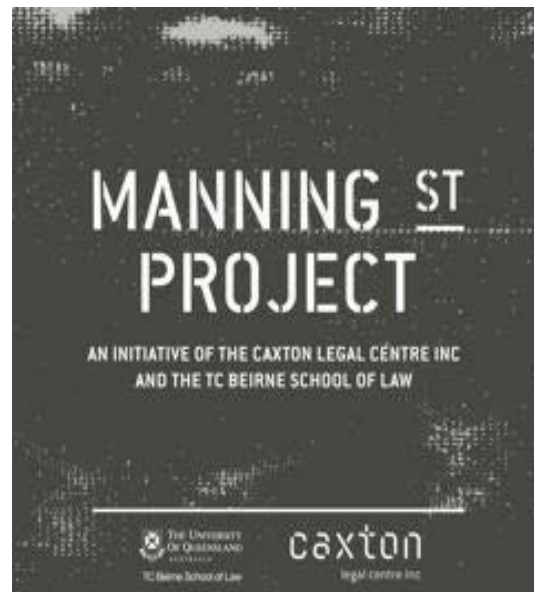


UQ PRO BONO CENTRE - MANNING ST PROJECT  
T.C. BEIRNE SCHOOL OF LAW  
UNIVERSITY OF QUEENSLAND



## **Coronial Inquests and Investigative Processes in Queensland**

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## EXECUTIVE SUMMARY

This project aims to critically examine the coronial laws and practices in Queensland in relation to deaths in custody since the enactment of the *Coroners Act 2003* (Qld). The project focuses on the reasoning and outcomes of several prominent inquests - Cameron Doomadgee, Caitlin Hanrick, Michael Eddy and Antonio Galeano.

This project identifies several concerns to family members which have repeatedly arisen in relation to coronial investigations. These include: delay associated with investigations and reports, procedural fairness and independence of the coronial investigation (including collusion and poor communication between police officers and reliance of the coroner on biased evidence) and the ability for family members to challenge or review coronial findings through the courts.

The coronial reports, to a certain degree, have attempted to address the above issues of concern through their general power to comment on anything connected to the death.<sup>1</sup> However as this report demonstrates, the quality and detail of recommendations by the coroner have had a large bearing on their successful implementation.

## SUMMARY OF RECOMMENDATIONS

This paper offers the following recommendations with a view to improve the existing coronial justice system:

1. That the *Coroners Act 2003* (Qld) be amended to empower the coroner to enforce penalties against the Queensland Police Service where there is unreasonable delay in the presentation of important documents.

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<sup>1</sup> *Coroners Act 2003* (Qld) s 46.

2. That the coroner be given a discretionary power to release a preliminary report which includes recommendations to prevent similar deaths in future.
3. That opinions and comments of the coroner be contained in a separate section of the coroner's report, either the Recommendations section or a separate independent subsection created solely for statements of opinion.
4. In order to ensure that the Responses to Coronial Recommendations do not fall victim to a change in government policy, responses to coronial recommendations should be made mandatory by legislation.
5. That the State Coroner provide information to the Queensland Ombudsman so that the Ombudsman can monitor the implementation of coronial recommendations by public agencies.

## I. INTRODUCTION AND RATIONALE

This project focuses on deaths in police custody which are required to be investigated under s 11(7) of the *Coroners Act 2003*. Deaths in police custody or as a result of police action always raise social concerns, particularly given the positive duties of police officers to protect the general public. The standard of care owed to those detained by police is still higher; the detainees' relative dependence on police means that police responsibility for their welfare becomes a positive duty to prevent harm. Under the *Police Powers and Responsibilities Act 2000* and the *Coroners Act*, there is an increased level of social and political interest in the events surrounding deaths in custody. However, while mandatory coronial inquests into deaths in custody increase transparency and accountability, there are few mechanisms for ensuring the independence and integrity of the coronial process. A fundamental conflict of

interest arises in situations where members of the Queensland Police Service (*QPS*) are allowed to be involved in the initial investigation into a death in custody.

The coronial process facilitates the investigation of deaths which cannot be adequately explained by medical personnel, or which raise important social or legal issues.<sup>2</sup> If possible, the coroner is required to find whether a death has occurred, the identity of the deceased, when, where and how the death occurred and what caused the person to die.<sup>3</sup> The aim is to inform the family and public of what happened and to make recommendations which decrease the likelihood of similar deaths.<sup>4</sup>

Part I of this paper explains the methodology in undertaking this project, including resources consulted and the project aims.

Part II analyses the extent to which family members' concerns appear to be acknowledged and addressed within the coronial inquest and reports. This includes concerns with delay, coronial independence and the police investigative processes.

Part III considers the recommendations made by coroner under s46 of the *Coroners Act 2003*. Where recommendations have been clearly made, this section will analyse their language and presentation, and investigate whether those recommendations have in fact been implemented by the Queensland government or other applicable bodies.

## A. METHODOLOGY

This project came about through the Manning St Project upon the request of Caxton Legal Centre. The Manning St Project is a partnership between the UQ Pro Bono Centre and

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<sup>2</sup> *Coroners Act 2003* (Qld) s 8

<sup>3</sup> *Coroners Act 2003* (Qld) s 45

<sup>4</sup> *Coroners Act 2003* (Qld) ss 46-47

Caxton Legal Centre, which offers law students the opportunity to work on action research and law reform projects on a pro bono basis. Under the supervision of Scott McDougall, Director and Principal Solicitor of Caxton, four students were selected to undertake the research. The project seeks to inform Caxton Legal Centre's law reform program and its broader efforts to reform Queensland and Australia's coronial laws and practices, particularly in relation to deaths in custody.

Caxton Legal Centre is the largest generalist Community Legal Centre in Queensland. The Centre undertakes a wide range of casework and representation each year on various matters, one of which is inquests relating to deaths in custody.<sup>5</sup> The students attended Caxton Legal Centre on a weekly basis over the course of the academic semester to work on the project as a research group.

The research began with general research, including browsing relevant internet sources and reading related legislations such as the *Coroners Act 2003* and State Coroner's Guidelines 2003. Four prominent inquests in Queensland – Cameron Doomadgee, Caitlin Hanrick, Michael Eddy and Antonio Galeano – were closely examined and analysed. Additional cases in relation to deaths in custody in Queensland, as discovered on the Queensland Courts website, were read in order to gain a fuller understanding of how coronial matters have been dealt with. Under the supervision of UQ Pro Bono Centre Director Monica Taylor, the students also attended and observed an informal court session in relation to the inquest of Jason Protheroe in order to gain a fuller understanding of the practical aspects of the coronial process. These multiple cases enabled the students to identify similar issues of concern to families of the deceased as well as the general public in respect of the conduct of the

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<sup>5</sup> Caxton Legal Centre, *About Us* (28 May 2013) Caxton Legal Centre Inc <[http://www.caxton.org.au/about\\_us.html](http://www.caxton.org.au/about_us.html)>

Queensland Police Service, the quality and detail of recommendations made by the coroner and the degree to which the recommendations have been implemented.

Finally, the students closely analysed the coronial recommendations that have been implemented in terms of quality and degree. In addition to the cases mentioned above, a number of government publications such as the ‘Office of the State Coroner Annual Report’ and ‘The Queensland Government’s response to coronial recommendations’ were reviewed. Law reform literature from other Australian jurisdictions (including that of Victoria and Western Australia) was also reviewed. Throughout the course of the research, the students discovered several aspects where coronial practices could be improved and recommendations have been made accordingly.

## B. CURRENT LAW

The coronial process exists to ensure principles of transparency and social justice are preserved when deaths in custody and other reportable deaths are investigated. These principles are fundamentally undermined by the involvement of police in coronial investigations, however temporary that involvement may be. A touchstone of the Queensland justice system is that justice must not only be done, but must be seen to be done. The purpose of the coronial process, although not set out in legislation, is succinctly stated by the Coroner Michael Barnes in his inquest into the death of Philip Glen Spicer:

As can be readily appreciated, whenever a death is connected with police action it is essential the matter be thoroughly investigated to allay any suspicions that inappropriate action by the officers may have contributed to the death. The family and friends of the deceased person are entitled to expect a thorough investigation and an

account of how the death occurred. It is also desirable that the general public be fully apprised of the circumstances of the death so they can be assured the actions of the officers have been appropriately scrutinised. The police officers involved also have a right to have an independent assessment made of their actions so there can in future be no suggestion there has been any “cover up” of inappropriate action.<sup>6</sup>

It is not apparent, however, that the coronial process clearly accomplishes these goals. Although the coronial process is an administrative function, deaths in police custody necessarily have close links to criminal law: investigations into deaths in police custody will directly affect the public’s confidence in the QPS and the justice system. To the extent that the coronial process is informed by and connected to the criminal justice system, it should be governed by the same principles of natural justice and procedural fairness. For these reasons, this report places a particular focus on the investigative procedures used in coronial inquests and the involvement of the QPS and the Queensland Police Union (*QPU*) in those investigations.

### C. THE STEPS OF A CORONIAL INVESTIGATION

The Queensland Courts website outlines the nine-step process undertaken in a coronial investigation.<sup>7</sup> The coroner controls and coordinates the process of the investigation, and will generally be assisted by police officers. As will be seen throughout this paper, the length of the investigation process varies under different circumstances, and may often take months or years. The nine-step process outlines that:

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<sup>6</sup> Queensland Coroner’s Court, *Inquest into the Death of Philip Glen Spicer* (2011) Mr Michael Barnes,1-2.

<sup>7</sup> Queensland Courts, ‘Coronial Investigations’ *Queensland Courts*  
<<http://www.courts.qld.gov.au/courts/coroners-court/coronial-investigations>> (at 28 May 2013).



1. The death is reported to the coroner, usually from police who have attended the scene and obtained information.
2. A government contracted funeral director is arranged by the police to take the deceased to a mortuary.
3. The coroner requires the deceased person to be formally identified before they can be released to the family for the funeral.
4. Police assist the coroner in investigating the death and help to prepare an initial report for the coroner. The coroner may ask police to conduct further investigations.
5. The coroner may order an autopsy to help determine how and when the person died.
6. If satisfied with the autopsy, the coroner may then release the body.
7. The coroner possesses wide powers of investigation, and can request additional reports, statements or information about the death. This will often involve engaging relevant experts in the field depending on the circumstances.
8. Upon consideration of these enquiries, the coroner will then consider whether or not to hold an inquest into the death. This involves consultation with the family of the deceased as to whether the inquest will be held.
9. At the end of the investigation, the coroner must provide written findings in a report.

It has been held that rules of natural justice are applicable to coronial inquests. *Annetts v McCann* was a High Court case from 1990 involving coroner McCann of Western Australia.<sup>8</sup> The case revolved around the application of Section 24 of the *Coroners Act 1920 (WA)*, providing that any person who in the opinion of the coroner has a 'sufficient interest' in the

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<sup>8</sup> *Annetts v McCann* [1990] 170 CLR 596

subject or the result of the inquest may attend personally or by counsel and may examine or cross-examine witnesses.<sup>9</sup> The question in issue was whether or not this section displayed a legislative intention to exclude the rules of natural justice, in particular the common law right of the appellants to be heard in opposition to any potential finding which would prejudice their interests.<sup>10</sup>

The findings of Mason, Deane and McHugh JJ were that the rules of natural justice were applicable, and that a coroner cannot lawfully make any finding adverse to the interests of the appellants without first giving them the opportunity to make submissions against the making of such a finding. The legal principle therefore is that there is a legal entitlement to make submissions in respect of matters which may be the subject of adverse findings against *themselves* or *the deceased*. There is no legal right to make submissions regarding the general subject matter of the inquest.

## II. RECURRING ISSUES OF CONCERN TO FAMILY MEMBERS

In its current form, the coronial process often acknowledges the concerns of family members and provides some opportunity for them to ask questions about the death of the deceased.<sup>11</sup> However, it is possible to discern concerns which repeatedly arise in relation to coronial investigations involving varying circumstances.<sup>12</sup> The recurrence of the same concerns in multiple coronial inquests indicates a more systemic failure within the coronial

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<sup>9</sup> *Coroners Act 1920 (WA)* s 24

<sup>10</sup> *Annetts v McCann* [1990] 170 CLR 596

<sup>11</sup> *Coroners Act 2003 (Qld)* s 36 permits a person “who the coroners court considers has sufficient interest in the inquest” to appear at the inquest. This will include family members and close friends of the deceased.

<sup>12</sup> See Law Reform Commission of Western Australia, *Review of Coronial Process in Western Australia*, Dr Tatum Hands (June 2011).

process. Concerns include the delay associated with investigations and reports; the procedural fairness and independence of the coronial investigation, especially in police custody matters; the clarity of and adherence to proper police operating practices and investigative processes for a death in custody; and the ability of family members to challenge or review coronial findings through the courts

Part of the purpose of the coronial process is to provide answers to the families of the deceased and to address concerns which the families raise.<sup>13</sup> However, in some cases reports acknowledge family or wider public concerns with issues in the particular case, but fail to make any recommendation for change or offer an explanation for the issue.<sup>14</sup> Occasionally, inquests may raise concerns which are neither addressed nor acknowledged by the coronial report.<sup>15</sup> In the latter two cases, the coronial process can clearly be seen to be falling short of its explanatory and transparency goals.

#### A. DELAY

The problem of delay, viewed from the perspective of concerned family members, must include the entire investigative process, beginning with the discovery of the death and ending with the presentation of the coroner's findings. Part of the purpose of the coronial inquest is to provide family members with peace of mind through a conclusive determination of how the deceased died.<sup>16</sup> When significant periods of time are allowed to elapse between the death and the presentation of coronial conclusions, this purpose is not properly fulfilled. A delay in the period between the death and the coronial inquest may result in injustice, as

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<sup>13</sup> Ibid., 12. Although the *Coroners Act 2003* (Qld) does not explicitly set out the purposes of the Act or of the coroner, both the law reform paper and coroner's reports acknowledge the important role that family plays in the coronial process. It is inherent in the ability of a family to appear before the coronial court that their concerns should be addressed.

<sup>14</sup> See eg, Queensland Coroner's Court, *Inquest into the Death of Caitlin Hanrick* (2009) Mr Michael Barnes.

<sup>15</sup> See eg, Queensland Coroner's Court, *Inquest into the Death of George Lowe* (2012) Mr Michael Barnes.

<sup>16</sup> *Coroners Act 2003* (Qld) s 45.

witness recollections fade and the reliability of evidence is in doubt; delay in the presentation of findings may cause distress to the family. Of course, the delay in an inquest and in the presentation of findings must be considered in the circumstances which surround a particular inquest. Technical or complex matters will necessarily involve technical and complex evidence, and the coroner must first wait for and then consider and analyse this evidence:

*Coroners are dependent upon other agencies completing their parts of the investigative process (i.e. first response officers, forensic pathologists, toxicologists, forensic scientists, disaster victim identification officers, detectives, other specialist investigators & expert reviewers from diverse specialities), and must balance the benefits of timeliness against the risks of taking shortcuts.<sup>17</sup>*

The following table and graphs show the time lapse between the death of the person in police custody and the commencement of a coronial hearing, and the lapse between the end of the hearing and the delivery of findings:

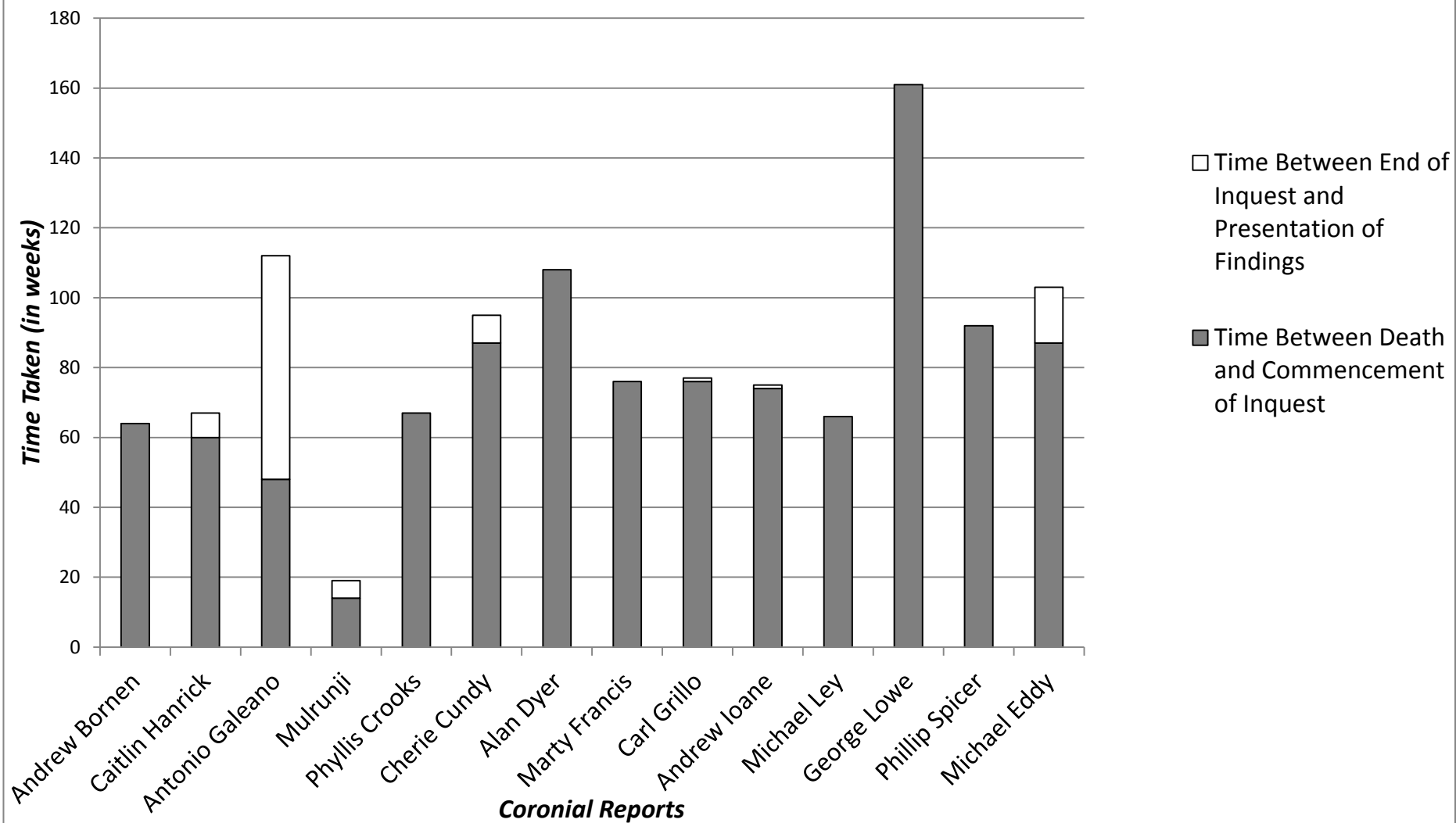
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<sup>17</sup> Queensland Courts, *Annual Report 2011-12*, 'Office of the State Coroner' (2012) 2.

Case	Death	Inquest Length	Findings	Time between death and Inquest	Time between Inquest conclusions and findings	Total time lapse
Andrew Borden	7-Feb-09	16 June 2010; 12-16 July 2010	16-Jul-10	64 weeks	0 days	64 weeks
Caitlin Hanrick	4-Dec-06	1 April 2009; 18-22 May 2009	17-Jul-09	60 weeks	7 weeks	67 weeks
Antonio Galeano	12-Jun-09	10 June 2010; 12 August 2010; 15 October, 1-11 November 2010, 3-13 March, 21 March-1 April, 14-16 June, 11-12 July 2011	14-Nov-12	52 weeks	64 weeks	172 weeks
Mulrunji	19-Nov-04	3 March 2005, 29-30 March 2005, 6 April 2005, 1-5 August 2005, 19 August 2005, 5 October 2005, 27 February-3 March 2006, 16 August 2006	27-Sep-06	14 weeks	5 weeks	97 weeks
Phyllis Crooks	12-Dec-09	19 May 2011; 20-22 June 2011	22-Jun-11	67 weeks	0 days	67 weeks
Cherie Cundy	3-Dec-07	21 September 2009, 9 December 2011-16 December 2011, 10 July 2012	13-Sep-12	87 weeks	8 weeks	95 weeks
Alan Dyer	31-May-08	27 August 2010; 27-29 September 2010	29-Sep-10	108 weeks	0 days	108 weeks

Marty Francis	4-Oct-08	2 July 2010; 15-16 November 2010	17-Nov-10	76 weeks	1 day	76 weeks
Carl Grillo	14-Dec-09	15 July 2011; 30 August-2 September 2011	7-Sep-11	76 weeks	1 week	77 weeks
Andrew loane	15-Dec-04	28-29 June 2006	30-Jun-06	74 weeks	1 week	75 weeks
Michael Ley	4-Jun-11	23 October 2012, 10-11 December 2012	12-Dec-12	66 weeks	1 day	66 weeks
George Lowe	25-Sep-09	9 September 2011; 2 November 2012	2-Nov-12	161 weeks	0 days	102 weeks
Phillip Spicer	21-Jan-09	4 November 2010; 8 February 2011	9-Feb-11	92 weeks	1 day	92 weeks
Michael Eddy	20-Feb-04	12-15 December 2005; 12 October 2006	12-Feb-07	87 weeks	16 weeks	103 weeks

## Coronial Inquest Time Lapse



Delay in the coronial process represents a fundamental concern to the family members of those who are the subject of investigations.<sup>18</sup> According to the Law Reform Commission of Western Australian its review of coronial practice within that state in 2011, delays of more than 12-18 months undermined the impact of the inquiry and findings:

*the circumstances of the death become historical and recommendations to prevent the occurrence of future deaths in similar circumstances are less meaningful. A number of respondents to the Commission's public survey who had been involved as witnesses in prison deaths also commented that the significant delays in the coronial process meant that it was difficult to recall events accurately and this made the experience of giving evidence very stressful.*<sup>19</sup>

The problems which result from delay in the coronial process can be seen in the cases of George Lowe, Alan Dyer, Caitlin Hanrick, and Antonio Galeano.<sup>20</sup> The first of these cases represent cases in which delay was either inexplicable or resulted from circumstances which might have been avoided by the coroner. The latter two exemplify the problems caused by delay, even where that delay is justified, in the resolution of controversial proceeds and the effectiveness of coronial recommendations.

George Robert Lowe was an 80-year-old man who died on 25 September 2009 as a result of injuries sustained in a traffic collision. The report into his death concluded that the brief police pursuit which preceded his death did not in any way

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<sup>18</sup> Above n 9, 50.

<sup>19</sup> Above n 9, 51.

<sup>20</sup> Queensland Coroner's Court, *Inquest into the Death of George Lowe* (2012) Mr Michael Barnes; Queensland Coroner's Court, *Inquest into the Death of Caitlin Hanrick* (2009) Mr Michael Barnes; Queensland Coroner's Court, *Inquest into the Death of Alan Dyer* (2012) Mr Michael Barnes; Queensland Coroner's Court, *Inquest into the Death of Antonio Galeano* (2012) Ms Christine Clements.



cause the collision.<sup>21</sup> It was found that the pursuing officers fully complied with QPS pursuit policy and the accident and death of Mr Lowe were not a result of their actions.<sup>22</sup> No recommendations were made. However, the coroner commented with concern that 22 months passed between the incident and the provision of the QPS accident report to the coroner.<sup>23</sup> The proceedings were relatively uncontroversial and there is no indication that the delay had an impact on the outcome of the inquest. Yet such a significant delay damages confidence in the coronial system, and undermines the ability of the coronial system to provide peace of mind and closure to family members. In the event, three years were allowed to elapse between Mr Lowe's death and delivery of the coroner's findings, which were given on the same day that the inquest concluded.<sup>24</sup>

Alan Dyer was killed in 2008 in an incident that the coroner ruled "suicide by cop"; that is, Mr Dyer intentionally threatened police officers he knew to be armed so that they would be forced to shoot him in self-defence.<sup>25</sup> As in Mr Lowe's case, the proceedings and outcome were relatively straightforward, and there was no indication of misconduct or fault by any of the parties involved.<sup>26</sup> The only recommendation made was a suggestion that police undergo additional training for "suicide by cop" situations, having regard to their increasing likelihood. However, between Mr Dyer's death at the end of May 2008 and the delivery of findings at the end of September 2010, over two years had passed.<sup>27</sup> Unlike Mr Lowe's report, the coroner gave no indication of why the proceedings suffered such a delay. The delivery of findings again coincided with the conclusion of the inquest, which ran for four days in August

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<sup>21</sup> Queensland Coroner's Court, *Inquest into the Death of George Lowe* (2012) Mr Michael Barnes, 1.

<sup>22</sup> *Ibid.*, 8.

<sup>23</sup> *Ibid.*, 2.

<sup>24</sup> *Ibid.*, 'Findings of Inquest.'

<sup>25</sup> Queensland Coroner's Court, *Inquest into the Death of Alan Dyer* (2012) Mr Michael Barnes, 1.

<sup>26</sup> *Ibid.*, 14.

<sup>27</sup> *Ibid.*, 'Findings of Inquest.'

and September of 2010.<sup>28</sup> The delay consisted solely in the pre-inquest preparation, during which time evidence and witness recollection was likely to have deteriorated. The result is that the integrity of the coronial process was again compromised, as findings were subject to stale evidence and the family's peace of mind was denied for over 24 months.

The coronial investigation into Mr Lowe's death was held up for almost two years by the known inaction of the QPS. No cause for the delay in Mr Dyer's case was given. Under s 16 of the *Coroners Act 2003* (Qld), the coroner has the power to request, orally or in writing, documents relevant to the investigation of a death. Although the coroner has the power to penalise under this section for non-compliance, there are no penalties for delay in compliance.<sup>29</sup> Police officers have a defined duty under s 794 of the *Police Powers and Responsibilities Act 2000* to assist the coroner in the investigation of a death, but this provision is similarly silent regarding delay. Given the negative consequences of long delay on the family, on public confidence in the coronial process, and on the efficacy of coronial recommendations, it is suggested that the coroner would benefit from an enforcement power designed to combat delay in the delivery of vital documents.

***Recommendation 1: That the Coroners Act 2003 (Qld) be amended to empower the coroner to enforce penalties against the Queensland Police Service where there is unreasonable delay in the presentation of important documents.***

In contrast to the inquests of Mr Dyer and Mr Lowe, the inquests into the deaths of Antonio Galeano and Caitlin Hanrick were highly controversial, subject to significant public scrutiny and media commentary, and publicity. In this situation the

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<sup>28</sup> *Ibid.*

<sup>29</sup> *Coroners Act 2003* (Qld) s 16(4).

confidence of the public in the coronial process is most paramount and also most fragile, and it is essential that coronial reports are not only independent, but efficient in all the circumstances. Antonio Galeano died in June 2009, after a police incident in which he was tasered multiple times and suffered heart failure. The inquest into his death commenced almost exactly a year later.<sup>30</sup> It took approximately 40 days which ran over a period of 13 months, and the final report on his death was not released until 14th November 2012, more than four years after his death.<sup>31</sup> The Galeano report in its final form is more than 100 pages long, and considers extremely complex testimony, expert witnesses and conflicting evidence. In these circumstances, the preparation and administration of the coronial inquest must necessarily be time-consuming. If it were brief, doubts might be raised about how thorough and accurate the coronial inquest really was. The final report which the State Coroner released on Mr Galeano's death included 18 recommendations for changes to police procedure and protocol<sup>32</sup> as well as a comparison of evidence and a timeline of Mr Galeano's final days.<sup>33</sup> Yet the four years that passed between Mr Galeano's death and the release of these recommendations renders many of them useless. For example, Recommendation 18 in the report concerns the health and safety of QPS equipment:

I consider this is enough of an issue on the available evidence to entitle the comment that QPS urgently review the standard and health and safety quality of the masks supplied to their officers.<sup>34</sup>

Other recommendations concerned updating the QPS Operating Policy Manual, updating police equipment, synchronising time devices and reviewing training

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<sup>30</sup> Queensland Coroner's Court, *Inquest into the Death of Antonio Galeano* (2012) Ms Christine Clements.

<sup>31</sup> *Ibid.*, 'Findings of Inquest'.

<sup>32</sup> *Ibid.*, 96-105.

<sup>33</sup> *Ibid.*, 3-5.

<sup>34</sup> *Ibid.*, 105.

standards and content on the use of Tasers.<sup>35</sup> Recommendations of “urgent” change made four years after the relevant event lack efficacy and are inadequate in the circumstances, as the opportunity to prevent deaths in the interim 4 years had been lost and in several cases changes to policy had already been undertaken by the QPS.<sup>36</sup>

Caitlin Hanrick was killed in the course of a police pursuit through Redcliffe on 4 December 2006, as she crossed the road of the split campus of her high school. The police had been pursuing a suspected stolen car, which was speeding in an attempt to avoid being detained.<sup>37</sup> Although the events leading to her death raised a number of issues about QPS pursuit policy, the coroner refrained from making recommendations regarding police pursuit policies, referring to a future report concerning a number of police pursuit deaths.<sup>38</sup> This report was released on 31 March 2010, more than three years after Caitlin Hanrick was killed. As in the Galeano case, the delay between her death and recommendations which might prevent similar deaths in future was significant. In such circumstances, in which it was clear that police pursuit policies represented a danger to the lives of the public, the delay in the recommendations should be considered damaging to both the peace of mind of her family and to the confidence of the public.

Although the recommendatory function of the coroner is largely discretionary and is not listed as one of its main purposes, it is submitted that the recommendations are a method for ensuring transparency in the executive government, especially where

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<sup>35</sup> *Ibid.* 96-105.

<sup>36</sup> *Ibid.* 105.

<sup>37</sup> Queensland Coroner’s Court. *Inquest into the death of Caitlin Hanrick*. (2009) Mr Michael Barnes, State Coroner, 6.

<sup>38</sup> *Ibid.*, 14.

deaths in custody have occurred.<sup>39</sup> This is reflected in the section of the *Coroners Act* which confers the power to make recommendations:

***46 Coroner's comments***

*(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*

The situations in which commentary is permitted are clearly connected to matters of public concern and importance. Without this recommendatory function the coronial process would lose much of its public relevance. Thus where recommendations are made redundant by the passage of time because similar or inconsistent changes have already been made, the coronial process is undermined. Not only is its private purpose of providing peace of mind to family members damaged, but its public purpose of ensuring transparency and confidence is weakened. Delay therefore represents a concern not only to family members of the deceased but to the community in general. Although in complex cases it is reasonable to expect a delay in the presentation of the coroner's report, in some cases a report can be written almost entirely based on written submissions and evidence. That this is possible is clear from cases outlined in the table above in which the coroners presented their findings on the day of the inquest. It is therefore recommended that where the matter is complex, there is likely

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<sup>39</sup> *Coroners Act 2003 (Qld)* s 46.

to be a long delay in the report, and the coronial matter raises an issue of significant public importance, the coroner should have a power to issue a preliminary report which includes recommendations which may prevent similar deaths in future.

***Recommendation 2: The coroner should have a discretionary power to release a preliminary report which includes recommendations to prevent similar deaths in future.***

Recommendations in relation to the delay inherent in the coronial process can minimise, but will not eliminate, the length of time between a death and the release of the coroner's report. The coroner's workload is not limited to deaths in police custody, and evidence from the Western Australian Law Reform Commission suggests that the coroner faces an increasing a number of cases.<sup>40</sup> If it is not possible to schedule an inquest then little can be done to ensure that the coroner's report is released quickly. The coroner's office itself does not make recommendations in relation to the delay in scheduling or concluding an inquest matter, and they have limited power to address this aspect of family concern.<sup>41</sup> However, the legislative reform outlined in the Recommendations 1 and 2 may decrease the length of the delay or perceived delay in many cases.

## B. ISSUES IN RESPECT OF THE INVESTIGATIVE PROCESS

The QPS plays a crucial role in the coronial investigation process, since it is charged under s14 of the *Coroners Act 2003* (Qld) with assisting the coroner to investigate reportable deaths, and will often be integral in deciding at a preliminary

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<sup>40</sup> Above n 9, 6-7.

<sup>41</sup> *Coroners Act 2003* (Qld) s 46 confers a power to make recommendations relevant to the subject of the coronial inquest, but not to improving the coronial process itself.

stage whether a death is a reportable death.<sup>42</sup> That police conduct their investigations with integrity and efficiency is fundamental to ensuring transparency in the system and the achievement of justice. Proper procedures are set out in the ‘Operational Procedures Manual’ of the QPS.<sup>43</sup> In some circumstances, integrity and efficiency can be undermined; officers involved in investigations concerning a death in custody have enormous potential to downplay the level of their involvement and extent to which their actions were inappropriate. This damages the level of accountability provided to family members of the deceased as well as to the general public. Cases such as Doomadgee, Galeano, Eddy, Spicer and Francis illustrate the issues around police collusion, inefficient communication, and the failure to separate police officers after the death. These issues undermine the independence of the police service.

#### **SEPARATION OF POLICE OFFICERS AND INDEPENDENCE OF THE INVESTIGATION**

Whenever there is a death in police custody, a conflict of interest between the role of the police as investigators of a death and the possible involvement of those same police in the death will necessarily arise. The QPS has created guidelines derived from the *Police Powers and Responsibilities Act 2000* (Qld)<sup>44</sup> which are designed to minimise the conflict of interest in these situations, including requirements that police should be immediately separated after a death in custody and requirements that they are questioned separately.<sup>45</sup> However, adherence to these guidelines is largely a matter of self-governance and there have been a number of cases in which police officers have been afforded the opportunity to discuss a death in

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<sup>42</sup> *Coroners Act 2003* (Qld) s 14(4)(b).

<sup>43</sup> Queensland Police, ‘Queensland Police Policies and Procedures’ *Queensland Police* <<http://www.police.qld.gov.au/rti/published/policies/qpsPolicyProc/>> (at 28 May 2013)

<sup>44</sup> *Ibid.*; Queensland Coroner’s Court, *Inquest into the Death of Philip Glen Spicer* (2011) Mr Michael Barnes, 10.

<sup>45</sup> Queensland Coroner’s Court, *Inquest into the Death of Antonio Galeano* (2012) Ms Christine Clements, 103.

custody before they are questioned. This failure undermines the reliability of police evidence disclosed in the coronial inquest and should be a focus of criticism and recommendations by the coroner. However, while this failure is often acknowledged, it is not afforded significant emphasis or attention.<sup>46</sup>

Michael John Eddy died at 26 years of age on 20 February 2004 as a result of restraint asphyxia, amphetamine abuse and extreme exertion.<sup>47</sup> In the report into Eddy's death, the coroner acknowledged that insufficient effort was devoted to separating the four officers directly involved in the incident.<sup>48</sup> After Eddy was pronounced dead, the officers had been permitted to discuss the incident.<sup>49</sup> However, the coroner concluded that there was no evidence of collusion whereby the officers agreed to provide the same recount of the incident or that the integrity of the investigation was undermined as a result.<sup>50</sup> Despite this, the fact that the police were not immediately separated after the incident undermines confidence in the coronial justice system. It inevitably increases suspicions that inappropriate action by the officers may have contributed to the death and that they are 'covering up' such actions. This in turn damages the effectiveness of the coronial system to respond to the rights of family members to be afforded a thorough account of what really happened.

In the death of Antonio Galeano, Senior Constable Myles and Constable Cross were the police officers in whose custody Mr Galeano died. After being tasered 28 times over a 7 minute period, sprayed with OC spray and handcuffed, Mr Galeano

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<sup>46</sup> In Queensland Coroner's Court, *Inquest into the Death of Antonio Galeano* (2012) Ms Christine Clements acknowledged the failure to separate the officers at 52, 55, 56, 57, 58, and 103. The only recommendation in relation to this failure is found at 103, and merely recommends that the police reflect on the failure in their policy.

<sup>47</sup> Queensland Coroner's Court, *Inquest into the Death of Michael Eddy* (2007) Mr Michael Barnes.

<sup>48</sup> *Ibid.*, 18

<sup>49</sup> *Ibid.*, 5

<sup>50</sup> *Ibid.*



stopped breathing. Although police attempted CPR, Galeano died shortly afterward.<sup>51</sup> Despite regulations dictating that officers involved with a death in custody should be immediately separated, the officers' Senior Sergeant Oates subsequently asked Myles what had happened in the presence of Constable Cross.<sup>52</sup> Oates then left the scene for a significant period of time in order to get coffee from his house, leaving Cross and Myles alone together. Senior Constable Myles was subsequently driven back to the police station by a representative of the Queensland Police Union before his initial questioning by Ethical Services Command.<sup>53</sup> Although the coroner commented on the difficulty that police face in investigating deaths in custody, the recommendation made to address this was merely that the police should "reflect upon what treating a death in custody like a homicide means."<sup>54</sup> The fact that the police had the opportunity to discuss the incident and to consult with the QPU before being questioned was not acknowledged or taken into account when the coroner considered evidence tendered by the police officers.

The failure to separate may be perceived as less serious in circumstances where there is no indication of police wrongdoing. However, the appearance of a full and accurate investigation into a death in custody remains paramount. In the case of Philip Glen Spicer, police attended the residence of Spicer but were unable to prevent him from cutting his own neck with a razor.<sup>55</sup> The officers involved were subsequently allowed to ride back to the police station in the same car.<sup>56</sup> Although there was no indication that the police were in any way involved in or responsible for

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<sup>51</sup> Queensland Coroner's Court, *Inquest into the Death of Antonio Galeano* (2012) Ms Christine Clements, 45.

<sup>52</sup> *Ibid.*, 53.

<sup>53</sup> *Ibid.*, 54.

<sup>54</sup> *Ibid.*, 103.

<sup>55</sup> Queensland Coroner's Court, *Inquest into the Death of Philip Glen Spicer* (2011) Mr Michael Barnes, 1.

<sup>56</sup> *Ibid.*, 10.

Mr Spicer's death,<sup>57</sup> this was a clear infringement of QPS guidelines. Attention should be called to such infringements, not to increase scrutiny of police action, but to ensure that the outcome of a coronial inquest is accurate and unbiased. The coroner in this case acknowledged that this was the purpose of the inquest process:

The family and friends of the deceased person are entitled to expect a thorough investigation and an account of how the death occurred. It is also desirable that the general public be fully apprised of the circumstances of the death so they can be assured the actions of the officers have been appropriately scrutinised. The police officers involved also have a right to have an independent assessment made of their actions so there can in future be no suggestion there has been any "cover up" of inappropriate action.<sup>58</sup>

However, despite noting the failure to separate the officers, the coroner did not make any recommendation relating to the separation or take account of it in accepting the evidence of the officers.<sup>59</sup>

Investigating the fatal police pursuit that led to the death of Caitlin Hanrick, Inspector Smith played an audio recording of police radio communications to the officers involved.<sup>60</sup> The coroner was of the opinion that it would have been preferable not to do so, however he did not believe there is any indication that would suggest the officers adapted their answers after listening to the recording.<sup>61</sup> Nevertheless this incident raises concerns regarding the maintenance of the impartiality of the QPS investigative process. The coroner determined that the matter had been thoroughly and professionally investigated, and that all sources of relevant information had been accessed and analysed.

Cameron Doomadgee died on the morning of November 19 2004 at the Palm Island police station shortly after he had been arrested for public nuisance by Senior

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<sup>57</sup> *Ibid.*

<sup>58</sup> *Ibid.*, 1-2.

<sup>59</sup> *Ibid.*, 12. The only recommendation made by the coroner was that a commendation for bravery be conferred on one of the officers involved in the incident.

<sup>60</sup> Queensland Coroner's Court. *Inquest into the death of Caitlin Hanrick*. 17 July 2009, 3.

<sup>61</sup> *Ibid.*

Sergeant Chris Hurley. Upon arrival at the police station following his arrest the evidence was that Doomadgee resisted Hurley's attempts to extricate him from the police vehicle.<sup>62</sup> The evidence was that Doomadgee punched Hurley in the face and it was alleged that Hurley punched Doomadgee in response to this.<sup>63</sup> As Hurley attempted to take Doomadgee through the doorway of the police station the evidence is that both parties fell into the police station hallway, possibly tripping over the step at the entrance.<sup>64</sup> At this point Doomadgee, now limp, was dragged into a cell by Hurley and another police officer. He died in the cell a short time later.<sup>65</sup>

The medical evidence was that the cause of death was "intra-abdominal haemorrhage, due to the ruptured liver and portal vein",<sup>66</sup> which must have occurred during the fall through the doorway.<sup>67</sup> Therefore, the crucial element for the coroner to determine was the circumstances surrounding the fall. The majority of the coroner's findings were devoted to determining whether the injuries suffered by Doomadgee were caused by Hurley accidentally landing on him or whether directly after the fall Hurley with deliberate force, dropped his knee into Doomadgee.<sup>68</sup>

Over the course of the inquiry it became abundantly clear that the investigation following the death of Doomadgee had been unsatisfactory as a result of a severe lack of independence by the investigating officers. The involvement of officers from Townsville and Palm Island was inappropriate and undermined the integrity of the investigation.<sup>69</sup> This was compounded by the fact that the initial investigation was conducted by people who knew Hurley, and Hurley had in fact

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<sup>62</sup> Queensland Coroner's Court. *Inquest into the death of Mulrunji*. 14 May 2010, 13.

<sup>63</sup> *Ibid.*, 50.

<sup>64</sup> *Ibid.*, 69.

<sup>65</sup> *Ibid.*, 13.

<sup>66</sup> *Ibid.*, 37.

<sup>67</sup> *Ibid.*, 69.

<sup>68</sup> *Ibid.*, 51.

<sup>69</sup> *Ibid.*, 144.

picked the investigating officers up from the airport, been escorted to the scene of Doomadgee's arrest by Hurley and met at Hurley's residence.<sup>70</sup> The investigation also suffered from a failure to separate witnesses after the death of Doomadgee. Hurley was not asked to leave the station as he had been for other complaints. The witnesses were not kept apart by investigators and Hurley and Sergeant Leafe admitted speaking to each other and Bengaroo about what had occurred, contrary to the Operation Procedures Manual.<sup>71</sup> There was also suspected collusion between Hurley and those conducting the investigation. A witness, Roy Bramwell, when interviewed described seeing Hurley move his elbow up and down as if punching Doomadgee from an obstructed vantage point. He believed that these strikes were to the face of Doomadgee, which is consistent with injuries to the eye and jaw of Doomadgee.<sup>72</sup> In his first interview, which took place prior to the interview of Bramwell, Hurley made no mention of any actions that were consistent with the "elbow up and down" motion. In Hurley's subsequent interview following Bramwell's, Hurley recalled attempting to lift Mulrunji from the ground by his shirt numerous times, but each time his shirt ripped.<sup>73</sup>

The coroner addressed these issues of concern through the evidence he accepted and the conclusions and recommendations he arrived at. The coroner was particularly critical of Hurley's altered version of events and concluded that there had been collusion between Hurley and those investigating the death of Doomadgee.<sup>74</sup> On this basis the coroner did not accept Hurley's evidence as to this point and determined that Hurley had punched Doomadgee.<sup>75</sup> The lack of integrity throughout the

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<sup>70</sup> *Ibid.*, 122.

<sup>71</sup> *Ibid.*, 109.

<sup>72</sup> *Ibid.*, 94.

<sup>73</sup> *Ibid.*, 72.

<sup>74</sup> *Ibid.*, 95.

<sup>75</sup> *Ibid.*, 121.

investigation resulted in a lack of credibility of the evidence of Hurley and Leafe.<sup>76</sup> Ultimately, however, the coroner concluded that the flawed investigation substantially compromised the fact-finding process and “compromised the investigative opportunities in this case.”<sup>77</sup> The recommendations made by the coroner attempted to address these independence issues. The first recommendation was aimed at ensuring independence by having the Crime and Misconduct Commission solely or primarily investigate the death.<sup>78</sup> The second recommendation was aimed at ensuring witnesses influence the account of other witnesses by having the same legal counsel.<sup>79</sup>

#### ***POLICE COMMUNICATION***

Efficient and effective communication by police officers is fundamental to ensuring that processes undertaken by police in dealing with the public and investigating a death in custody are thorough, appropriate and conform with regulations. Issues with police communication are predominantly apparent in cases involving police pursuit, such as that of Marty Tanui Francis and Caitlin Hanrick; however, organisational and communication problems were also present in Galeano’s case.

Marty Tanui Francis died on 4 October 2008 as a result of massive soft tissue and bony trauma.<sup>80</sup> Mr Francis, while under the influence of alcohol, passed a police vehicle and in an attempt to evade interception, lost control of his vehicle. Under the QPS pursuit policy, officers in pursuit are required to make radio contact with the police station. This is necessary to confirm the category of pursuit as well as to ask for

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<sup>76</sup> *Ibid.*, 109.

<sup>77</sup> *Ibid.*, 122.

<sup>78</sup> *Ibid.*, 150.

<sup>79</sup> *Ibid.*, 159.

<sup>80</sup> Queensland Coroner’s Court. *Inquest into the death of Marty Tunui Francis*. 17 November 2010. At p. 8.

assistance. The coroner has stated that this is ‘vitaly important’, particularly when only one officer is involved in the pursuit. In this case, radio communication with the station was made three times, all of which were unsuccessful. Subsequent interviews of officers found that the communications equipment at the station was faulty. The problem had persisted for 20 years.<sup>81</sup> While the coroner noted this problem has now been addressed with the addition of new equipment, such delay in addressing a relatively non-complex yet critical issue undermines confidence in the police force’s ability to ensure proper and impartial law enforcement.

In the Caitlin Hanrick inquiry, the senior officer in the pursuit car, Sergeant Lindsay, was obliged to contact the communications centre however he failed to do so. Subsequently, he failed to advise of the reasons for the pursuit and the pursuit category. Coroner Barnes stated that the confusion ‘may have been due to the unusual circumstances in which this pursuit commenced with the officer who was soon to become the pursuit controller, detailing the job to the officer who was soon to commence the pursuit.’ Coroner Barnes was only prepared to concede that adherence to the policy ‘may’ have assisted in avoiding the incorrect categorisation of the pursuit, reflecting the unwillingness at the time to engage in a critical analysis of the QPS.<sup>82</sup>

In the Galeano inquiry, communication issues arose largely in relation to the investigation into police conduct, but the role of police communications during events leading to Galeano’s death was also critiqued.<sup>83</sup> For example, although police communications were in a position to notify the Queensland Ambulance Service

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<sup>81</sup> *Ibid.*, 16.

<sup>82</sup> Queensland Coroner’s Court. *Inquest into the death of Caitlin Hanrick*. Mr Michael Barnes, State Coroner. 17 July 2009. At pp. 14-19.

<sup>83</sup> Queensland Coroner’s Court, *Inquest into the Death of Antonio Galeano* (2012) Ms Christine Clements, 102.

immediately when it became clear that Mr Galeano was unwell, they did not do so.<sup>84</sup> They were also in a position where they had immediate access to the police operating procedure manual and could have advised the officers of health procedures and investigative procedures, but they similarly failed to communicate any guidelines or procedures to the officers on the scene.<sup>85</sup>

However, more essential issues of communication arose in relation to the investigation of the police involved with the death in custody. The order of events when the investigation was commenced was confused and irregular. When ESC Superintendent Sheppard was informed of Galeano's death, he immediately appointed Inspector Sakzewski to lead the investigation. Inspector Sakzewski was to inform both the coroner and the CMC of the death and needed to travel from Brisbane to Ayr to begin the investigation. However, at the scene Acting Inspector Kitching had taken a lead role in the investigation until the arrival of Sakzewski. Kitching was later replaced by Inspector Brian Cannon, the regional traffic coordinator, because of concerns about Kitching's previous work. This appointment was arranged by Chief Superintendent Keating. Inspectors Dominic McHugh and Harms from ESC both arrived on the scene before Kitching; when Kitching arrived he took over from McHugh and commenced his investigation. When Cannon later arrived at the scene, the officers involved in the death had already left. Cannon was briefed by Kitching and then left to notify the next of kin, leaving Kitching in charge despite orders from the Chief Superintendent. Kitching's lead role was further affirmed when Assistant Police Commissioner O'Regan called Kitching for a debriefing on the situation. It was not until the Chief Superintendent arrived on the scene himself that Kitching was officially replaced by Cannon. When Sakzewski eventually arrived at the scene it was

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<sup>84</sup> *Ibid.*

<sup>85</sup> *Ibid.*

almost 12 hours after the death had occurred, the scene had already been processed and the witnesses and police had spoken to each other and had been questioned. The initial stages of the investigation were thus confused by problems at ESC and at the scene.<sup>86</sup> Since the initial investigation will obtain the freshest picture of the relevant events, the confusion meant that the immediate recollections of witnesses and officers were lost to the ESC investigators who were ultimately placed in charge. The communication difficulties undermined the clarity and efficiency of the investigation and arguably compromised the evidence of the coronial inquest. A number of issues appeared to arise based on the remoteness of the location in which the death took place. The limited personnel who would be immediately available and their relationships to each other hindered the investigation. This is an issue which may be confined to rural areas but should be addressed and taken into account by the coroner in a report. However, the extent to which a coroner is critical of the police evidence must be discretionary, and making recommendations as to police investigative policy is beyond the scope of this report.

### **Evidence and language relating to police action**

Transparency to the public and peace of mind to family members cannot be achieved when the coronial process fails to ensure that its conclusions are based on strong foundations of independent fact. Although the coronial inquest is not a trial and the findings of a coroner are not a judgment, the same principles that apply to judicial reasoning should apply to the coronial process, especially since the coroner's decision has the power to affect the lives of those involved in the inquest.<sup>87</sup> Although it would

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<sup>86</sup> *Ibid.*, 53-56. This part of the coroner's report provides a summary of the first stages of the investigation into the death in custody.

<sup>87</sup> *Coroners Act 2003* (Qld) s 48 allows the coroner to decide whether an officer should be referred to the Crime and Misconduct Commission; s 47 confers an ability to report to various government



impair the flexible and inquisitorial nature of the coronial process to impose rules of evidence or strict court protocols, it is a legitimate concern of family members that the coroner's decision is not impartial and independent, or does not appear to be impartial and independent.

Galeano's case represents an example in which the presentation of the evidence appeared both biased and partial to the police. Although it is impossible to argue that the evidence ultimately accepted by the coroner was incorrect, it is clear throughout the report that the coroner accepts the evidence given by police, despite remarking that police recall in the case was conflicted and that the circumstances meant that accurate recollection was unlikely.<sup>88</sup> The coroner was critical of evidence given by civilian witnesses and lauded the efforts of police within the report.<sup>89</sup> Although the coroner should not be unnecessarily critical of police and may, as part of its comments, draw attention to police actions above the call of duty, it is inappropriate for such comments to appear throughout the text of the report. The coronial process and report should be sensitive to the tension between family members of the deceased and the police officers in whose custody the death took place. The coronial process is a fact-finding endeavour and the findings should be presented as impartially as possible in the circumstances.

It is important to note that there exists incidences of coroners refuting police evidence and instead choosing to refer the police to the DPP. The inquest into the death of Andrew Borden provides one such example. The death occurred after police had handcuffed Mr Borden face down on the road in a quiet suburban street. With the

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departments about the conduct of other state employees. This will have a direct impact on government officers, and will indirectly affect the ability of family members of the deceased to obtain closure and certainty about the death of the deceased.

<sup>88</sup> Queensland Coroner's Court, *Inquest into the Death of Antonio Galeano* (2012) Ms Christine Clements, 22.

<sup>89</sup> *Ibid.*, 33, where the coroner commended the "brave move" of one of the officers.

night providing poor visibility, Mr Borden was soon struck by a passing motorist who failed to see either Mr Borden lying on the road or the police officers imploring the driver to stop.<sup>90</sup> The coroner was critical of the actions of the police officers involved, and chose to refer them to the DPP under s48(2). In reaching his decision, the coroner dismissed police evidence that Borden was acting in a provocative manner which necessitated his immediate arrest and handcuffing whilst still on the road. The coroner reached his conclusion after taking into account the evidence of members of the community, including evidence given concerning prior events which, when viewed as a whole, made the evidence presented by the police officers to be unlikely.<sup>91</sup>

***Recommendation 3: That opinions and comments of the coroner be contained in a separate section of the coroner's report, either the Recommendations section or a separate independent subsection created solely for statements of opinion.***

### C. LACK OF FAMILY INVOLVEMENT IN THE CORONIAL PROCESS

The Supreme Court of Queensland case of *Nona & Anor v Barnes & Anor*<sup>92</sup> provides an interesting example of the operation of the judicial review of coronial inquests. In 2005, a Vessel called Malu Sara was lost at sea in the Torres Strait, killing several people, including the appellant's brother. In February 2009, coroner Barnes found that deaths were a 'totally avoidable disaster,' and that 'several people dismally failed to do their duty over many months.' Coroner Barnes however did not refer the matter to the Department of Public Prosecutions under s 48(2) of the *Coroners Act 2003*.

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<sup>90</sup> Queensland Coroner's Court. *Inquest into the death of Andrew John Borden*. Mr Michael Barnes, State Coroner, 16 July 2010, 8.

<sup>91</sup> *Ibid.*, 14.

<sup>92</sup> *Nona & Anor v Barnes & Anor* [2012] QCA 346.

After ascertaining that no referral had been made, the solicitors of the appellant enquired about Coroner's observation. Coroner Barnes responded that his role in the inquiry had concluded. The appellant's solicitor challenged his remark in a later exchange, leading to Coroner Barnes agreeing that if he reasonably suspected an offence had been committed, he was obliged to refer information to the Department of Public Prosecutions under s 48(2). The solicitor requested that Coroner Barnes discharge his 'undischarged duty' to consider referring. Coroner Barnes responded that upon consideration of s48(2), he did not believe that there was a basis upon which to refer. The appellant's solicitor requested a statement of reasons, of which Coroner Barnes refused. The question before the Court was whether Coroner Barnes should have been required to give reasons.

Fraser JA upheld the conclusions of the primary judge to dismiss the appellant's application for an order under s 38 of the *Judicial Review Act* 1991, referring to the joint reasons in *Griffith University v Tang*<sup>93</sup> given by Gummow, Callinan and Heydon JJ of the High Court. While the appellants had an interest in the course which had been taken, or not taken, by the Coroner, the decision not to send information to the DPP did not itself confer, alter or otherwise affect legal rights or obligations.

In view of that difficulty, the appellants submitted to the primary judge that the relevant decision was instead the Coroner's conclusion, formed before it was manifested in the correspondence or otherwise, that there was no basis upon which he should refer to the DPP. Fraser JA held that until the coroner's function under s 48(2) is brought to an end through their findings, his or her uncommunicated state of mind – the holding of the relevant suspicion or the absence of such a suspicion – is

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<sup>93</sup> *Griffith University v Tang* (2005) 221 CLR 99.

necessarily not conclusive of anything. The uncommunicated state of mind is not equal to a finding/determination/decision. This view accords with Mason CJ in *Australian Broadcasting Tribunal v Bond*.<sup>94</sup> The word ‘decision’ is indicative of some form of ‘finality’, whereas an uncommunicated mind is inherently changeable.

The decision raises the issue of the inherent difficulties of family members accessing judicial review of coronial decisions. The requirement of *Griffith University v Tang* that legal rights and obligations be affected is an overwhelming stumbling block for families seeking review.

### III. RECOMMENDATIONS AND IMPLEMENTATION OF CORONER’S COMMENTS

Under section 46 of the *Coroners Act 2003*, the coroner may comment on anything connected with a death investigated at an inquest that relates to public health or safety, the administration of justice or ways to prevent deaths from happening in similar circumstances in the future.<sup>95</sup> As a matter of practice these comments take the form of recommendations. The coroner is not required to make recommendations, though it is desirable when the coroner has been critical of events leading to, and the investigation of, a death in custody.

This section will examine the response to and of implementation of coronial recommendations involving deaths in police custody. This will include an analysis of whether the strength and specificity of the recommendations impact their implementation. Specifically, these issues will be examined in terms of the coronial inquests into the deaths of Cameron Doomadgee, Michael Eddy and Andrew Borgen.

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<sup>94</sup> *Australian Broadcasting Tribunal v Bond* (1990) 170 CLR 321.

<sup>95</sup> *Coroners Act 2003* (Qld) s 46

The coronial inquest into the death of Caitlin Hanrick was also examined and as recommendations in relation to her death were considered during the coronial inquest into the police pursuit policy, the recommendations from the police pursuit policy inquest will also be considered. The recent release of the findings into the death of Antonio Galeano meant that there was insufficient information at the time of writing to examine the implementation of recommendations from this finding.

Impediments to effective implementation of coronial recommendations begin with the responses to coronial recommendations. For a number of years the implementation of coronial recommendations was undermined by the absence of a mandated requirement to respond to coronial recommendations. The coronial inquest into the death of Michael Eddy is an example of the lack of accountability of coronial recommendations and the lack of easily accessible information about the responses to and implementation of recommendations. The first recommendation of the coroner in the findings, released in 2007, was that the QPS review the training provided to officers concerning the use of O.C. spray and the dangers of restraint asphyxia to ensure that the risk of fatalities are appropriately emphasised.<sup>96</sup> The absence of a mechanism of reporting implementations of coronial recommendations meant this report was unable to establish whether this recommendation was implemented.

In a study published in the Australian Indigenous Law Reports that focused on the implementation of coronial recommendations, a finding was that jurisdictions that mandated responses to recommendations are likely to have a better rate of implementation.<sup>97</sup> In Queensland there is no statutory requirement that agencies

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<sup>96</sup> Queensland Coroner's Court. *Inquest into the death of Michael Eddy*. 12 February 2007, p. 29.

<sup>97</sup> Ray Watterson, Penny Brown and John McKenzie, 'Coronial Recommendations and the Prevention of Indigenous Death' (2008) 12(6) *Australian Indigenous Law Review* 4, p. 12.

respond to coronial recommendations,<sup>98</sup> despite the Queensland Ombudsman proposing in 2006 that responses to coronial recommendations be made mandatory.<sup>99</sup> Responses to all coronial recommendations are mandated by legislation in the Northern Territory and Victoria.<sup>100</sup> Legislation in South Australia and the Australian Capital Territory mandates responses in cases of deaths in custody only.<sup>101</sup> However, while there is no response required by legislation, since 2008 the Queensland Government has released an annual report outlining the responses and actions by government agencies to coronial recommendations. The annual report has improved the likelihood of implementation of coronial recommendations by publicly providing information about intended actions. This has opened the agencies up to pressure from the media, advocacy groups and the community to fully implement the stated strategies, which according to the ALIR study increases the chances of implementation.<sup>102</sup>

**Recommendation 4: In order to ensure that the Responses to Coronial Recommendations do not fall victim to a change in government policy, responses to coronial recommendations should be made mandatory by legislation.**

While publicly available responses to coronial recommendations have improved the implementation of coronial recommendations, other issues still limit the effectiveness with which coronial recommendations are implemented. The planned actions and strategies outlined in government responses to coronial recommendations

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<sup>98</sup> Federation of Community Legal Centres 'Saving Lives by joining up justice: why Australia needs coronial reform and how to achieve it' *Australian Inquest Alliance* (October 2012), 31.

<sup>99</sup> Queensland Ombudsman, *The Coronial Recommendations Project: An Investigation into the administrative practice of Queensland public sector agencies in assisting coronial inquiries and responding to coronial recommendations* (December 2006) p. 31.

<sup>100</sup> *Coroners Act 1993* (NT) s 46A, 46B; *Coroners Act 2008* (Vic) s 72(3)-(4).

<sup>101</sup> *Coroners Act 1997* (ACT) s 76; *Coroners Act 2003* (SA) s 25(5).

<sup>102</sup> Watterson ALIR p. 19.

often address the recommendations in vague and non-committal terms. This issue was considered in regards to the Western Australian coronial process, where the Standing Committee on Environment and Public Affairs stated that the Government Response to Coronial Recommendations are, “often superficial and lacks clear timelines for implementation”.<sup>103</sup> This is apparent in the response to the first recommendation made by the coroner in the inquest into the death of Cameron Doomadgee. The coroner’s comment, per section 46 of the *Coroners Act*, in this instance was specific and strong and read:

*That the future investigation of deaths in police custody, which exhibit indicia of unnatural causes or which have occurred in the context of police actions or operations be undertaken solely or primarily by the CMC, as the specialist misconduct and anti-corruption body for the State of Queensland. To enable this to occur, I recommend that the CMC be resourced and empowered (by legislative fiat) to undertake the role.<sup>104</sup>*

This recommendation was specific in that it provided a detailed outline of when the CMC should lead the investigation and specifically provided that legislation should be amended to ensure this occurs. The Response to Coronial Recommendations report states that this recommendation has been addressed by agreeing to an interim and proposed arrangements recorded in a Memorandum of Understanding (*MOU*). This *MOU* is said to “clarify roles and responsibilities, resourcing and conflict resolution”.<sup>105</sup>

This response falls well short of the recommendation of the coroner. Firstly, an *MOU* lacks the effect of a legislative change. Furthermore, the clarification of roles and responsibilities clearly demonstrates the superficiality and vagueness

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<sup>103</sup> Legislative Council Standing Committee on Environment and Public Affairs, Parliament of Western Australia, *Inquiry into the Transportation of Detained Persons: The Implementation of the Coroner’s Recommendations in Relation to the Death of Mr Ward and Related Matters* (July 2011), 43-4 [2.173].

<sup>104</sup> Queensland Coroner’s Court, *Inquest into the Death of Cameron Doomadgee* (2010) Mr Brian Hines, 150.

<sup>105</sup> The Queensland Government’s Response to Coronial Recommendations 2010, 30.

described above. That the MOU will “clarify roles and responsibilities” is inherently vague, providing very little actual insight into how investigations will be handled in the future and the extent to which the recommendation of the coroner will be implemented. It is a significantly watered down version of the recommendation made by the coroner that the CMC be the sole or primary investigator.

The effective implementation of coronial recommendations is also inhibited by delays and failures to implement recommendations in a timely manner. This is evident if we return to the aforementioned recommendation of the coroner following the death of Cameron Doomadgee. The coroner released his findings on May 14 2010 and despite this, at present it does not appear that the MOU has been implemented. The CMC website states that the MOU is still being considered.<sup>106</sup> Delay is also evident in the implementation of a recommendation made by the coroner following the death of Michael Eddy. In his findings the coroner recommended that an amendment to the *Births Deaths and Marriages Act 2003* to require that the Registrar amend the details of deaths in the register in accordance with the findings of the coroner.<sup>107</sup> Despite the uncontroversial nature of this recommendation, the legislation was not amended until 2 November 2009,<sup>108</sup> almost three years after the coroner released his findings.

The implementation of the recommendations of the coroner is limited by the absence of any monitoring procedure to ensure that the strategies and policies outlined in the government responses are actually put into practice. The Western

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<sup>106</sup> Crime and Misconduct Commission Queensland ‘Deaths in Custody’ *Crime and Misconduct Commission* <<http://www.cmc.qld.gov.au/topics/police-and-the-cmc/misconduct-by-police/deaths-in-custody-1>> (at March 25 2013)

<sup>107</sup> Queensland Coroner’s Court. *Inquest into the death of Michael Eddy*. 12 February 2007, 31.

<sup>108</sup> Queensland Government. ‘Births Deaths and Marriages Registration Act 2003’ *Queensland Legislation*. <[http://www.legislation.qld.gov.au/Acts\\_SLs/Superseded/SUPERS\\_B/BirthsDMA03.](http://www.legislation.qld.gov.au/Acts_SLs/Superseded/SUPERS_B/BirthsDMA03.)> (at 28 May 2013)



Australian Review of Coronial Practice called for a similar model to the Victorian Prevention Unit, which would allow a body to monitor and collect information on the response and implementation of coronial recommendations.<sup>109</sup> However, ultimately the Victorian model involves the mere publication of resources on the internet.<sup>110</sup> The Queensland Ombudsman, in its 2006 report, expressed a willingness to undertake this role of monitoring the implementation of coronial recommendations.<sup>111</sup> There is no entity with the responsibility and resources to follow up on what happens once agencies have responded to recommendations and it is therefore necessary for the various jurisdictions to allocate this essential role to a body that, if it is not able to enforce implementation, at least can bring the issue to government and public notice.

**Recommendation 5: That the State Coroner provide information to the Queensland Ombudsman so that the Ombudsman can monitor the implementation of coronial recommendations by public agencies.**

Another problem that undermines attempts to implement coronial recommendations is the increased likelihood that a recommendation of the coroner will not be implemented thoroughly where the coroner has not used specific language or has adopted a weak recommendation.<sup>112</sup> A weak recommendation in this instance is a recommendation that calls only for an agency to consider adopting a change or review whether a specified course of action is appropriate.

The lower rate of implementation of recommendations of this nature should be considered in light of the fact that the coroner was unsure of the appropriateness of

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<sup>109</sup> Above n 12, 170.

<sup>110</sup> *Ibid.*

<sup>111</sup> Queensland Ombudsman, *The Coronial Recommendations Project: An Investigation into the administrative practice of Queensland public sector agencies in assisting coronial inquiries and responding to coronial recommendations* (December 2006) p. xv.

<sup>112</sup> Above n 80, 29.

the recommendation to only call for consideration of the issue by a body that is better positioned to investigate the suitability of the recommendation. It may well be the case that upon further review, the implementation of that recommendation is not appropriate.

The police pursuits policy coronial inquest provides a clear example of a failure to implement a weak recommendation. Recommendation 12 of the coroner was that the CMC “consider recommending mandatory licence disqualification upon conviction and more flexible vehicle impounding arrangements” for an “evade police” offence.<sup>113</sup> The CMC considered the issue and ultimately decided against recommending the implementation of either proposal. The CMC provided reasons for not implementing these policies, namely that they did not believe they would be effective because most drivers were already unlicensed or had a disqualified license, plus it increased the incentive to take more risk and a substantial number of offences were committed in stolen cars.<sup>114</sup> However, because of the wording of the coroner’s recommendation, the Queensland Government Response to Coronial Recommendations considers this recommendation to have been agreed to and completed by virtue of the fact that it was “considered”.<sup>115</sup>

Another instance of a failure to adopt a weak recommendation comes from the coronial inquest into the death of Andrew Bornen. Coroner Barnes recommended that “the QPS Uniform Review Committee consider changes to the standard QPS uniforms that would enhance visibility of officers at night.” The QPS considered this

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<sup>113</sup> Above n 88, 16-23.

<sup>114</sup> *Ibid.*

<sup>115</sup> *Ibid.*

recommendation but rejected it on the basis that it would place officers at risk where concealment is necessary.<sup>116</sup>

A further example of a failure to fully implement a weak recommendation is from the inquest into the death of Cameron Doomadgee. The coroner recommended that the CMC “gives closer consideration to insisting upon separate legal representation for police witnesses in serious contentious matters.”<sup>117</sup> This is a much weaker recommendation because it only calls for the CMC to consider the idea. The coroner goes on to make this recommendation conditional upon the Chairman’s opinion. The response was that the recommendation was not implemented in the manner recommended by the coroner, especially in that it has not been enacted by legislative framework. Instead, the recommendation was merely noted by the CMC and will be “actioned in appropriate investigations”, which is another instance of a vague, non-specific response.<sup>118</sup>

There is some evidence to suggest that coronial recommendations that lack specificity and detail are less likely to be implemented, however it is difficult to determine whether the failure to implement such recommendations are justified. Ultimately, if the coroner is confident that a particular recommendation be implemented the recommendation should be framed in a manner that does not merely call for an agency to review or consider the recommendation.

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<sup>116</sup> Above n 17.

<sup>117</sup> Queensland Coroner’s Court, *Inquest into the Death of Cameron Doomadgee* (2009) Mr Brian Hine, 159.

<sup>118</sup> Above n 88, 31.

## IV. CONCLUSION

Coronial inquests provide for a greater opportunity in determining the circumstances surrounding a death, allowing for evidence to be given under oath by relevant parties in a setting less formal than a conventional court. Recommendations given by the coroner can help to prevent similar deaths from occurring in the future, allowing for improvements to be made regarding matters related to public health and safety or the administration of justice.

Despite this, the potential for the current state of the coronial laws and practices to provide peace of mind to family members of the deceased and transparency to public is not maximised. Consideration of the recommendations suggested in this paper will hopefully increase the future efficiency of both the coroner and the Queensland Police in reducing the likelihood of similar deaths occurring in the future.