**2020**

**THE LEGISLATIVE ASSEMBLY FOR THE**

**AUSTRALIAN CAPITAL TERRITORY**

 **CORONERS AMENDMENT BILL 2020**

**EXPLANATORY STATEMENT**

**and**

**HUMAN RIGHTS COMPATIBILITY STATEMENT**

**(*Human Rights Act 2004*, s 37)**

**Presented by**

**Gordon Ramsay MLA**

# CORONERS AMENDMENT BILL 2020

**This bill is not a significant bill.** Significant Bills are bills that have been assessed as likely to have significant engagement of human rights and require more detailed reasoning in relation to compatibility with the *Human Rights Act 2004*.

##  OVERVIEW OF THE BILL

The bill amends the *Coroners Act 1997* to better respond to the justice needs of families engaging with the coronial system and to make it easier for the Coroners Court to implement restorative approaches in its daily practice.

The amendments contained in this bill are one part of a larger project aimed at making Canberra a Restorative City. Restorative cities are based upon the principles of restorative practice – which recognise that relationships are central to our wellbeing, our community and our society.

The amendments to the Coroners Act acknowledge the significant impact that an inquest or inquiry may have on the family and friends of a deceased person and that, wherever possible, families should be able to engage with the process and be kept informed of the particulars and progress of an inquest into their family member’s death. Further, the bill includes an amendment to make clear that, as far as it is practicable to do so, cultural considerations should be taken into account and respected throughout the coronial process.

The bill also includes amendments to:

* create the definition of ‘death in care’ which will apply to deaths where a person was subject to an order under the *Mental Health Act 2015* or section 309 of the *Crimes Act 1900*;
* include stepparents in the definition of ‘member of the immediate family’ for the purpose of the Coroners Act;
* create an error correction power for the Coroners Court to allow a coroner to amend their findings to correct an error, mistake or omission. This will also clarify for families that they do not need to appeal to the ACT Supreme Court to correct an error in coronial findings resulting from an accidental slip or omission;
* create a guidelines making power which will allow the Attorney‑General to issue guidelines to assist in the preparation of government responses to coronial findings under section 57 of the Coroners Act; and
* clarify notice periods for providing information to families in relation to hearings.

## CONSULTATION ON THE PROPOSED APPROACH

The proposed amendments are the result of extensive consultation with key stakeholders and families with lived experience of the ACT coronial system. The input from stakeholders has significantly informed the amendments proposed in this Bill.

## CONSISTENCY WITH HUMAN RIGHTS

Section 9 of the *Human Rights Act 2004* (HRA) protects the right to life. This right is based on the right to life under article 6(1) of the International Covenant on Civil and Political Rights (ICCPR) and article 1 of the Second Optional Protocol to the ICCPR. The right to life has three core elements to it:

* it prohibits Government from arbitrarily killing a person;
* it imposes an obligation on Government to protect people from being killed by others or reasonably identified risks; and
* it requires the state to undertake an effective and proper investigation into all deaths where the Government is involved (the duty to investigate).

The duty of investigate, as implied from the right to life, specifically requires that there be an effective official investigation into all deaths which result from state use of force and where the state has failed to protect life. Such an investigation must be:

* brought by the state in good faith and on its own initiative;
* independent and impartial;
* adequate and effective;
* carried out promptly;
* open to public scrutiny; and
* inclusive of the family of the deceased and allow the family access to information relevant to the investigation.[[1]](#footnote-2)

Coronial inquests are an important mechanism by which the ACT Government fulfils this obligation. This is because they provide for independent and impartial investigations into deaths. The measures outlined in this bill promote the right to life by strengthening these processes including in respect of the inclusion of family members.

Currently, section 42(b) of the *Coroners Act 1997* provides the coroner with a discretion to grant leave to a person who, in the opinion of the coroner, has a sufficient interest in the subject matter of the inquest or inquiry, to appear in person at a hearing or to be represented by a lawyer. A person granted that leave can then examine and cross examine witnesses on matters relevant to the inquest or inquiry to which the hearing relates. While this provides for the participation of family members, the bill strengthens the ability of family members to be informed about and included in coronial processes including by:

* providing that, in carrying out the objects of the Act in relation to an inquest into a person’s death, for greater inclusion of the deceased person’s family members, including:
	+ recognising the family and friends of the deceased person have an interest in having all reasonable questions about the circumstances of the person’s death answered;
	+ the death of a person, and an inquest into the person’s death, has a significant impact on the person’s family and friends;
	+ members of the immediate family for the deceased person should, where appropriate, be kept informed of the particulars and progress of the inquest into the person’s death; and
	+ that different cultures have different beliefs and practices about death that should, where possible, be respected (clause 6, proposed section 3BA(2)(a);
* providing the coroner must take reasonable steps to notify a member of the immediate family of the deceased person about the time and place of the hearing (clause 13, section 37(1)); and
* providing that a coroner must, where practicable, provide 28 days public notice of a hearing, date, time and place (rather than the current 14 days) (clause 14, section 38).

##

## Coroners Amendment Bill 2020

#### Human Rights Act 2004 - Compatibility Statement

In accordance with section 37 of the *Human Rights Act 2004* I have examined the **Coroners Amendment Bill 2020**. In my opinion, having regard to the outline of the policy considerations and justification of any limitations on rights outlined in this explanatory statement, the Bill as presented to the Legislative Assembly isconsistent with the *Human Rights Act 2004.*

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Gordon Ramsay MLA
Attorney-General

## CLAUSE NOTES

### Clause 1 Name of Act

This is a technical clause that names the short title of the Act. The name of the Act will be the *Coroners Amendment Act 2020* (the Act).

### Clause 2 Commencement

This clause provides information about when the bill’s provisions commence. All provisions will commence on a day fixed by the Minister by written notice. If a provision has not commenced within 6 months beginning on the notification day, it automatically commences on the first day after that period (see Legislation Act, section 79).

### Clause 3 Legislation amended

This clause outlines the legislation that is amended by the Act. This Act amends *the Coroners Act 1997*.

### Clause 4 Objects of Act

### Section 3BA (1) (d)

This clause amends the objects clause to clarify that one of the objects of the Act is to allow a coroner to make comments on public safety as well as recommendations. This clause relates to the requirement in section 52 (4) (ii) for a coroner to comment on a matter of public safety if one is found to have arisen in connection with an inquest or inquiry.

### Clause 5 Section 3BA (2) (a)

This provision substitutes section 3BA (2) (a) to enshrine restorative principles within the objects of the Coroners Act. Section 3BA currently provides that the main objects of the Act are to establish the Coroners Court and the position of Chief Coroner, while providing that magistrates are also coroners. It also outlines the functions of coroners, and outlines that as far as is practicable, the objects of the Act must be carried out in particular ways, such as by recognising the interests of the person’s immediate family to have all reasonable questions about the circumstances of that person’s death answered and to be kept informed of important developments throughout the inquest.

New section 3BA (2) (a) amends the objects clause to provide that as far as is practicable, the objects of the Act are to be carried out in a way that, in relation to an inquest into a person’s death, recognises:

1. the impact that a person’s death, and any inquest into that death, has on the family and friends of the deceased;
2. that where appropriate, members of the immediate family should be provided opportunities to engage in, and be kept informed of the progress of, the inquest into their family member’s death; and
3. that cultural differences should, wherever possible, be respected by the Court in the conduct of the coronial process.

This clause has been drafted in order to respond directly to the principles of harm minimisation, appropriate communication, mutual respect and the implementation of a person-centric ethos that is key considerations in restorative practices.

### Clause 6 New section 3BB

This clause inserts a new definition for ‘death in care’ into Division 1.2 *Objects and important concepts*. A death in care means the death of a person while being taken into or detained in custody, or subject to an order, under the *Mental Health Act 2015* or the *Crimes Act 1900*, section 309 (assessment whether emergency detention required), or because of a fatal injury sustained while being taken into or detained in custody, or subject to an order under these Acts.

The insertion of this definition provides a distinction between a death in custody and a death in care. This amendment has resulted from extensive community consultation, including with families with lived experience of the coronial system, who advocated that the Act should distinguish between a death in a correctional centre and a death under a mental health order, where involvement in the criminal justice system should not be assumed.

This new definition does not alter the investigative requirements placed upon the Territory by the right to life (*Human Rights Act 2004*, section 9). Any investigative requirement which currently applies to a death in custody will continue to apply where a person dies ‘in care.’ This is achieved through consequential amendments made by this bill throughout the Act to identify that a requirement applies to a ‘death in custody’ or a ‘death in care.’

### Clause 7 Meaning of *death in custody*

### Section 3C (1)

This clause is a consequential amendment resulting from the inclusion of new section 3BB set out above.

### Clause 8 Section 3C (1) (c)

This clause removes current section 3C (1) (c) to remove from the definition of ‘death in custody’ the circumstance where a person is being taken into custody or detained under the *Mental Health Act 2015*. This omission is consequential as a result of the inclusion of new section 3BB set out above.

### Clause 9 Deputy coroners’ functions

### Section 9 (2)

This is a consequential amendment that ensures the same powers, obligations and investigative requirements apply to a ‘death in care’ as a ‘death in custody.’

### Clause 10 Coroner’s jurisdiction in relation to deaths

### Section 13 (1) (i)

This section confirms that the coroner must hold an inquest into the manner and cause of death of a person who dies in care.

### Clause 11 Consideration of immediate family

### Section 23 (1)

This is a consequential amendment that ensures the same powers, obligations and investigative requirements apply to a ‘death in care’ as a ‘death in custody.’

### Clause 12 Decision not to conduct hearing

### Section 34A (2)

This clause is a consequential amendment that confirms that all the obligations that previously applied to deaths in custody continue to apply to deaths in care.

### Clause 13 Notification of immediate family

### Section 37 (1)

Section 37 (1) currently provides that, before conducting a hearing, a coroner must have regard to whether a member of the immediate family has been notified of the hearing, and if they have not been notified, whether reasonable efforts were made to do so.

This clause substitutes section 37 (1) to require the coroner to, as far as reasonably practicable, take steps to notify a member of the immediate family of the time and place of the hearing. This recognises the need for families to be made aware of a hearing into the death of their family member.

### Clause 14 Notice relating to conduct of hearing

### Section 38

This clause increases the public notification period for the date, time and place of the hearing from 14 to 28 days. This recognises the needs of families to have more time to prepare and/or make any arrangements for the hearing if they wish.

### Clause 15 Inquests into non-custodial deaths and inquiries – discretion to appoint counsel assisting

### Section 39 (1)

This is a consequential amendment that ensures the same powers, obligations and investigative requirements apply to a ‘death in care’ as a ‘death in custody.’

### Clause 16 Section 39 (3), note

This is a consequential amendment that ensures the same powers, obligations and investigative requirements apply to a ‘death in care’ as a ‘death in custody.’

### Clause 17 Section 54 heading

This is a technical amendment to more accurately reflect the contents of the section.

### Clause 18 Section 54 (1)

This is a consequential amendment that ensures the same powers, obligations and investigative requirements apply to a ‘death in care’ as a ‘death in custody.’

### Clause 19 New section 57A

This clause inserts a formal power to enable a coroner to correct a mistake, error or omission in a coronial finding or report. This power is akin to section 76 of the *Coroners Act 2008* (VIC) and codifies the ‘slip rule’ to allow a party to an inquest to request the coroner correct an error which has been made as a result of an accidental slip or omission, or a clerical mistake.

A coroner may make an amendment on their own initiative or on request of a person with sufficient interest in the inquest or inquiry.

### Clause 20 Part 6 heading

This is a consequential amendment that ensures the same powers, obligations and investigative requirements apply to a ‘death in care’ as a ‘death in custody.’

### Clause 21 Sections 69 to 71

The amendments to these provisions are consequential to ensure that the same powers, obligations and investigative requirements apply to a ‘death in care’ as a ‘death in custody.’

### Clause 22 Section 72 heading

This is a consequential amendment that ensures the same powers, obligations and investigative requirements apply to a ‘death in care’ as a ‘death in custody.’

### Clause 23 Section 72

This is a consequential amendment that ensures the same powers, obligations and investigative requirements apply to a ‘death in care’ as a ‘death in custody.’

### Clause 24 Section 73

This is a consequential amendment that ensures the same powers, obligations and investigative requirements apply to a ‘death in care’ as a ‘death in custody.’

### Clause 25 Findings about quality of care, treatment and supervision

### Section 74

This is a consequential amendment that ensures the same powers, obligations and investigative requirements apply to a ‘death in care’ as a ‘death in custody.’

### Clause 26 Copies of reports of findings

### Section 75 (1)

This is a consequential amendment that ensures the same powers, obligations and investigative requirements apply to a ‘death in care’ as a ‘death in custody.’

### Clause 27 Section 75 (1) (b)

This is a consequential amendment that ensures the same powers, obligations and requirements apply to a ‘death in care’ as a ‘death in custody.’

### Clause 28 Section 75 (2)

This is a consequential amendment that ensures the same powers, obligations and requirements apply to a ‘death in care’ as a ‘death in custody.’

### Clause 29 Response to reports

### Section 76 (1)

This clause is a consequential amendment to the substitution of section 75 (1) (b) above.

### Clause 30 Section 78 heading

This is a consequential amendment that ensures the same powers, obligations and investigative requirements apply to a ‘death in care’ as a ‘death in custody.’

### Clause 31 Section 78 (a)

This is a consequential amendment that ensures the same powers, obligations and investigative requirements apply to a ‘death in care’ as a ‘death in custody.’

### Clause 32 Deaths in institutions – retention of records of dead person Section 100 (2)

This is a consequential amendment that ensures the same powers, obligations and investigative requirements apply to a ‘death in care’ as a ‘death in custody.’

### Clause 33 Section 100 (4)

This is a consequential amendment that ensures the same powers, obligations and investigative requirements apply to a ‘death in care’ as a ‘death in custody.’

### Clause 34 New section 100A

This clause introduces a ministerial power to make guidelines in relation to responses made under section 57 (4) (b) and section 74 of the Act. The purpose of this provision is to enable the Attorney‑General to issue guidelines to assist in the preparation of government responses to coronial findings and to prescribe the kind of information which must be included in these responses.

### Clause 35 Annual report of court

###  Section 102 (2) (a)

This is a consequential amendment that ensures the same powers, obligations and investigative requirements apply to a ‘death in care’ as a ‘death in custody.’

### Clause 36 Dictionary, new definition of *death in care*

This is a consequential amendment that ensures the same powers, obligations and investigative requirements apply to a ‘death in care’ as a ‘death in custody.’

### Clause 37 Dictionary, definition of *member of the immediate family*, except note

This clause amends the definition of *member of immediate family* within the dictionary to include a step-parent. This inclusion removes any ambiguity about whether a step-parent can engage in an inquest into the death of a step-child.

1. See, for example, United Nations Human Rights Committee, *General comment No. 36 (2018) on article 6 of the International Covenant on Civil and Political Rights*, *on the right to life*, CCPR/C/GC/36 (30 October 2018) *McCann v United Kingdom* (1996) 21 EHRR 97, [3], [188]; *R (Middleton) v West Somerset Coroner* [2004] 2 AC 182; *R (Amin) v Secretary of State for the Home Department* [2004] 1 AC, 653, [19] to [20]; *Osman v United* *Kingdom* (1998) 29 EHHR 245, [115]. See, also, Concluding Observations of the Human Rights Committee, 9 November 1995, Hong Kong, para 11; Concluding Observations of the Human Rights Committee, 9 August 2005, Syrian Arab Republic, para 9; Concluding Observations of the Human Rights Committee, 1 December 2005, Brazil, para 13; the United Nations Basic Principles of the Use of Force and Firearms by Law Enforcement Officials (UN Force and Firearms Principles); and the United Nations Principles on the Effective Prevention and Investigation of Extra-Legal Executions. [↑](#footnote-ref-2)