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Exploring fatal facts: current issues in coronial law, policy and practice

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Abstract

Death investigation and coronial practices have undergone significant social, political and legal scrutiny in recent years. A wave of coronial reform has occurred across jurisdictions, including in the United Kingdom (UK), Australia, Canada and New Zealand, with a concomitant focus on the adequacy of death investigation law and policy. Taking key coronial developments in the UK and Australia as its starting point, this paper explores a legal jurisdiction undergoing immense legal and policy reform to illustrate why coronial law and practice is of increasing scholarly interest. It begins by tracing the contentious landscape of UK coronial law reform, which has also resonated internationally, thereafter examining key controversies that refocused attention on the value of the jurisdiction, before discussing contemporary coronial issues including, publicity, human rights and death prevention.

I. Introduction: an exclusive concern

In April 2016, two very different but significant inquests on opposite sides of the world were in their final stages. In Sydney, Australia, the inquest into the deaths resulting from the seventeen-hour siege at the Lindt café in December 2014 (the Sydney Siege inquest) was undergoing its final segment of hearings before State Coroner Michael Barnes, after beginning in January 2015. The inquest scrutinised the siege and events around it, including key questions such as why the gunman was on bail, what the authorities knew about him, and police decision-making in response to the siege. Meanwhile, in Warrington, Cheshire, in the northwest of England, following a two-year hearing beginning in March 2014, the jury emerged after two weeks of deliberation to deliver the determination of 'unlawful killing' in the Hillsborough Inquests before the Right Honourable Sir John Goldring, sitting as Assistant Coroner for South Yorkshire (East) and West Yorkshire (West).[3] Both inquests were landmark coronial events: the Sydney Siege inquest held uniquely segmented hearings dealing with discrete issues, after commencing just six weeks after the December 2014 siege – a promptness unheard of in Australian coronial history. The Hillsborough inquests represent the longest coronial hearing in English history, heard in the largest purpose-built courtroom in England, and on an unprecedented scale.

The Hillsborough Inquests are the second inquests to investigate the deaths of ninety-six people who died as a result of the fatal crush at the Hillsborough Stadium, Sheffield, England, on 15 April 1989, when they were attending the Football Association Cup Semi-Final between Liverpool and Nottingham Forest. In the case sequelae, the original inquests (1990–1991) were part of a constellation of numerous official investigations, reviews and inquiries into the disaster. In April 2009, the then Secretary for Culture,

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3 See David Conn, 'Hillsborough Inquests Jury Rules 96 Victims Were Unlawfully Killed', *The Guardian* (27 April 2016), online: ‹http://www.theguardian.com/uk-news/2016/apr/26/hillsborough-inquests-jury-says-96-victims-were-unlawfully-killed› (last accessed 28 April 2016).

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Media and Sport, Andy Burnham, and MP Maria Eagle, advocated for the full public disclosure of information about Hillsborough, publicly supporting the Hillsborough Family Support Group's twenty-year campaign.[4] In 2010, the United Kingdom (UK) Home Secretary appointed the Hillsborough Independent Panel to oversee and manage the public disclosure of documents relating to the disaster, to consult with the Hillsborough families, and to work on archiving the documents. When the Panel released its report in 2012, it remarked that, despite an eleven-year period of official scrutiny, 'many bereaved families and survivors considered that the true context, circumstances and aftermath of Hillsborough had not been adequately made public' (Hillsborough Independent Panel, 2012, p. 4). Correspondingly, the Panel's report revealed a catalogue of official failings, including police alteration of statements and the inadequacy of the inquest process, simultaneously razing the official 'truth' of Hillsborough, which had blamed the Liverpool fans.

Following the Panel's report, the Hillsborough families called for the original inquest verdicts of 'accidental death' to be overturned, and for fresh inquests to be held.[5] The emphasis on the failure of the original inquests to declare the truth and deliver justice was strong in the wake of the Independent Panel's report. Referring to the Panel's findings in a statement to the House of Commons, it was the 'significant doubt over the adequacy of the original inquest' that Britain's Prime Minister David Cameron himself identified as perhaps the most significant finding of all.[6] Labour MP Andy Burnham spotlighted the inquest process, both for its resounding failure to net justice *and* its capacity to ultimately deliver it. He said, 'I will never be able to accept or allow a verdict of accidental death to remain on the public record. We need a new inquest, a new verdict and only then can we say we have put right one of the greatest injustices in our country's history in the 20th century.'[7] In the wake of the Independent Panel's report, commentators reviewed the potential legal options to redress injustice, including new inquests, public inquiries or criminal proceedings. Notwithstanding the flawed process of the first Hillsborough inquests, legal commentator Joshua Rozenberg recognised that 'an inquest verdict, as a finding of the court, may carry greater weight with the relatives of those who died than the findings of another inquiry'.[8]

On 19 December 2012, the original Hillsborough inquests, at that point the longest in British legal history, were judged a failure when the High Court quashed the original inquisitions, allowing new inquests to be held.[9] The new Hillsborough Inquests opened on 31 March 2014. That the families of

4 See 'Minister Andy Burnham Calls for Full Disclosure on Hillsborough Tragedy', *The Guardian* (16 April 2009), online: ‹http://www.theguardian.com/football/2009/apr/16/hillsborough-tragedy-andy-burnham-liverpool-full-disclosure-documents› (last accessed 10 April 2016).

5 See 'Hillsborough Families Demand New Inquests be Held', *The Guardian* (17 September 2012), online: ‹http://www.theguardian.com/football/2012/sep/17/hillsborough-families-seek-new-inquest› (last accessed 10 April 2016); see also Attorney-General Dominic Grieve's statement of intention to apply to the High Court to quash the verdicts: United Kingdom House of Commons, *Written Ministerial Statements* (16 October 2012) Col 9WS (Mr Dominic Grieve, Attorney-General).

6 David Cameron, 'David Cameron's Full Statement on the Hillsborough Panel's Report', *The Guardian* (12 September 2012), online: ‹http://www.theguardian.com/football/2012/sep/12/david-cameron-hillsborough-report-statement› (last accessed 10 April 2016).

7 Cited in Haroon Siddique and Alexandra Topping, 'Hillsborough Disaster Report Published – Wednesday 12 September', *The Guardian* blog (12 September 2012), online: ‹http://www.theguardian.com/football/2012/sep/12/hillsborough-disaster-report-panel-released-live› (last accessed 10 April 2016).

8 Joshua Rozenberg, 'Hillsborough Families Have the Truth. Justice will Take Longer', *The Guardian* (13 September 2012), online: ‹http://www.theguardian.com/law/2012/sep/12/hillsborough-families-truth-justice› (last accessed 10 April 2016).

9 *Attorney-General v. HM Coroner of South Yorkshire (West)* [2012] EWHC 3783 (Admin). See also Owen Gibson, 'High Court Quashes Hillsborough Inquest Verdicts', *The Guardian* (19 December 2012), online: ‹http://www.theguardian.com/football/2012/dec/19/hillsborough-high-court-quashes-inquest-verdicts?intcmp=239› (last accessed 10 April 2016).

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the Hillsborough victims wanted the original verdicts overturned, as the 'number one priority',[10] and new inquests to be held, illustrates the signal importance of this aspect of the Hillsborough record. The perceived significance of the coroner's inquest as a process for setting the record straight and delivering justice cannot be overstated. That moment came when, on 26 April 2016, the Hillsborough Inquests jury answered fourteen questions relating to the cause and circumstances of the deaths of the ninety-six people who died. In addition to concluding that the ninety-six Liverpool fans who died were unlawfully killed, the jury also concluded that the behaviour of football supporters did not contribute to the dangerous conditions, rejecting police claims to the contrary. Together with determinations about stadium defects, licensing, oversight and management, the jury delivered a damning indictment of the police, concluding that there were errors and omissions in respect of the police planning, preparation for, and policing of the match, and the police and ambulance service responses to the disaster. Ostensibly, with these determinations, after twenty-seven years, the record has been corrected to achieve this crucial aspect of 'justice for the 96'. Yet the experience of the Hillsborough families also highlights the vexing nature of the coronial jurisdiction. While inquests are public fact-finding exercises directed towards ascertaining the identity of the deceased, the place, and the cause and circumstances of death – often referred to as the 'who, where, what and how' – they can, and do, realise much more than these 'facts'.

Taken at their narrowest achievement, 'they can productively contribute to the bereavement process of families or friends of the deceased, and at their widest they can contribute to public health and safety and the prevention of avoidable deaths. Additionally, inquests can allay suspicion, safeguard public scrutiny of contentious deaths and ensure justice is seen to be done' (Scott Bray, 2013, p. 449). But this potential is tempered by the reality that inquests can also be arenas of deep disappointment and distress, exacting damage instead of justice (see Scraton and Chadwick, 1987).[11] This tension explains why, for some commentators, 'inquests have long been a poor medium for revealing important information surrounding controversial deaths',[12] while others assert that:

> 'imperfect and variable as the coroner system is in helping relatives to understand the events leading up to the death of a family member, it is, in many cases, the only mechanism which even attempts to do this. There are other forums in which a death may be discussed or investigated, but … [i]t is only in the inquest that the deceased is the focus of proceedings, rather than being a shadowy figure in somebody else's story.' (Davis, Lindsey, Seabourne and Griffiths-Baker, 2002, p. 77)

Put another way, Wells writes, 'death features in the work of civil and criminal courts as well as often being the motivation for the establishment of a public inquiry. But the inquest is the only formal state tribunal whose exclusive concern is death' (1996, p. 213). This paper affirms the importance of an

10 Paul Gallagher and Mark Townsend, 'Hillsborough Families' Lawyer Calls for Permanent "Commission of Truth"', *The Guardian* (16 September 2012), online: ‹http://www.theguardian.com/football/2012/sep/16/hillsborough-lawyer-commission-truth?intcmp=239› (last accessed 10 April 2016).

11 See e.g. United Kingdom, *Death Certification and Investigation in England, Wales and Northern Ireland: The Report of a Fundamental Review* (Cmd 5831, 2003) (Tom Luce, Chair) p. 16 at [1]; Dame Janet Smith, *The Shipman Inquiry. Third Report: Death Certification and the Investigation of Deaths by Coroners* (Cm 5854, 2003); Victorian Parliamentary Law Reform Committee, *Coroners Act 1985: Final Report* (Government Printer, Melbourne, 2006); Law Reform Commission of Western Australia, *Review of Coronial Practice in Western Australia, Background Paper Project No 100* (2010); Davis *et al.* (2002); INQUEST (2002).

12 Tim Newburn, 'The Hillsborough Report Once and for all Lays Bare the Lies', *The Guardian* (12 September 2012), online: ‹http://www.theguardian.com/commentisfree/2012/sep/12/hillsborough-report-lays-bare-the-lies› (last accessed 10 April 2016).

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inquest's 'exclusive concern' for death. Given the preventative trajectory of the coronial jurisdiction, there is much to be gained from interrogating – and so *acknowledging* – deaths, so as to hopefully avoid others. Taking key coronial developments in the UK and Australia in recent years as its starting point, the paper spotlights a jurisdiction undergoing immense legal and policy reform to illustrate why coronial law and practice deserves further scholarly consideration. It begins by tracing the contentious landscape of UK coronial law reform that resonated internationally. It thereafter examines key controversies that refocused attention on the value of the jurisdiction, before a final discussion of contemporary coronial challenges, including publicity, human rights and death prevention.

II. The landscape of reform

Death investigation and coronial practices have undergone significant international social, political and legal scrutiny in recent years. A wave of coronial reform has occurred across jurisdictions including the UK, Australia, Canada and New Zealand, with a concomitant focus on the adequacy of death investigation law and policy.[13] This reform has, in part, stemmed from troubled histories around post-mortem practices, beginning with the emergence of human tissue and organ controversies in the UK in the late 1990s and early 2000s. The resulting inquiries, including the Bristol Royal Infirmary Inquiry,[14] the Royal Liverpool Children's Inquiry,[15] and the McLean Inquiry in Scotland,[16] investigated post-mortem removal and retention of organs, and found that consent procedures relating to organ and tissue retention had been insufficient, and that, in many cases, consent had not been sought or had been overridden, thus exposing illegal or paternalistic hospital and coronial post-mortem practices. Further attention was drawn to hospital and coronial post-mortem practices when in 2000 the Chief Medical Officer at the UK Department of Health undertook a census of organs and tissues retained by the National Health Service, revealing that organs and tissue had been routinely retained post-mortem in hospital and coronial cases.[17]

The reputation of coronial and death certification practices in the UK became increasingly cataclysmic with the conviction in January 2000 of Dr Harold Shipman for the murder of fifteen patients while he was a practising general practitioner. The subsequent Shipman Inquiry, chaired by Dame Janet Smith, was tasked with investigating how Shipman's crimes remained undetected,

13 See, for example, Ontario Law Reform Commission, *Report on the Law of Coroners* (October 1995); New Zealand Law Commission, *Coroners: A Review: A Discussion Paper*, Preliminary Paper 36 (August 1999); New Zealand Law Commission, *Coroners*, Report 62 (August 2000); United Kingdom, Home Office, *Reforming the Coroner and Death Certification Service: A Position Paper* (Cm 6159, March 2004); Victorian Parliamentary Law Reform Committee, *Coroners Act 1985: Final Report* (Government Printer, Melbourne, 2006); Law Reform Commission of Western Australia, *Review of Coronial Practice in Western Australia, Final Report Project No 100* (2012).

14 Bristol Royal Infirmary Inquiry, *The Inquiry into the Management of Care of Children Receiving Complex Heart Surgery at the Bristol Royal Infirmary, Interim Report: Removal and Retention of Human Material* (May 2000); Bristol Royal Infirmary Inquiry, *The Report of the Public Inquiry into Children's Heart Surgery at the Bristol Royal Infirmary 1984–1995: Learning From Bristol* (CM 5207(I), July 2001) (The Kennedy Report).

15 *The Royal Liverpool Children's Inquiry Report* (London: Stationery Office, London, 2001) (the Redfern Report).

16 Independent Review Group on Retention of Organs at Post-mortem, *Final Report* (Edinburgh: HMSO, November 2001) (Sheila McLean QC, Chair); Independent Review Group on Retention of Organs at Post-mortem, *Report on Phase 3* (Edinburgh: HMSO, November 2003) (Sheila McLean QC, Chair).

17 United Kingdom Department of Health, *Report of a Census of Organs and Tissues Retained by Pathology Services in England* (conducted in 2000 by the Chief Medical Officer) (London: HMSO, 2001). These events attracted robust scholarly attention to resultant concerns, including legal concepts and rights regarding the dead body, e.g. Mason and Laurie (2001); Skene (2002a, 2002b, 2007); Renteln (2002); consent issues around post-mortem examinations, e.g. Brazier (2002, 2003); ethics, e.g. Harris (2002); and the evolving legal framework, e.g. Price (2003); Liddell and Hall (2005); Dewar and Boddington (2004).

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and any associated issues with UK death investigation and registration practices. Simultaneous to the Shipman Inquiry, the UK government commissioned an independent inquiry into death certification and investigation processes chaired by Tom Luce (the Luce Review), which described UK death certification and coroner services as no longer 'fit for purpose';[18] a sentiment that was ultimately shared by Dame Janet Smith.[19] The assessment of coronial services was grim: coroners lacked leadership and training, and bereaved families received inconsistent service. These reviews were accompanied by a significant research study into family experiences of the coroner service and inquests (Davis *et al.*, 2002). The study affirmed the findings of all inquiries that families both deserved and required better information provision during death investigation, a view echoed by community organisations such as advocacy group INQUEST, which detailed grievances on behalf of the bereaved (INQUEST, 2002).

This unparalleled focus on the adequacy of coronial practice, death investigation and certification provided the impetus for reform, where, by all accounts, the coroner service was in dire need of change (Freckelton and Ranson, 2006a, pp. 24–28). In response to this scrutiny, and taking account of the recommendations of the Luce Review and the Shipman Inquiry, the government developed a position paper to reform the coroner and death certification service,[20] resulting in a draft Coroners Bill in 2006[21] and a draft Charter for bereaved people.[22] After consultation and comment, in January 2009 the Coroners and Justice Bill was introduced into the House of Commons by the then Labour government. Among other reform matters, a core proposal was to establish a Chief Coroner to provide leadership, to ensure coronial consistency, and to improve standards across a fragmented and variable coronial service.

The Coroners and Justice Act 2009 (UK) is the result of sustained attention to death investigation, certification and post-mortem practices throughout UK jurisdictions which highlighted the need to better respond to families.[23] This need was further recognised by Judge Peter Thornton QC, who,

18 United Kingdom, *Death Certification and Investigation in England, Wales and Northern Ireland: The Report of a Fundamental Review* (Cmd 5831, 2003) (Tom Luce, Chair) p. 16 at [1].

19 Dame Janet Smith, *The Shipman Inquiry. Third Report: Death Certification and the Investigation of Deaths by Coroners* (Cm 5854, 2003), p. v; see also United Kingdom, House of Commons Constitutional Affairs Committee, *Reform of the Coroners' System and Death Certification, Eighth Report of Session 2005–06*, HC 902-I (1 August 2006) p. 5.

20 United Kingdom, Home Office, *Reforming the Coroner and Death Certification Service: A Position Paper* (Cm 6159, March 2004).

21 Department for Constitutional Affairs, *Draft Coroners Bill*, online: ‹http://webarchive.nationalarchives.gov.uk/+/http://www.dca.gov.uk/legist/coronersreform.htm› (last accessed 10 April 2016); Joint Committee on Human Rights, *Draft Coroners Bill (Letters to the Government)* (19 December 2006) from Andrew Dismore MP, Chair, online: ‹http://www.parliament.uk/documents/upload/draft-coroners-bill-191206.pdf› (last accessed 10 April 2016); See also Liberty, *Draft Coroners Bill, Liberty Briefing* (September 2006), online: ‹https://www.liberty-human-rights.org.uk/sites/default/files/draft-coroners-bill.pdf› (last accessed 10 April 2016); INQUEST, *INQUEST's Response to the Draft Coroners Reform Bill* (15 September 2006), online: ‹http://inquest.gn.apc.org/pdf/INQUEST_CRB_submission_september_2006.pdf› (last accessed 10 April 2016); Luce (2007).

22 The Draft Charter was developed in 2006 and subsequently revised. See United Kingdom, House of Commons Justice Committee, *Coroners and Justice Bill, Second Report of Session 2008–09*, HC 185 (London: Stationery Office, 23 January 2009) at [15]–[17], [35]. The government came under criticism in 2011 when it announced plans to abolish the Chief Coroner's office, concerns which were addressed by INQUEST in their response to the 2011 revised Charter: see INQUEST, *Response to Consultation Paper CP 5/2011 'The Draft Charter for the Current Coroner Service'* (August 2011). See also United Kingdom, Ministry of Justice, *Guide to Coroners and Inquests and Charter for Coroner Services* (March 2012). See also Freckelton (2010, pp. 472–473).

23 See e.g. the Explanatory Note to the Bill: *Coroners and Justice Bill, Bill 9* (15 January 2009). See also the House of Commons Second Reading debate: United Kingdom, House of Commons, *Coroners and Justice Bill, Second Reading* (26 January 2009) Col 33 (Mr Jack Straw, Secretary of State for Justice and Lord Chancellor).

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when addressing the Coroners' Society of England and Wales for the first time as Chief Coroner of England and Wales on 17 September 2012, acknowledged:

> 'When somebody once wrote that death was "The certain end of all pain and of all capacity to suffer pain", they were not thinking of those left behind. The bereaved rightly expect justice from the coroner system ... They should be at the heart of the process. We must therefore all work together to provide justice and a better coroner service. Not only for bereaved families but for the wider public.'[24]

The UK is not the only jurisdiction to recognise the needs of families in the coronial process. The UK human tissue and organ retention scandals of the late 1990s and early 2000s resonated internationally, including in Australia, where they generated debate on coronial reform, and prompted state and territory reviews on organ and tissue retention practices more broadly.[25] Australia has since experienced a significant degree of coronial law and policy reform, including in Queensland with the Coroners Act 2003 (Qld), in Victoria with the commencement of the Coroners Act 2008 (Vic), and in New South Wales with its Coroners Act 2009 (NSW). Law reform is still afoot in other jurisdictions, including Western Australia, which conducted a major review of coronial law and practice in 2010–2011.[26] Core concerns in Australian coronial reform have centred on post-mortem examination practices and the management of the deceased; information provision to family members, and the rights and role of families in the coronial process; the place of prevention in the legislative framework; the scope of inquests; and targeted coronial recommendations and responses to them.

These reforms provide a rich statutory mandate giving regard to cultural concerns around, for example, post-mortem practices – matters which are not comparatively legislated for in UK coronial law. However, these quite universal coronial issues are tackled differentially throughout Australian states and territories. For example, the focus on families finds various forms of legislative expression. When reviewing the Coroners Act 1985 (Vic), the Victorian Parliamentary Law Reform Committee highlighted the needs of families,[27] and the Coroners Act 2008 (Vic), Section 8, recognises families in the Act's objectives, legislatively enshrining values around access to information, professional support, and respect for cultural and religious beliefs, while also acknowledging the potential counter-therapeutic aspects of the jurisdiction, such as protracted coronial proceedings.[28]

Other jurisdictions approach matters in a more piecemeal fashion, recognising the needs of families on specific matters, such as autopsy. The Coroners Act 2003 (Qld), Section 19, provides for

24 Judge Peter Thornton QC, 'Speech for the Annual Conference: Coroners' Society of England and Wales' (21 September 2012) at [68], online: ‹https://www.judiciary.gov.uk/announcements/chief-coroner-speech-coroners-society-conference-21092012/› (last accessed 10 April 2016).

25 New South Wales Health Department, *Interim Report into the Retention of Tissue & Organs Following Post-mortems in NSW* (North Sydney, NSW, February 2001); Bradley Maxwell Selway QC, *Report into the Retention of Body Parts after Post-mortems* (Solicitor General, South Australia, Adelaide, 2001); Peter Panegyres and Alan Bansemer, *Final Report: Removal and Retention of Organs and Tissue Following Post-mortem Examinations: A Report to the Minister for Health* (2001). See also Bret Walker, *Inquiry into Matters Arising from the Postmortem and Anatomical Examination Practices of the Institute of Forensic Medicine* (New South Wales Department of Health, 2001).

26 Law Reform Commission of Western Australia, *Review of Coronial Practice in Western Australia, Background Paper Project No 100* (2010); *Discussion Paper Project No 100* (2011); *Final Report Project No 100* (2012).

27 See Victorian Parliamentary Law Reform Committee, *Coroners Act 1985: Final Report* (Melbourne: Government Printer, 2006).

28 *Coroners Act 2008* (Vic), s. 8. See Freckelton (2010).

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options for autopsy, including an external, a partial or a full internal examination of the body, with a requirement that before ordering an internal examination of the body the coroner must, where practicable, consider that in some cases the deceased's family may be distressed by such an order (Section 19(5)(a)), and consider any concerns raised by the family in relation to the type of examination (Section 19(5)(b)). Queensland's State Coroner guidelines augment these provisions, stipulating the principle of the least intrusive examination being ordered.[29] And so, while law reform reports and parliamentary debates have expressed concerns for families facing the coronial process[30] – acknowledging that post-mortem practices can be distressing[31] – Australian jurisdictions exercise varied responses to what is a common and widespread concern.

Other issues illustrate the common coronial values that exist across jurisdictional boundaries, but their quite different legislative and policy expression throughout Australian states and territories. For example, all coroners in Australia possess the statutory power to make coronial recommendations, a power which represents 'the distillation of the preventive potential of the coronial process', as coroners communicate the lessons of death to the broader community, including government agencies and policy-makers (Halstead, 1998, p. 187). Yet, mandatory responses to coronial recommendations are required in only some jurisdictions and, even then, there remains the thorny matter of enforceability. Coronial recommendations are just that: solely recommendatory, with Australian coroners possessing no power to make enforceable orders. Arguably, this limitation potentially forfeits the preventative power of coroners (Scott Bray, 2008). Some jurisdictions, such as Victoria, have developed the prevention principle to full statutory expression, legislatively enshrining prevention as part of the role of coroners in both the preamble to, and the purposes of, the Coroners Act 2008 (Vic).[32] And so, while Australian coronial law exhibits the comparable importance placed on the death prevention principle throughout its states and territories, the jurisdictional manifestation of such a core modern coronial value still varies (see Scott Bray, 2010).

Arguably, while Australian coronial law and practice has received reform wisdom from international experiences, such as the post-mortem and death investigation controversies in the UK (discussed above), its evolution still owes much to the specific legacies of Australian death and attendant inquiries, such as the Royal Commission into Aboriginal Deaths in Custody (RCIADIC). The RCIADIC was established in 1987 to investigate the high number of Aboriginal deaths in custody, and 2016 marks the twenty-fifth anniversary of the RCIADIC findings. The RCIADIC's 1991 *National Report* revealed 'the pervasive and troubling failure' of the coronial system in every Australian state and territory to uncover the circumstances of Aboriginal deaths in custody and to make appropriate coronial recommendations (Watterson, Brown and McKenzie, 2008, p. 6). The RCIADIC thus brought considerable attention to the coronial process and the specific issue of Indigenous death prevention, recognising the vital role of the coroner and making thirty-four

29 Queensland State Coroner's Office, *State Coroner's Guidelines, Queensland* (December 2003) p. 5.5; see also Carpenter *et al.* (2009, 2011).

30 Victorian Parliamentary Law Reform Committee, *Coroners Act 1985: Final Report* (Melbourne: Government Printer, 2006); Victoria, Legislative Assembly, *Parliamentary Debates* (9 October 2008) p. 4033 (Attorney General Rob Hulls); see also the Legislative Assembly debate on the Bill: Victoria, Legislative Assembly, *Parliamentary Debates* (11 November 2008) pp. 4480–4490; New South Wales, Legislative Assembly, *Parliamentary Debates* (4 June 2009) pp. 15781–15789 (Hon John Hatzistergos, Attorney General and Minister for Industrial Relations); Queensland, Legislative Assembly, *Parliamentary Debates* (3 December 2002) pp. 5220–5222 (Hon Rod J. Welford, Attorney-General and Minister for Justice).

31 See e.g. New South Wales, Legislative Assembly, *Parliamentary Debates* (4 June 2009) pp. 15785–15786 (Hon John Hatzistergos, Attorney General and Minister for Industrial Relations).

32 See *Coroners Act 2008* (Vic), s. 1(c). See also Victorian Attorney General Rob Hulls's Second Reading Speech, where he outlined the issue of prevention as a key theme in the Victorian reforms: Victoria, *Parliamentary Debates*, Legislative Assembly (9 October 2008), pp. 4035–4037 (Rob Hulls, Attorney General).

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recommendations aimed at modernising the system and enhancing its preventative potential, which have been variously implemented (see Amnesty International, 2015; Vines and McFarlane, 2000).[33]

Ostensibly, while the fact-finding task of the coroner may seem, at first blush, uncontroversial, scholars have unpacked that labour to highlight how death's 'facts' have an extra-legal life, where the call for justice is loaded with particular histories. This is especially notable in Indigenous deaths in custody, which can 'petition distinct socio-legal legacies', such as social injustice and the historical tenor of policing practices (Scott Bray, 2010, 2013, p. 464). Correspondingly, it is by stretching back through Australia's social and legal past that historical facts, such as the policing of Indigenous people, come to make sense of contemporary death. When the facts of death freight very specific histories of Indigenous life *and* death, coronial inquiries have implications well beyond 'mere' fact-finding in individual cases. Notwithstanding the different legal architectures of coronial systems in Australia and the UK, for example, coronial justice in any jurisdiction is always weighted with the particular histories and legacies of place (Scott Bray, 2008).[34]

III. Diluting justice in UK coronial reform

3.1 The spectre of secrecy

It should be evident from the previous discussion that coronial law and practice has not been immune from critical scrutiny. Despite this, the coroner's jurisdiction was staunchly defended when, in 2008, the UK government proposed introducing what have become colloquially known as 'secret inquests' – i.e. closed, juryless inquests with government-vetted coroners and counsel – into deaths where the inquest would involve sensitive material, including material that should not be made public in the interests of national security (see Scott Bray, 2012; Martin and Scott Bray, 2013). Announced in the context of counter-terrorism with the Counter-Terrorism Bill 2008 (UK), the secret inquest clauses ushered in a three-year period in which successive UK governments repeatedly sought to pass legislation that prescribed holding closed inquests. The Counter-Terrorism Bill 2008 (UK) was followed by secret inquest proposals in both the Coroners and Justice Bill 2009 (UK), and the 2011 Justice and Security Green Paper. All inquest reform proposals were met with considerable controversy, raising cross-party concerns about the role of the executive, human rights, public scrutiny of deaths involving state agents, and the fundamental principle of open justice; concerns echoed by key advocacy groups, such as INQUEST and LIBERTY (see Scott Bray, 2012; Martin and Scott Bray, 2013).

The debate around secret inquests was contextualised by the public interest status of coronial proceedings – including the practical and symbolic importance of the inquest jury in prescribed cases, such as deaths in custody – and the UK's obligations under Article 2 of the European Convention on Human Rights (ECHR). The concern was that proposals for juryless, secret inquests removed public scrutiny from the deaths that most require it, including deaths involving state agents. For such inquests, the public interest is underscored in part by the presence of 'ordinary people, independent of the state'[35] in judicial proceedings, who figure as both instrumental fact-finders and symbols of openness. To remove this public presence would be equivalent to evacuating the public scrutiny that precisely safeguards open, transparent and accountable justice

33 See the Special Issue of the *Australian Indigenous Law Review* (2008) 12(2), on the topic of 'Coronial Reform and Preventing Indigenous Death'.

34 See also Carrington, Hogg and Sozzo (2016) for their discussion of the project of Southern Criminology, which aims to reorient the production of criminological knowledge away from privileging the theories, practices and methods of the Global North to an appreciation of the specificities of the Global South.

35 INQUEST, *Briefing for Second Reading of the Counter-Terrorism Bill* (April 2008) p. 6, online: ‹http://inquest.gn.apc.org/pdf/INQUEST_briefing_2nd_reading_counter_terrorism_bill_2008.pdf› (last accessed 15 April 2016).

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in these circumstances (see Scott Bray, 2012).[36] In the UK, the principle of open justice was legislatively recognised in 1953 pursuant to the Coroners (Amendment) Act 1926 (UK), and is provided for in rules such as Rule 11 of the Coroners (Inquests) Rules 2013 (UK), which states that '[a]n inquest hearing and any pre-inquest hearing must be held in public', unless the coroner considers it would be in the interests of national security to exclude the public. While inquests have never been uncontroversial, and the coronial system remains an evolving institution (Freckelton and Ranson, 2006b), the inquest is a 'people's court', underscored by the principle of open justice (Scott Bray, 2013, p. 451).

Corresponding to the concern about the absence of juries in significant cases was alarm over the dismissal of human rights obligations which underpin the UK approach to investigating death. Since the Human Rights Act 1998 (UK) incorporated the ECHR into domestic law, UK coronial practice is necessarily contextualised by ECHR obligations. Arguably the most significant influence has come from the impact of Article 2, the right to life. For deaths that engage Article 2, public scrutiny finds even greater purchase. In the event of such deaths – which include those allegedly involving state agents – the state has certain procedural obligations, including an obligation to conduct independent, effective, reasonably prompt, transparent investigations that allow the next of kin to participate to the extent necessary to safeguard their interests (see *Jordan v. United Kingdom*: paragraphs 105–109; *R (Amin) v. Secretary of State for the Home Department; Edwards v. United Kingdom*: paragraphs 69–73).[37]

Human rights litigation has reshaped the field of UK death investigation by clarifying the coronial role in the context of ECHR obligations, determining, for example, what the ECHR requires by way of verdict, judgment, findings or recommendations of an Article 2 investigation, and how the regime governing the conduct of inquests be revised so as to meet ECHR obligations (see *R (Middleton) v. HM Coroner for West Somerset*: paragraph 4). Correspondingly, recent statutory law reform has recognised human rights principles in death investigation with the Coroners and Justice Act 2009 (UK) (see, for example, Section 5(2)). These are changes of real consequence for coroners (see Freckelton and McGregor, 2014, p. 584). Accordingly, ECHR obligations materially effect the work of coroners, from the structure and parameters of their inquiries to the form of coronial findings, and exhibit the degree to which human rights have emerged as 'an important yardstick' in terms of contemporary death investigation expectations and requirements (p. 584). For commentators, the Bill proposals for secret inquests threw up fears that resulting legislation would contravene ECHR obligations.

The 2008/2009 secret inquest proposals were precipitated by a legal impasse around the issue of inadmissible intercept evidence at the inquest into the death of Azelle Rodney, who was shot dead during a police operation in London in 2005. At a pre-inquest hearing in 2007, the coroner was presented with redacted police material relevant to the coronial investigation, but conceded that he could neither see the material nor put it before a jury.[38] As Thomas, Straw, Machover and Friedman (2014, p. 655) state, the 'working assumption' was that the material in question was evidence of intercept, which is inadmissible in UK legal proceedings under Section 17 of the

36 INQUEST, *Briefing on the Counter-Terrorism Bill 2008 for the House of Lords 2nd Reading* (July 2008), online: ‹https://www.opendemocracy.net/files/INQUEST%20Counter%20Terrorism%20-%20Lords%202nd%20Reading.pdf› (last accessed 15 April 2016).

37 *Jordan v. United Kingdom* (2003) 37 EHRR 2; *R (Amin) v. Secretary of State for the Home Department* [2004] 1 AC 653. In England and Wales an inquest satisfies the state's procedural obligations under art. 2: see *R (Middleton) v. West Somerset Coroner* [2004] 2 AC 182 at [47]. See also the United Kingdom High Court's endorsement of the coronial regime in discharging the state's art. 2 obligations: *R (on application of Mousa) v. Secretary of State for Defence* [2013] EWHC 1412 (Admin).

38 Andrew Walker, *In the Matter Touching the Death of Azelle Rodney, Reasons for the Ruling Made August 2 2007* (2 August 2007) pp. 3–5.

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Regulation of Investigatory Powers Act 2000 (UK) (RIPA). The coroner acknowledged the tensions between the prohibition on the material's disclosure under Section 17 of RIPA and obligations under both the then Coroners Act 1988 (UK) to hold a jury inquest and Article 2 of the ECHR to hold an Article 2 compliant inquest. With Article 2 obligations including 'the disclosure of core documents'[39] – a fact prohibited in Rodney's case by the unlawfulness of intercept disclosure – the coroner's hands were tied and he adjourned the inquest into Rodney's death.

Despite government assertions that the secret inquest proposals would, in fact, ameliorate the bind it was in to satisfy the state's Article 2 obligations in circumstances where sensitive material could not be disclosed, such as in Azelle Rodney's inquest, it was widely argued that Article 2 obligations would be further frustrated, not advanced, by a lack of public scrutiny, independence, transparency and accountability (Scott Bray, 2012, p. 579). In essence, the 'knee-jerk' but 'wide-reaching' proposals were assessed as creating more problems than the issue they were trying to resolve.[40] In the face of widespread censure, and to address the continuing legal stalemate, the government eventually amended RIPA to enable disclosure of intercept evidence under the Inquiries Act 2005 (UK) to panels and counsel to the inquiry. Following the defeat of the secret inquest proposals in both the Counter-Terrorism Bill 2008 and the Coroners and Justice Bill 2009, on 10 June 2010 the Justice Secretary announced a public inquiry into Azelle Rodney's death under the Inquiries Act 2005 (UK), which was to be chaired by retired High Court Judge Sir Christopher Holland. Over eight years after Azelle Rodney's death, and an inquiry that cost £2.5 million, a finding of unlawful killing was reached. Despite this significant finding, the case took a circuitous route before the inquiry, ostensibly reinvoking critical claims in the push for coronial reform, including the need for streamlined death investigation (see Scott Bray, 2012; Martin and Scott Bray, 2013).

Azelle Rodney's case was not the only inquest to throw up issues of sensitive material and call attention to the coronial jurisdiction's fact-finding efficacy in difficult circumstances. When, in 2011, the UK coalition government proposed secret inquests in its Justice and Security Green Paper (the Green Paper), commentators noted that the inquests pinpointed as a fillip for reform – the inquests into the 7 July 2005 London Bombings (the 7/7 Inquests) – actually evidenced the general success of the extant coronial framework in dealing with sensitive material. In those inquests, coroner Lady Justice Hallett, wrestling with the issue of the reception of sensitive material from the security services, and whether she possessed the power to receive the material in a closed hearing, ruled that she did not possess the power to hold closed hearings and exclude interested persons, including the bereaved.[41] Nevertheless, she was able to discharge her coronial duties with respect to the 7/7 deaths.

In the Green Paper, the government positioned the 7/7 Inquests as evidence of a weakness in an outmoded system that needed reform to stand up to the contemporary demands around managing sensitive evidence. The government claimed that while the 7/7 Inquests were able in that instance to fulfil the coronial purpose, 'the situation may be more challenging in future inquests' if relevant information could not be properly considered.[42] In this sense, the 'ad hoc solutions' applied in the 7/7 Inquests (such as the use of Public Interest Immunity claims) actually increased

39 Andrew Walker, *In the Matter Touching the Death of Azelle Rodney, Reasons for the Ruling Made August 2 2007* (2 August 2007), p. 3.

40 INQUEST, *Briefing for Second Reading of the Counter-Terrorism Bill* (April 2008) p. 4, online: ‹http://inquest.gn.apc.org/pdf/INQUEST_briefing_2nd_reading_counter_terrorism_bill_2008.pdf› (last accessed 15 April 2016).

41 Ruling of Lady Justice Hallett, *Coroner's Inquests into the London Bombings of 7 July 2005* (3 November 2010) pp. 3, 44–45. The government unsuccessfully appealed the coroner's ruling: *Secretary of State for the Home Department v. Assistant Deputy Coroner for Inner West London* [2010] EWHC 3098 (Admin).

42 United Kingdom Government, *Justice and Security Green Paper* (Cm 8194, 2011) p. 16.

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risks around the use of sensitive material, rather than mitigated them.[43] The UK Joint Committee on Human Rights (JCHR) concurred with the views of advocacy groups such as INQUEST that coroners display productive creativity with regard to handling sensitive evidence in the extant legislative framework, citing inquest cases such as Jean Charles de Menezes in supporting their criticism of the proposals.[44] In short, according to the JCHR, the government's case for closed inquest hearings was not made out.[45] Once again, after significant disquiet, the government dropped inquests from the Justice and Security Bill 2012 (UK).

3.2 Up in smoke: the Chief Coroner and the 'bonfire of the quangos'

Between the enactment of the Coroners and Justice Act 2009 (UK) and the October 2011 release of the Green Paper, coronial reform was again in the spotlight. And yet again, advocacy groups sought to defend the reform that was many years in the making, and that, with the passage of the Coroners and Justice Bill 2009 (UK), had seemed finally, statutorily settled. In October 2010, the new coalition government announced that, due to the economic climate, the Office of the Chief Coroner – a key aspect of the previous Labour government's coronial reform agenda – would be abolished. In what became known as the 'bonfire of the quangos',[46] Schedule 1 of the Public Bodies Bill 2010 (UK) listed a number of quangos set to be scrapped, including the Chief Coroner, which was a key and bipartisan reform item. The Bill provided the power for a Minister to abolish the offices of the Chief Coroner, Deputy Chief Coroners, Medical Advisors to the Chief Coroner and Deputy Medical Advisors to the Chief Coroner, and to transfer any or all of their functions.

The UK government's plans to abolish the Chief Coroner's post were met with cross-party condemnation and attracted ire from community groups, especially The Royal British Legion and INQUEST, who subsequently campaigned strongly, both separately and together, to refute the government's arguments for abolition.[47] During the committee stage in the House of Lords, an amendment was tabled successfully by Baroness Finlay of Llandaff to remove the Chief Coroner from the list of public bodies to be abolished.[48] However, on 14 June 2011, the government announced its plans to proceed with operationalising the Coroners and Justice Act 2009 (UK) reforms without the Chief Coroner. In a written ministerial statement, the Lord Chancellor and Secretary of State for Justice, Kenneth Clarke, outlined that the Office of the Chief Coroner would be listed in Schedule 5 of the Public Bodies Bill 2010 (UK). As a result, the office would remain on the statute books, but the Bill would enable some of its statutory functions to be transferred to the Lord Chancellor or Lord Chief Justice, such as functions:

43 United Kingdom Government, *Justice and Security Green Paper* (Cm 8194, 2011) p. 15.

44 United Kingdom, Joint Committee on Human Rights, *The Justice and Security Green Paper, Twenty-fourth Report of Session 2010–12*, HL Paper 286, HC 1777 (4 April 2012) at [138], [150]; see INQUEST, *INQUEST and the INQUEST Lawyers Group's Submission to the JCHR Inquiry into the Justice and Security Green Paper* (January 2012) at [56]–[62].

45 United Kingdom, Joint Committee on Human Rights, *The Justice and Security Green Paper, Twenty-fourth Report of Session 2010–12*, HL Paper 286, HC 1777 (4 April 2012) at [144].

46 Quangos are quasi-autonomous non-governmental organisations.

47 See, for example, INQUEST, *Public Bodies Bill [HL], Briefing for Second Reading*, November 2010, online: ‹http://inquest.org.uk/pdf/briefings/INQUEST%202nd%20Reading%20Briefing%20for%20House%20of%20Lords%20on%20Public%20Bodies%20Bill.pdf› (last accessed 15 April 2016); INQUEST, 'Bereaved Families' Concerns Ignored by Coalition Government', press release 13 December 2010; 'Leave it out Ken!', social media campaign by the Royal British Legion; INQUEST, *Briefing on Coronial Reform: Report Stage of Public Bodies Bill*, October 2011 (which includes 'Our Proposal: A Pragmatic Way forward by INQUEST and the Royal British Legion'), online: ‹http://www.inquest.org.uk/pdf/briefings/INQUEST_October_2011_Briefing_on_Public_Bodies_Bill.pdf› (last accessed 15 April 2016).

48 United Kingdom, House of Lords, *Public Bodies Bill* (14 December 2010) Cols 528–549.

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> '[a]llowing the Lord Chancellor to make regulations about the way in which the coroner system is expected to operate in relation to bereaved relatives; allowing the Lord Chancellor to make regulations about the practice and procedure in coroner investigations, such as the disclosure of information to bereaved relatives and minimum standards for post mortem examinations; allowing the Lord Chief Justice to make rules to regulate practice and procedure at inquests; allowing the Lord Chief Justice to make rules in relation to the training of coroners, including specialist training, for instance, relating to military inquests; allowing the Lord Chancellor to amend coroner areas; and allowing the transfer of military cases to and from Scotland.'[49]

Those functions not transferred would not be implemented, due to cost, such as the Chief Coroner's responsibility for a new appeals system,[50] which many perceived as a significant casualty of the coronial reform agenda.[51] The Justice Secretary also proposed establishing a ministerial board to focus on the non-judicial aspects of the coroner service, including matters of policy, administration and service standards. The board would be responsible for advising the Lord Chancellor on his statutory duties, set priorities for action, and consider national statistics; it would also be supported by a Bereaved Organisations Committee, which would be responsible for monitoring the 'National Charter for the Coroner Service' that the government published for consultation in May 2011. INQUEST dissected the proposals, noting that neither a ministerial board nor a 'committee made up of charities and non-profit organisations inputting their views and experience on a voluntary basis' were suitable substitutes for a 'dedicated judicial post-holder empowered to implement changes in the form of the Chief Coroner'.[52] INQUEST also criticised the government's new coronial services charter. Instead of being the 'robust set of standards' articulated in a charter for the bereaved that was 'systemically linked to the new legislation', INQUEST argued the new charter was a 'watered down', 'generic document' that would have little impact on the bereaved, and which was, in fact, the impetus for the original charter.[53]

Despite the lobbying, on 11 October 2011 the Public Bill Committee agreed to the insertion of the Chief Coroner in Schedule 5.[54] A subsequent amendment was moved unsuccessfully during the Commons report stage to leave the Chief Coroner and associated offices out of Schedule 5. Ahead of the debate, eighteen national charities, including INQUEST and the Royal British Legion, wrote a letter to *The Times* newspaper urging MPs to support the amendment. This was accompanied by a social media campaign by the Royal British Legion entitled 'Leave it Out Ken!', which it promoted through Facebook. During the House of Lords consideration of Commons amendments, Baroness Finlay of Llandaff had intended to move an amendment to disagree with the government's amendment to include the Chief Coroner in Schedule 5. Facing possible defeat, on

49 As outlined at Commons report stage: United Kingdom, House of Commons, *Public Bodies Bill* (25 October 2011) Col 258 (Mr Jonathan Djanogly, Parliamentary Under-Secretary of State for Justice).

50 United Kingdom House of Commons, *Written Ministerial Statements* (14 June 2011) Cols 64WS–66WS (Mr Kenneth Clarke, Lord Chancellor and Secretary of State for Justice).

51 For example, see INQUEST, *Briefing on Coronial Reform: Report Stage for Public Bodies Bill*, October 2011, online: ‹http://www.inquest.org.uk/pdf/briefings/INQUEST_October_2011_Briefing_on_Public_Bodies_Bill.pdf› (last accessed 15 April 2016); INQUEST and the Royal British Legion, press release, 23 November 2011.

52 INQUEST, *Briefing on Coronial Reform: Consideration of Amendments, Public Bodies Bill*, November 2011, p. 11 at [25]; p. 10 at [23], online: ‹http://inquest.org.uk/pdf/briefings/INQUEST_November_2011_Briefing_on_Public_Bodies_Bill.pdf› (last accessed 15 April 2016).

53 INQUEST, *Briefing on Coronial Reform: Consideration of Amendments, Public Bodies Bill*, November 2011, p. 13 at [34]; p. 12 at [32]; p. 13 at [34], respectively, online: ‹http://inquest.org.uk/pdf/briefings/INQUEST_November_2011_Briefing_on_Public_Bodies_Bill.pdf› (last accessed 15 April 2016).

54 United Kingdom, House of Commons, Public Bill Committee, *Public Bodies Bill* (11 October 2011) Cols 224–241.

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22 November 2011 Kenneth Clarke announced that, having listened to and reflected on concerns, the Office of the Chief Coroner would be implemented. The following day, during the Lords consideration of Commons amendments, government amendments were agreed to without division. On 17 September 2012, His Honour Judge Peter Thornton QC took up his post as Chief Coroner of England and Wales.

IV. Settling down to business

Coronership dates, at least, from the Articles of Eyre in 1194 (McKeough, 1983). As the principle means by which unexpected, sudden and unnatural deaths are investigated, coronial inquiries carry a weight of expectation (Scott Bray, 2013). A wave of international law reform has sought to refine coronial practice in the light of contemporary expectations for effective death investigation, with many jurisdictions now adjusting to revitalised coronial frameworks. Such significant change entails concomitant challenges, including, but not limited to, questions of publicity, human rights and death prevention, which we now take in turn.

4.1 Going public

Since the Chief Coroner was appointed, the Office of the Chief Coroner has developed a considerable Internet presence,[55] with a website that contains annual reports, published law sheets, and guidance by the Chief Coroner on matters including, for example, the use of post-mortem imaging (Guidance No. 1), and Reports to Prevent Future Deaths (Guidance No. 5).[56] The website is also a repository for Reports to Prevent Future Deaths made under paragraph 5, Schedule 7 of the Coroners and Justice Act 2009 (UK),[57] which upgraded the making of prevention of future deaths reports from a rule to part of the substantive Act, thus securing a coroner's duty (instead of a discretion) to make a preventative report where a concern is identified. Similarly, albeit for quite a few years now, all coroners' offices in Australian states and territories display an online presence, with varying degrees of information provision, including publishing coronial findings and recommendations.[58] In Victoria, the importance of Internet information finds a statutory footing. The Coroners Act 2008 (Vic) Section 73(1) stipulates that coronial findings, comments and recommendations made following an inquest must be published on the Internet unless otherwise ordered by a coroner and, under Section 72(5)(a), coroners must publish on the Internet those responses of public statutory authorities and entities to coronial recommendations.

Internationally, coronial practice is therefore experiencing a new dimension of publicity, making what, in the past, has been a largely invisible – though public – process, more visible, accountable and able to be evaluated (see Freckelton, 2009). However, despite a modernised, digital coronial bureaucracy, this new publicity manifests most dramatically when high-profile and contentious inquest cases have an online presence, which quite significantly progresses the public nature of

55 See the webpage of the Chief Coroner, online: ‹https://www.judiciary.gov.uk/related-offices-and-bodies/office-chief-coroner/› (last accessed 10 April 2016).

56 Online: ‹https://www.judiciary.gov.uk/related-offices-and-bodies/office-chief-coroner/guidance-law-sheets/› (last accessed 10 April 2016).

57 Online: ‹https://www.judiciary.gov.uk/related-offices-and-bodies/office-chief-coroner/pfd-reports/› (last accessed 10 April 2016).

58 Online: ‹http://www.coroners.justice.nsw.gov.au/›; ‹http://www.coronerscourt.vic.gov.au/›; ‹http://www.courts.qld.gov.au/courts/coroners-court›; ‹http://www.coronerscourt.wa.gov.au/›; ‹https://cmsexternal.nt.gov.au/justice/courts/coroners-decisions›; ‹http://www.magistratescourt.tas.gov.au/divisions/coronial›; ‹http://www.courts.sa.gov.au/OurCourts/CoronersCourt/Pages/default.aspx›; ‹http://www.courts.act.gov.au/magistrates/courts/coroners_court› (last accessed 10 April 2016). See also New Zealand's Coronial Services website, online: ‹http://www.justice.govt.nz/courts/coroners-court› (last accessed 10 April 2016).

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inquests in contemporary times. There are two key elements to this: first, the use of dedicated inquest websites for specific cases, and second, the proliferation of social media in response to those inquests. A number of high-profile UK inquests in recent years have had a unique public presence with specific websites that publish evidence and/or daily transcripts. Examples include, in the UK, the Jean Charles de Menezes Inquest, the 7/7 Inquests, the inquest into the death of Ian Tomlinson, the inquest into the death of Mark Duggan, the Hillsborough Inquests, and, in Australia, the Sydney Siege Inquest.[59]

While the UK inquests were the most developed in terms of their online presence, publishing daily inquest transcripts, the Sydney Siege Inquest, held in segmented hearings throughout 2015–2016, televised the opening address to each segment, consisting of remarks by the State Coroner and then Counsel Assisting. The opening addresses were statements of summary, but the most lengthy and detailed address was given at the beginning of final public segment, which commenced in March 2016. This segment was arguably the most controversial and certainly the most closely regarded, as it heard both from the hostages about their experiences inside the Lindt Café, and from the police about their decision-making around operational matters. The two-day opening address to this segment presented key evidence, including CCTV footage, photographs of evidential objects, and audio-recordings of 000 emergency calls, as it summarised events as a precursor to calling testimony. In an unprecedented move, the opening addresses keyed the public into core matters subsequently raised at the inquest. And when hearings were held in camera, the opening address served as the valve for publicity where it otherwise could not be achieved for public interest reasons; a move that recognised the importance of public access to coronial information.

The inquests listed above have all scrutinised state practices, but they have done so against the backdrop of a new media environment, saturated with social media and practices such as Twitter, podcasts and live rolling blogs.[60] In Sydney, Australia, the government Twitter account for the New South Wales Department of Justice, *Justice NSW*, tweeted on witness evidence and case updates in the Sydney Siege Inquest, such as inquest adjournments and resumptions. Added to this were the manifold journalist tweets on the case under the hashtag #sydneysiege, *The Guardian* newspaper's 'Sydney Siege Inquest Recap' available on iTunes,[61] and dedicated press webpages.[62] Similarly, in London in 2011, the inquest into the death of Ian Tomlinson – who died during the G20 protests in London on 1 April 2009 after he was struck by a baton and pushed to the ground by a police officer – witnessed an inquest website, media blogs, Twitter accounts and hashtags

59 See, respectively, *Coroner's Inquest into the Death of Jean Charles de Menezes*, online: ‹http://webarchive.nationalarchives.gov.uk/20090317235546/http://www.stockwellinquest.org.uk/› (last accessed 10 April 2016); *Coroner's Inquests into the London Bombings of 7 July 2005*, online: ‹http://webarchive.nationalarchives.gov.uk/20120216072438/http://:/7julyinquests.independent.gov.uk/› (last accessed 10 April 2016); *Coroner's Inquest into the Death of Ian Tomlinson 1 April 2009*, which used to be available at: ‹http://www.tomlinsoninquest.org.uk/tomlinson/› but has not been archived; *Inquest into the Death of Mark Duggan*, online: ‹http://dugganinquest.independent.gov.uk/index.htm› (last accessed 10 April 2016); *Hillsborough Inquests*, online: ‹https://hillsboroughinquests.independent.gov.uk/› (last accessed 10 April 2016); *Inquest into the Deaths Arising from the Lindt Café Siege*, online: ‹http://www.lindtinquest.justice.nsw.gov.au/› (last accessed 10 April 2016).

60 See *Ian Tomlinson Inquest Live Blog*, online: ‹http://www.theguardian.com/uk/series/ian-tomlinson-inquest-live-blog› (last accessed 10 April 2016); *J7: 7/7 Inquests Blog*, *J7: The July 7th Truth Campaign*, online: ‹http://www.julyseventh.co.uk/index.html› (last accessed 10 April 2016); the Jean Charles de Menezes family campaign 'Justice4Jean' consisted of campaign and inquest websites (which are no longer active): *The Jean Charles de Menezes Family Campaign*, online: ‹http://www.justice4jean.org/index.html›; *Jean Charles de Menezes Inquest*, online ‹http://inquest.justice4jean.org/›.

61 The inquest recap was also available on *The Guardian* website, online: ‹http://www.theguardian.com/australia-news/series/siege-inquest-podcast› (last accessed 10 April 2016).

62 For example, see *The Guardian* page online: ‹http://www.theguardian.com/australia-news/sydney-siege› (last accessed 10 April 2016).

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that, in chorus, discussed the case. This has meant that such inquests 'have a contemporaneous social presence that is extensively networked, with information rapidly and widely shared', illustrating just how much how the digital age has influenced the coronial system (Scott Bray, 2013, p. 456). It also confirms that the contemporary manifestation of open justice in coroners' courts undeniably resides in a multimedia world. The corollary is that such practices pinpoint relatively new coronial terrain, and highlight consequent, emerging issues, such as sensitivities around the public presentation of evidence relating to death.[63] How might the fact that information now can be disseminated so widely affect the delivery and quality of coronial justice in ways that have, hitherto, been unimaginable? Correspondingly, such unprecedented offsite access to inquests and coronial information requires us to consider the ways in which these developments are reshaping traditional ideas about both the publicity of, and public access to, coroners' inquests.

4.2 Rights-based or rights-attuned?

Another core issue for twenty-first-century coronership is the importance of human rights considerations in death investigation. In Europe and the UK, human rights jurisprudence emanating from Strasbourg has exerted a powerful influence upon death investigation law, strongly impacting normative coronial practice and fine-tuning expectations. Australia, on the other hand, has no federal bill of rights or overarching human rights legislative framework, with only two jurisdictions, Victoria and the Australian Capital Territory (ACT), enacting human rights legislation.[64] Australia is a signatory to a number of human rights treaties, including the International Covenant on Civil and Political Rights (ICCPR) and the International Covenant on Economic, Social and Cultural Rights (ICESCR). However, international obligations under these conventions do not provide for domestically enforceable rights in the absence of Australian statutory law incorporating those rights, although aggrieved individuals can, for example, communicate their claim in respect of a breach of the ICCPR to the United Nations Human Rights Committee. Both Victoria, by way of its Charter of Human Rights and Responsibilities Act 2006 (Vic), and the ACT by virtue of its Human Rights Act 2004 (ACT), give some domestic effect to human rights, providing for rights-protecting legislative scrutiny and the requirement that public authorities act consistently with human rights. Yet these latter instruments do not have the 'array of teeth' as the ECHR does in the UK in terms of compensatory remedies (Freckelton and McGregor, 2014, p. 587). Effectively, then, there remains a weakness in enforcing obligations and addressing any possible breach.[65]

63 See, for example, the NSW State Coroner's reasons for dismissing the application to prohibit publication of the 000 emergency call with siege victim Tori Johnson during the Sydney Siege Inquest's opening address on 21 March 2016: *Reasons for decision re application made for orders under s. 74 and s. 65 on 21 March 2016*, online: ‹http://www.lindtinquest.justice.nsw.gov.au/Pages/documents.aspx› (last accessed 15 April 2016). Other inquests have also released visual evidence. In October 2012, during the inquest into the death of Brazilian student Roberto Laudisio Curti, who was tasered by police in Sydney, the NSW State Coroner authorised the media release of video evidence of police tasering and restraining Mr Curti; the footage was released to the press with the support of his family: Lisa Davies, 'Distressing Video of Tasered Student Released', *The Sydney Morning Herald* (9 October 2012), online: ‹http://www.smh.com.au/nsw/distressing-video-of-tasered-student-released-20121009-27afq.html› (last accessed 10 April 2016).

64 See, respectively, *Charter of Human Rights and Responsibilities Act 2006* (Vic) and *Human Rights Act 2004* (ACT).

65 See also the advocacy group Australian Inquest Alliance's (AIA) submission to the 2011 Australian government's draft Baseline Study, released as part of the process of implementing a National Human Rights Action Plan. In their submission, AIA outlined the relevance of the coronial system to Australia's human rights obligations, documenting a number of areas that highlight the coronial capacity to protect human rights. The AIA also noted the limitations that frustrate and potentially breach these rights, such as delays in inquest, lack of resources for coroners, and limitations with respect to coronial recommendations (AIA, 2011).

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In many ways, and despite the absence of a federal bill of rights, Australia already has progressive coronial law and practice, and Australian coroners do not ignore human rights considerations in discharging their investigative duty. In Australian inquests, human rights intermittently concern coroners because interested parties (such as community organisations, human rights agencies and community legal centres) increasingly raise human rights concerns derived from European Court of Human Rights decisions, noting state obligations and the requirements of 'a human-rights compliant death investigation' (Freckelton and McGregor, 2014, p. 585).

Human rights interveners are typically granted leave to appear as interested parties to assist the coroner with such matters as: identifying human rights issues; understanding the interplay between those rights and the circumstances of death; and appreciating state obligations with respect to the implementation and protection of those rights. In practice, this also means making submissions on matters such as inquest scope, and coroners' comments and recommendations. Examples include the (then) Australian Human Rights and Equal Opportunity Commission's (HREOC) submissions to the inquest into the death in custody of Mulrunji Doomadgee in 2004 on Palm Island, Queensland, the inquest into the death of Elder Ward during prison transportation in Western Australia in 2008,[66] and the Human Rights Law Centre (HRLC) submissions to the inquest into the death of fifteen-year-old Tyler Cassidy, who was shot dead by police in Victoria in 2008 (HRLC, 2008). Such contributions are often effective, testifying to the coronial protection of human rights (Hunyor, 2008, pp. 70–71; see also Hunyor, 2009). For example, the HREOC's final submission in the inquest into the death of Mulrunji Doomadgee outlined forty recommendations across four main areas (including arrest and policing), which the coroner adopted, demonstrating that human rights interveners can have very material impacts (pp. 70–71).[67] Increasingly, as the impact of human rights on Australian death investigation grows, it constitutes an issue that Australian and New Zealand coroners and governments 'will have no choice but to come to terms with over the next decade' (Freckelton and McGregor, 2014, p. 585).[68]

And while the above example of interveners demonstrates the accommodation of Australian coroners to human rights concerns, Australian statutory coronial law does not disregard the protection of human rights in the death investigation context. As with the UK, Australia has undergone considerable coronial reform that reflects the degree to which its coronial law and practice is practically 'fashioned and influenced by considerations that are respectful of human rights' (Freckelton and McGregor, 2014, p. 599). A broadly principled approach to rights is evident in both clause-by-clause reforms and comprehensive jurisdictional reviews.[69] Typically, throughout Australia, coronial law reform has focused on a range of issues that highlight the degree to which Australian coronial law demonstrates a uniquely rights-attuned focus, such as

66 See the respective submissions online: ‹https://www.humanrights.gov.au/right-life› (last accessed 10 April 2016).

67 See Prictor (2012) for a critical discussion of public interest intervention at inquests.

68 See also Freckelton and McGregor (2014), where they discuss the Tyler Cassidy case, which is highlighting the impetus for change around Australian right to life obligations in the coronial context. Cassidy was fifteen years old when he was shot dead by Victoria Police in a Melbourne suburb. In May 2013, the HRLC submitted a communication to the UNHRC on behalf of Tyler's mother, Shani Cassidy, contending that Australia had breached art. 6(1) (right to life) of the ICCPR by not providing an independent and effective investigation into Tyler's death, as Victoria Police investigated a death at the hands of its own officers; and that art. 2 of the ICCPR (effective remedy) was also breached as the state did not ensure an effective remedy via the inquest process itself nor its recommendations (HRLC, (2013, pp. 54–57; 2015). Freckelton and McGregor argue that the Cassidy communication has spotlighted the Australian coronial system 'in an international forum where Australia is increasingly out of step with jurisprudential developments' (2014, p. 585).

69 See, for example, Victorian Parliamentary Law Reform Committee, *Coroners Act 1985: Final Report* (Melbourne: Government Printer, 2006).

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involvement of families and autopsy appeal rights. The Coroners Act 2008 (Vic), Section 8, firmly incorporates the recognition of families into the Act's objectives, and, on the subject of post-mortem procedures, provisions allow for 'preliminary examinations' of the deceased (Section 23) – which can include a visual examination of the body, the use of imaging techniques such as Computed Tomography (CT) scans, the taking of bodily samples, and the collection and review of health information and fingerprinting – which have reduced autopsy rates from 85 per cent of deaths reported to the coroner to 50 per cent (Ranson, 2010, p. 488), with a corresponding significant decrease in objections to autopsy (Lynch and Woodford, 2014, p. 778).

Such reforms quite practically give life to rights, such as the right to privacy, family and cultural life (Article 8 of ECHR; Articles 17, 23, 27 ICCPR), and the right to freedom of religion (Article 9 of ECHR, Article 18 of ICCPR). Arguably, despite recent reform and its fuller rights-based statutory mandate, UK coronial law historically has been paradoxically less rights-attuned than its Australian counterpart, and still does not contain, for example, comparative statutory provisions around objections to post-mortems, and has only recently seen guidance on preferred practice vis-à-vis invasive autopsies.[70] Accordingly, those matters have been tested in the courts. The 2015 UK High Court case of *R (Rotsztein) v. HM Senior Coroner for Inner London North* (*Rotsztein)* dealt with the approach to be taken by coroners when ordering invasive post-mortem examinations in circumstances where the deceased's family has raised religious objections under Article 9 of the ECHR. Following the death of eighty-six-year-old Sarlotta Rotsztein, an Orthodox Jew, in September 2014, and differing medical opinions as to the cause of death, the coroner ordered a traditional (i.e. invasive) autopsy. The family raised their concerns, requesting – and offering to pay for – a non-invasive autopsy (CT Scan and coronary angiography). The coroner rejected the proposal and the family sought an urgent injunction to halt the autopsy, which was granted. A Professor Roberts then performed the non-invasive autopsy. Taking those results together with Mrs Rotsztein's blood and urine culture hospital results, the coroner accepted Professor Roberts's determination as to cause of death. The family was granted permission to bring a test case against the coroner, on the grounds that the case raised questions of principle, which were likely to arise in other cases. *Rotsztein* found the coroner engaged in flawed reasoning because she did not ask herself whether the initial use of non-invasive techniques would have compromised any subsequently necessary invasive autopsy.

Following *Rotsztein*, the Chief Coroner amended the guidance on *The Use of Post-Mortem Imaging (Adults)*, to note that in cases where there is 'an established religious tenet that invasive autopsy is to be avoided' and Article 9 ECHR is engaged, the coroner should be guided by the propositions stated in *Rotsztein* in making a proportionate decision.[71] Those propositions are, first, there must be an established religious tenet that invasive autopsy is to be avoided before any question of avoidance on Article 9 grounds arises; second, there must be a realistic possibility that non-invasive procedures will establish the cause of death and allow the coroner to fulfil her statutory duty; third, the whole post-mortem examination must be capable of being undertaken without undue delay; fourth, the performance of non-invasive or minimally invasive procedures must not impair the effectiveness of any ultimately required invasive autopsy; and fifth, there must be no good

70 *R (Rotsztein) v. HM Senior Coroner for Inner London North* [2015] EWHC 2764 (Admin); *R Goldstein v. HM Coroner for Inner North London* [2014] EWHC 3889. See Chief Coroner England and Wales, *Guidance No. 1 The Use of Post-Mortem Imaging (Adults)*, 4 September 2013 (amended 14 January 2016), online: ‹https://www.judiciary.gov.uk/wp-content/uploads/2013/09/guidance-no-1-use-of-port-mortem-imaging.pdf› (last accessed 10 April 2016).

71 Chief Coroner England and Wales, *Guidance No. 1 The Use of Post-Mortem Imaging (Adults)*, 4 September 2013 (amended 14 January 2016), para. 12, online: ‹https://www.judiciary.gov.uk/wp-content/uploads/2013/09/guidance-no-1-use-of-port-mortem-imaging.pdf› (last accessed 10 April 2016).

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reason founded on the coroner's duty to ascertain how, when and where the deceased came by his or her death to require an immediate invasive autopsy.[72]

How coroners (and courts) manage objections to autopsy, and the post-mortem investigation process itself, is an evolving issue internationally, and it is emerging in tandem with the possibilities of technologies such as CT scans. While Australia has no Chief Coroner uniform guidance on post-mortem imaging, it has, as outlined earlier, long heralded an advanced reformist agenda, and this also is with respect to autopsy. Victoria's modernised approach to medico-legal death investigation, with the statutory innovation of 'preliminary investigations',[73] illustrates the balancing act between capturing a depth of information about the deceased in a climate of increased familial concerns about invasive post-mortem techniques. In New South Wales, the Coroners Act 2009 (NSW), provides that, if more than one procedure is available to establish cause and manner of death, the person conducting the examination is to endeavour to use the least invasive procedures that are appropriate in the circumstances; the Act then provides examples at Section 88(2).

There is also a not inconsiderable body of Australian jurisprudence arising from objections to autopsy, stretching from the 1990s, which, when coupled with research, elucidates a more comprehensive picture around the nature of objections and legal decision-making (see Lynch and Woodford, 2007). In effect, there is instance-by-instance decision-making on the balance between public and family interests.[74] And, according to some commentators, when religious and cultural objections to autopsy arise, the courts have nonetheless been 'deciding the cases on psychological grounds' (Vines, 2000, p. 433). In this sense, the courts have appeared less concerned with the substance of cultural and religious objection, and more with 'the fact that culture or religion may exacerbate the level of distress' (p. 433; see also Vines, 2007). Australian courts have not granted applications to prevent invasive autopsies 'specifically on the basis that such interference with the deceased person is contrary to that person's dignity or any privacy rights under statute (for example Victoria's *Charter*)[75] or common law' (Baer Arnold and Bonython, 2016, p. 29). Ostensibly, despite the emergence of human rights considerations in Australian coronial matters, at law there still exist somewhat typical objection scenarios.

Taking matters at the earlier point of coroners' decision-making, Australian research has illuminated the influence of religious and familial concerns upon coroners' decisions to order less invasive autopsies. In Queensland, Carpenter, Tait, Adkins, Barnes, Naylor, and Begum (2011) have revealed that less invasive autopsies have been ordered for deceased with a known religious proscription against autopsy (such as Judaism and Islam), but also in the context of a 'genuine family concern' being expressed around: suffering of the deceased, fear of further bodily damage, or clarity about the cause of death (pp. 330–331). Notwithstanding this accommodation, the same research discovers that the Indigenous status of the deceased makes 'no difference to autopsy decision-making', despite Australian Indigenous proscriptions against autopsy (p. 331; see also Carpenter, Tait, Quadrelli and Drayton, 2015; Carpenter and Tait, 2009; Vines, 2000).[76] In view of the over-representation of Indigenous people in the coronial system, and thus in invasive coronial

72 *R (Rotsztein) v. HM Senior Coroner for Inner London North* [2015] EWHC 2764 (Admin) at [27]–[29] per Mitting J.

73 *Coroners Act 2008* (Vic) s. 23.

74 See, for examples, cases where the court has upheld familial objection to autopsy include *Re Unchango; Ex parte Unchango* (1997) 95 A Crim R 65; *Green v. Johnstone* [1995] 2 VR 176; *Evans v. Northern Territory Coroner* [2011] NTSC 100; cases where the court has overruled familial objections to autopsy include *Magdziarz v. Heffey* [1995] VSC 201; *Pope v. State* Coroner (1998) 70 SASR 387; Wuridjal *v. The Northern Territory Coroner* (2001) 11 NTLR 202.

75 *Charter of Human Rights and Responsibilities Act 2006* (Vic).

76 For a similar discussion in the New Zealand context, see Selket *et al.* (2015).

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autopsies, it appears crucial to interrogate not only the broader circumstances of Indigenous death, but also death investigation processes (Carpenter and Tait, 2009). While it is clear that the landscape of autopsy is generally being re-sketched in the light of new technologies, statutory rights to objections, coronial guidance and greater recognition of families, it remains the case that questions about what information is available, how decisions are reached and accommodations exercised, do not lose their currency in a modernised and sensitised coronial era.[77]

4.3 Realising the coroner's preventative potential

The challenge for many coronial jurisdictions lies in realising the preventative potential at the heart of modern coronial frameworks. European human rights jurisprudence has steered contemporary UK coronial law and practice in a greater preventative direction. Cases such as *R (Amin) v. Secretary of State for the Home Department*,[78] have described that the purposes of an Article 2 death investigation include:

> 'to ensure so far as possible that the full facts are brought to light; that culpable and discreditable conduct is exposed and brought to public notice; that suspicion of deliberate wrongdoing (if unjustified) is allayed; that dangerous practices and procedures are rectified; and that those who have lost their relative may at least have the satisfaction of knowing that lessons learned from his death may save the lives of others.' (paragraph 31)

Cases such *Amin* – with its emphasis on *lessons learned* from death as part of the investigative purpose – have encouraged the preventative coronial role (Freckelton and McGregor, 2014, p. 590). The preventative principle has been supported in other ways. For example, the net effect of *Middleton*[79] was a broadening of the scope of inquests, which 'ushered in an era of more probing investigation of the overall context and issues that give rise to deaths' with a corresponding focus on whether they are preventable (p. 588). *Middleton* determined that to satisfy the procedural duty in Article 2 cases, coroners and juries were to take a broad approach to the statutory question of 'how' the deceased died. The investigation of 'how' the deceased came by their death was to be interpreted as not confined to 'by what means' (as stated in *R v. Coroner for North Humberside and Scunthorpe; Ex parte Jamieson*)[80] but 'by what means and in what circumstances'. Accordingly, in some cases, the jury's conclusions might not be sufficiently accommodated in a short-form verdict.[81] Instead, this change of approach to the interpretation of how the deceased came by their death could require the coroner to invite a narrative verdict (paragraph 35), which may be more

77 Nor are autopsy issues isolated from questions of jurisdiction, resourcing and delay. Overreporting of apparently natural causes deaths arguably has the capacity to further compound family grief and derail justice, leading some commentators to call for greater intake rigour to ensure that only truly reportable deaths become coroners' cases; see Barnes *et al.* (2014).

78 *R (Amin) v. Secretary of State for the Home Department* [2004] 1 AC 653.

79 *R (Middleton) v. HM Coroner for West Somerset* [2004] 2 AC 182. Following the Hillsborough Inquests, commentators have pointed to the impact of art. 2 on the inquests. They state that, due to art. 2 and the effect of *Middleton*, the Hillsborough Inquests were more wide-ranging than they would otherwise have been. Commentators also note the 'central status' accorded to relatives of the deceased as a result of the ECHR, see 'Hillsborough Inquests: Michael Mansfield on "Far-reaching Consequences"', *The Guardian* (29 April 2016), online: ‹http://www.bbc.com/news/uk-england-merseyside-36155541›; see also David Allen Green, Jack of Kent Blog (27 April 2016), online: ‹http://jackofkent.com/2016/04/ft-post-on-theresa-may-hillsborough-human-rights-law-and-the-politics-of-superficiality/›; Hannah Lynes, 'Hillsborough and Human Rights – The Round-up', UK Human Rights Blog (3 May 2016), online: ‹https://ukhumanrightsblog.com/› (all last accessed 4 May 2016).

80 *R v. Coroner for North Humberside and Scunthorpe; Ex parte Jamieson* [1995] QB 1.

81 Short-form verdict examples include: accident, misadventure, unlawful killing, lawful killing, suicide, neglect.

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informative than short verdicts such as 'misadventure', and give greater scope to appreciating the surrounding circumstances of a death.[82]

In Australia, the coroner's jurisdiction has moved from a reactive to a more proactive assessment of deaths, as demonstrated by coroners' recommendatory functions. Despite not being preoccupied wholesale by the same Article 2 enunciations that find purchase in *Middleton*, Australian coronial fact-finding has nevertheless echoed the *Middleton* approach, with *Atkinson v. Morrow* determining that the expression 'how the death occurred' should be given the broad construction of 'by what means and in what circumstances the death occurred'.[83] Notwithstanding this appellate clarification, in Australia, the narrative form of coronial findings has long been a strong feature of coronial practice. Australian coroners routinely declare their findings of fact through discursive statements of circumstances. And while the form of coronial findings varies from jurisdiction to jurisdiction, the robust contextual narration of findings is a common feature, and arguably significantly more discursive than even the most fulsome UK narrative verdicts. This approach has been known to frustrate the courts, who have, at times, castigated Australian coroners for prolix findings (see *Keown v. Kahn)*.[84] In the UK, the frustration has been with statistical coding of narrative verdicts, specifically impacting suicide cases and possible underestimation of those deaths (see Hill and Cook, 2011; Carroll, Hawton, Kapur, Bennewith and Gunnell, 2011; Tait *et al.*, 2015, p. 245).

The rise of 'narrative verdicts' (or 'narrative conclusions') in the UK, together with the making of preventative reports,[85] is now illuminating the question of *what to do* with coroners' insights in that jurisdiction. Advocacy group INQUEST has published numerous reports addressing institutional deaths, arguing for auditing, follow-up and compliance monitoring of coronial recommendations (see, e.g., INQUEST, 2015b).[86] And so, somewhat paradoxically, greater attention to the preventative potential of the coronial jurisdiction is highlighting the possible short-circuiting of

82 The *Coroners and Justice Act 2009* (UK) replaces 'verdicts' with 'conclusions', which can be short-form or narrative. See *Form 2: Record of Inquest*, available in: Chief Coroner England and Wales, *Guidance No. 17: Conclusions: Short-Form and Narrative*, online: ‹https://www.judiciary.gov.uk/wp-content/uploads/2013/09/guidance-no-17-conclusions.pdf› (last accessed 15 April 2016). The coroner or jury must now make 'determinations' on the questions of who the deceased was, how, when and where the deceased came by their death, and 'findings' as regards the particulars needed to register the death: see *Coroners and Justice Act 2009* (UK), s. 10. In relation to this change in terminology, the Chief Coroner noted the 1971 Brodrick Committee's recommendation of the use of 'findings': Judge Peter Thornton QC, 'Speech for the Annual Conference: Coroners' Society of England and Wales' (21 September 2012) at [39], online: ‹http://www.judiciary.gov.uk/media/speeches/2012/chief-coroner-speech-coroners-society-conference-21092012› (last accessed 10 April 2016). See also United Kingdom, *Report on the Committee on Death Certification and Coroners, Vol. 1* (Cmnd 4810, 1971) (N. Brodrick, Chair). The Brodrick Committee noted (at [16.37]): '[o]ne of the original purposes of an inquest was to determine whether a death had resulted from a criminal act and, if so, the identity of the person responsible for the act. Thus, the verdict was in its origins (and still is) the pronouncement by a coroner's jury which decided whether a person was to stand trial for homicide.' The Committee added (at [16.39)] that 'verdicts do not purport to have any legal consequences, but they are surprisingly similar in character to the verdicts which impute criminal guilt'. The Committee favoured the move away from any attribution of blame and, by consequence, the spectre of liability in the coronial jurisdiction towards fact-finding in the public interest, resolving that this was best achieved by abolishing the term 'verdict' and replacing it with 'findings' (at [16.40]–[16.43]). Forty-two years after the Brodrick Committee's report, this change was enacted.

83 *Atkinson v. Morrow* [2005] QSC 92; *Atkinson v. Morrow* [2005] QCA 353.

84 *Keown v. Kahn* [1999] 1 VR 69.

85 These were referred to as 'Rule 43 reports', corresponding to the revoked Coroners Rules 1984, r. 43, and are now termed 'Prevention of Future Death Reports'. The *Coroners and Justice Act 2009* (UK), Schedule 5, para. 7(1) provides a duty that coroners make reports to prevent deaths where relevant. See also Coroners (Investigations) Regulations 2013, reg. 28; see also Coles and Shaw (2012).

86 See also INQUEST (2015a); Coles and Shaw (2012); Prison Reform Trust/INQUEST (2012).

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fully realisable death prevention. In Australia, this has been an ongoing concern since coronial recommendations signalled the preventative evolution of coronial law (Bugeja and Ranson, 2003),[87] leading commentators to question the ultimate impact of coronial insight, and the devastating amount of coronial expertise that is stockpiling without consequence throughout Australia (Scott Bray, 2008, p. 36; Watterson *et al.*, 2008; Brazil, 2011).

Notably, in 2000, Australia established the National Coronial Information System, a database of coronial information on all Australian deaths reported to the coroner (Pearse and Daking, 2007; Bugeja, Ibrahim, Ferrah, Murphy, Willoughby and Ranson, 2016), and, as outlined earlier, Australian states and territories coroners' offices regularly publish coronial findings – containing their recommendations – on their websites. In addition, specialist death review teams exist throughout Australia, such as the NSW Domestic Violence Death Review Team, to further hone the preventative capacity of coronial death review.[88] Despite these established activities of death review and audit, the question remains: How can society support and enhance key coronial functions, such as the recommendatory function, considered so vital to protecting life through its preventative ethos? In this area, despite their distinct legal architectures, both the UK and Australia have some way to go until coronial recommendations and death reviews reach their preventative promise, including resources for informed recommendations and any enforceability.[89]

5. Conclusion: beyond justice

When Lady Justice Hallett was considering the receipt of the security services material during the 7/7 Inquests, she observed that if the material could not be gisted in open hearings, and if its exclusion undermined the coronial investigation, then the inquest could be dispensed with in favour of a public inquiry ordered by the Lord Chancellor. Yet this transition from an inquest to an inquiry would not necessarily be easy, nor any more public. In effect, the whole investigative process would be restarted, a scenario best avoided, she said, because:

> 'The bereaved families and survivors have waited over five years since the bombings and I have promised them an end to these proceedings by next spring. Many witnesses have been through the ordeal of giving evidence and I am sure would not wish to repeat that experience. The families have had to suffer the distressing experience of hearing witnesses speak of the death of their loved ones in all too graphic terms. They would not wish to relive that experience. And, of course, there is the question of the considerable quantity of public resources expended so far.'[90]

Lady Justice Hallett is not alone in drawing attention to the multiple stakes of death investigation, not least the deleterious emotional effects of extended investigations, highlighting that coronial processes are far from dispassionate, bureaucratic events. Research confirms the entirely affective

87 See also Malbon (1998); Sutherland *et al.* (2014); 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).

88 See *Coroners Act 2009* (NSW) Chapter 9A. See also the Coroner's Prevention Unit of the Victorian Coroner's Office, online: ‹http://www.coronerscourt.vic.gov.au/› (last accessed 10 April 2016).

89 See also the recent call by the President of the Australian Human Rights Commission for a national monitoring programme on the implementation of coronial recommendations, online: ‹http://www.theguardian.com/australia-news/2016/mar/04/gillian-triggs-says-coroners-should-have-greater-powers-on-domestic-violence› (last accessed 10 April 2016). For a discussion on coronial recommendations in New Zealand, see Mok (2014) and Moore (2014).

90 Ruling of Lady Justice Hallett, *Coroner's Inquests into the London Bombings of 7 July 2005* (3 November 2010) pp. 6–8.

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impacts of coronial processes (e.g., Davis *et al.*, 2002); impacts that are bound up in questions of resources and delays, but also the very nature of the investigative exercise.[91] Insights into bereavement are essential for tracking justice outcomes, including in the coronial jurisdiction. Criminologist Phil Scraton participated in Daniel Gordon's documentary, Hillsborough, which was first released in 2014, and subsequently updated following the Inquests' conclusion in April 2016. Hillsborough was shown in the UK for the first time on 8 May 2016 on the BBC. Speaking in Hillsborough of the years before the new Inquests' vindication of the Hillsborough families' fight for justice, years that had included the lengthy and flawed first coronial investigation, Phil Scraton said:

> 'what I witnessed was the distress and depression associated with injustice, that exacerbated bereavement; deep, hurtful, painful suffering over a long period of time; people taking their own lives; people dying prematurely; people broken by the struggle for justice'. (in Gordon, 2014/2016)

Inquests can deliver justice, but they have also been known to stall, derail and dilute it; and ultimately those who are left to embrace the inquest's benefits, or bear its failings, are the bereaved.[92] Coronial law and practice are wholly lived and experienced by bereaved families and friends and, correspondingly, coronial inquisitions are not reducible to a simple fact-finding endeavour (Scott Bray, 2010, 2012). They perform a much broader meaning-making task around death.[93] The experiences of the Hillsborough families tell us as much.

The Hillsborough Inquests have settled part of the justice record for the ninety-six people who died, but in the aftermath of the unlawful killing conclusion, much is already being written about *where to now*.[94] Where the Inquests are now being portrayed as but one piece of resolving the Hillsborough disaster, commentators are canvassing the possible paths ahead: suing the police, resignations, if not the disbanding, of the South Yorkshire police, and criminal prosecutions. Some commentators note that the Inquests are a shot across the bow, highlighting the need for greater vigilance against unaccountable power.[95] The Hillsborough Inquests, with their resounding determinations, are now a catalyst for *more*: more accountability, better recompense, and greater redress. In many senses, the Inquests' aftermath highlights how coronial work and its effects often operate *beyond justice*. Just as the coronial jurisdiction does not operate in a socio-legal vacuum, and is often part of a complicated case sequence around contentious deaths (including public inquiries, and a criminal and/or civil trial), its outcomes entail more than justice work. Therefore, following significant international reform, the task moving forward is to consider more fully the nature of this work, and what else the coronial process might achieve.

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91 See also Trabsky and Baron (2016) and Tait *et al.* (2016), who discuss emotions and trauma in the context of work by coronial professionals.

92 See Amanda Porter, 'Why We Should Honour the Humanity of Every Person Who Dies in Custody', *The Conversation* (15 April 2016), online: ‹https://theconversation.com/why-we-should-honour-the-humanity-of-every-person-who-dies-in-custody-57272› (last accessed 20 April 2016); Scraton and Chadwick (1987); Scraton (1999).

93 Arguably, that there is a danger that deaths become reducible to the 'facts', where '[t]he "facts" of death are registered, but the wider contexts in which they are located, their true meanings, and their full implications are negated' (Goldson, 2006, p. 57).

94 David Conn '"It Starts Now": Hillsborough Vigil Marks End of One Fight and Start of Another', *The Guardian* (28 April 2016), online: ‹http://www.theguardian.com/football/2016/apr/27/it-starts-now-hillsborough-vigil-end-one-fight-start-liverpool-96?CMP=share_btn_tw› (last accessed 29 April 2016).

95 Owen Jones, 'Think Hillsborough Couldn't Happen Today? Think Again', *The Guardian* (28 April 2016), online: ‹http://www.theguardian.com/commentisfree/2016/apr/28/hillsborough-could-happen-again-police-views-liverpool-fans?CMP=share_btn_tw› (last accessed 29 April 2016).

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