

# MINIMISING THE COUNTER-THERAPEUTIC EFFECTS OF CORONIAL INVESTIGATIONS: IN SEARCH OF BALANCE

IAN FRECKELTON QC\*

*The entire legal profession – lawyers, judges, law teachers – has become so mesmerised with the stimulation of the courtroom contest that we tend to forget that we ought to be healers – healers of conflicts.<sup>1</sup>*

*For more than a decade, analyses of coronial processes inspired by both therapeutic jurisprudence and restorative justice have identified the potential for maximising the therapeutic and public health benefits of the investigative functions of coroners' courts and minimising their counter-therapeutic potential. The focus of both scholarly literature and law reform proposals has been upon addressing deficits in respect of the role of families in coronial investigations and especially coroners' inquests. This has been a constructive contribution and has improved sensitivity to the risk that family members will be disenfranchised and alienated at a highly vulnerable time after they have been bereaved. This article chronicles the development in awareness of such issues. However, the potential for adverse effects on parties other than family members has been inadequately recognised in the literature, save for empirical studies conducted in 2011 for the Coronial Council of Victoria and another study published in 2014 in New Zealand. This article seeks to redress that imbalance. It argues that it is appropriate also to have regard to such potential in endeavouring to provide an approach to the work of coroners that is influenced by the sensibilities of therapeutic jurisprudence and seeks to reduce, so far as possible, counter-therapeutic outcomes for all parties, while at the same time prioritising accurate and robust fact-finding and formulation of constructive recommendations to avoid avoidable deaths. It calls for further empirical research on the impact of coroners' investigations on all affected parties and argues in favour of extension of improved funding to enable approaches to be informed by therapeutic jurisprudence and in particular to enhance eligibility for the counselling services attached to coroners' courts.*

## I INTRODUCTION

For over a decade it has been observed that the inquisitorial nature of coroners' investigations into sudden, unnatural and unexpected deaths and their interface with matters of high emotion creates the potential for them to be therapeutic but also counter-therapeutic in their impact upon

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\*Ian Freckelton QC, Barrister, Crockett Chambers, Melbourne; Professorial Fellow of Law and Psychiatry, University of Melbourne; Adjunct Professor of Law and Forensic Medicine, Monash University; [I.Freckelton@vicbar.com.au](mailto:I.Freckelton@vicbar.com.au). The author acknowledges the helpful feedback and suggestions on an earlier draft of this article by former Deputy State Coroner of NSW, Hugh Dillon, South Australian State Coroner Mark Johns, Tasmanian Coroner Olivia McTaggart, Victorian State Coroner Sara Hinchey, Western Australian State Coroner Ros Fogliani, Professor David Wexler of the University of Arizona, Professors Warren Brookbanks and Kate Diesfeld of Auckland University of Technology, Associate Professor David Ranson of Monash University, and Dr Jennifer Moore of Otago University and Dr Patricia Molloy. However, all views expressed and errors and omissions are those of the author alone. In addition, no inference should be drawn that any of the arguments mounted or issues canvassed arise from cases in which the author has been involved as counsel.

<sup>1</sup> Warren E Burger, 'The State of Justice' (1984) *American Bar Association Journal* 62, 66.



interested parties, especially relatives of the deceased.<sup>2</sup> On many occasions, courts have recognised and lamented the pressures under which family members labour when they find themselves bereft or at odds in the aftermath of a death.<sup>3</sup> As long ago as 1969 Kübler-Ross identified a sequence of five stages of grief: denial, anger, bargaining, depression and acceptance.<sup>4</sup> Her analysis has not been without its critics, though, who have argued that while such a model is seductive, it is incapable of capturing the complexity, diversity and idiosyncratic quality of the grieving experience. Many have argued too that models based upon the idea of stages are simplistic and reductionist – they do not address adequately the multiplicity of physical, psychological, social and spiritual needs experienced by the bereaved.<sup>5</sup> Significantly, later in life,<sup>6</sup> Kübler-Ross qualified her analysis by accepting that the terminology of stages, which implies progression, is not appropriate for all persons who have been bereaved. However, a lasting contribution of the work of Kübler-Ross is the awareness she has generated of the different emotions that often emerge after the death of a loved one and the risk that anger and aggrievement can stand in the way of the acquisition of acceptance of the fact of a death, the development of perspective and the acquisition of resolution and closure. What follows for the coronial jurisdiction is that all involved need to practise in a way that is trauma-informed so as to reduce the potential for adverse consequences of investigations and hearings and so as to build an environment within coroners' courts that is best calculated to secure identification of collaborative options for enhanced and safer work practice.<sup>7</sup>

A number of important points need to be made in the coronial context about grief and about the potential for coronial practice to be meaningfully trauma-informed. Firstly, at the very heart of understanding people's reactions after a death is the fact that death is a differentiated experience – both in terms of the circumstances of death and how people diversely connected with the death react to it. Moreover, the grief of one person and how it is expressed can interact conflictually with or exacerbate the grief of another. Secondly, grief in the context of the deaths dealt with by coroners has particular characteristics. It is compounded by trauma and potentially by stigma, shame and confusion that can disenfranchise the griever and complicate the bereavement experience.<sup>8</sup> It has been observed that the trauma of an unexpected death 'poses specific and daunting challenges which do not necessarily follow a non-traumatic death.'<sup>9</sup> The manner and cause of sudden and unexpected deaths can weigh heavily on the grieving process and impact upon a range of other dynamics which are affecting people's lives

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<sup>2</sup> See generally J Kim Wright (ed), *Lawyers as Peacemakers: Practicing Holistic, Problem-Solving Law* (American Bar Association, 2010) 277.

<sup>3</sup> See, for eg, in respect of issues relating to disputes about bodily remains *Joseph v Dunn* [2007] WASC 238 [24] (Heenan J); *Keller v Keller* [2007] VSC 118 (Hargrave J); *Leeburn v Derndorfer* (2004) 14 VR 100 [10] (Byrne J).

<sup>4</sup> Elizabeth Kübler-Ross, *On Death and Dying* (Routledge, 1969).

<sup>5</sup> For a useful synthesis of the critiques, see Christopher Hall, "Beyond Kübler-Ross: Recent Developments in Our Understanding of Grief and Bereavement" (2011) *InPsych* <<https://www.psychology.org.au/publications/inpsych/2011/december/hall/>>.

<sup>6</sup> Elizabeth Kübler-Ross, *On Grief and Grieving: Finding the Meaning of Grief Through the Five Stages of Loss* (Simon & Schuster, 2005).

<sup>7</sup> See Melanie Randall and Lori Haskell, 'Trauma-Informed Approaches to Law: Why Restorative Justice Must Understand Trauma and Psychological Coping' (2013) *The Dalhousie Law Journal* 501.

<sup>8</sup> See Belinda Carpenter, Gordon Tait and Carol Quadrelli, 'The Body in Grief: Death Investigations, Objections to Autopsy, and the Religious and Cultural "Other"' (2014) 5 *Religion* 165; Kenneth J Doka (ed), *Disenfranchised Grief: New Directions, Challenges and Strategies for Practice* (Research Press, 2002); Jeffrey Kaufman, *The Shame of Death, Grief and Trauma* (Routledge, 2011).

<sup>9</sup> See LM Redmond, 'Sudden Violent Death' in Kenneth J Doka (ed), *Living with Grief: After Sudden Loss: Suicide, Homicide, Accident, Heart Attack, Stroke* (Taylor & Francis, 2014); John Drayton, 'Organ Retention and Bereavement: Family Counselling and the Ethics of Consultation' (2011) 5(3) *Ethics and Social Welfare* 227.

and their relationships. Experience of death is always contextual, like most aspects of life.<sup>10</sup> In addition, what occurs after a death, including how it is investigated and portrayed, can impact upon the grief process, potentially either distorting it or bringing it to resolution.

Coronial investigations and, in particular, inquests constitute a significant opportunity to reflect upon therapeutic jurisprudence in action – to search for a workable rapprochement between rigour of investigation, accuracy of fact-finding and maximisation of positive outcomes from the litigation process, on the one hand, and minimisation of counter-therapeutic consequences on the other hand. They constitute a complex meeting point between the often conflicting and raw perspectives on the part of different parties, the risk that grief will be compounded, the need to enable a coroner's court to make sound findings of fact about circumstances and causes of death, and the aspiration to have a coroner's court make informed recommendations directed toward minimising the potential for future avoidable adverse events. This means that the potential for coronial processes to exacerbate feelings of distress and anger (including to the point of pathology) arising from a death are significant. Put another way, coroners' processes, if they are poorly managed, not only can generate secondary trauma but can be pathogenic.

Until the present, writing about therapeutic jurisprudence and coroners' investigations has focused almost exclusively upon the adverse consequences that can ensue from investigations that are not 'emotionally intelligent' and attuned to the wellbeing of family members. The deficit in such analyses has been a failure to acknowledge adequately that deaths and allegations or insinuations of culpability in deaths can have adverse consequences for a variety of persons beyond those who are part of the family unit of the deceased. This article identifies the development of therapeutic jurisprudence perspectives in the context of coroners' investigations and explores the phenomenon of harm caused by curial processes in the coronial context, incorporating analysis of an empirical study conducted in 2011 for the Coronial Council of Victoria, and a New Zealand study, which focused on interviews with organisations affected by the coronial jurisdiction. It reflects on the potential for coronial processes to do damage to the reputation, career and emotional wellbeing of non-family members, as well as family members. It makes initial suggestions about approaches and specific measures which can be utilised in order to achieve a fair balance which maintains the confidence of all in the coronial process. It argues in favour of extension of funding to enable coroners' courts to operate not just as inquisitorial courts seeking out the truth but as therapeutic justice courts, including providing counselling support to all parties affected by coronial investigations.

## II THERAPEUTIC JUSTICE INSIGHTS INTO CORONIAL PROCESSES

Therapeutic jurisprudence ('TJ') and restorative justice ('RJ') are all about balance: balance between achieving justice and reducing the potential for harm caused by the legal process; balance in recognising and dealing with potentially destructive emotions; and balance between persons who may have diametrically or apparently irreconcilable perspectives. TJ and RJ have postulated that management of the emotions of those involved in legal disputation is fundamental to its resolution.<sup>11</sup> Each has identified that procedural justice ('PJ'), in particular,

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<sup>10</sup> See Robert T Hale and Mila Ruiz Tecala, *Grief and Loss Identifying and Proving Damages in Wrongful Death Cases* (Trial Guides, 2009). See also Christina Staudt and J Harold Ellens (eds), *Our Changing Journey to the End: Reshaping Death, Dying and Grief in America* (Praeger, 2013).

<sup>11</sup> See David B Wexler, *Therapeutic Jurisprudence: The Law as a Therapeutic Agent* (Carolina Academic Press, 1990); David B Wexler and Bruce J Winick (eds), *Essays in Therapeutic Jurisprudence* (Carolina Academic Press, 1991), David B Wexler, 'Applying the Law Therapeutically' (1996) 5 *Applied and Preventive Psychology* 179; Marilyn McMahon and David Wexler, 'Therapeutic Jurisprudence: Developments in Australia and New Zealand'

enables incorporation of insights and findings from disciplines such as psychology and criminology to refresh thinking about how legal proceedings are conducted and to enhance the respect for law and legal processes, which in turn has the potential to enhance quality of decision-making.<sup>12</sup>

Drawing on notions of emotional intelligence, for instance, King has argued in favour of the need for courts to be alert to emotional dynamics within litigation and endeavour to deal with ‘underlying issues’.<sup>13</sup> Tait and Carpenter,<sup>14</sup> in the coronial context, have rightly contended that management of subjectivity is fundamental to dealing with grieving families and that it is a responsibility of coroners to deal sensitively with the emotional wellbeing of family members.

Sudden, unexpected or unnatural deaths are particularly traumatic for survivors,<sup>15</sup> both for those who are family members and others. Within coroners’ courts such emotions include bereavement grief,<sup>16</sup> survivor guilt,<sup>17</sup> post-traumatic shame,<sup>18</sup> anxiety and depression. It has been argued that it should not simply be assumed that encouraging survivors to recount a trauma to which they have been exposed, and which did not result in their own death, will be salutary; mandated ventilation of such matters in a court, or in many other contexts, can be noxious, triggering a range of re-experiencing, somatic consequences, psychotic episodes and even suicidality for the person involved,<sup>19</sup> never mind for those who are the subject of their narration. Particular and complex issues exist for members of a family whose relative has

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(2003) 20(2) *Law in Context* 1 in Marilyn McMahon and David Wexler (eds), *Therapeutic Jurisprudence* (The Federation Press, 2003).

<sup>12</sup> See, for eg, David B Wexler, ‘Guiding Court Conversation along Pathways Conducive to Rehabilitation: Integrating Procedural Justice and Therapeutic Jurisprudence’ (2015) DP No 15–33: *Arizona Legal Studies* <<http://www.civiljustice.info/cgi/viewcontent.cgi?article=1007&context=tj>>.

<sup>13</sup> Michael King, ‘Restorative Justice, Therapeutic Jurisprudence and the Rise of Emotionally Intelligent Justice’ (2008) 32(3) *Melbourne University Law Review* 1096.

<sup>14</sup> Gordon Tait and Belinda Carpenter, ‘Suicide and the Therapeutic Coroner: Inquests, Governance and the Grieving Family’ (2013) 2(3) *International Journal for Crime, Justice and Social Democracy* 92.

<sup>15</sup> See, for eg, Ruth Davidhizar, ‘Helping Survivors Cope with Sudden Death’ (1993) 11(4) *Health Care Supervisor* 41.

<sup>16</sup> For a history of the study of grief from the influential essay by Freud on mourning and melancholia in 1917 until the present see: Leeat Granek, ‘Grief as Pathology: The Evolution of Grief Theory in Psychology from Freud to the Present’ (2010) 13(1) *History of Psychology* 46. Pathological grief can take the form of ‘Persistent Complex Bereavement Disorder’ (PCBD) within the meaning of DSM-5 (American Psychiatric Association, *Diagnostic Manual of Mental Disorders* (APA, 5<sup>th</sup> ed, 2013) 789–792), whose prevalence is approximately 2.4–4.8%. See in relation to its overlap with and the risk of misdiagnosis by reference to depression or post-traumatic stress disorder Richard A Bryant, ‘Is Pathological Grief Lasting More than 12 Months Grief or Depression?’ (2013) 26(1) *Current Opinion in Psychiatry* 41; Andreas Maercker and John Lalor, ‘Diagnostic and Clinical Considerations in Prolonged Grief Disorder’ (2012) 14(2) *Dialogues in Clinical Neuroscience* 167. The diagnosis remains controversial: see, for eg, Jerome C Wakefield, ‘Should Prolonged Grief be Reclassified as a Mental Disorder in DSM-5?: Reconsidering the Empirical and Conceptual Arguments for Complicated Grief Disorder’ (2012) 200(6) *Journal of Nervous and Mental Disease* 499; Margaret Stroebe et al, ‘On the Classification and Diagnosis of Pathological Grief’ (2000) 20(1) *Clinical Psychology Review* 57. For a psychoanalytic perspective, see Hugo Bleichmar, ‘Rethinking Pathological Mourning: Multiple Types and Therapeutic Approaches’ (2010) 79(1) *Psychoanalytic Quarterly* 71.

<sup>17</sup> Sadie P Hutson, Joanne M Hall and Frankie L Pack, ‘Survivor Guilt: Analysing the Concept and its Contexts’ (2015) 38(1) *Advances in Nursing Science* 20. For an analysis of how survivor guilt can influence the development of eating disorders, see Michael Friedman, ‘Survivor Guilt in the Pathogenesis of Anorexia Nervosa’ (1985) 48(1) *Psychiatry* 25.

<sup>18</sup> See, for eg, John P Wilson, Boris Drozdek and Silvana Turkovic, ‘Posttraumatic Shame and Guilt’ (2006) 7(2) *Trauma Violence Abuse* 122.

<sup>19</sup> See Rachel Rosenblum, ‘Postponing Trauma: The Dangers of Telling’ (2009) 90(6) *International Journal of Psychoanalysis* 1319.

committed suicide,<sup>20</sup> or is believed to have done so, as well as for persons who have been the victims of homicide or have died in socially uncomfortable circumstances such as auto-erotic asphyxia. An example in the suicide context is the impact of the content of a suicide note on the reactions of survivors; blame and guilt have been found to play primary roles in grief reactions in such a situation.<sup>21</sup> Manifestly, how the contents of a note are explored in the course of a coronial inquest (if there is one at all) and the extent to which they are made available for public reporting by the media would have ramifications in this regard.

Practical dilemmas can also be posed in relation to deaths where the family of the deceased is fragmented geographically or emotionally. This has the potential to be manifested in what is often described by courts as ‘unseemly disputation’ about the person to whom the body should be released, who should have the right of disposition of the body, whether the body should be buried or cremated, and who should have access to the remains.<sup>22</sup>

In 2003, Biddle concluded that the inquest process has the potential to affect the resolution of grief in at least two adverse ways – by exacerbating common grief reactions associated with the death of a family member such as shame, guilt and anger, and by interfering with necessary grief processes, such as arriving at a meaningful and acceptable account of the death.<sup>23</sup> The study concentrated upon suicide deaths and identified from qualitative interviews that particular trauma was caused by the judicial atmosphere of inquests, media activity associated with them, what was perceived as invasion of the deceased person’s privacy and the experience of giving evidence. Biddle also identified exposure to graphic evidence about the death, delays in inquests, confiscated suicide notes dealing with personal matters, and a failure by inquests to provide adequate explanations of deaths and to deal with blame as having been reported as distressing by members of the family of persons who had committed suicide. Biddle called for greater clarity in coronial processes for dealing with relatives of deceased persons throughout coronial investigations.

A decade later, Wertheimer developed Biddle’s work and emphasised the toxic effects of delays in coronial investigations and a feeling that grief has to be suspended unnaturally until the conclusion of the inquest process, noting also that anticipation of the inquest can leave ‘survivors’ feeling extremely apprehensive, particularly if they are to be called as witnesses.<sup>24</sup> She found from interviews that if family members are not given the opportunity at an inquest to tell their story as they see it, for instance, because of the application of the rules of relevance, they can feel shut out and that this can compound grief. In addition, she identified that ‘open verdicts’ can cause confusion and that media reporting, especially if it is selective or in any way incorrect, is a cause of particular concern for family members.<sup>25</sup> Wertheimer emphasised

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<sup>20</sup> See Julie Cerel, John R Jordan and Paul R Duberstein, ‘The Impact of Suicide on the Family’ (2008) 29(1) *Crisis* 38.

<sup>21</sup> Kjell Rudestam and Paul Agnelli, ‘The Effect of the Content of Suicide Notes on Grief Reactions’ (1987) 43(2) *Journal of Clinical Psychology* 211.

<sup>22</sup> See Ian Freckelton, ‘Release by Coroners of the Bodies of Deceased Persons’ (2017) 24 *Journal of Law and Medicine* (forthcoming).

<sup>23</sup> Lucy Biddle, ‘Public Hazards or Private Tragedies: An Exploratory Study of the Effect of Coroners’ Procedures on Those Bereaved by Suicide’ (2003) 56 *Social Science and Medicine* 1033; see also Daniel Harwood et al, ‘The Grief Experiences and Needs of Bereaved Relatives and Friends of Older People Dying Through Suicide: A Descriptive and Case-Control Study’ (2002) 72 *Journal of Affective Disorders* 185.

<sup>24</sup> Alison Wertheimer, *A Special Scar: The Experiences of People Bereaved by Suicide* (Routledge, 2013) 81.

<sup>25</sup> See too Alison Chapple, Sue Ziebland and Keith Hawton, ‘A Proper Fitting Explanation? Suicide Bereavement and the Grieving Family’ (2013) 3 *International Journal for Crime, Justice and Social Democracy* 92.

that ‘to some survivors the inquest feels like a trial where both they and the person who died are under judgment.’<sup>26</sup>

To a similar effect, as part of the review of Victoria’s 1985 coronial legislation, Myndscape Consulting, which undertook interviews with stakeholders in the coronial process, identified the adverse effects of families’ lack of understanding about the roles, functions and processes of the coroner and their ability to engage in the coronial process.<sup>27</sup> It emphasised the need for improvements in the frequency of communication from a coroner’s court regarding the progress in the investigation, reasons for any delays and the likely timeframes for completion of the investigation. It also found a need to improve the experience of family members attending inquests through better preparation of them in terms of what to expect, as well as increasing their awareness of the right to be legally represented.

In 2007, the argument was advanced that family members could be disadvantaged by delays in inquest outcomes, exclusion from the process, inability for meaningful participation, and ineffective communication with them by court staff during investigations and even at the stage of inquest findings.<sup>28</sup> In the same year, Took and Johnstone contended that therapeutic principles such as party participation in the coronial process, collaboration, timely provision of information to the parties and problem-solving could be incorporated into the work of coroners’ courts.<sup>29</sup> At the Coroners’ Society Conference of the same year, Johnstone, then the Victorian State Coroner, urged adding ‘the human dimension’ to the work of coroners, including enhancing information provision processes to family members, allocation of a case manager for each case, minimising case delays, adherence to sensitive communications from coroners’ offices, early intervention processes for families, and using less formal processes at inquests.<sup>30</sup>

In 2008 in an important paper Michael King, who had been a coroner in Geraldton in Western Australia, advanced a series of proposals for enhancing the therapeutic potential of coroners’ investigations.<sup>31</sup> He argued for a dual track system for coronial matters to implement a problem-solving approach. His proposal was that cases in a ‘general track’ should not be accorded intensive case management but, instead, processes such as counselling and other support services, restorative justice conferences and the opportunity for family members and others intimately involved with a death being given the opportunity to provide statements about the effects of a death and to express any grievances. He recommended a second track, ‘the complex track’, which would involve intensive case management by a multidisciplinary team chaired by the coroner:

Members of the team would include a psychologist or counsellor based at the coroner’s court, coroner’s assistant or counsel assisting the coroner, family members assisting the coroner, family members representing the family (if they so wish), other parties with a direct interest

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<sup>26</sup> Ibid 80.

<sup>27</sup> Myndscape Consulting, *Review of the Coroner’s Act 1985: Final Report* (March 2006).

<sup>28</sup> See Ian Freckelton, ‘Death Investigation, the Coroner and Therapeutic Jurisprudence’ (2007) 15 *Journal of Law and Medicine* 242; see also Ian Freckelton and David Ranson, *Death Investigation and the Coroner’s Inquest* (Oxford University Press, 2007).

<sup>29</sup> G Took and Graeme Johnstone, *Therapeutic Jurisprudence and the Coroner’s Office* (unpublished paper, State Coroner’s Office, Melbourne, Victoria, May 2007).

<sup>30</sup> Graeme Johnstone, ‘Adding the Human Dimension: The Future and a Therapeutic Approach to the Independent Work of the Coroner’ (Paper presented at the Asia-Pacific Coroners Society Conference, Hobart, November/December 2007).

<sup>31</sup> Michael S King, ‘Non-Adversarial Justice and the Coroner’s Court: A Proposed Therapeutic, Restorative, Problem-Solving Model’ (2008) 16 *Journal of Law and Medicine* 442.

in the investigation (such as those who may be subject to an adverse finding), lawyers acting for the parties and any other professionals who may assist in the case management process in the particular case.<sup>32</sup>

He argued too that mediation should play a role in the coroner's court. He urged the relevance of restorative justice concepts with family members being viewed as 'victims' so that the family and the 'perpetrator' could be offered the option of 'meeting in a safe, non-adversarial environment of listening to other people's experience of how the situation may have affected them, of telling their own story and expressing their own feelings about the situation that may well have affected them deeply on different levels of their life, and, where possible, of reaching an agreement as to any remedial measures to be taken.'<sup>33</sup> He argued for the possibility of a restorative justice conference to be held after the coroner has made a finding to offer the person who may have played an instrumental role in the death the opportunity of explaining how the coroner's recommendations relating to public health or safety are being or have been implemented. He raised too, the option of family members making a statement about the impact of the death upon them, either orally or in writing. For the most part, King's proposals have not (yet) been implemented in Australia, although it is becoming increasingly common for family members to make the kind of formal statement envisaged by him.

A study conducted by Sweeney Research shortly prior to the introduction of the 2008 *Coroners Act* in Victoria<sup>34</sup> emphasised the significance of the emotional impact of deaths of family members upon those related to them and the sensitivity of family members to being treated as 'just another case'. The report emphasised the importance of communication from the Coroners Court and made the point that not enough information can be frustrating for people and that too much information can be painful for them – there is a need for balance, as well as compassion.<sup>35</sup> The appointment of a case manager was recommended.<sup>36</sup>

In 2015 in an extensive chapter in Warren Brookbanks' collection on therapeutic jurisprudence in New Zealand, Jennifer Moore emphasised the counter-therapeutic effects of delay and made a number of fresh points.<sup>37</sup> She identified the importance reported by her interviews with participants in the coronial process of parties being enabled to respond in advance to matters upon which coroners proposed to make adverse comments. She emphasised the sensitivities attaching to the taking and retention of samples and body parts, and the fact that very private matters can make their way into the public domain through media coverage of coroners' inquests. In addition, she drew attention to the advantages of post-investigation communication with family members, identifying that enhancement of the human dimension to coronial inquests by provision to families of:

- “Voice”, specifically the opportunity to make statements;
- The opportunity to decide whether the deceased's name, or “deceased”, should be used in the coroner's findings;
- Prompt and sensitive communication about all coronial processes and their rights;

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<sup>32</sup> Ibid 446.

<sup>33</sup> Ibid 452.

<sup>34</sup> Sweeney Research, 'Families' Information Needs and Experiences of the Victorian Coronial System' (Report, Victorian Department of Justice, 2008).

<sup>35</sup> Ibid 11, 18.

<sup>36</sup> Ibid 38.

<sup>37</sup> Jennifer Moore, 'The Impact of Therapeutic Jurisprudence on the New Zealand Coronial Jurisdiction' in Warren J Brookbanks (ed), *Therapeutic Jurisprudence: New Zealand Perspectives* (Thomson Reuters, 2015) 179–222.

- A case manager;
- Less formal processes at inquest;
- Coronial inquiries that take a sensitive approach to evidence that may be distressing to bereaved families.<sup>38</sup>

Most recently, in 2016 Tait, Carpenter, Quadrelli and Barnes – the New South Wales (and former Queensland) State Coroner – undertook a survey of coroners, forensic pathologists, coronial nurses, police officers working in the coronial area and coronial counsellors.<sup>39</sup> The authors argued that inherent in the coroner’s processes is the need to engage with intense emotions and that an ethic of care should be incorporated into what they called ‘the normative theory of the coroner’s court’. They contended that such a step ‘would require coroners to be better trained in this aspect of their role, and recognition by the higher courts and perhaps in legislation of the importance of this factor.’<sup>40</sup> The challenge arising from their analysis is to define what constitutes the ethic of care and determining to whom it extends and how it can be operationalised in the processes of a coronial investigation.

### III LAW REFORM PERSPECTIVES

Three Australasian reports in the modern era have recommended reforms to coronial law and practice based upon a range of identified deficits, including how coronial procedures have impacted upon family members.

The 2000 report of the New Zealand Law Commission emphasised a perception that in the coronial system inadequate regard was being paid to the cultural values and beliefs of communities, particularly of the Maori community.<sup>41</sup> Another issue raised was the need for improved communication by coroners’ courts with family members so that accurate information was imparted within suitable and prompt timeframes and so that the deceased, including body parts, was returned to the family as quickly as possible.<sup>42</sup> Recommendations were made concerning changes to the law to enable objections to autopsy,<sup>43</sup> as well as extension of the possibility for the family of the deceased to view and touch the deceased prior to the post-mortem examination.<sup>44</sup>

The 2006 report of the Law Reform Committee of the Victorian Parliament (which led to the *Coroners Act 2008* (Vic)) received extensive criticism of the adverse impact of coronial processes, principally on family members.<sup>45</sup> The Committee identified significant levels of under-reporting of deaths to coroners and made recommendations to broaden the net of deaths

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<sup>38</sup> Ibid 207–208.

<sup>39</sup> Gordon Tait et al, ‘Decision-Making in a Death Investigation: Emotion, Families and the Coroner’ (2016) 23 *Journal of Law and Medicine* 571.

<sup>40</sup> Ibid 581. Trabsky and Baron have invoked the idea of “intimate citizenship” to highlight the potential for secondary traumatisation of all personnel who work in the coronial jurisdiction and to argue for further steps to be taken to support their wellbeing: Marc Trabsky and Paula Baron, ‘Negotiating Grief and Trauma in the Coronial Jurisdiction’ (2016) 23 *Journal of Law and Medicine* 582.

<sup>41</sup> New Zealand Law Commission, *Coroners*, Report No 62 (2000)

<<http://www.lawcom.govt.nz/sites/default/files/projectAvailableFormats/NZLC%20R62.pdf>>.

<sup>42</sup> Ibid [237].

<sup>43</sup> Ibid [265].

<sup>44</sup> Ibid [274].

<sup>45</sup> Law Reform Committee, Parliament of Victoria, *Coroners Act 1985* (2006)

<[http://www.parliament.vic.gov.au/images/stories/committees/lawrefrom/coroners\\_act/final\\_report.pdf](http://www.parliament.vic.gov.au/images/stories/committees/lawrefrom/coroners_act/final_report.pdf)>.

which should be reported, especially focussing upon deaths in hospitals and nursing homes.<sup>46</sup> The Committee summarised accounts it had received about ‘unacceptable delays in police investigations’<sup>47</sup> and also in the length of coronial investigations generally.<sup>48</sup>

The Committee found that families involved in the coronial process could be deeply affected by its procedures and investigations.<sup>49</sup> In particular, it noted that ‘one of the main difficulties for families was the lack of resolution from the inquest findings. A major task for families is constructing a ‘last chapter’ for the person who died.’<sup>50</sup> It made a series of recommendations for improving the provision of information to families, explanations of the coronial process, rights of the family to object to autopsy, retention of records and evidence, and access to such information.<sup>51</sup>

The Committee recommended that coroners be given a degree of discretion to recognise significant relationships other than the hierarchically prescribed list of senior next-of-kin.<sup>52</sup> It observed that such a change would accommodate the cultural practices and spiritual beliefs of sections of the community. It recommended too, that wherever practicable the coroner permit members of the immediate family of the deceased to view and touch the body of the deceased.<sup>53</sup> The Committee identified a disenfranchising effect for family members when, as often occurs, they are unable to afford skilled legal representation for inquests and recommended the development of a self-help kit as well as investigation of the feasibility of provision of legal advice and assistance for families affected by a coronial inquest.<sup>54</sup> It also urged the use of imaging options to reduce autopsies where feasible, in part because of the distress such procedures can cause for family members.<sup>55</sup>

In 2012, the Law Reform Commission of Western Australia generated a report on coronial practice.<sup>56</sup> It too identified dissatisfaction with ‘lengthy delays in completion of coronial cases’<sup>57</sup> and the need for enhancement of the Coronial Counselling Service.<sup>58</sup> It urged improvements in communication by the court to family members<sup>59</sup> and the enabling of family members more readily to view and touch deceased persons.<sup>60</sup> The Commission also argued for it to be mandatory within legislation for the coroner to have to consider concerns raised by a family member or another person with a sufficient interest in relation to the type of a post-mortem examination to be conducted.

What emerges from the law reform reports over the period 2000–2012 is a consciousness of a number of factors that can have adverse outcomes for family members. The reports particularly

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<sup>46</sup> Ibid 48, 114.

<sup>47</sup> Ibid 200.

<sup>48</sup> Ibid 469–472.

<sup>49</sup> See too Hugh Dillon and Marie Hadley, *The Australasian Coroner’s Manual* (Federation Press 2015) 32–58.

<sup>50</sup> Ibid 424.

<sup>51</sup> Ibid 468.

<sup>52</sup> Ibid 445.

<sup>53</sup> Ibid 453.

<sup>54</sup> For a useful analysis of this issue, see Frances Gibson, ‘Legal Aid for Inquests’ (2008) 15 *Journal of Law and Medicine* 587.

<sup>55</sup> Ibid 507.

<sup>56</sup> Law Reform Commission of Western Australia, *Review of Coronial Practice in Western Australia: Final Report*, No 100 (2012) <[http://www.lrc.justice.wa.gov.au/\\_files/P100-FR.pdf](http://www.lrc.justice.wa.gov.au/_files/P100-FR.pdf)>.

<sup>57</sup> Ibid 14.

<sup>58</sup> Ibid 114.

<sup>59</sup> Ibid 120.

<sup>60</sup> Ibid 135.

identify cultural sensibilities and deficits in communication by the courts with family members, the toxic effects of delays, as well as the potential for processes to exclude relatives of the deceased, thereby compounding trauma. While the language employed by the law reform bodies is not explicitly that of therapeutic jurisprudence, an important aspiration of each report is to reduce the distress, confusion and alienation from the coronial process of family members. Another feature that the reports share is that the consequences of the coronial process for other interested parties, such as those instrumentally involved in the death, are not the subject of any significant acknowledgment or treatment. In this regard, they are consistent with general commentary, including explicitly therapeutic jurisprudence commentary, on the subject.

#### IV EMPIRICAL KNOWLEDGE ABOUT EXPERIENCE OF THE CORONIAL PROCESS BY NON-FAMILY MEMBERS

A 2011 qualitative research report was undertaken for the Coronial Council of Victoria by Sweeney Research to ‘engage with those who have experienced the coronial system as part of their employment and gain insight to inform the development of approaches which adopt a therapeutic framework in the coronial system’.<sup>61</sup> Twenty interactive journals and 19 in-depth interviews were conducted with stakeholders:

**Table 1- Interviews with Stakeholders**

<b>Role/Employment Type</b>	<b>Interviews</b>	<b>Journals</b>
Emergency Services	1	1
Medical	7	6
Mental Health	3	-
Police	2	8
Social Services	6	5
<b>Total</b>	<b>19</b>	<b>20</b>

The report relates to one jurisdiction only and involved only a limited number of persons. However, its findings were striking. The authors observed that a number of factors had a clear impact upon respondents’ experiences with the coronial jurisdiction including that:

Respondents whose role in relation to the deceased was ‘hands-on’ felt a great deal of responsibility to them. Often times they had developed a relationship with the deceased and were experiencing emotions of grief and loss at the time of death which were exacerbated by their involvement in the inquest. For many, the questioning at coronial inquests was seen as accusatory in nature. As a result, any sense of guilt, self-doubt or anxiety they may have already had were intensified.<sup>62</sup>

They identified too, that inquests that arose from matters taking place in smaller communities were perceived to attract additional pressures. Those who were unused to the forensic environment and therefore what to expect experienced particular levels of anxiety: ‘These

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<sup>61</sup> Sweeney Research, ‘A Qualitative Research Report for the Coronial Council of Victoria’ (Report, 2011); The Coronial Council of Victoria was established by s 109 of the *Coroners Act 2008* (Vic) to ‘provide advice, and make recommendations, to the Attorney-General either (a) of its own motion; or (b) at the request of the Attorney-General. Such advice and recommendations must be in respect of (a) issues of importance to the coronial system in Victoria; (b) matters relating to the preventative role played by the Coroners Court; (c) the way in which the coronial system engages with families and respects the cultural diversity of families; (d) any other matters relating to the coronial system that are referred to the Council by the Attorney-General.’ (s 110(2)).

<sup>62</sup> Sweeney Research, above n 61, 8.

respondents said they were ill-prepared in terms of what to expect on the day of inquest, something they now see as having contributed to their overall feelings of apprehension.<sup>63</sup>

While police officers, those in emergency medicine, and mental health professionals viewed death as an unfortunate but unavoidable part of their work, for others the death of a client of patient was a significant and memorable event: 'It was considered 'out of the ordinary' and had a long lasting impact on them. ...when they were questioned as part of an investigation they were not responding solely as a professional but also as a person mourning the death of someone close to them. Following the death, they believed they experienced emotions of grief and loss just as the family did.'<sup>64</sup>

The Sweeney Report found that the respondents expected to receive the findings of a coroner as soon as they were handed down and that this was not always the case was a cause of great frustration: they 'felt that their expectations should be managed more effectively in order to improve the overall experience and minimise their anxiety'.<sup>65</sup> They identified that becoming aware of the findings would have enabled them to move forward after the death more quickly.

A number of respondents lamented their uncertainty as to what to include in their statements and reports but others were:

aggravated by what they saw as professional and personal attacks during cross-examination. They felt that had they known what to expect they could have felt more prepared to deal with it. Respondents felt that the cross examination focused on 'pointing fingers' rather than uncovering the truth and bred a culture of blame which in some cases prevented them from providing accurate information to the best of their ability. Respondents were surprised and disappointed by what they described as the 'adversarial' nature of the investigation. ... This form of questioning, when combined with the respondents' anxiety, pressure and stress during an inquest, amplified the existing feelings of guilt and self-doubt. ... Even those who with the benefit of reassurance had presumed the process was going to implicate them; that their role was almost to exonerate themselves rather than giving a testimony.<sup>66</sup>

Respondents identified that the presence of the surviving family members at the inquest added to the pressure they already felt and this was especially so when the family was believed to harbour anger and frustration regarding the death:

In cases where the family chose to represent themselves respondents said they felt unable to be as honest as they would have liked to for fear of upsetting the family. Even in cases where a barrister was appointed by the family the professional felt the questioning became more accusatory than investigative under the assumption the lawyers was trying to address the family's need for blame someone for the death. Respondents were concerned that this style of questioning and even visibility of the family per se got in the way of discovering the truth. The witnesses would be less honest and lawyers more accusatory.<sup>67</sup>

Most respondents said that they particularly valued support but were unaware that the Victorian court offered counselling to witnesses, believing the facility to be directed toward the surviving

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<sup>63</sup> Ibid 8.

<sup>64</sup> Ibid 9.

<sup>65</sup> Ibid 10.

<sup>66</sup> Ibid 11.

<sup>67</sup> Ibid 12.

family. The more personal involvement the respondent had had with the deceased, the higher the level of stress they reported from coronial investigations:

These emotions often had negative impacts on respondents' personal and professional lives. Those who were a step removed felt concern, but not personal anguish. Many respondents reported severe anxiety leading up to an inquest. They felt that anxiety was debilitating to a certain extent because it adversely affected their ability to present the information to the best of their ability. Some respondents felt a long term emotional impact following their coronial experience. They spoke about having to take stress leave from work and feeling depressed. One respondent drew a comparison to the emotional impact of having been involved in a series of traumatic incidents. Another said that she was composing her letter of resignation from her job while on the stand during the inquest.<sup>68</sup>

Respondents reported that they wanted a clearer understanding of how the coronial system works in order to be better prepared to present the information they had to the coroner, what to expect and what coroners would want to know from them so as to provide helpful assistance. Almost all respondents 'mentioned how long a coronial investigation takes from the time of the client or patient's death to the findings being handed down and the negative impact that this extended timing' had for them in terms of obtaining personal and professional closure, and also for others in terms of preventing unnecessary deaths, with recommendations for change being delivered too late to avoid other deaths in comparable circumstances.<sup>69</sup>

In 2014, Moore and Henaghan reported on interviews they undertook with 15 New Zealand coroners, 100 senior personnel from 79 organisations and eight interested parties, as well as questionnaires completed by 42 representatives of organisations.<sup>70</sup> The focus of the study was upon the exercise of recommendatory powers by coroners. A range of frustrations was also expressed by interviewees and those who completed the questionnaire about whether recommendations were evidence-based, logistically or economically viable, sufficiently clear or fair. A complaint ventilated by one organisation (Pharmac) was that it had not been notified or given an opportunity to comment on two occasions to have input before recommendations/adverse comments were made.<sup>71</sup>

## V IMPACT OF DEATHS ON NON-FAMILY MEMBERS

A death that occurs in circumstances that give rise to allegations or suspicions of impropriety generates ripples of distress that can radiate out in a variety of ways which are experienced as damaging and distressing. For family members, if they are excluded in substance or alienated from the coronial process by lack of information or deprivation of a meaningful voice, this can compound a sense of loss and distress. In addition, if they perceive that the death of their loved one was 'the fault' of another person or institution, or that any taint surrounds the removal of organs or retention of tissue, this can exacerbate their feelings of loss. Such a perception is also likely to generate anger and a retributive desire to denounce and 'expose' what they regard as the culpability of the other party,<sup>72</sup> so that that person or entity becomes the subject of a public and adverse finding, or at least critical comment by a coroner. Sometimes, this is framed as an

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<sup>68</sup> Ibid 18.

<sup>69</sup> Ibid 24.

<sup>70</sup> Jennifer Moore and Mark Henaghan, 'New Zealand Coroners' Recommendations, 2007–2012', (Report by the Legal Issues Centre, Faculty of Law, University of Otago, 2014).

<sup>71</sup> Moore and Henaghan, above n 70, 234–236.

<sup>72</sup> For a discussion of ethical handling of angry clients, see Robin Wellford Slocum, 'The Dilemma of the Vengeful Client: A Prescriptive Framework for Cooling the Flames of Anger' (2009) 92(3) *Marquette Law Review* 481.

altruistic wish to protect others from negligence, poor practice or indifference to persons' wellbeing, but at base there is often a deep wellspring of anger motivating their stance and a desire for that to be ventilated publicly to name and shame the malefactor.

An outcome can be a strongly expressed desire for an open inquest to be convened so that such matters can be canvassed and so that those suspected of wrongdoing can be held to account under cross-examination. However, it is not unusual for such requests to be declined, amongst other things, if a coroner forms the view that an inquest would 'provide a forum for publicising baseless but damaging allegations against individuals or institutions.'<sup>73</sup> In addition, resourcing and logistical exigencies mean that only a small number of reportable deaths can result in a formal inquest. When the convening of an inquest is declined, this can result in conspiracy theories, feelings of exclusion, a perception that the death is regarded by the coroner as not mattering, and the generation of appellate litigation.<sup>74</sup> Dealing with these emotions and the extent to which blame can be levelled in findings, or inferred from them, is an important challenge for coroners who are minded to optimise pro-therapeutic outcomes from inquests and coronial processes, and to minimise outcomes that are counter-therapeutic.

A fundamental issue is how the desire of a percentage of family members for retributive blaming should be dealt with by coroners. At the extreme, it is argued that coroners should not engage at all in allocation of culpability in respect of deaths: 'It is not his/her task to attribute or hint at blame.'<sup>75</sup> Whether this is realistic or even helpful in terms of the coroner's obligation to set the public record straight about what occurred in the lead-up to a death is questionable. The decision to which reference is often made in this context is that of Lord Lane in *R v South London Coroner, Ex parte Thompson*<sup>76</sup> where the Chief Justice said:

Once again it should not be forgotten that an inquest is a fact finding exercise and not a method of apportioning guilt. The procedure and rules of evidence which are suitable for one are unsuitable for the other. In an inquest it should never be forgotten that there are no parties, there is no indictment, there is no prosecution, there is no defence, there is no trial, simply an attempt to establish facts. It is an inquisitorial process, a process of investigation quite unlike a criminal trial ... The function of an inquest is to seek out and record as many of the facts concerning the death as [the] public interest requires.

This passage was cited without demur by Toohey J in *Annetts v McCann*.<sup>77</sup> The Norris Report in Victoria put the issue similarly:

In future the function of an inquest should be simply to seek out and record as many of the facts concerning the death as public interest requires, without deducing from those facts any determination of blame. The findings of the coroner or jury should in terms be findings of fact only. To quote the Brodrick Committee again:- 'In many cases, perhaps the majority, the facts themselves will demonstrate quite clearly whether anyone bears any responsibility for the

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<sup>73</sup> *State Coroner's Guidelines 2013* (Qld), Chapter 9, 8

<[http://www.courts.qld.gov.au/\\_\\_data/assets/pdf\\_file/0013/206140/osc-state-coroners-guidelines-chapter-9.pdf](http://www.courts.qld.gov.au/__data/assets/pdf_file/0013/206140/osc-state-coroners-guidelines-chapter-9.pdf)>.

<sup>74</sup> See, for eg, *Chol v White* [2016] VSC 561; *Helmer v State Coroner of Victoria* [2011] VSC 25; *Conway v Jerram* [2010] NSWSC 371; *Gentner v Barnes* [2009] QDC 307; *Chiotelis v Coate* [2009] VSC 256; *Domaszewicz v The State Coroner* [2004]; *Rouf v Johnstone* [1999] VSC 396; *Clancy v West* [1995] VICSC 207; [1996] 2 VR 647.

<sup>75</sup> See *Perre v Chivell* [2000] SASC 279 [54].

<sup>76</sup> (1982) 126 SJ 625.

<sup>77</sup> (1990) 170 CLR 596 [12].

death; there is a difference between a form of proceedings which affords to others the opportunity to judge an issue and one which appears to judge the issue itself.<sup>78</sup>

Callinan J in the important decision in *Keown v Khan*<sup>79</sup> concluded that findings of ‘moral responsibility or some other form of blame’ are precluded: ‘the proceeding is inquisitorial; the conclusion would be more indeterminate than a conclusion about legal responsibility; and there would be no prospect of a trial at which the person blamed might ultimately be vindicated by an acquittal.’<sup>80</sup>

A constraint upon findings that take an explicit form of criticism is found in a common, albeit varying form, in coronial legislation. In many statutes there are specific inhibitions on the wording and content of findings that can be made by coroners, regardless of the wishes of parties. For instance, section 25(3) of the *Coroners Act 2003* (SA) precludes coroners from making ‘any finding, or suggestion, of criminal or civil liability’. Likewise under section 45(5) of the *Coroners Act 2003* (Qld) a coroner is prohibited from including in their findings any statement that a person is or may be guilty of an offence or ‘civilly liable for something.’<sup>81</sup> In New Zealand it is prescribed that the role of the coroner is not to determine civil, criminal or disciplinary liability.<sup>82</sup> In jurisdictions such as New South Wales, Victoria, Tasmania and the Northern Territory it is simply provided there can be no finding by a coroner that a person is or may be guilty of a criminal offence.<sup>83</sup> This constitutes a level of restriction in terms of the framing of findings but also thereby on the focus of inquests. Amongst other things, it plays a role in avoiding inquests functioning as a preliminary form of either criminal or civil litigation.<sup>84</sup>

However, it leaves a level of uncertainty over the extent to which, in a real sense, coroners can or should make findings which are tantamount to civil or criminal findings in terms of identifying breaches of duties of care or commission of errors. As a matter of law and practice, a measure of latitude exists in this regard by reason of the fact that findings as to the circumstances and manner of death, placed within their context are delivered in narrative form in both Australia and New Zealand. As the Brodrick Committee in the United Kingdom put it: ‘In many cases, perhaps the majority, the facts themselves will demonstrate quite clearly whether anyone bears any responsibility for the death; there is a difference between a form of proceedings which affords to others the opportunity to judge an issue and one which appears to judge the issue itself.’<sup>85</sup>

The preclusions on the usage of civil or criminal liability of their nature, are limited in extent – they prevent the usage of language which is unmistakably that of criminal or civil fault or the

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<sup>78</sup> JG Norris, ‘The Coroners Act 1958: A General Review’ (Discussion Paper, State of Victoria, 1981) [153].

<sup>79</sup> [1999] 1 VR 69, 76.

<sup>80</sup> *Ibid.*

<sup>81</sup> Section 25(5) of the *Coroners Act 1996* (WA) is to a similar effect.

<sup>82</sup> *Coroners Act 2006* (NZ) s 57(1).

<sup>83</sup> *Coroners Act 2009* (NSW) s 81(3); *Coroners Act 2008* (Vic) s 69(1); *Coroners Act 1995* (Tas) s 28(4); *Coroners Act* (NT) s 34(3).

<sup>84</sup> The role played by the two early inquests into the death of Azaria Chamberlain remains controversial, given their facilitation of the prosecution of Lindy and Michael Chamberlain. See *Coroner Gavin’s findings in the second inquest into the death of Azaria Chamberlain* (February 1982) <<http://law2.umkc.edu/faculty/projects/ftrials/chamberlain/galvinfindings.html>>; Ken Crispin, *The Crown Versus Chamberlain, 1980–1987* (Albatross Books, 1987); John Bryson, *Evil Angels* (Penguin, 1986).

<sup>85</sup> Committee on Death Certification and Coroners (Brodrick Committee), *Report*, HO 375, 1971.

application of criminal or civil law in respect of liability issues arising from facts found.<sup>86</sup> They do not inhibit a coroner from making findings which of their nature determine that a person failed to discharge their responsibilities in accordance with their obligations or even that they failed to take steps that were reasonably open to them to protect safety and risk to life.<sup>87</sup> These can be highly significant findings in terms of clarifying the circumstances of death and laying a foundation for coroners' recommendations. They can also cause a Director of Public Prosecutions to consider the laying of charges, whether or not a coroner formally urges such a course, or a party to commence legal proceedings (usually a dependency claim or an action for psychiatric injury, both founded on allegations of a breach of a duty of care) against another party to the coronial proceedings. It is such findings to which family members often aspire, and for which they argue, when permitted, if they feel that a death has been caused when it should not have been – either maliciously or by reason of indifference, incompetence or carelessness.

The fear of such accusations and the media coverage that surrounds proceedings, as well as the delivery of findings, can be potent indeed. For professionals, those in public life or those in organisations that may be the subject of criticism, as well as for those who are psychologically vulnerable, sensitivity about adverse findings can generate considerable anxiety and distress. All can also suffer a variety of deleterious consequences, including notoriety that is likely to inhibit career progression, ongoing employment or re-engagement.

At an emotional level too, the inquest process can come at a considerable toll for those other than family members. Being the instrument of a death, such as by the discharge of a firearm, even in the course of duty and for good reason, undertaking an operative or resuscitative procedure without success, driving a conveyance that caused death, locating a person who has hanged or otherwise killed himself or herself, or being the innocent mechanism by which a person commits suicide, is often highly damaging psychologically. Many persons in such a situation become preoccupied with memories of the deceased (such as train drivers seeing the face of a person lying on railway tracks immediately before their death), feelings of guilt, whether or not well-founded, as well as the question of whether they could have done more or better to prevent the person's death. Often such questions are not amenable to an easy answer and a loss of perspective can occur with deleterious consequences in terms of equilibrium. Depression, and even suicidality, can ensue. At a lesser level, there can be erosion of confidence which imperils the person's ongoing viability in the role that they were playing at the time of their involvement in the person's death. It is common, for instance, for police who have discharged their firearm in the context of a fatal shooting to cease to be able to continue in an operational role in a police force – rather 'retreating' into roles such as communications, search and rescue, animal handling or intelligence. Similarly, health care professions such as surgeons, emergency physicians, anaesthetists, obstetricians, general practitioners, and midwives (to name but some) who are involved in a death that becomes the subject of a coronial investigation can lose the capacity to be decisive in evaluations and thereby the capacity to respond adequately to emergencies and procedural exigencies – this can deprive them of the ability to continue in their ordinary environment. When such outcomes eventuate, the community, as well as the individual can be the loser – in the sense of being deprived of a valuable resource. There can be deterrence of persons entering specialist areas of medicine, or performing public service such as volunteering as firefighters or paramedics in rural areas, or functioning in particular units within police forces or prisons.

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<sup>86</sup> See *Perre v Chivell* [2000] SASC 279 [56].

<sup>87</sup> For the need for there to be such a nexus see, for eg, *Harmsworth v State Coroner* [1989] VR 989.

Another toll that inquests can take is upon the community's confidence in professions, departments and state entities. To erode such confidence without adequate warrant by permitting sensationalist allegations of ineptitude, mala fides or indifference to people's wellbeing can give rise to unhealthy paranoia and suspicion within the community. It can derogate from trust in instruments of the state, for instance, which largely function well in spite of the fact that improvements in culture, training and performance may need to be made. Trust in such entities can be important in times of crisis or when public co-operation with such entities is needed in the interest of community safety.

To make such observations, which are far from profound, highlights the fact that to speak of 'victims' and 'perpetrators', as King has done in advocating for the introduction of restorative justice processes into coroners' courts,<sup>88</sup> is unhelpfully reductionist and misplaced. Just as there are no winners and losers in coronial investigations, at least technically, so too is it important not to ignore (or be insensitive to) the consequences of investigations, including inquest proceedings, for any category of party because of the inherently emotive nature of what is transacted and the many forms of vulnerability that are present. To privilege proceedings in favour of one category of party, family members, risks tilting the balance that should obtain and imperilling the confidence that should exist in the even-handedness and fairness of the coronial process. What follows is that a role for therapeutic jurisprudence in coroners' investigations should be to sensitise not just to the emotional ramifications of investigations for family members and their particular needs, but to the sensibilities, vulnerabilities and reputations of all parties, in which the community may have an important investment. Inevitably, while some of these considerations will exist in all investigations, and in particular inquests, they will vary depending on the particular persons and entities involved.

An important dynamic in modern inquests is the intense scrutiny that can accompany them. There is nothing new in identifying the level of press, television and radio coverage that high profile inquests can engender.<sup>89</sup> As long ago as 1998 the Canberra journalist, Jack Waterford contended that:

A coronial inquest is particularly focused around publicity. There is a very good argument that publicity is its primary function, and the one which secures its survival at a time when the need for the inquest, either as a vehicle for committal or trial, or even as a source of making formal recommendations to authorities arising out of a death or a fire, is under question in various jurisdictions.<sup>90</sup>

More latterly, the 2016 *Tasmanian Coronial Practice Handbook* has delineated a modern perspective on how many coroners' courts attempt to work constructively with the media:

The media play an important role in coronial proceedings, conveying the coroner's findings into the public arena. It is through media reports that most people become aware of coronial findings and therefore, it is through the media that inquests and findings can make their most significant impact on the public. One of the coroners' most important roles is to protect the public, and therefore the coroners' office works with the media so that the public is made

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<sup>88</sup> Michael S King, 'Non-Adversarial Justice and the Coroner's Court: A Proposed Therapeutic, Restorative, Problem-Solving Model' (2008) 16 *Journal of Law and Medicine* 442, 451.

<sup>89</sup> See, for eg, Jack Waterford, 'The Media and Inquests' in Hugh Selby (ed) *The Inquest Handbook* (Federation Press, 1998) 52–64.

<sup>90</sup> *Ibid* 52; see also Evan Whitton, 'A View from the Bleachers' in Hugh Selby (ed), *The Aftermath of Death* (Federation Press, 1992), 244–264, especially 249.

aware of coroners' comments, warnings and recommendations, and their knowledge and wellbeing are increased.

The media can also play an important role for families. If the families and friends of a deceased person feel that the death of their loved one could have been avoided, the public naming of any authorities that may have contributed to the death can have a positive emotional effect. People feel that their voice has been heard and this can help them to cope. The death of a loved one is a tragic event and the knowledge that others have been saved this pain can be a comfort in difficult times.<sup>91</sup>

In 2016, a new phenomenon emerged. An unparalleled level of scrutiny was imposed upon the 2014 decision of Victorian Coroner White in relation to the death of Phoebe Handsjuk.<sup>92</sup> The Coroner concluded that the deceased entered a garbage chute in a zolpidem- and alcohol-induced sleep-walking-like state, or while deeply confused and disorientated, without awareness of the dangers in her behaviour.<sup>93</sup> Other theories about how her death came to pass have been mooted. What distinguished the inquest was the publication of a six-part podcast, *Phoebe's Fall*, produced by a Fairfax-employed team, Richard Baker, Michael Bachelard and Nick McKenzie.<sup>94</sup> The podcasts were accompanied by high profile ongoing coverage and controversy suggesting that the decision of the Coroner was in error and that changes to the law to enable coroners' findings to be appealed more readily were required.<sup>95</sup> In short, the aftermath of the inquest was a campaign in the media for a revisiting of the outcome of the inquest decision and for reforms to the law.

While the naming of authorities that may have contributed to a death may be experienced as just and salutary by family members, there is another side to the coin which should not be forgotten – it may be experienced as devastating by individuals employed by or working within the authorities.

There have also been high profile examples of persons who have 'springboarded' from deaths and the publicity that has resulted from them to mount high profile campaigns in relation to social issues related to deaths. For instance, in Canada, John Lewis wrote *Beware the Grieving Warrior*.<sup>96</sup> It followed Ontario's Deputy Chief Coroner ordering an inquest into the death of two children due to post-operative complications resulting in deaths in a Hamilton Hospital. The book is co-written by the father of one of the two children, Claire, and recounts the obstacles encountered in seeking adverse findings in respect of the circumstances of the two deaths. The open and sincere aspirations of Mr Lewis were summarised in the foreword to the book:

A child's death raises unimaginable stresses and horribly real feelings of guilt and responsibility for the surviving parents, not to mention the indescribable sense of loss. A

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<sup>91</sup> Tasmanian Coronial Practice Handbook (2016), 42

<[http://www.magistratescourt.tas.gov.au/about\\_us/coroners/coronial\\_practice\\_handbook](http://www.magistratescourt.tas.gov.au/about_us/coroners/coronial_practice_handbook)>.

<sup>92</sup> *Finding in Relation to the Death of Phoebe Handsjuk* [2014] Victorian Coroners Court (10 December 2014)

<[http://www.coronerscourt.vic.gov.au/resources/0b4a4ed8-7170-493b-bac2-6927ff528b64/phoebehandsjuk\\_460510%286%29.pdf](http://www.coronerscourt.vic.gov.au/resources/0b4a4ed8-7170-493b-bac2-6927ff528b64/phoebehandsjuk_460510%286%29.pdf)>.

<sup>93</sup> *Ibid* [354].

<sup>94</sup> The Age/SMH, *Phoebe's Fall* <<http://www.smh.com.au/interactive/2016/phoebesfall/index.html>; <https://itunes.apple.com/au/podcast/phoebes-fall/id1155393027?mt=2>>.

<sup>95</sup> See, for eg, Richard Baker and Michael Bachelard, 'Phoebe's Fall Prompts Rethink on Appeals from Inquests' *Sydney Morning Herald* (online), 6 October 2016 <<http://www.smh.com.au/national/investigations/phoebes-fall-prompts-rethink-on-appeal-rights-for-inquests-20161006-grw6jy.html>>.

<sup>96</sup> Larry Hicock and John Lewis, *Beware the Grieving Warrior: A Child's Preventable Death – A Struggle for Truth, Healing and Change* (ECW Press, 2004).

preventable death such as Claire's increases those feelings exponentially. And if a preventable death is combined with an unwillingness by the health care providers involved to take responsibility for their actions, it leaves in its wake an anger of unspeakable magnitude. Anger can create change; anger can also destroy and obstruct any hope of change. My advocacy was born out of anger, hurt, and loss. To that end, *Beware the Grieving Warrior* carries my hopes for change.<sup>97</sup>

Another example of recent inquests that have given rise to a high profile campaign for change was the pair of inquests into the death of Luke Batty (by murder) and his father, Greg Anderson (by suicide, utilising police: 'suicide by cop'). They were accompanied by a nationwide campaign, which incorporated prominent action through social media, starting during the inquests for thoroughgoing reform to legal and other responses to domestic violence. Rosie Batty, who later became Australian of the Year, released her autobiography on the day the State Coroner handed down his findings into Luke's death.<sup>98</sup>

A further example of an inquest that became enmeshed with a campaign was the death of 15-year-old Tyler Cassidy, who was shot dead by police at a skate park in Northcote in inner-city Melbourne. Shortly after the conclusion of the inquest,<sup>99</sup> Tyler's mother, Shani Cassidy, lodged a communication with the United Nations Human Rights Committee asserting that Australia had breached its human rights obligation by allowing police to assist the coroner to investigate her son's death and thereby failing to have an independent and effective investigation into his death.<sup>100</sup>

An additional modern element of the coronial inquest is the social media coverage that can emanate from (and even during) inquest proceedings and which in turn can provide a fillip for orthodox media coverage of proceedings or issues arising from inquests. Guidance No 25, *Coroners and the Media*,<sup>101</sup> issued by the Chief Coroner of England and Wales in 2016 specifically adverts to the role of journalists texting and tweeting coverage of coroners' inquests, observing that such live-based communications have the potential to facilitate fair and accurate reporting of proceedings. This is a straightforward acknowledgment of the reality of modern means of reporting, as well as consumption of information within the contemporary community. However, it raises the issue of what coroners' courts need to do to ensure that their proceedings are, and are perceived to be, a dignified search for truth, rather than a vehicle for media exposes which frequently will focus upon blame and fault-finding.

It has become increasingly common for bereaved relatives and those supporting them or representing them to engage in commentary in the media in the course of inquests about evidence that has been given and for highly professional campaigns from those with a particular interest in a category of death (such as police-involvement deaths, prison deaths, domestic violence deaths, or deaths in immigration detention) to be run arising from and utilising the

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<sup>97</sup> Ibid 9.

<sup>98</sup> Rosie Batty, *A Mother's Story* (Harper Collins, 2015); *Inquest into the Death of Luke Batty* [2015] Coroners Court of Victoria (28 September 2015)

<<http://www.coronerscourt.vic.gov.au/home/coroners+written+findings/findings+085514+luke+geoffrey+batt>>.

<sup>99</sup> *Inquest into the Death of Tyler Cassidy* [2011] Coroners Court of Victoria (23 November 2011) <<http://www.coronerscourt.vic.gov.au/home/coroners+written+findings/findings++inquest+into+the+death+of+tyler+cassidy>>.

<sup>100</sup> See Human Rights Law Centre, *Individual Communication Lodged by Shani Cassidy* (2015) <<http://hrlc.org.au/wp-content/uploads/2015/03/Clean-version-of-background-document-provided-by-HRLC-for-updating.pdf>>.

<sup>101</sup> Guidance No 25, *Coroners and the Media* (30 September 2016) <<https://www.judiciary.gov.uk/wp-content/uploads/2016/10/guidance-no-25-coroners-and-the-media.pdf>>.

evidence given in an inquest. This generates its own dynamics. At the most banal level, it ratchets up the pressure for those giving evidence in an inquest, especially if they anticipate being the subject of hostile cross-examination. In this respect, it has the potential to inhibit or impair the investigative processes of an inquest. In addition, the reality is that if the media coverage is sensationalist and/or lacks balance, it can generate antagonism in the workplace or the general community at a level which is both emotionally distressing and vocationally problematic. There are no rights for those the subject of such publicity to procure their own publicity in reply. In some instances, soliciting such publicity may be inappropriate or run the risk of being misinterpreted, including by a coroner. The result is that the one-sided publicity can generate perceptions of fault which ultimately may not be corroborated by findings. However, the publicity itself may have its own noxious effect, be enduring and be more prominent in the media than the coverage of actual findings and recommendations made by a coroner. These observations made, there are only limited measures that can be taken by coroners' courts to inhibit media coverage that lacks balance.

## VI THE QUEST FOR BALANCE

Coroners' investigations of death inevitably take place in a highly charged emotional atmosphere in the aftermath of a death that by definition of its being 'reportable' has been sudden, violent, unnatural or unexpected.<sup>102</sup> This means that the investigation of its very nature is surrounded and influenced by a maelstrom of conflicting emotions, including grief, distress, anger, survivor (and other forms of) guilt, and confusion.<sup>103</sup> Notwithstanding the existence of such emotions, and the likelihood that those experiencing them will have different needs and objectives from the coronial process, there is the potential for the role of the coroner to have therapeutic outcomes – for instance, to shed light on and assist understanding about previously unclear circumstances of a death, and to enable resolution for family members and others, even to generate emotional catharsis as a result of their coming to terms with those things which had been preventing closure for their grief. At its best, the coronial process can facilitate understanding of the circumstances of a death, forgiveness for error or fault, and adoption of better and safer processes with the potential to avoid deaths occurring in comparable circumstances – something positive can emerge from tragedy.<sup>104</sup>

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<sup>102</sup> *Coroners Act 1997* (ACT) s 77; *Coroners Act 2009* (NSW) s 6; *Coroners Act* (NT) s 12; *Coroners Act 2003* (Qld) s 8; *Coroners Act 2003* (SA) s 3; *Coroners Act 1995* (Tas) s 3; *Coroners Act 2008* (Vic) s 8; *Coroners Act 1996* (WA) s 3.

<sup>103</sup> See, for eg, George Gort, 'Pathological Grief: Causes, Recognition, and Treatment' (1984) 30 *Canadian Family Physician* 914.

<sup>104</sup> For a contemporary analysis of the role that coroners' recommendations play in enhancing public health and safety, see Jennifer Moore, *Coroners' Recommendations and the Promise of Saved Lives* (Edward Elgar, Cheltenham, 2016). See also Graeme Johnstone, 'An Avenue for Death and Injury Prevention' in Hugh Selby (ed) *The Aftermath of Death* (Federation Press, 1992); Lyndal Bugeja and David B Ranson, 'Coroners' Recommendations: A Lost Opportunity' (2005) 13(2) *Journal of Law and Medicine* 173; David M Studdert and Stephen M Cordner, 'Impact of Coronial Investigations on Manner and Cause of Death Determinations in Australia, 2000–2007' (2010) 192(8) *Medical Journal of Australia* 444; Lyndal Bugeja et al, 'Application of a Public Health Framework to Examine the Characteristics of Coroners' Recommendations for Injury Prevention' (2012) 18(5) *Injury Prevention* 326; Jennifer Moore, 'Coroners' Recommendations about Healthcare-Related Deaths as a Potential Tool for Improving Patient Safety and Quality of Care' (2014) 127 *New Zealand Medical Journal* 35; Elena Mok, 'Harnessing the Full Potential of Coroners' Recommendations' (2014) 45 *Victoria University of Wellington Law Review* 321; Georgina Sutherland, Celia Kemp and David M Studdert, 'Mandatory Responses to Public Health and Safety Recommendations Issued by Coroners: A Content Analysis' (2016) 40(5) *Australian and New Zealand Journal of Public Health* 451.

However, a significant number of forms of feedback have demonstrated that family members can be deleteriously affected by coronial investigations and inquest processes, amongst other things, because these will involve some element of re-living of the death and the circumstances surrounding it and giving rise to it. In addition, inevitably there will be some element of delay which can be experienced as oppressive and which can retard the grieving process. Further, however well-informed family members may be about coronial investigations, they are likely to find aspects of an inquest confronting and distressing. Personal health issues may become public, difficult intra-familial dynamics may be exposed, uncomfortable aspects of the behaviour of the deceased may come to light. Many comparable considerations apply to persons who have had some form of instrumental involvement or exposure to the death, prior to its occurring or immediately afterwards.

A major contribution made by therapeutic jurisprudence over the past decade and a half has been to highlight ways in which family members are at risk of being adversely affected by the way in which coroners' investigations are undertaken in the immediate aftermath of a death, during the process of investigation leading up to an inquest, and then during an inquest itself up to and including when findings are delivered and recommendations made by coroners. It has become apparent that disenfranchisement from the process by inadequate communication from a court, by excessive inhibitions on providing information to a court, by lack of legal representation, and by delays and erroneous or unclear findings are experienced as toxic by many family members. Similarly, a failure to respect cultural and religious sensibilities and a propensity to prioritise throughput and resolution of cases over acknowledgment of the sensitive and individual circumstances of a death can arrest and distort grief, giving a fillip to anger and a propensity to make accusations and allegations, some of which may be based more in suspicion than in fact.<sup>105</sup> Such experiences can disillusion family members, causing them to doubt the authenticity of the coroner's role and the rigour, thoroughness and independence of a coronial inquiry.

For others affected by coronial investigations, a risk is that the improved sensitisation to the needs and wishes of family members will be perceived as tilting the coronial process in favour of families and without proper acknowledgment that coronial processes and the aftermath of reportable deaths can be adverse in their effects for others as well. If inquests are permitted to function as adjuncts or media opportunities for social justice campaigns, collateral harm of many kinds can be done and a perception generated that the coronial process is more receptive to concerns for the wellbeing of family members than it is for that of other interested parties.

An important question from the issues outlined above is how a coroner's court should resolve the competing interests of family members and those of others. While it is correct to describe coroners' inquests as inquisitorial, rather than adversarial, the reality is that in many inquests the interests of parties may be polarised. The question arises in a variety of contexts, some major, some minor. A constructive yardstick for guidance in locating such balance is by reference to the roles of a coroner,<sup>106</sup> namely:

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<sup>105</sup> A tension, of course, exists between coronial efficiency that emphasises throughput and comprehensive investigation which, necessarily, takes longer and gives rise to counter-therapeutic delays. Resourcing for coroners' courts can impact upon the capacity to deal with this tension.

<sup>106</sup> Moore, above n 38, 196, interestingly identifies coroners in the sample she interviewed as describing themselves diversely, including as 'manager of evidence', 'watch dog', 'social geographer', 'independent investigator', 'judicial officer with an investigative role', 'story teller', 'fact finder', 'expert in death', and 'advocate for the family of the deceased.'

- To make findings as to identity, place, time, manner and cause of death;
- To clarify the public record about such matters and thereby to allay unreasonable rumours or suspicion; and
- To make recommendations about the avoidance of avoidable deaths.<sup>107</sup>

Given the subject matter of inquests, it is inevitable that some measure of distress will be caused to parties, family members and others, by a rigorous investigative process which prioritises discharge of the statutory role to determine the facts fearlessly and without favour and to explore whether there are feasible ways to avoid comparable, avoidable deaths. This is a necessary incident of the adjudicative process of the coroner's inquest from which all involved should not shrink: the public interest in integrity of fact-finding and the role of coroners in respect of public health and safety must take precedence over consequential distress to parties and witnesses. The challenge for coroners' courts seeking to implement the tenets of therapeutic jurisprudence is to maximise the potential, consistent with securing soundly based findings and constructive recommendations, for high quality coroners' investigations and, in particular, inquests, and to minimise the potential for them to generate counter-therapeutic consequences for parties – to cause foreseeable and avoidable harm.

A crucial aspect of an inquest, which is most likely to achieve such outcomes, is delineation at an early juncture of its parameters and a statement that the focus of an inquest is not upon attribution of blame but upon identification of lessons to be learned. This can be done at a directions or pre-inquest hearing set down prior to the start of the hearing when an investigation is well advanced.<sup>108</sup> It is important that at such a hearing the parties have a proper opportunity to identify the issues with which they contend the inquest should grapple. After hearing submissions, ideally, a coroner will make clear rulings about what will be within and outside the scope of the inquest and clarify the ongoing purpose of the investigative responsibilities of the coroner in the case. Such rulings have the potential to reduce misunderstandings as to the trajectory of an inquest, as well as unhelpful acrimony and adversarialism during an inquest generated by accusatoriness and defensiveness on the part of parties.

They can also reduce the potential for prolongation of an inquest and distraction into matters which may be collateral or even tangential to the issues into which the inquest needs to inquire. This is not to suggest that there should be rigid adherence to such parameters because necessarily an investigation is a fluid process that needs to retain flexibility; the parameters may need to be amended in the course of an inquest as a result of new information that has come to light. However, a process of submissions and ruling about inquest parameters, as well as explication of the purposes of the inquest process, optimises the chances of avoiding cross-examination or final submissions which are directed toward accusations or contentions that will not assist the coroner because they are outside the designated scope of the inquest.

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<sup>107</sup> See Brodrick Committee, above n 86; see too *Morris v Dublin City Coroner* [2000] 3 IR 603; *R v Coroner for North Humberside; ex parte Jamieson* [1995] QB 1; JG Norris, *The Coroner's Act 1958: A General Review* (State of Victoria, 1985), 72. See too the Magistrates Court of Tasmania, *Tasmanian Coronial Practice Handbook* (2016), 9 <[http://www.magistratescourt.tas.gov.au/about\\_us/coroners/coronial\\_practice\\_handbook](http://www.magistratescourt.tas.gov.au/about_us/coroners/coronial_practice_handbook)> where the purposes and objectives of the coroner's court are usefully identified as to: "identify deceased persons; find out how and why a person died; establish the cause and origin of fires and explosion; learn from experience to help prevent similar deaths occurring; improve our systems of public health and safety; further the administration of justice; allay suspicions and fears; hold public agencies to account for deaths in the State's custody or care; such as police, prisons and health services; investigate in public where appropriate; reinforce the rule of law in democratic societies; and provide quality assurance in the death investigation process."

<sup>108</sup> See J Abernethy et al, *Waller's Coronial Law and Practice in New South Wales*, (Lexis Nexis Butterworths, 4<sup>th</sup> ed, 2010) 149 (and following) in relation to case management.

Thereafter, a challenge for the presiding coroner is to require substantive adherence to the designated scope of the inquest, in face of attempts to extend, alter and adjust the scope when the grounds for doing so are not made out.

A related issue relates to the extent to which coroners should scrutinise *all* of the circumstances of a death or how a death occurred.<sup>109</sup> The spotlight of a coroner's investigation is apt to identify a range of conduct, only some of which is strictly relevant to what caused a death. A distinction exists not just between foreground and background matters,<sup>110</sup> or causal and non-causal factors. The discriminating yardstick should be that which is logically relevant to findings that a coroner is obliged to make. This means that investigation and the findings that are its outcome should be conducted in a circumscribed way that avoids collateral or merely contextualising matters. An advantage of such an approach is that it avoids ventilation of extraneous facts which have the potential to cause distressing and, ultimately, irrelevant focus upon matters that have no potential properly to be the subject of findings.

As identified above, an increasing focus of inquests is the making of recommendations and comments by coroners. The inference can readily be drawn that such recommendations and comments needed to be made because of deficits in conduct engaged in by entities that were, or at least were given the opportunity to be, interested parties before the inquest. This may or may not be correct but it highlights the need for inquest reasons to be clearly expressed, including when the inquest simply furnishes the opportunity to proffer recommendations or make comments directed toward enhancing public health or safety. In addition, there is much to be said where there is the potential for such a step to be taken by a coroner for a formal opportunity to be provided to affected parties to have input into whether recommendations or comments should be made, and, if so, how they should be framed. Therapeutic jurisprudence has highlighted the counter-productive aspects of the use of coercion or engagement in paternalism.<sup>111</sup> When this is done by the making of recommendations or comments with little or no notice of the intention by a coroner to do so, it tends to create a sense of grievance and thereby reduce the likelihood of constructive responsiveness. When there are such practices, which may be perceived by parties, as punitive or overtly critical, it also tends to militate against an atmosphere in which apologies and concessions will be made. Pointedly, Moore found that 'All of the seventy nine organisations interviewed also reported that they would prefer increased communication, consultation and collaboration with the CSNZ and coroners.'<sup>112</sup> This led her to argue that: '... enhanced consultation and communication between the Coroner's Court and all parties would be therapeutic.'<sup>113</sup>

Generally, it will not be constructive for an inquest to devote time and energy to allocating individual blame in the narrative findings at the conclusion of an inquest. One of the reasons, once again, for such an approach not being helpful is that of its nature it is alienating and

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<sup>109</sup> Coroners make findings under s 67(1)(c) of the *Coroners Act 2008* (Vic) about "the circumstances in which the death occurred"; under s 52(1)(c) of the *Coroners Act 1997* (ACT) about "any relevant circumstances concerning the death"; under s 34(1)(v) of the *Coroners Act* (NT) and s 81(1)(c) of the *Coroners Act 2009* (NSW) about "the manner of a death"; under s 45(2)(b) of the *Coroners Act 2003* (Qld), s 28(1)(b) of the *Coroners Act 1995* (Tas) and s 25(1)(b) of the *Coroners Act 1996* (WA) about how the person died"; and under s 11(1) of the *Coroners Act 2003* (SA) and s 57 of the *Coroners Act 2006* (NZ) about the circumstances of the death.

<sup>110</sup> See *Keown v Khan* [1998] VSC 297; [1998] VICSC 83; [1999] 1 VR 69, 76 (Callinan J).

<sup>111</sup> See, for eg, Bruce J Winick, 'On Autonomy: Legal and Psychological Perspectives' (1992) 37 *Villanova Law Review* 1705, 1756; see also Tom R Tyler, *Why People Obey the Law* (Princeton University Press, 2<sup>nd</sup> ed, 2006); cf Frederik Schauer, *Coercion and the Law* (Harvard University Press, 2015).

<sup>112</sup> Moore, above n 38, 205.

<sup>113</sup> *Ibid.*

thereby reduces the likelihood of institution of remedial and prophylactic measures identified by a coroner as being necessary or at least worthwhile. Occasions where there is potential homicidality or significant personal and culpable contribution to a death will be exceptions. However, for the most part, personal deficiencies in the discharge of responsibility occur within an institutional and systemic context that tends to be a more fruitful focus of investigation and analysis. The health sector has grappled with this for some time in its development of root cause analyses for adverse events.<sup>114</sup> If the aim of the coronial process is conceptualised as risk reduction and behaviour change,<sup>115</sup> there is much to be said for the focus to be on issues other than individual blameworthiness. As Tinkner and Tyler have put it, ‘research consistently demonstrates that socializing supportive values and encouraging favourable attitudes not only motivates compliance with the law but promotes voluntary and willing cooperation with legal authorities.’<sup>116</sup>

At a more specific level, a wish articulated by some family members is that the deceased person be portrayed in some pictorial or similar way in the course of proceedings so that the fact that the inquest is about their death is unequivocally clear and present throughout proceedings. In an ordinary adversarial case, no such representation would be permitted but in coroners’ courts, on occasions, a photograph of the deceased has been permitted to be placed in the courtroom. There are several options in this regard. In the *Inquest into the Death of Luke Batty*<sup>117</sup> the wish of Luke’s mother, Rosie Batty, was that his picture be placed in front of the coroner looking out to the court. Judge Gray, the Victorian State Coroner, permitted Luke’s picture to remain for the duration of the inquest in front of the witness box with the result that all asking questions and looking at a witness would see the picture of the deceased. Another option would have been the placement of such a picture in the area of the court opposite the witness box where the attention it garnered would not have been so constant or dramatic. A further option is for a family member to be permitted to hold such a picture when giving evidence and to show it to the coroner in the course of speaking. The issue is how the court can find a compromise between acknowledging that the inquest is about the death of a particular deceased person, who lived a unique and valuable life that perhaps should not have ended as it did, preserving the dignity and objectivity of the process, and avoiding the balance of the inquiry appearing to tip too far in the direction desired by family members who have a particular perspective on how they wish a deceased person to be remembered.

A related wish expressed by some family members has also been to present a video tribute to the deceased in the course of inquest proceedings. Generally, this has not been permitted by coroners on the basis that it would change the nature of proceedings in a way which does not comport with the objectives of a coronial inquest. The problematic analogy in this regard is the drift of the coroner’s proceeding from a fact-finding exercise into a memorial or tribute to the deceased.

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<sup>114</sup> See, for eg, Health Victoria, *Root Cause Analysis (RCA) Statements and Reports* (2015) <<https://www2.health.vic.gov.au/hospitals-and-health-services/quality-safety-service/clinical-risk-management/investigation-of-incidents/rca-statements-and-reports>>.

<sup>115</sup> For instance, a purpose of the *Coroners Act 2008* (Vic) is prescribed by s 1(c) to be ‘to contribute to the reduction of the number of preventable deaths and fires through the findings of the investigation of deaths and fires, and the making of recommendations, by coroners.’

<sup>116</sup> Rick Tinkner and Tom R Tyler, ‘Legal Socialization: Coercion Versus Consent in an Era of Mistrust’ (2016) 12 *Annual Review of Law and Social Science* 417.

<sup>117</sup> *Inquest into the Death of Luke Batty* [2015] Coroners Court of Victoria (28 September 2015) <[http://www.coronerscourt.vic.gov.au/resources/07cc4038-33f8-4e08-83b5-fd87bd386ccc/lukegeoffreybatty\\_085514.pdf](http://www.coronerscourt.vic.gov.au/resources/07cc4038-33f8-4e08-83b5-fd87bd386ccc/lukegeoffreybatty_085514.pdf)>.

A variant on the visual options referred to above is the wish expressed, and from time to time permitted by coroners, that a close relative of the deceased inform the coroner from the witness box about the background and personality of the deceased and communicate to the court the effect that the death has had upon his or her family. The conceptual genesis of such an aspiration is victim impact statements in the criminal context which both alert the sentencing judge to the effect of criminal conduct upon victims (which is both a reality check and can be relevant to the sentence imposed) and provide family members with a voice in the course of proceedings. Insofar as relatives of the deceased may have information to provide which is pertinent to the fact-finding task of the coroner, their evidence is wholly unexceptionable and has the potential to be therapeutic. However, again, the risk if they are given complete latitude as to what they say and how they say it is that the witness box can be utilised to express particular grievances which may be publicised by the media but which may not advance the task which by statute the coroner is obliged to undertake. The process of uttering aggrievements, traversing matters of evidence in the form of commentary, or ventilating distress may be cathartic and therapeutic for the family member/s but it may be seriously and irremediably damaging for others, as well as unhelpful for the court. In addition, it may redirect the proceedings into a level of emotionality that is not consistent with a dignified, calm or balanced exploration of the factual and policy issues surrounding a death.

In each of these instances, there can be a tension between being respectful and sensitive toward the memory of the deceased and the wishes of grieving relatives, on the one hand, and, on the other hand, adding fuel to an already complex campaign being conducted through the media which seeks to blame individuals or institutions for the death of the person the subject of the inquest. The challenge for the coroner's court is to facilitate the centrality of the deceased person to the inquest process and to enable some measure of latitude for relatives if it has the potential to be therapeutic for them, while maintaining the dignity and integrity of proceedings and avoiding unduly counter-therapeutic consequences for others who may have played some role in the person's death. An option in this regard is the development of a practice whereby counsel assisting an inquest reviews statements to be made by family members to try to avoid difficulties in advance, and the clear stipulation by a presiding coroner that a family member should not trespass into identified proscribed areas and that if they do this may require the recalling of witnesses and result in the family member being cross-examined about new issues that they raise.

A related issue is that there is the potential for it to be constructive and even therapeutic for persons other than family members to articulate the impact that a death has had upon them and the steps that have been taken as a consequence by them and others associated with them as a result of a death. For a court to enable such matters to be said can play a role in defusing unhelpful tensions that can exist in coroners' proceedings and even in enabling rapprochement between interested parties.

This overlaps with the relationship between coroners' proceedings and the involvement of the media. As identified above, coverage of inquest proceedings, as well as findings and recommendations and any responses to them, is fundamental to the efficacy of inquest outcomes. For this reason, some coroners' courts employ the services of a media liaison professional. On occasions, a website for a particular inquest has been generated by a court to

enable public access to what is taking place.<sup>118</sup> However, it is important that securing media coverage does not become an end in itself and that proceedings are not distorted by the desire for a particular kind of coverage to be generated. That is an issue for the parties, but if coroners permit their own courts to have overmuch familiarity with the media or if they have personal contact with its representatives (as some in Australia have done), again there is a risk that perceptions of coronial even-handedness will be eroded and respect for the jurisdiction will be compromised.

Given the interest of the media in the course of an inquest, especially where parties fan such interest by background briefings and ‘tip-offs’ about evidence which may be particularly reportable, there are particular sensitivities about release of both exhibits and parties’ submissions. This is a further area in which there may be conflict between what aggrieved parties may wish and what is both best for the integrity of the inquest and what is fairest for the parties who may be the subject of the aggrievement. A compromise in terms of access was arrived at, for instance, in the Lindt Café Inquest where Michael Barnes, the New South Wales State Coroner, ruled after hearing argument, that the parties’ submissions not be published until two clear days after the handing down of findings.<sup>119</sup> A consequence of such a ruling is that the likely focus of media reporting is upon the actual decision of the coroner, rather than upon the arguments and contentions of the parties, although these will be available for scrutiny and ongoing evaluation in accordance with ordinary principles of open justice. There is much to be said for such an approach.

Many coroners’ courts make available grief counselling services for family members of deceased persons the subject of report to coroners. Such services are often not funded as extensively as necessary and the need for them is often in excess of the services that budget constraints permit. However, for changes to be made in this regard, it would be constructive, and in keeping with the therapeutic role of coroners’ courts, for such services’ ambit to be extended so that they could offer assistance to all who have the potential to be affected by coronial investigations. This would recognise the reality that coronial investigations, including inquests, have the potential to exacerbate pathological responses in all of those who have been affected by deaths the subject of investigation by coroners. The risks in this regard include family members but extend well beyond them. Further research into the benefits experienced from the receipt of such services would generate an empirical basis for enhanced funding for them on cost-benefit health grounds.

## VII SUMMARY

This article has focused on trauma-informed coronial practice.<sup>120</sup> Its prime contention is that there is a need in the coronial context to service the needs of all participants to investigations by coroners in a humane and empathic way, which provides information, and endeavours to arrive at understanding about what has been responsible (factually and medically) for the

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<sup>118</sup> See, for eg, in the Lindt Café inquest between 2015 and 2017: *Inquest into the Deaths Arising from the Lindt Café Siege* (7 October 2016) <<http://www.lindtinquest.justice.nsw.gov.au>>.

<sup>119</sup> Lindt Café Inquest, *Ruling Re Submission Timetable and Access Restrictions* (7 October 2016) <<http://www.lindtinquest.justice.nsw.gov.au/Documents/Ruling-re-siege-segment-submissions-7-Sept-2016.pdf>>. The ruling was pursuant to s 74(1)(b) of the *Coroners Act 2009* (NSW).

<sup>120</sup> See Sarah Katz and Deeya Haldar, ‘The Pedagogy of Trauma-Informed Lawyering’ (2016) 22 *Clinical Law Review* 359, who argue that trauma-informed practice occurs when lawyers put the trauma experiences of clients at the centre of their practice and adjust their practice approach in accordance with the trauma-caused needs of clients. They argue too that trauma-informed practice encompasses legal practitioners employing modes of self-care to counter-balance the effects their clients’ trauma experiences may have on practitioners.

occurrence of deaths. The striking findings of the 2011 Sweeney report emphasise that for the most part this should avoid imposition of blame in findings, recommendations and comments because ultimately this is the domain of anger, blame and retribution – issues more appropriately dealt with in criminal and civil litigation. Rather, coroners' investigations have the potential to do something different, something more emotionally sophisticated and something authentically therapeutic because they do not involve winners and losers in adversarial contests. They can enable closure of grief and a perception that a constructive outcome has been extracted from tragedy by creating the conditions for healing and resolution, by identifying ways to reduce the likelihood of future deaths, and by laying the groundwork for apologies and shared sadness, rather than accusation and antagonism.

The argument of this article is that to accomplish such outcomes, more must be done than to extend sympathy, forensic flexibility and latitude to one party in coronial inquests, family members. It requires the creation of a culture of sensitivity to the hurtful sequelae of sudden, unexpected and unnatural fatalities, recognising the distress and potential damage that can be done by coroner's investigations to many persons who are affected by such deaths.

The article has chronicled and welcomed the contribution of therapeutic jurisprudence to recognising that, in spite of the therapeutic potential of inquisitorial coroners' courts, family members too often have been adversely affected by coronial procedures that have been experienced as insensitive, process driven, legalistic or opaque.

However, it has proceeded to argue that a balanced approach to coroners' investigations informed by principles of therapeutic jurisprudence should acknowledge that persons other than family members of a deceased person have the potential also to be deleteriously affected in important ways. Those the subject of negative publicity, or findings, recommendations or comments that impute instrumentality or culpability in respect of deaths the subject of coronial investigation can be affected psychologically, vocationally and reputationally in ways which are not easily remediated. Their interests should be incorporated in the complex admixture of considerations that impact upon how investigations, inquests and courts' counselling services are constructed, triaged and dispensed. This can be facilitated by measures such as clarification of the parameters of inquests at an early juncture, reduction of stress-inducing delays, incorporation of third parties in processes of information receipt during investigations, and creation, where possible, of a non-blaming environment that enables the making of concessions and apologies, without the fear of retributive consequences within and beyond the coronial framework. On occasions, such an environment may draw upon processes and options of non-adversarial justice when dealing with dilemmas driven by emotions predictably resultant from the trauma of unexpected death.

There is a need for improved sensitivity to the plight of family members as they participate in coronial processes, especially in a context in which media coverage of inquests on occasion is evolving into public campaigns. So too is there a need for balance so that the reality and the perception can be that the interests of all participants in the coronial process are incorporated in the dispensing of justice and the minimisation of counter-therapeutic consequences from coroners' investigations. Further empirical research into the needs of parties, both family members and others, would provide an evidence-based opportunity for recalibration of coronial approaches and, potentially, a strong ground for enhanced funding for coroners' counselling services so that they can be provided comprehensively to those who suffer in the aftermath of reportable deaths.