COMMUNITY
LEGAL CENTRES
TASMANIA

11 September 2024

Members of the Legislative Council
Parliament House
Hobart TAS 7000

To all members of the Legislative Council,
Re: *Justice and Related Legislation (Miscellaneous Amendments) Bill 2024*

The *Justice and Related Legislation (Miscellaneous Amendments) Bill 2024* is likely to be debated in the coming week/s. Whilst the Bill makes amendments to a number of Acts including the *Criminal Code Act 1924* (Tas), the *Legal Profession Act 2007* (Tas) and the *Police Offences Act 1935* (Tas) we are concerned about the practical consequences that will arise with the proposed amendment to the *Coroners Act 1995* (Tas):

> ***24. Jurisdiction of coroner to hold inquest into a death***
> *(1) Subject to section 25, a coroner who has jurisdiction to investigate a death must hold an inquest if the body is in Tasmania or it appears to the coroner that the death, or the cause of death, occurred in Tasmania or that the deceased ordinarily resided in Tasmania at the time of death and –*
> ...
> *(eb) the coroner suspects that family violence has materially contributed to the death of the deceased; or*
> ...

Review of other Australian Jurisdictions

There is no jurisdiction in Australia that requires the Coroners Court to hold an inquest into a death where family violence materially contributed to the death. Most other jurisdictions have however introduced a Death Review Team, most commonly within the Coroners Court but also established within Government departments or the Ombudsman's Office.

- ***Victoria***

In Victoria, a Systemic Review of Family Violence Deaths unit was established in 2009.[1] The VSRFVD is located within the Coroners Court of Victoria and has five legislative functions:[2]

· to examine deaths suspected to have resulted from family violence;

[1] Coroners Court of Victoria, *Systemic Review of Family Violence Deaths – First Report* (Melbourne: November 2012) at 4.
[2] Section 102W of the *Coroners Act 2008* (Vic).

· to identify risks and contributory factors associated with deaths resulting from family violence;
· to identify trends and patterns in deaths resulting from family violence;
· to identify trends and patterns in responses to family violence;
· to provide coroners with information obtained through the exercise of the VSRFVD's functions described in paragraphs (a), (b), (c) and (d).

The VSRFVD consists of seven staff from across the court, including a manager, senior solicitor, case investigators, family liaison officer, registrar and a project officer.[3]

- ***New South Wales***

The Domestic Violence Death Review Team was established in 2010 under the *Coroners Act 2009* (NSW) to review deaths occurring in the context of domestic violence in New South Wales.[4] The Domestic Violence Death Review Team has the following functions:[5]

· To review closed cases of domestic violence deaths occurring in New South Wales;
· To analyse data to identify patterns and trends relating to such deaths;
· To make recommendations as to legislation, policies, practices and services for implementation by government and non-government agencies and the community to prevent or reduce the likelihood of such deaths;
· To establish and maintain a database (in accordance with the regulations) about such deaths; and
· To undertake, alone or with others, research that aims to help prevent or reduce the likelihood of such deaths.

The DVDRT is staffed permanently by an Executive constituting a Manager and a Research Analyst.[6]

- ***Queensland***

In 2011 the Queensland Government established the Domestic and Family Violence Death Review Unit. The unit does not have an explicit statutory mandate (as occurs in Victoria and NSW), instead being established under the power of the Coroner as per the *Coroners Act 2003* (Qld). The DFVDRU provides specialist advice and assistance to coroners in their investigations of domestic and family violence related homicides and suicides and the deaths of children who were known to the child protection system. In October 2015, the Queensland Government established the Domestic and Family Violence Death Review and Advisory Board.[7] With the creation of the Board, Queensland has a two tiered domestic and family violence death review process.

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[3] Coroners Court of Victoria, *Annual Report 2022-23* (September 2023) at 28. Also see Chris Vedelago, 'Delays to key findings on fatal family violence', *The Age*, Monday 1 July 2024 at 3.
[4] *Coroners Amendment (Domestic Violence Death Review Team) Act 2010 (NSW).*
[5] Chapter 9A of the Coroners Act 2009 (NSW).
[6] Coroners Court of NSW, 'Domestic violence death review'. As found at https://coroners.nsw.gov.au/resources/domestic-violence-death-review.html (accessed 10 September 2024).
[7] Part 4A of the *Coroners Act 2003* (Qld).

Tier 1

The Domestic and Family Violence Death Review Unit assists Coroners in their investigations of domestic and family violence-related deaths and those child deaths where there has been prior contact with the child protection system.

Tier 2

The Domestic and Family Violence Death Review and Advisory Board has the following functions under the *Coroners Act 2003*:

- reviewing domestic and family violence deaths in Queensland
- analysing data and applying research to identify patterns, trends and risk factors relating to domestic and family violence deaths in Queensland
- conducting or commissioning research to prevent or reduce the likelihood of domestic and family violence deaths
- writing systemic reports into domestic and family violence deaths, identifying key learnings and elements of good practice in the prevention and reduction in the likelihood of domestic and family violence deaths in Queensland
- making recommendations to the Minister about improving legislation, policies, practices, services, training, resources and communication to prevent or reduce the likelihood of domestic and family violence deaths in Queensland
- monitoring the implementation of the Board's recommendations.

In 2022-23, the Queensland Government allocated funding of $4.5M to "enhance and address domestic and family violence reviews and to maintain and expand Queensland's domestic and family violence homicide and suicide data set.[8] The funding is being used to employ eight staff and a temporary coroner to assist with domestic and family violence death reviews and three staff to improve the homicide and suicide data set.

- ***South Australia***

In 2011, the South Australian Government established a Senior Research Officer (Domestic Violence) position to support the Coroner's office on domestic violence cases, to collect data relevant to domestic violence deaths and conduct research projects to identify trends, gaps and areas for improvement.[9] The senior research officer position is based within the Coroner's office and works in partnership with the Office for Women.

- ***Western Australia***

Since 2012, Western Australia has required the Ombudsman to undertake regular Family and Domestic Violence Fatality Reviews.[10] The core functions of the Family and Domestic Violence Fatality Review process are:

· To review the circumstances in which family and domestic violence fatalities occur;

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[8] Coroners Court of Queensland, *CCQ 2022-23 Annual Report* at 17. As found at https://www.coronerscourt.qld.gov.au/__data/assets/pdf_file/0012/798528/coroners-court-of-queensland-annual-report-2022-23.pdf (accessed 10 September 2024).

[9] Government of South Australia, Coroner's research position. As found at https://officeforwomen.sa.gov.au/womens-policy/womens-safety/coroners-research-position (accessed 10 September 2024).

[10] Ombudsman WA, *Annual Report 2022-23 – Family and Domestic Violence Fatality Review*. As found at https://www.ombudsman.wa.gov.au/Publications/AR2223/Family-Domestic-Violence-Fatality-Review-Annual-Report-2022-23.pdf (accessed 10 September 2024).

· To identify patterns and trends that arise from reviews of family and domestic violence fatalities; and
· To make recommendations to public authorities about ways to prevent or reduce family and domestic violence fatalities.

- ***Australian Capital Territory***

The ACT's Domestic and Family Violence Review (DFVR) was established in 2021 with the appointment of a Domestic and Family Violence Review Coordinator. The Coordinator undertakes research of domestic and family violence incidents, identifies preventative measures, seeks to increase understanding of domestic and family violence contexts, impact and circumstances and make recommendations. In 2023, the first biennial report of the ACT Domestic and Family Violence Review was released.[11]

Australian jurisdictions summary

The brief review of death review mechanisms demonstrates that the majority of Australian jurisdictions have processes in place to assist the Coroner with investigations and review family violence homicides. In Victoria and NSW, the *Coroners Act* explicitly recognises the Death Review Team within the Coroners Court infrastructure. In Queensland, there are staff located within the Coroner's Office as well as a Board who provide recommendations to the relevant Minister. In South Australia, there is a senior research officer working in the Coroner's Office whilst in the ACT the biennial review is carried out by the ACT Domestic, Family and Sexual Violence Office. In Western Australia, the Ombudsman's Office reviews family violence. Relevantly, no Australian jurisdiction requires the Coroner to undertake an inquest where "family violence has materially contributed to the death of the deceased".

Jari Wise

After the *Justice and Related Legislation (Miscellaneous Amendments) Bill 2024* was passed by Parliament in December 2023, Tasmania's Coroner's Court handed down its decision in Jari Elliot Ernest Wise.[12] In that decision, Coroner Cooper made the following observations:

> *It is worth noting that a coroner in Tasmania is an independent judicial officer. She or he has jurisdiction to investigate any death which appears to have been unexpected or unnatural. Obviously, the circumstances of Mr Wise's death meets this test. When investigating a death, a coroner performs a role very different to other judicial officers. The coroner's role is inquisitorial. She or he is required to look at the circumstances surrounding a death and answer the questions (if possible) that section 28(1) of the Act asks. These questions include who the deceased was, how he or she died, the cause of the person's death and where and when the person died. This process requires the making of various findings, but without apportioning legal or moral blame for the death.*

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[11] ACT Domestic and Family Violence Review, *Domestic and Family Violence Homicides 2000 – 2022*. As found at https://www.act.gov.au/open/domestic-and-family-violence-review-biennial-report-2023 (accessed 29 July 2024).

[12] Coroners Court of Tasmania, Jari Elliot Ernest Wise (13 May 2024). As found at https://www.magistratescourt.tas.gov.au/__data/assets/pdf_file/0003/759117/Wise-Jari-Finding-SJC-Web-Version.pdf (accessed 29 July 2024).

In excess of 900 deaths are reported to coroners in this state every year. Routinely, coroners make decisions about whether or not to hold an inquest. They do that by having regard to any submissions from interested parties and by independently applying the law.

In exercising the power, the Attorney General was obviously motivated by the strident advocacy of the Senior Next of Kin, Ms Tkalac who embarked upon a campaign to change the Act so that coroners must hold inquests into every death where a coroner suspects that family violence contributed.

Early estimates indicate that Tasmanian coroners will, as a result of the amendment, be required to hold at least double the number of public inquests. The effect of this upon an already strained coronial system will be to significantly delay all inquests, thereby increasing the grief and trauma of many families in our community.

It will also mean that coroners will be required to hold public inquests into many deaths where no additional evidence is to be gained and not appropriate for recommendations to improve the safety of members of the community – such as this case. Further, in many cases, many families would not wish for a public inquest, which will necessarily result in a prolonged process and the ventilation of sensitive information about the deceased and their family members – for no good reason at all.

Coroners in this state are well accustomed by reason of training and experience to determine when matters should or should not be the subject of an inquest. On a not infrequent basis, coroners determine that particular deaths involving family violence issues should be the subject of public inquest.

I urge the appropriate authorities to consider taking steps to reverse this most unfortunate exercise in 'law reform'.

Analysis

Whilst the majority of Australians jurisdictions have specialist family violence staff who assist the Coroner with investigations and an evidence base of family violence including risks, contributory factors and trends as well as recommendations aimed at reducing family violence, it is the Coroner who continues to have discretion about whether a death warrants an inquest.

If the proposed amendment to the *Coroners Act 1995* (Tas) is passed, it is likely to result in an increase in the workload of the Coroners Court. Research has found that just over half of all homicides carried out in Victoria between 2000-2010 involved an intimate partner or other family member, or otherwise occurred in a context of family violence.[13] In New South Wales almost one-third of all homicides occurred in a context of domestic or family violence.[14] Given that there are around 900 reportable deaths in Tasmania each year and in 2022-23 only 25 inquests were held, the amendment is likely to result in an

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[13] Coroners Court of Victoria, *Victorian Systemic Review of Family Violence Deaths* (November 2012) at 4. As found at https://www.coronerscourt.vic.gov.au/sites/default/files/2018-11/vsrfvd%2Bfirst%2Breport%2B-%2Bfinal%2Bversion.pdf (accessed 29 July 2024).

[14] NSW Government, Domestic Violence Death Review Team Annual Report 2021-23 at xix. As found at https://coroners.nsw.gov.au/documents/reports/DVDRT_Annual_Report_2021-23.pdf (accessed 10 September 2024).

increased workload, even with the requirement that family violence must have "materially contributed" to the death of the deceased.[15]

In South Australia, 270 reviews of family and domestic violence cases have resulted in nine coronial inquests being held.[16] We are concerned that requiring family violence inquests to be held may result in work being carried out which provides no new information, no new recommendations to prevent further deaths and where further trauma may be encountered by friends and relatives of the decreased.

In the event that the amendment is passed, it is clear that the Tasmanian Coroner's Court needs a significant increase in resources as was recently highlighted by Coroner Webster in the Coroner's Court decision of Mary Kathleen Stuart:[17]

> *Before finalising this finding there is a legitimate concern which has been raised by the senior next of kin Jill McNiece. She has written to my office outlining the fact that she phoned on at least four occasions in the previous two years and has questioned the delay in the provision of the finding in relation to her sister's death. She says in her correspondence that matters associated with her sister's estate cannot be finalised until a coroner's decision has been made. From her point of view there is no reason for the delay and she has been anxious about it and considers that her sister is not "at peace" until the matter is concluded.*
>
> *There are three full-time coroners who are responsible for all reportable deaths in Tasmania. At the time I prepared this decision there were 964 pending cases which is in excess of 320 cases each. In the financial year ended 30 June 2017 reportable deaths numbered 579. In the subsequent six financial years ending on 30 June 2023 that number rose to 895 which is an increase of 54%. Despite that increase in the 2022/2023 financial year 943 matters were finalised. To be able to finalise that number of matters means each coroner is finalising in excess of one investigation each business day. This financial year reportable deaths increased to 1142 which is a 97% increase on the number of reportable deaths in the 2016/2017 financial year. I note in more recent times some additional investigative resources and a family liaison officer have been provided to the coronial office which are very welcome additions however the same number of coroners are ultimately responsible for what seems is an ever increasing work load. In addition there has been a significant turnover of staff within the office, due to the nature and conditions of the work, and delays have been encountered in appointing and training new staff. These issues have inevitably led to delays in finalising matters. In addition, as Coroner Cooper pointed out in Jari Elliott Ernest Wise [2024] TASCD 237, an amendment to the Coroners Act 1995 is likely to significantly increase the number of public inquests and it is likely to require more extensive enquiries to be made by coronial staff. As he said at paragraph 87 of that*

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[15] *Magistrates Court of Tasmania Annual Report 2022-23*. As found at https://www.magistratescourt.tas.gov.au/__data/assets/pdf_file/0008/760436/FINAL-Magistrates-Court-Annual-Report-2022-2023.pdf (accessed 29 July 2024).

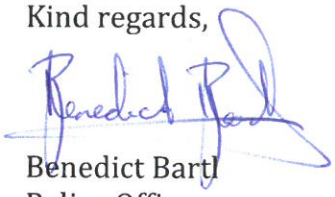
[16] Government of South Australia, Coroner's research position. As found at https://officeforwomen.sa.gov.au/womens-policy/womens-safety/coroners-research-position (accessed 10 September 2024).

[17] Coroners Court of Tasmania, Mary Kathleen Stuart (31 July 2024). As found at https://www.magistratescourt.tas.gov.au/__data/assets/pdf_file/0005/778046/Stuart,-Mary-Kathleen-RBW-WEB.pdf (accessed 29 July 2024).

decision "[t]he effect of this upon an already strained coronial system will be to significantly delay all inquests, thereby increasing the grief and trauma of many families in our community." Not only will this reform delay all inquests it will delay the finalisation of matters such as this one. This situation and the difficulties which people like Mrs McNiece find themselves in can only be remedied by the provision of more resources.

If you have any queries, please do not hesitate to contact us.

Kind regards,



Benedict Bartl
Policy Officer
Community Legal Centres Tasmania