AUSTRALIAN CORONIAL LITIGATION: AN EMPIRICAL PROFILE

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In the wake of a reportable death, persons who dispute coronial decisions or findings may face the daunting and costly prospect of superior court review. Little is known about the characteristics of coronial litigation, despite its significance to parties, coronial systems and the community. This article presents an empirical profile of Australian coronial litigation, investigating the parties, claims, death circumstances, case durations and outcomes in decided cases (1993–2022). Case numbers and applicant self-representation have increased, while applicant success rates have dwindled. Case profiles also vary according to whether applicants are family members of the deceased. The study has important implications for efforts by courts, coronial staff and support services to better meet the needs of parties in these high-stakes proceedings.

I INTRODUCING CORONIAL LITIGATION

Coroners play a vital role as judicial inquisitors in the investigation of more than 21,500 reportable deaths in Australia each year.[1] Reportable deaths include those which are unexpected, unnatural, violent or resulted from an accident or injury; causally related to a medical procedure or medical care; or where the death

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1 This reflects the combined number of cases finalised (or cases lodged in Tasmania) in the available annual reports of Coroners Courts in Australian jurisdictions: see Coroners Court of Victoria, *Annual Report 2022–2023* (Report, September 2023) 1 ('*Vic Annual Report*'); ACT Coroners Court, *Annual Report 2022–23* (Report, 20 December 2023) 5; Magistrates Court of Tasmania, *Annual Report 2022–2023* (Report, 20 November 2023) 16; Office of the State Coroner for Western Australia, *Annual Report 2022–2023* (Report, 30 October 2023) 5; Coroners Court (SA), *2022–23 Annual Report* (Report, 31 October 2023) 9 ('*SA Annual Report*'); Coroners Court of Queensland, *2022–23 Annual Report* (Report, 22 November 2023) 7; 'Coroners Court Overview', *Coroners Court of New South Wales* (Web Page, 11 May 2023) <https://web.archive.org/web/20241016065238/https://coroners.nsw.gov.au/how-the-coroners-court-work/coroners-court-overview.html>.

occurred in care or police custody.[2] Coroners may make a range of directions and decisions during the course of an investigation in addition to their ultimate factual findings regarding a death. These decisions and findings range from the reportability of a death to the holding of an inquest and establishing the cause of a death.[3] Individuals and entities with a connection to a death may dispute and seek to challenge the coroner's decisions or findings. We use the term 'coronial litigation' to describe these disputes when they progress to judicial review applications and appeals in court.[4]

Coronial litigation is distinct from other kinds of litigation in important ways. The coronial jurisdiction is distinct from Australia's civil and criminal jurisdictions, by virtue of its inquisitorial rather than adversarial nature. In the setting of coronial litigation, the role of the coroner whose decision or finding is being challenged is typically confined to making submissions setting out the material which was before the coroner and which might be relevant to the appeal. However they do not make submissions as to the merits of the appeal, nor are they active participants in proceedings, unlike a more active defendant in other kinds of litigation.[5] The legal framework for coronial litigation – and Australian coronial law – is principally shaped by individual and discrete Coroners Acts, enacted in each state and territory.[6] The common law also plays a role in contextualising the discretionary role of the coroner,[7] who is tasked with investigating causes and circumstances of deaths.[8] Each of the Coroners Acts in Australia sets out the grounds for appeal upon which coronial litigation may be commenced and by whom.[9] In some circumstances, it may be possible or even required for review to be sought first by application to the

2 *Coroners Act 1997* (ACT) s 13 ('*ACT Coroners Act*'); *Coroners Act 2009* (NSW) ss 6, 23 ('*NSW Coroners Act*'); *Coroners Act 1993* (NT) s 12(1) (definition of 'reportable death') ('*NT Coroners Act*'); *Coroners Act 2003* (Qld) s 8 ('*Qld Coroners Act*'); *Coroners Act 2003* (SA) s 3(1) (definition of 'reportable death') ('*SA Coroners Act*'); *Coroners Act 1995* (Tas) s 3 (definition of 'reportable death') ('*Tas Coroners Act*'); *Coroners Act 2008* (Vic) s 4 ('*Vic Coroners Act*'); *Coroners Act 1996* (WA) s 3 (definition of 'reportable death') ('*WA Coroners Act*').

3 The types of findings that coroners can make are prescribed in the legislation: see, eg, *Vic Coroners Act* (n 2) s 67.

4 These cases are 'disputes' in the sense that applicants actively object to or disagree with some aspect of the coronial decision or finding.

5 Coroners as decision-makers in the context of judicial review adopt a *Hardiman* position: see *R v Australian Broadcasting Tribunal*; *Ex parte Hardiman* (1980) 144 CLR 13, 35–6 (Gibbs, Stephen, Mason, Aickin and Wilson JJ) ('*Hardiman*'). The *Hardiman* principle will be further discussed in Part V(C)(2).

6 *ACT Coroners Act* (n 2); *NSW Coroners Act* (n 2); *NT Coroners Act* (n 2); *Qld Coroners Act* (n 2); *SA Coroners Act* (n 2); *Tas Coroners Act* (n 2); *Vic Coroners Act* (n 2); *WA Coroners Act* (n 2).

7 There are expanded common law review pathways beyond the statutory appeal grounds in that there are also common law obligations on coroners which may be challenged via judicial review in appellate courts: see, eg, *Annetts v McCann* (1990) 170 CLR 596 ('*Annetts*'); *Hecht v Coroners Court of Victoria* [2016] VSC 635; *Somerville v Coroners Court of Victoria* [2016] VSC 543 ('*Somerville*'); *Mortimer v West (in his capacity as Deputy State Coroner)* (2018) 56 VR 608.

8 See Ian Freckelton, 'Editorial: Procedural Fairness and the Coroner' (2018) 26(1) *Journal of Law and Medicine* 7, 7–8.

9 See, eg, *Vic Coroners Act* (n 2) s 87(1A), which provides that an appeal to the Supreme Court on a question of law includes an appeal on the grounds that the finding which is appealed is against the evidence and the weight of evidence is such that no reasonable coroner could have made that finding.

coroner.[10] In others, a party with sufficient interest or standing can move directly to a superior court to appeal the coroner's decision.[11] An interested party may alternatively make an application for judicial review under the relevant Supreme Court Rules and these grounds broadly include claims of jurisdictional error, error of law or denial of procedural fairness.[12] In summary, coronial litigation typically takes the form of appeals or judicial review in state and territory Supreme Courts, with the exception of Queensland, where cases are brought in the District Court.[13]

While each of the Coroners Acts operate independently, when viewed together, the Acts represent a patchwork of different rights and dispute pathways. Despite similarities of some appeal grounds and rights across jurisdictions, the landscape reflects the sheer variety and complexity of coroners' work, with decisions ranging from who is the senior next of kin[14] and whether a body may be exhumed[15] to whether an investigation should be reopened.[16] The differences also reflect the diversity of legal arrangements in a federation. Appendix A captures this, setting out the superior court appeal rights for each Australian jurisdiction under the relevant Coroners Acts. Recent inquiries in Victoria and New South Wales ('NSW') have reviewed the bases on which coronial decisions and findings can be appealed, and particularly the challenges family members may experience in these cases.[17] This attention has led to recommendations for changes to law and practice, including clarifying the grounds of appeal.[18] In Victoria, significant changes to the *Coroners Act 2008* (Vic) ('*Vic Coroners Act*') have sought to make it easier for families to seek review in both the Coroners Court and the Supreme Court. These changes will be discussed further in Part V below.

The value of coronial litigation includes promoting fairness, equity and access to justice, by allowing interested parties to challenge a coronial decision affecting them. As noted above, the common law complements the statutory grounds of appeal. Cases such as *Annetts v McCann* have emphasised the significance of

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10 See, eg, *Tas Coroners Act* (n 2) ss 58(2), (7), regarding the reopening of investigations.

11 See, eg, *Vic Coroners Act* (n 2) s 83.

12 For example, an interested party can apply for judicial review under the *Supreme Court (General Civil Procedure) Rules 2015* (Vic) ord 56 ('*Vic Civil Procedure Rules*') about coronial exercise of jurisdiction, which is outside of the specific grounds of appeal under the *Vic Coroners Act* (n 2).

13 See *Qld Coroners Act* (n 2) s 50.

14 See, eg, *Vic Coroners Act* (n 2) s 3(3).

15 See, eg, *WA Coroners Act* (n 2) s 38(1).

16 See, eg, *NT Coroners Act* (n 2) s 44A(2).

17 See Coronial Council of Victoria, *Coronial Council Appeals Review* (Reference Report No 4, November 2017) 4 ('*Council Appeals Review*'); Coronial Council of Victoria, *Review into Improving the Experience of Bereaved Families with the Coronial Process* (Final Report, March 2022) 21–5 ('*Improving Experiences of BFMs*'); Select Committee on the Coronial Jurisdiction in New South Wales, Parliament of New South Wales, *Coronial Jurisdiction in New South Wales* (Report No 1, April 2022) 99–100 [4.116]–[4.120] ('*Coronial Jurisdiction in NSW*'); NSW Department of Communities and Justice, *Report on the Statutory Review of the Coroners Act 2009* (Report, December 2023) 59–62 ('*NSW DCJ Statutory Review Report*').

18 See, eg, *Council Appeals Review* (n 17) 72–5. Other examples from the Victorian reviews include establishing mechanisms to collect and analyse court performance data and undertaking periodic client feedback surveys: at 85. Other examples from the NSW reviews include the issuing of warrants for the exhumation of the deceased person's body or remains: *NSW DCJ Statutory Review Report* (n 17) 63.

natural justice principles.[19] For parties affected by a coroner's decisions or findings, coronial litigation can provide an important opportunity for participation and 'being heard'.[20] 'Being heard' is a demonstrated need that stakeholders have in the coronial processes[21] and the 'day in court' that coronial litigation can provide is significant. As a review mechanism, coronial litigation also supports accurate and high-quality coronial information and decisions and helps to reinforce the prevention purpose of the Coroners Court.[22] At the same time, however, coronial litigation gives rise to the persistent challenge common to civil justice systems: balancing costs and delay with achieving accurate outcomes.[23] It cannot be a mechanism for ventilating generalised dissatisfaction with coronial processes or findings, nor 'resolve the inevitable limitations of the coronial process to provide outcomes that satisfy families deeply affected by a death in tragic circumstances'.[24] Further, the proper administration of justice must 'take into account the fair treatment of third parties engaging in coronial processes'.[25]

Despite the important functions of coronial litigation, there is little empirical evidence about trends in the nature, prevalence and outcomes of these cases. Coronial litigation also represents a poorly understood aspect of the work of families in 'constructing a "last chapter" for the person who died'.[26] This data deficit[27] is an impediment for efforts to improve the availability and management of coronial litigation as there is no baseline for evaluating the impact of reforms. To address this dearth of data and shed light on the coronial litigation landscape, this article presents a quantitative analysis of judgments in Australian coronial litigation in the period 1993–2022. The study sought to determine the characteristics of claims, deaths, parties and outcomes in coronial litigation. In view of the recent law reform, policy and research focus on the experiences of family members in coronial processes, we also specifically explored cases brought by bereaved family members ('BFM').[28] The study identifies a number of important features of the coronial litigation landscape. Coronial litigation often requires parties to be exposed to legal processes for protracted periods of time. There has been a marked

19 *Annetts* (n 7).

20 See Stephanie Dartnall, Jane Goodman-Delahunty and Judith Gullifer, 'An Opportunity to Be Heard: Family Experiences of Coronial Investigations into Missing People and Views on Best Practice' (2019) 10 *Frontiers in Psychology* 2322:1–17, 5 <https://doi.org/10.3389/fpsyg.2019.02322>.

21 See, eg, Belinda Carpenter, Gordon Tait and Carol Quadrelli, 'The Body in Grief: Death Investigations, Objections to Autopsy, and the Religious and Cultural "Other"' (2014) 5(1) *Religions* 165 <https://doi.org/10.3390/rel5010165>.

22 *Council Appeals Review* (n 17) 57 [6.10].

23 See Rabeea Assy, 'Taking Seriously Affordability, Expedition, and Integrity in Adjudication' in Rabeea Assy and Andrew Higgins (eds), *Principles, Procedure, and Justice: Essays in Honour of Adrian Zuckerman* (Oxford University Press, 2020) 179, 179–80 <https://doi.org/10.1093/oso/9780198850410.003.0009>.

24 *Council Appeals Review* (n 17) 67 [6.50].

25 Ibid 72 [6.72].

26 Law Reform Committee, Parliament of Victoria, *Coroners Act 1985* (Final Report No 229, September 2006) 424.

27 See generally *Coronial Appeals Review* (n 17) 88.

28 We elect to use the term 'bereaved' on the basis that in every judgment in this study involving a family member applicant, the judgment indicated that they are aggrieved by the death.

increase in the number of appeals over time, with much of this growth attributable to case numbers in Victoria. We also show that BFM applicants are more likely than others to be unrepresented and that applicants who are represented are more likely to achieve a successful outcome. These and other findings raise important questions about the justice being meted out in coronial litigation, and whether there are opportunities to do better in resolving these disputes.

Part II of this article provides a synthesis of the existing literature and limited evidence regarding disputes in the coronial context. Part III sets out the research design and Part IV presents the study findings. Part V of this article discusses key findings, providing deeper analysis of case numbers over time; case durations; the case types and legal representation issues for BFMs; and potential avenues for resolution. Part VI sets out the implications of the study for the conduct and management of coronial litigation, with a particular focus on measures that courts could use to bring about earlier and more satisfying resolution of these cases. We also canvass the strengths and limitations of the study.

II DISPUTES IN THE CORONIAL SETTING: EVIDENCE REVIEW

One of the distinct strengths of the coronial jurisdiction is its emphasis on promoting public health and safety and the administration of justice.[29] These principles are furthered by the practice of publishing coronial findings, recommendations and research data.[30] In Victoria, this quality is reinforced by the Victorian Coroners Court's coverage by the *Open Courts Act 2013* (Vic), which 'recognise[s] and promote[s] the principle that open justice is a fundamental aspect of the Victorian legal system'.[31] There is a general acceptance by Australian courts of substantive open justice rules.[32] As such, the Australian coronial jurisdiction has reinforced and demonstrated intentions for transparency.

Against the backdrop of this commitment to transparency, there is scarce publicly available evidence about the characteristics of complaints, disputes and litigation in relation to coroners' decisions and findings. The annual reports of Australian Coroners Courts almost never convey the numbers of complaints

29 See *Vic Coroners Act* (n 2) Preamble.

30 The Australian Coronial Law Library hosted by the Australian Legal Information Institute ('AustLII') advances these objectives by providing digital access to coronial findings, case law and other legal materials: 'Australian Coronial Law Library', *AustLII* (Web Page) <https://www.austlii.edu.au/au/special/coronial/>. Additionally, the National Coronial Information System is an online repository of coronial data from Australia and New Zealand: *National Coronial Information System* (Web Page, 6 December 2024) <https://www.ncis.org.au>.

31 *Open Courts Act 2013* (Vic) s 1(aa). The Act also addresses reform and consolidation of provisions for suppression orders relating to information derived from proceedings applicable to all Victorian courts including the Coroners Court: at s 1(a).

32 JJ Spigelman, 'The Principle of Open Justice: A Comparative Perspective' (2006) 29(2) *University of New South Wales Law Journal* 147, 153.

and disputes the courts handle.[33] Published coronial findings following coronial investigations or inquests sometimes indicate that a family member or other interested party has made a complaint to a coroner, or that a request for inquest has been refused. This insight provides only a very partial view, and there are other kinds of objections, complaints or disputes that are not mentioned in the findings. Periodical reports and investigations occasionally result in more information about disputes being made available,[34] but this is also not regular or systematic.

In recent years there has been a considerable policy focus on the experiences of family members of deceased persons and other stakeholders in the broader coronial system. The research evidence base has identified a range of challenging experiences stakeholders have – including in relation to participation,[35] delays,[36] access to information,[37] power imbalances[38] and compounding of trauma and grief through the legal process.[39] This research and policy attention has most frequently been confined to the processes associated with death investigations and inquests. There has been very little attention to the experience, nature or empirical profile of coronial litigation. Where coronial litigation has been studied, the focus is typically confined to doctrinal analyses of the cases.[40]

The main exception is the Coronial Council of Victoria's 2017 *Coronial Council Appeals Review* ('*Council Appeals Review*').[41] This inquiry identified the chief functions of coronial litigation as promoting access to justice and facilitating high quality coronial decisions and data.[42] It also presented evidence of the substantial costs of coronial litigation, including the significant time and resource implications for workload-burdened courts; financial implications for families and other stakeholders; emotional impacts on affected people; the risk

33 One exception is the brief and generically worded summaries of complaints in *SA Annual Report* (n 1) 29–30.

34 The Coroners Court of Victoria includes a small amount of reporting on appeals to the Supreme Court in a recent annual report: *Vic Annual Report* (n 1) 44. See also a discussion relating to a rise in objections to autopsy in the early 2000s: Ian Freckelton and David Ranson, *Death Investigation and the Coroner's Inquest* (Oxford University Press, 2006) 376.

35 See Phil Scraton and Gillian McNaull, Irish Council for Civil Liberties, *Death Investigation, Coroners' Inquests and the Rights of the Bereaved* (Research Report, April 2021) 7.

36 See Dominic Aitken, 'Investigating Prison Suicides: The Politics of Independent Oversight' (2022) 24(3) *Punishment and Society* 477, 488 <https://doi.org/10.1177/1462474521993002>.

37 See Mark Ngo et al, 'Information Needs of Bereaved Families following Fatal Work Incidents' (2020) 44(8) *Death Studies* 478, 479 <https://doi.org/10.1080/07481187.2019.1586792>.

38 See Katy Snell and Steve Tombs, '"How Do You Get Your Voice Heard when No-One Will Let You?" Victimization at Work' (2011) 11(3) *Criminology and Criminal Justice* 207, 215–7 <https://doi.org/10.1177/1748895811401985>.

39 See Belinda Carpenter, Gordon Tait and Steph Jowett, 'Managing Families' Expectations in the Coronial Jurisdiction: Barriers to Enacting an Ethic of Care' (2022) 29(4) *Journal of Law and Medicine* 1040, 1041; Ian Freckelton 'Minimising the Counter-therapeutic Effects of Coronial Investigations: In Search of Balance' (2016) 16(3) *QUT Law Review* 4, 5 <https://doi.org/10.5204/qutlr.v16i3.696> ('Counter-therapeutic Effects of Coronial Investigations').

40 See Alon Januszewicz, 'Appeal of Coroner's Decision Not to Hold an Inquest Dismissed in "*Trotta v The Coroners Court of Victoria and Anor*"' (2022) 30(3) *Australian Health Law Bulletin* 55; Freckelton and Ranson (n 34) 376–82, 680–710.

41 *Council Appeals Review* (n 17).

42 Ibid 57 [6.10].

of undermining confidence in the original proceeding; and delay affecting the implementation of recommendations designed to protect the community.[43] Notably, the *Council Appeals Review* made apparent that the Coronial Council itself had difficulty establishing the number and identity of cases appealed to the Supreme Court in Victoria[44] and in other jurisdictions.[45] In a rare insight into applications made directly to coroners, the *Council Appeals Review* reported that from 2012 to 2017 there were 39 applications for review to Victorian coroners and that 29 of these (74%) were refused.[46] It is not known whether or how many of these refused applicants went on to appeal in the Supreme Court.

Mapping the landscape of Australian coronial litigation advances our understanding of the features of the cases, including who is bringing the appeals, what the cases are about, the outcomes being achieved and whether there is inter-jurisdictional variation. Against the backdrop of the considerable costs associated with court proceedings and access to justice concerns, it also enables us to understand the duration of the cases and the extent to which the cases involve self-represented applicants. Given the research establishing the challenging nature of coronial processes and the continued policy and law reform attention to these issues,[47] an improved evidence base on coronial litigation will also be valuable for informing consideration of changes to policy, law and practice in this area. The next part of this article introduces the research design we used to explore coronial litigation.

III RESEARCH DESIGN

A Study Sample: Coronial Appeal or Review Proceedings 1993–2022

Study data were drawn from judgments across all Australian states and territories, where the respondent in the proceeding was a coroner or a Coroners Court itself, in the years 1993–2022. The 1993 starting year was proximate to the earliest Australasian Legal Information Institute ('AustLII') data across all jurisdictions.[48] To locate relevant judgments, the keyword 'coroner' was searched within the AustLII Supreme Court case law databases for each state and territory as well as the District Court of Queensland database. The identified cases were then reviewed to ensure they involved a coroner or a Coroners Court as a respondent.[49]

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43 Ibid 57 [6.11].

44 Ibid 14 [1.15]. The *Council Appeals Review* (n 17) provides an incomplete list of cases appealed to the Supreme Court in the timeframes of 1991–2002 (at 92–3 app G), and 2011–17 (at 91 app F). This was determined by cross-checking all cases with those in this study (gleaned from AustLII) which demonstrated that some cases appearing on AustLII were not referred to in either of the lists in the respective appendices.

45 *Council Appeals Review* (n 17) 14 [1.15].

46 Ibid 88.

47 See, eg, *NSW DCJ Statutory Review Report* (n 17); *Coronial Jurisdiction in NSW* (n 17); Department of Justice (WA), *Statutory Review of the Coroners Act 1996 (WA)* (Final Report, July 2021).

48 Supreme Court of Queensland judgments available on AustLII commence from 1994.

49 A small number of cases were excluded for being outside the scope of the research, namely those that related to a fire without a death; involved a coroner other than as a respondent (eg as amicus curiae); applications for sperm retrieval; and costs disputes.

The final sample comprised 169 judgments. The corresponding coronial findings (where available) were also collected and used as a supplementary source of data in cases where information such as date and circumstances of death were not set out in the judgment.

B Study Variables and Coding

We systematically collected data from the judgments on variables of interest.[50] We began by creating a tentative set of variables relevant to the study. Categories of claim types, death circumstances and party type were initially derived based on close analysis of the judgments and condensed into the categories presented in Table 1 below. We coded cases by their main claim type, being the focus of the applicant in terms of the coronial decision they were disputing. The study was focussed on the substance of the appeal rather than the formal grounds for appeal or judicial review, and as such, claim types were categorised by the specific essence of their appeal, rather than according to which provision of the relevant Coroners Act it fell under or whether it was an application for judicial review provided by the Supreme Court Civil Procedure Rules in the relevant jurisdiction.[51] Similarly, commonalities between death circumstances allowed us to generate meaningful categories. For example, deaths in 'medical and aged care' settings represented an array of locations and circumstances in which inpatients, outpatients, aged care residents, psychiatric patients or maternity patients died. A similar process was undertaken for applicant party types, whereby detailed coding of specific characterisations of the applicant took place (with attention to factors including the applicant's familial relationship with the deceased). These were synthesised into categories capturing the applicant's status as a BFM or other party type. Coronial decisions or findings which are the subject of the applicant's claim are referred to as 'coronial events'. A draft coding guide was created and tested through pilot coding of 10 judgments. The variables and guide were refined and finalised and data were then collected from the entire sample. The key variables are presented in Table 1 below.

50 See generally Mark A Hall and Ronald F Wright, 'Systematic Content Analysis of Judicial Opinions' (2008) 96(1) *California Law Review* 63.

51 For example, a challenge regarding reportability status was categorised as 'inquest, autopsy or reportability' for the purposes of this study. However, the grounds upon which the appeal was brought may have been related to defective exercise of powers or jurisdictional error via an application for judicial review under order 56 of the *Vic Civil Procedure Rules* (n 12).

Table 1: Study Variables

Variable	Coding Details
Case jurisdiction	State or territory
Case year	Year of judgment
Date of coronial event	Date of litigated finding or decision
Time between death and coronial event	Time in months
Time between death and judgment	Time in months
Time between coronial event and judgment	Time in months
Main claim type	Challenging findings; inquest, autopsy or reportability decision; body burial or release; administrative matters; limiting evidence or potential penalty; coroner role or jurisdiction; procedural fairness.
Circumstances of death	Home; workplace; missing person; police or custody; road trauma, medical or aged care; self-inflicted; criminal element; disaster; unknown.
Applicant party type	Individual, company, government entity
Applicant gender	Male, female or not specified
Applicant a bereaved family member	Yes or no
Applicant legally represented	Yes or no
Case outcome	Appeal dismissed or successful

C Data Analysis

Study data were analysed using STATA SE (Version 17). Our analyses mostly involved calculating counts and proportions. We used chi-squared tests as appropriate to test for significant differences between variables of interest, with significance set at 0.05. We also calculated odds ratios to explore 'the ratio of the odds of the outcome event in the exposed group compared to the odds in the unexposed group'.[52] In the report of the findings that follows, we refer to 'case' as the unit of analysis. Where we refer to the characteristics of the applicant, we are referring to the first-named applicant in a case.

52 Betty R Kirkwood and Jonathan AC Sterne, *Essential Medical Statistics* (Blackwell Publishing, 2nd ed, 2003) 159 (emphasis omitted).

IV FINDINGS

A Key Case Characteristics

Our review identified 169 coronial litigation cases in the period 1993–2022. The key characteristics of the cases are presented in Table 2 below. The cases involve deaths occurring between 1968 and 2002. The greatest share of cases (45%) are from the most recent of the three decades (2013–22), with the number of cases increasing over each decade of the study timeframe. In fact, nearly a third of cases were from the final four years of the study timeframe in 2018–22 (n=54, 32%). Victoria was the jurisdiction with the highest proportion of cases (n=61, 36%), followed by NSW (n=27, 16%) and Western Australia (n=24, 14%). The number of cases in Victoria grew in each decade studied, from 15 in 1993–2002, to 19 in 2003–12, and 27 in 2013–22.

Table 2: Characteristics of Australian Coronial Litigation, 1993–2022 (n=169)

Characteristic	n (%)
Judgment year (range 1993–2022)	
1993–2002	37 (22%)
2003–12	56 (33%)
2013–22	76 (45%)
Death year (range 1968–2022)	
1968–2002	55 (33%)
2003–12	63 (38%)
2013–22	49 (29%)
Case jurisdiction	
Victoria	61 (36%)
New South Wales	27 (16%)
Western Australia	24 (14%)
Queensland	21 (12%)
South Australia	16 (9%)
Australian Capital Territory	7 (4%)
Northern Territory	7 (4%)
Tasmania	6 (4%)
Applicant type	
Individual	141 (83%)
Government entity	19 (11%)
Company	9 (5%)
Applicant gender (individuals)	
Female	60 (43%)
Male	78 (57%)
Applicant a bereaved family member	
No	68 (41%)
Yes	99 (59%)

Characteristic	**n (%)**
Applicant legally represented	
No	30 (18%)
Yes	139 (82%)
Case outcome	
Dismissed	106 (63%)
Successful	63 (37%)

Due to missing data for some variables and rounding some proportions do not sum to 100%.

More than four out of five first applicants were individuals (n=141, 83%) with government entities or actors (n=19, 11%) and companies (n=9, 5%) making up the remainder. In cases involving a natural person applicant, the applicant was male in 78 cases (57%) and female in 60 cases (43%). In 59% of cases (n=99), the applicant was a BFM, including a deceased's spouse, domestic partner, offspring, sibling, parent, or step-relative. Non-BFM individual applicants included medical staff, aged care service staff or management, alleged murderers, members of the police force, employers, prison or correctional facility staff and representatives of media outlets.

The applicant was legally represented in 82% of cases (n=139) and applicants achieved some degree of successful outcome in 37% of cases (n=63). The case outcomes by year are presented in Figure 1 below, which illustrates a recent upward trajectory in applicants' cases being unsuccessful.

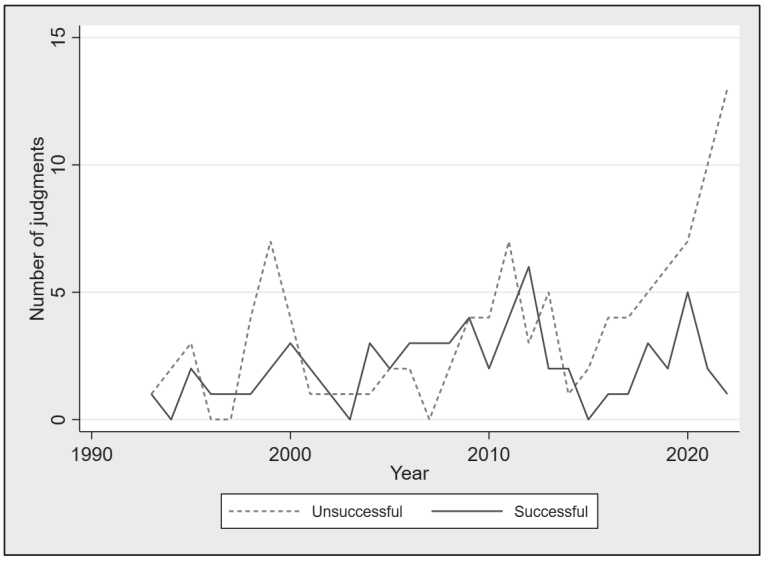

Figure 1: Case outcomes in Australian coronial litigation, 1993–2022

In fact, applicants were unsuccessful in three quarters of the cases decided between 2013 and 2022 (n=57, 75%), compared with 53% of cases in the two decades from 1993–2012. The cases decided in the 10 years to 2022 were 2.7 times more likely to be unsuccessful than the cases in the previous two decades (OR 2.7, 95% CI 1.5–5.2, p=0.003). There were 25 self-represented applicants in the final 10 years of the study sample, compared with only five self-represented applicants in the 20 years before that; only three self-represented applicants were successful in their litigation, one in NSW in 2019 and two in Western Australia (in 2020 and 2021). There were no significant differences in case outcomes or legal representation by jurisdiction.

B Claim Types, Death Circumstances and Case Duration

In Table 3 on the next page we present the prevalence of claim types and death circumstances in the cases. We also present data on the amount of time that elapsed between two key milestones: (a) the death and the coronial decision being challenged; and (b) the coronial decision and the court's judgment. The duration data were highly heterogeneous, as might be expected given the variety of claim types and death circumstances the cases involve. Accordingly, we present the lapse of time between key case events in months, with the mean, median and interquartile range ('IQR') (which is the difference between the first and third quartiles of the data).[53]

The most common claim types involved inquest, autopsy or reportability decisions (n=57, 34%). Some of these cases challenged a coroner's decision about whether a death was reportable, which is relevant to the invocation of coronial jurisdiction. The second most common claim type involved attempts to have findings set aside or for a further investigation to occur (n=42, 25%). These cases included applications to reopen investigations or inquests or to challenge the language of a coronial finding. Cases in this second category on occasion overlapped with cases relating to autopsy, inquest or reportability decisions (for example, where the applicant sought to have an inquest reopened and also for the coroner's findings to be set aside). Cases were categorised according to the claim type which best represented the essence of the claim (that is, they were counted only once).

In 29 cases (17%), the focus of the applicant's case was an evidentiary or procedural challenge that sought to limit evidence or their exposure to potential prosecution or a civil penalty. These cases also dealt with evidentiary matters such as privilege against self-incrimination; client legal privilege; public interest immunity; propensity evidence; public access to evidence; non-publication orders; and excluding evidence. The next most common claim type involved the release or burial of bodies of the deceased (n=19, 11%). These cases were frequently brought by BFMs and often involved claims against another person closely connected to the deceased, as well as the coroner (for example, a parent of the deceased who brought a claim against the coroner as well as the de facto partner of the deceased). Medical and aged care was the most common setting for the deaths in the cases (n=43, 25%), including deaths in hospitals and aged care services, or

53 Ibid 33–5.

that occurred immediately after leaving health services. The second most common death circumstances were in police or custodial settings (n=38, 23%), with road trauma accounting for a further 18 cases (11%).

Table 3: Case Duration, by Claim Type and Circumstances of Death

Case feature	n (%)	Death to judgment (months)			Coronial decision to judgment (months)		
		Mean	Median	IQR	Mean	Median	IQR
Case type							
Inquest, autopsy or reportability	57 (34%)	40	8	63	20	3	24
Challenging findings	42 (25%)	116	77	66	85	33	58
Limiting evidence or potential penalty	29 (17%)	83	37	30	10	5	14
Body burial or release	19 (11%)	2	2	2	2	1	1
Coroner role or jurisdiction	10 (6%)	83	40	25	9	8	12
Procedural fairness	9 (5%)	44	31	17	13	11	10
Administrative matters	3 (2%)	95	7	277	8	6	16
Circumstances of death							
Medical or aged care	43 (25%)	49	35	84	30	10	45
Police or custody	38 (22%)	57	44	25	30	13	23
Road trauma	18 (11%)	45	34	76	28	10	42
At home	15 (9%)	25	1	1	24	0	0
Criminal element	13 (8%)	156	89	275	93	11	63
Unknown	13 (8%)	6	1	3	25	1	4
Self-inflicted	9 (5%)	43	33	65	20	23	26
Disaster	8 (5%)	44	35	56	16	9	32
Missing person	6 (4%)	420	479	106	41	31	18
Workplace	6 (4%)	31	31	21	7	7	8

The data paint a striking picture of the significant amount of time that frequently elapses in coronial litigation. Concentrating on the most common claim types, the data show that a median of 77 months (more than six years) elapsed between the death and the coronial litigation judgment in cases involving a challenge to the coronial findings; for cases involving procedural or evidentiary challenges, the equivalent period was just over three years (37 months). Turning to the period between the challenged coronial decisions and judgment in the litigation, a median time of 33 months elapsed in cases challenging coronial findings; for procedural and evidentiary claims it was much less at five months. In contrast, cases involving disputes about release or burial of the deceased's body had a median duration of two months from the death to the court judgment.

If we consider these data by death circumstances, we see that in the large number of cases involving deaths connected with medical or aged care, the median time between the death and the coronial litigation judgment was nearly three years (35 months); for police or custody deaths and road trauma deaths, the equivalent

median durations were 44 and 34 months respectively. For the medical and aged care, police or custody and road trauma death cases (accounting for 58% of cases), the median time from the challenged coronial decision to the court's judgment was between 10 and 13 months.

Closer inspection of the intersection of claim type and death circumstances revealed some particularly prevalent combinations in the study sample (Table 4).

Table 4: Intersection of Claim Type and Death Circumstances

Claim type	n	Death circumstances			
		Medical or aged care	Police or custody	Road trauma	At home
Inquest, autopsy or reportability	57	20 (35%)	2 (4%)	7 (12%)	13 (23%)
Challenging findings	40	11 (28%)	13 (33%)	5 (13%)	1 (3%)
Limiting evidence or potential penalty	29	3 (10%)	15 (52%)	2 (7%)	0 (0%)

Most of the 38 police or custody death cases (85%) were claims involving procedural or evidentiary challenges (n=15) or challenges to findings (n=13). More than two thirds of the 43 medical and aged care death cases were either inquest, autopsy or reportability cases (n=20, 35%) or challenges to findings (n=11, 28%).

C Characteristics of Cases Involving Bereaved Family Member Applicants

We explored the characteristics of cases involving BFM applicants (Table 5). The applicant was a BFM in 59% of the cases (n=99). Their legal representation profile differed to other applicants: BFMs were 3.3 times more likely than non-BFM applicants to be self-represented (OR 3.3, 95% CI 1.3–8.6, p=0.014). BFM applicants achieved successful outcomes in 33% of the cases they were involved in (33 out of 99 cases) compared with applicant success in 42% of cases where the applicant was not a BFM (29 out of 68 cases). This difference was not statistically significant (p=0.22).

Table 5: Characteristics of Australian Coronial Litigation Involving Bereaved Family Member Applicants, 1993–2022

Characteristic	Non-BFM n (%)	BFM n (%)	Total n (%)
Applicant legally represented			
No	6 (20%)	24 (80%)	30 (100%)
Yes	62 (45%)	75 (55%)	137 (100%)
Case year			
1993–2002	17 (49%)	18 (51%)	35 (100%)
2003–12	25 (45%)	31 (55%)	56 (100%)
2013–22	26 (34%)	50 (66%)	76 (100%)

Characteristic	Non-BFM n (%)	BFM n (%)	Total n (%)
Case outcome			
Dismissed	39 (37%)	66 (63%)	105 (100%)
Successful	29 (47%)	33 (53%)	62 (100%)
Applicant gender			
Male	32 (42%)	45 (58%)	77 (100%)
Female	5 (8%)	54 (92%)	59 (100%)
Claim type			
Inquest, autopsy or reportability	7 (12%)	50 (88%)	57 (100%)
Challenging findings	19 (46%)	22 (54%)	41 (100%)
Limiting evidence or potential penalty	24 (83%)	5 (17%)	29 (100%)
Body burial or release	3 (16%)	16 (84%)	19 (100%)
Coroner role or jurisdiction	6 (67%)	3 (33%)	9 (100%)
Procedural fairness	8 (89%)	1 (11%)	9 (100%)
Administrative matters	1 (33%)	2 (67%)	3 (100%)
Death circumstances			
Medical or aged care	12 (29%)	30 (71%)	42 (100%)
Police or custody	30 (79%)	8 (21%)	38 (100%)
Road trauma	3 (17%)	15 (83%)	18 (100%)
At home	0 (0%)	15 (100%)	15 (100%)
Criminal element	10 (77%)	3 (23%)	13 (100%)
Unknown	1 (8%)	12 (92%)	13 (100%)
Self-inflicted	2 (22%)	7 (78%)	9 (100%)
Disaster setting	3 (43%)	4 (57%)	7 (100%)
Missing person	2 (33%)	4 (67%)	6 (100%)
Workplace death	5 (83%)	1 (17%)	6 (100%)
Jurisdiction			
Victoria	17 (28%)	43 (72%)	60 (100%)
New South Wales	10 (38%)	16 (62%)	27 (100%)
Western Australia	5 (21%)	19 (79%)	24 (100%)
Queensland	8 (38%)	13 (62%)	21 (100%)
South Australia	15 (94%)	1 (6%)	16 (100%)
Australian Capital Territory	7 (100%)	0 (0%)	7 (100%)
Northern Territory	1 (14%)	6 (86%)	7 (100%)
Tasmania	5 (83%)	1 (17%)	6 (100%)

BFMs were the first applicant in 72% of Victorian cases (n=43). The odds of a case involving a BFM first applicant were 2.3 times greater in Victorian cases compared with non-Victorian cases (OR 2.3, 95% CI 1.2–4.5, p=0.016). The jurisdiction with the second highest number of BFM applicants was Western Australia (n=19, making up 72% of cases from that state), followed by NSW (n=16, 62% of NSW cases) (Figure 2).

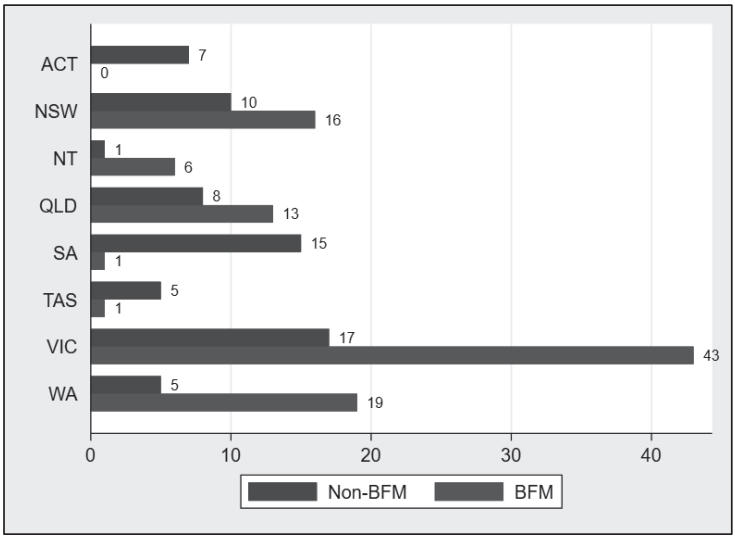

Figure 2: Frequency of BFM first applicants in Australian coronial litigation (by jurisdiction), 1993–2022

Cases with BFM first applicants increased marginally over time as a proportion of all cases (from 51% in 1993–2002 to 66% in 2013–22). That growth was particularly driven by increasing numbers of BFM first applicants in Victoria (22 BFM-led cases from 1993–2012 and 21 in the single decade 2013–22) and Western Australia (four BFM-led cases from 1993–2012 rising to 15 in the decade 2013–22).

The most common claim type for BFM-led cases were inquest, autopsy or reportability decisions (n=50, accounting for 88% of such cases) and the most common claim type for non-BFMs was limiting evidence or potential penalty (n=24, accounting for 83% of those cases). The most common death circumstances in BFM cases were medical or aged care related deaths (n=30, accounting for 71% of those cases) while the most common death circumstances in non-BFM claims were policy or custody related deaths (n=30, 79% of those cases). The vast majority of female first applicants were BFMs (n=54, 92% of the 59 female first applicants) whereas male first applicants were more evenly distributed amongst BFMs (n=45, 58%) and non-BFMs (n=32, 42%).

V DISCUSSION

Our analysis of 30 years of Australian coronial litigation provides new insight into the characteristics of the cases, the parties involved and the outcomes achieved. We identified that the number of cases has increased over time. The most common circumstances of death in the cases were aged or medical care and police or custody settings. The most common subjects of dispute varied by

whether the applicant was a BFM: cases about inquest, autopsy or reportability decisions were more commonly brought by BFMs than non-BFMs. Non-BFMs were most commonly seeking to challenge evidence or their exposure to penalty or prosecution. Cases involving BFM applicants were more likely to occur in Victoria than in other jurisdictions.

Our research also identified growth in the number of self-represented applicants in coronial litigation. We found that more BFMs were unrepresented than non-BFM applicants. Successful outcomes were much more likely when an applicant was represented. Only one third of BFM applicants had successful outcomes. There was not, however, a relationship between BFM status and case outcomes.

In this part of the paper, we delve into the key findings, offering potential explanations and making connections with the broader literature on coronial matters and the experiences of the stakeholders involved. We particularly focus on the findings relating to BFM and unrepresented applicants, with a view to considering the implications for the design and operation of legal processes and potential use of appropriate dispute resolution ('ADR') for coronial litigation involving these parties.

A Increasing Case Numbers Over Time: A Victorian Story

This study identified an increase over time in judgments in appeals against coronial decisions in Australia. The greatest proportion of judgments was in Victoria, the second most populous state,[54] which accounted for 36% of cases. In fact, the number of Victorian cases in the final of the three decades studied (2013–22, n=27) was the same as the number of cases in the second-highest ranked state (NSW) over the entire period of the study (1993–2022). Why might this be?

We caution against leaping to the conclusion that the Victorian prominence in the sample reflects problematic practice in that state. Coronial litigation is a very rare event in the context of the number of reportable deaths dealt with by coroners each year, especially over the extended period of the study timeframe. The lack of published data about the number of disputes that are resolved informally also makes it hard to interpret jurisdictional differences. Jurisdictional variation in disputes and litigation data is likely the product of a range of disparate factors that shape access to and decision-making about pursuit of a case. The scholarly literature on the selection of cases for litigation (from its early law and economics focus and beyond)[55] is unlikely to be a good fit in explaining interested persons' choices about and pursuit of coronial litigation and its frequently very personal,

54 Australian Bureau of Statistics, *National, State and Territory Population* (Catalogue No 3101.0, September 2023). The increase in cases over time is not proportionate to the population increase in Victoria versus other states: for the 2003–22 period, Victoria's population increase rate was behind three other states/territories and for the period 2013–22, it had the second highest population increase compared with other states/territories.

55 See, eg, Gregory Mitchell, 'Why Law and Economics' Perfect Rationality Should Not Be Traded for Behavioral Law and Economics' Equal Incompetence' (2002) 91(1) *Georgetown Law Journal* 67.

non-pecuniary qualities.[56] This may particularly be the case for family members of deceased persons, who we identified as more likely to be the applicants in Victorian cases than in other jurisdictions.

Differences in the availability of services and support for those considering coronial litigation may play a part in preventing litigation in some jurisdictions.[57] The legal capability of persons affected by coronial decisions, together with their capacity to fund litigation or bear the associated costs risks, will also have a bearing on their capacity to engage in coronial litigation.[58] Another possibility is that jurisdictional variation in the rules governing appeals has a bearing on how easy it is to engage in coronial litigation. Coronial legislation in Victoria and Tasmania provides the clearest and greatest number of specific grounds for appeal to superior courts, compared with other Australian jurisdictions.[59] It is possible that in jurisdictions where the rules are less clear than in Victoria about grounds for appeal there are impacts on the ability of affected persons to pursue coronial litigation, particularly given the increasing numbers of self-represented applicants. It is a stretch to expect that most family members and others affected by a death are driven by the clarity of legislation itself in pursuing their cases.[60] Our analysis was not designed to explore the relationship between the clarity of the legislation and the number of cases. Further analysis would clearly be required to be conclusive on that point.

Specific awareness-raising campaigns by Coroners Courts may play a role in generating coronial litigation. One example of this activity in Victoria is in relation to autopsy matters, a subset of the claim type 'inquest, autopsy and reportability decisions' in this study, which made up the largest proportion of Victorian claims. Objections to autopsy made directly to the Coroners Court reportedly increased significantly in the years 2000 to 2004.[61] Ian Freckelton and David Ranson suggest

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56 *Council Appeals Review* (n 17) 76 [7.2] notes the common motivations of litigants in coronial disputes, and these can be categorised as different to motivations commonly and historically associated with litigation – such as traditional pecuniary interests. For a discussion about the complexities regarding litigant motivations, see generally John Griffiths, 'The General Theory of Litigation: A First Step' (1983) 5(2) *Zeitschrift für Rechtssoziologie, Heft* 145.

57 The Coroners Court of Victoria website provides a list of support services for bereaved families, including links to legal services: see 'Supports and Resources', *Coroners Court of Victoria* (Web Page) <https://coronerscourt.vic.gov.au/families/supports-and-resources>.

58 Pascoe Pleasence and Nigel J Balmer, 'Justice and the Capability to Function in Society' (2019) 148(1) *Daedalus* 140, 141 <https://doi.org/10.1162/daed_a_00547>.

59 See *Vic Coroners Act* (n 2) for grounds of appeal to the Supreme Court, for example: at ss 83(2) (findings of inquest), 84(1) (refusal to reopen an investigation), 85(1) (release of body), 87(1A) (appeal against finding on a question of law). See also *Tas Coroners Act* (n 2) for grounds of appeal to the Supreme Court, for example: at ss 3B (specifying senior next of kin), 26(2) (decision not to hold an inquest), 38(3) (autopsy directed against senior next of kin's objections), 58(7) (Chief Magistrate's refusal to reopen investigation). See app A of this article for a comprehensive list of possible appeals across all Australian jurisdictions.

60 On the plain language legislative drafting movement: see Jeffrey Barnes, 'The Continuing Debate about "Plain Language" Legislation: A Law Reform Conundrum' (2006) 27(2) *Statute Law Review* 83 <https://doi.org/10.1093/slr/hml004>; Jeffrey Barnes, 'When "Plain Language" Legislation is Ambiguous: Sources of Doubt and Lessons for the Plain Language Movement' (2010) 34(3) *Melbourne University Law Review* 671, 672.

61 Freckelton and Ranson (n 34) 376.

that one reason for this increase was the widespread media reporting at the time about the alleged illegal retention of organs and tissues at autopsy in the United Kingdom and Australia. These developments resulted in improved communication by the Coroners Court of Victoria to families about their right to object to autopsy decisions.[62] Following these changes, objections to autopsy received by the Coroners Court of Victoria increased from 134 in 2000 to 455 in 2004.[63] If some of these written objections were refused, it is possible that they resulted in a subsequent superior court appeal.

What we can say is that in view of the multiple potential drivers of litigation, further attention is warranted to investigate the impacts of reforms that seek to improve access to coronial litigation. Recent legislative reforms to the *Vic Coroners Act* sought to improve access to justice by introducing measures 'to clarify and enhance the way in which families and other interested parties can seek to re-open a coronial investigation or appeal a finding'.[64] These changes, which came into force on 28 October 2018, included:

- Extending the time limit for lodging an appeal in the Supreme Court against a refusal by the coroner to reopen an investigation from 28 days to 90 days;[65]
- Enabling families to apply to the Coroners Court to change the wording of a coronial finding (final record);[66]
- Permitting appeals in the Supreme Court challenging coronial findings where the weight of evidence does not support the conclusion;[67] and
- Enabling persons to apply to the Coroners Court to allow coroners to reopen cases and investigations due to the emergence of new evidence or facts.[68]

The reforms followed the *Council Appeals Review* which identified stakeholder views that the former grounds of appeal (only on an error of law) were too restrictive.[69] Our analysis suggests that even before these recent reforms, Victoria had comparatively more coronial litigation than other jurisdictions, with the number of appeals in the most recent decade (2013–22) representing an increase of more than 40% compared with the previous decade (2003–12). The reforms are recent, and given the case timelines this study identified, long-term follow-ups will be required to understand whether the reforms play a part in driving case numbers upward. Growth does not appear to have been anticipated by the Coronial

62 Ibid.
63 Ibid.
64 Victoria, *Parliamentary Debates*, Legislative Assembly, 21 June 2018, 2147 (Martin Pakula, Attorney-General).
65 *Vic Coroners Act* (n 2) s 84(2).
66 Ibid s 76A.
67 Ibid s 87(1A). It should be noted that this provision relates only to appeals in relation to a coroner's *finding*, not to all coronial *decisions*, as the present study encompasses. Appeals in relation to findings are a subset of the judgments analysed, but they make up a significant proportion of the claim types (66%) for Victorian cases.
68 Ibid s 77.
69 *Council Appeals Review* (n 17) 5.

Council of Victoria, which suggested that broadening the grounds of appeal was 'very unlikely to increase the number of appeals significantly'.[70]

The chief intention behind the Victorian reforms in 2018 was to improve access to justice for families and other stakeholders.[71] In practice, the decade to 2022 saw an increased number of appeals, but with successful outcomes in only 11% of cases (3 out of 27) compared with 53% of cases in each of the decades before that. It seems likely that the jurisdiction is seeing a higher quantity rather than quality of appeals, which raises questions about whether this is the kind of access to justice that was envisaged by reformers. In making this assessment, we do not disregard the importance for applicants of procedural justice and the right to be heard in a court:[72] this may have been part of the objective of the law reform, and facilitating participation in litigation has positive aspects. The costs are also very considerable, however. A more comprehensive evaluation of the impacts of the changes is needed and our findings will provide a critical baseline for that work.

B Unpacking Delays in Coronial Litigation

This study's findings shed valuable light on the long periods of time persons affected by deaths and associated coronial decisions might spend engaged in legal proceedings. Taken at its broadest, this exposure spans the date of death, to coronial decision, coronial litigation and the ultimate court judgment. Delay is an unavoidable feature of the coronial landscape[73] and can be a source of considerable distress for family members and others affected by reportable deaths.[74] In some cases, extended case durations are a product of the elapse of time between the death and the coronial event (for example, in cases involving missing persons). Delays between death and coronial decision can prevent emotional, financial, administrative and legal resolution (especially with regards to dealing with the deceased's estate),[75] and they can also have a detrimental effect on the efficacy and efficiency of investigations and related public interest recommendations.[76] Delay may also be a feature of the complex investigation process which must be undertaken by the Coroner in some cases, necessarily in concert with other forensic bodies, in this inquisitorial jurisdiction. For example, there is a requirement in Australian jurisdictions that criminal proceedings must be completed prior to the conclusion of coronial investigations and the issuing of findings.[77]

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70 Ibid 6.

71 See Victoria, *Parliamentary Debates*, Legislative Assembly, 21 June 2018, 2147 (Martin Pakula, Attorney-General).

72 See Ronald L Cohen, 'Procedural Justice and Participation' (1985) 38(7) *Human Relations* 643, 645 <https://doi.org/10.1177/001872678503800703>.

73 Aitken (n 36) 488.

74 David M Studdert et al, 'Duration of Death Investigations That Proceed to Inquest in Australia' (2016) 22(5) *Injury Prevention* 314, 314.

75 Federation of Community Legal Centres (Victoria), 'Saving Lives by Joining Up Justice: Why Australia Needs Coronial Reform and How to Achieve It' (Issues Paper, March 2013) 19 ('Saving Lives').

76 Law Reform Commission of Western Australia, *Review of Coronial Practice in Western Australia* (Discussion Paper No 100, June 2011) 82, 87, 118.

77 See, eg, *NSW Coroners Act* (n 2) s 78(2)(b).

Other factors also shape the duration of the parties' exposure to the legal process. Some disputes are urgent: we found the shortest coronial litigation centred on disputes about the release or burial of a body. In these cases, the deceased's remains are in the custody of the coroner at the time that the appeal is made. Our findings indicate that the coronial decision is typically made within a very short time following the death (a day or two) and that on average two months elapses between the death and coronial decision and the judgment which decides burial rites. Though this represents coronial litigation moving at its fastest pace, the elapse of time is still likely to be perceived as considerable for the families involved.

In the broader sample, however, the median time between the coronial event and the judgment for cases about setting aside findings and reopening investigations was substantial (three years and six months); deaths relating to police or custody had a median time lapse of one year and one month between coronial event and judgment. It is difficult to make generalisations about the reasons for the durations given the diversity of the cases. Some of the delay may be a product of the speed with which parties challenge coronial decisions, for example where families initiate their case decades after the coronial findings.[78] The time limits for appeals to superior courts in relation to coronial decisions or findings vary across jurisdictions; some even have no time limit in relation to particular types of appeals.[79] As such, what might appear to be delays may in fact be the time taken when appeals are brought a long time after the coronial event. The way cases are managed by courts may also play a role. In any event, the length and variability of case timelines suggests that persons affected by coronial decisions who are considering litigation could benefit from clear information about the likelihood that the process will be lengthy. Our findings are a useful contribution in that respect.

C The Distinct Profile of Appeals by Bereaved Family Members

Our findings provide valuable new information about the profile and trends associated with coronial litigation by BFMs. They suggest that BFMs engaged in coronial litigation are disproportionately female, are more often self-represented than other applicants in these cases and rarely achieve successful outcomes. BFM applicants are also concentrated in cases involving a particular profile of claim type and death circumstances.

1 The Types of Cases BFMs Bring (and Those They Don't)

The most common claims brought by BFMs related to coroners' inquest, autopsy and death reportability decisions. Medical and aged care deaths were the most prevalent in this group of cases, often involving families seeking answers

78 For example, in *Somerville* (n 7), the mother of the deceased brought the appeal 26 years after the coronial finding seeking to change a finding that suggested her son had contributed to the death of his sister when he was a child.

79 In Tasmania, Australian Capital Territory, Western Australia and Northern Territory there is no time limit relating to appeals to reopen investigations.

about deaths in hospital, aged, psychiatric and palliative care. The second most common BFM claim type, accounting for a quarter of claims, involved applications to set aside findings or seeking reinvestigation. The part of the coroner's findings that describes the circumstances of the death can sometimes trigger objections from affected family members. For example, the coroner might affirm that medical care was appropriate when the family believes this is not the case or describe activity the deceased was engaged in before their death in such a way that the family perceives an inappropriate implication that the deceased contributed to their own death.[80]

In contrast with BFM claims, the most common claims brought by non-BFMs sought to limit evidence or potential penalty (a case type almost entirely brought by non-BFMs). Nearly three quarters of the 38 police or custody death cases (both BFM and non-BFM claims) were claims either of this kind (15 of the 38) or challenges to findings (13 of the 38). Despite their formal non-participation in these cases, BFMs are likely to be profoundly impacted by what they might perceive as the efforts of police or others to avoid scrutiny or accountability for the circumstances of the death of their loved one.

2 BFM Self-Representation and Outcomes

We found that a quarter of BFM applicants were self-represented. BFMs were 3.3 times more likely than non-BFM applicants to be self-represented and BFM applicants achieved successful outcomes in 33% of cases compared with applicant success in 42% of cases where there was not a BFM involved (a difference that was not statistically significant). The prominence of self-representation and unsuccessful outcomes in cases involving BFMs requires further examination. It is important to note that Coroners Courts are bound by the *Hardiman* principle, which defines the parameters within which a decision-maker must conduct themselves within judicial review proceedings.[81] The principle effectively prohibits this decision-maker from taking an active role in its response or defence, in case such a role could damage their impartiality in subsequent proceedings or dealings with the applicant[82] (for example where a decision gets remitted back to the Coroners Court). Given the Coroners Court is not an active protagonist in these appellate proceedings, judicial decisions are not influenced by a respondent who advances ardent opposition to an appellant's submissions. As such, a 'successful outcome' for BFMs should be understood in the context of a judicial appraisal of the merits of their application, in light of the coroner's jurisdiction and powers.

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80 See, eg, Amy Bainbridge, 'Family of Volkswagen Driver Melissa Ryan Killed in Melbourne Freeway Crash Continues Fight for Justice', *ABC News* (online, 10 February 2016) <https://www.abc.net.au/news/2016-02-10/family-of-volkswagen-crash-victim-continues-fight-for-justice/7155070>.

81 See Margaret Allars, 'Reputation, Power and Fairness: A Review of the Impact of Judicial Review upon Investigative Tribunals' (1996) 24(2) *Federal Law Review* 235, 242 <https://doi.org/10.1177/0067205X9602400202>. See also *Hardiman* (n 5) 35–6 (Gibbs, Stephen, Mason, Aickin and Wilson JJ); *Comptroller-General of Customs v Disciplinary Appeal Committee* (1992) 35 FCR 466, 473 (Gummow J), where the Disciplinary Appeal Committee abided by the rule in *Hardiman*.

82 Dan Starr, 'Federal Court Judgments' (2022) 49(6) *Brief* 57, 57.

Cost is a critical factor shaping the pursuit of coronial litigation, as well as legal representation. The *Council Appeals Review* found that for many families, the cost of an appeal was a significant deterrent. One family reported having received estimates of the likely cost as being between $35,000 and $90,000.[83] Beyond the cost for families, the Coronial Council identified that coronial litigation also creates:

> significant expense for other parties with an interest in the outcome. More broadly, appeals to the Supreme Court come at a substantial financial cost to the community, and may divert attention and effort from other cases in the Victorian justice system.[84]

The risks of adverse costs orders are particularly concerning in light of our study's findings that there are increasing numbers of unsuccessful BFM applicants. Even where an applicant's appeal against a coroner's finding is successful, the court will typically make no order as to costs – meaning that even a successful applicant may not be able to recover costs to fund their own legal expenses.[85] The prospect of paying the costs of the other side in the event of unsuccessful coronial litigation is imposing. The hazard is illustrated by *Spear v Hallenstein*,[86] where a BFM applicant appealed against the coroner's finding that the BFM's brother, who had been shot by police, had contributed to his own death. Not only was this BFM unsuccessful in her appeal,[87] but she was ordered to pay the costs of the eight police co-defendants who had been involved in the incident leading to her brother's death.[88] If the chief mechanism for BFMs to understand the risk of adverse costs is being informed by their representing barrister, then self-representation is particularly problematic.

What might the reasons be for the lack of BFM success in coronial litigation? One consideration may be the 'high bar' of 'Wednesbury Unreasonableness' whereby a coroner's findings can only be quashed if the decision is so irrational or outrageous in its defiance of logic that 'no reasonable coroner' could have come to that decision or finding.[89] The absence of accessible and quality legal representation likely also plays a role – whether in assessing the strength of the case ahead of litigation, or in the way it is presented to court. The underlying objectives of BFM applicants may not be well-aligned with the 'narrow and supervisory'[90] focus of the court in coronial litigation, and legal advice would be an important corrective. Crucially, self-represented applicants will be unaccustomed to court procedures and the demands of filing a substantive appeal in a superior court setting, placing them at an inherent disadvantage as an applicant in the Supreme Court. The shift from the inquisitorial nature of the coronial setting to the traditional adversarial nature of the appeal setting requires further exploration in terms of the impact on applicants, particularly those who are self-represented. The less formal inquisitorial court room of the inquest (a process in which they may be merely an

83 *Council Appeals Review* (n 17) 69 [6.59].
84 Ibid 74 [6.81].
85 Ibid 62 [6.30].
86 [2018] VSC 169.
87 Ibid [120] (Niall JA).
88 *Spear v Hallenstein [No 2]* [2018] VSC 207, [15] (Niall JA).
89 Freckelton and Ranson (n 34) 685.
90 *Trotta v Coroners Court of Victoria* [2022] VSC 70, [110] (Matthews AsJ); Januszewicz (n 40) 58.

observer rather than a participant) contrasts starkly with the formality of a superior court, where the applicant is expected to actively participate and understand the legal protocols and rules. Furthermore, the necessarily antagonistic and partisan nature of party roles in an adversarial court setting can be taxing, especially for unrepresented BFMs.

There is wide variation across jurisdictions in terms of support for legal advice for persons considering coronial litigation.[91] Broadly, legal assistance is limited to referrals to legal advice rather than representation, and this assistance is usually only in relation to inquests rather than ongoing advice regarding appeals to a superior court.[92] There has been an apparent increase in community legal centres and Aboriginal legal services assisting families with appeals, however this is not systematic nor widespread. Family members with legal issues outside the scope of support, who cannot access assistance through other legal aid services nor afford legal representation, may resort to self-representation or forego the appeals process altogether. These two results, brought about by unmet legal need, have implications for courts and other stakeholders (in engaging with self-represented applicants) as well as the families themselves who may feel left with unanswered questions about the death and face other impacts associated with the costs of self-representation in litigation.[93]

3 The Potential Role of Appropriate Dispute Resolution

Our analysis demonstrates that a significant proportion of applicants are engaging in coronial litigation without success, and that self-representation is increasing over time. Participation in the courts is considered to be a facet of access to justice which promotes the values of liberal democracies.[94] It is possible that some applicants are using litigation to seek procedural justice, including a chance to be heard,[95] and these interests may be met regardless of the substantive outcome of the litigation. It seems likely, however, that alternatives to the superior court process could play a greater role in preventing the culmination of these disputes in superior courts. Writing about coronial inquests, Freckelton has advocated 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'.[96]

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91 For example, the NSW Coronial Inquest Unit is provided as a service of Legal Aid NSW to provide free legal advice to families, and in Queensland, the Caxton Legal Centre and Townsville Community Legal Service operate the Queensland Coronial Assistance Legal Service which provides families with advice and in some circumstances, representation: *Council Appeals Review* (n 17) 51 [5.10]–[5.11].

92 In Victoria, the Coronial Council recommended the creation of a Coronial Legal Advice Service through Victoria Legal Aid, which would provide advice to families about both the original coronial investigation and Supreme Court appeals, including the provision of indications regarding the likelihood for success in pursuing this superior court legal action: ibid 74 [6.82].

93 *Improving Experiences of BFMs* (n 17) app B s 7.4.

94 Jennifer A Leitch, 'Having a Say: "Access to Justice" as Democratic Participation' (2015) 4(1) *UCL Journal of Law and Jurisprudence* 76, 80.

95 See Cohen (n 72) 650.

96 Freckelton, 'Counter-therapeutic Effects of Coronial Investigations' (n 39) 6.

There may be scope for this rapprochement to be further explored in the context of coronial litigation through the use of ADR at the Coroners Court level and, in very limited circumstances, at superior court levels.

Where coronial litigation is underpinned by interests such as being heard or seeking answers about a death, ADR or other therapeutic communication interventions could be well-placed to provide an additional avenue for preventing the escalation of these disputes and avoiding a zero-sum litigation journey. The Coronial Council's *Review into Improving the Experience of Bereaved Families with the Coronial Process* identified restorative justice as a promising avenue for families involved in the coronial process,[97] in that it could allow families to resolve issues and questions following the conclusion of a coronial investigation.[98] Restorative justice encompasses a range of practices and can involve informal discussions between parties including perpetrators and victims or administrative decision-makers and those who have been impacted by crimes or situations which have involved trauma or grief.[99] The use of restorative justice conferences at the stage when a family member expresses an initial complaint or appeal directly to the Coroners Court may resolve issues early and divert parties away from embarking on coronial litigation, including through the use of explanations and apologies.[100] In recent years protocols have been introduced in both the NSW and Victorian Coroners Courts which provide for family meetings between First Nations BFMs and coronial personnel prior to the inquest or court process, to allow for information provision about the coronial process and discussion of relevant cultural considerations.[101] In the NSW context, the family meeting is designed to include discussion of findings of any post-mortem examination[102] and other issues the family wishes to raise regarding the coronial investigation,[103] potentially optimising understanding and acknowledgement which could result in diversion from subsequent dispute proceedings. In summary, ADR processes at the Coroners Court level could facilitate the pre-investigative provision of more detailed answers about medical treatment and the death; apologies; or adjusted funeral or burial arrangements.[104] That is, mediated outcomes may be possible

97 *Improving Experiences of BFMs* (n 17) 59.

98 *Council Appeals Review* (n 17) 82 [7.25].

99 Michael S King, 'Restorative Justice, Therapeutic Jurisprudence and the Rise of Emotionally Intelligent Justice' (2008) 32(3) *Melbourne University Law Review* 1096, 1098.

100 The Coronial Council refers to the potential for this process to contain an apology: *Council Appeals Review* (n 17) 81 [7.22].

101 Local Court of New South Wales, *Practice Note: State Coroner's Protocol: Supplementary Arrangements Applicable to Section 23 Deaths Involving First Nations Peoples*, 9 March 2022, 5–6 paras 10.1–10.8 ('*State Coroners Protocol*'); Coroners Court of Victoria, *Practice Direction No 6 of 2020: Indigenous Deaths in Custody*, 22 September 2020, para 5.2. In addition, in NSW, consultation initiatives such as healing circles, facilitated by Impact Policy, aim to ensure First Nations families are provided with information they require that may not be included in the coronial inquest process: see 'Healing Circles in the Coroners Court', *Impact Policy* (Web Page) <https://www.impactpolicyau.com/healingcircle>.

102 *State Coroners Protocol* (n 101) [10.2(b)].

103 Ibid [10.2(d)].

104 Hugh Dillon and Marie Hadley discuss a NSW case where the father of the deceased appealed in the Supreme Court of NSW after the partner of the deceased objected to an autopsy, noting that '[t]he case was resolved by compromise after two weeks'. Whilst it isn't clear which method of dispute resolution

in relation to non-factual decisions of Coroners (such as burial rites), but not in relation to disputes regarding finalised coronial findings.

The nature of the Coroners Court's fundamental fact-finding purpose and the Court's limited participation in judicial review as a result of its *Hardiman* obligations[105] places barriers to the comprehensive use of ADR at a superior court level to complement the litigation process. Perhaps more importantly, the fundamental fact-finding purpose of the Coroners Court does not allow for flexibility in the form of the kind of negotiated or mediated outcome ADR facilitates.[106] In some cases, however, it may be possible to employ a form of ADR at a superior court level, to allow applicants and (only) active respondents to engage in discussion or negotiations to achieve desired outcomes. One such example might be a case involving co-respondents such as family members in dispute over senior next of kin status and medical practitioners defending their professional management of the deceased. The potential of this approach may extend to cases where non-BFM applicants make claims to limit evidence or potential penalty, causing BFMs to become involved in the litigation as intervenors.[107] There could also be scope for coroners to participate in ADR purely as information providers, fulfilling their *Hardiman* obligations while providing more detailed reasons for decisions or findings (rather than negotiating or defending).

Within the limitations described above (involving BFM applicants and non-coronial actors who are respondents or intervenors), judicial mediation may form a useful part of the superior court's process.[108] This format of mediation, facilitated by a judge who can also provide educative interventions for parties about the parameters of the law in this context, may result in answers for the applicants, the delivery of procedural fairness, lower costs to all stakeholders and a potentially pro-therapeutic justice experience (through reduced exposure to adversarial processes involving well-resourced entities such as government, corporate or police actors). Mediation can be actioned more quickly than a court hearing,[109] is typically cheaper and might not require legal representation.[110] It is also a process

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was utilised here, 'compromise' suggests that the father and partner of the deceased were able to somehow negotiate between them, outside of, alongside or within the process of superior court review: see Hugh Dillon and Marie Hadley, *The Australasian Coroner's Manual* (Federation Press, 2015) 68.

105 Allars (n 81) 242.

106 This limitation and others are discussed in Varda Bondy et al, 'Mediation and Judicial Review: An Empirical Research Study' (Research Paper, The Public Law Project, June 2009) 30. See also Varda Bondy, 'Who Needs ADR?' (2004) 9(4) *Judicial Review* 306 <https://doi.org/10.1080/10854681.2004.11427327>, which discusses concerns surrounding the use of mediation in cases involving public law challenges.

107 See, eg, *Runacres v Coroners Court of Victoria* [2024] VSC 304, in which the applicant was a medical practitioner appealing against the coroner's adverse finding and the family intervened as a respondent in defence of the coroner's finding.

108 JJ Spigelman, 'Judicial Mediation in Australia' (2011) 10(3) *Judicial Review: Selected Conference Papers* 289, 290.

109 Tania Sourdin and Naomi Burstyner, 'Cost and Time Hurdles in Civil Litigation: Exploring the Impact of Pre-action Requirements' (2013) 2(2) *Journal of Civil Litigation and Practice* 66, 83 <https://doi.org/10.2139/ssrn.2721423>.

110 See Isabel Roper, 'Mediation: Good Faith, Bad Faith' (2015) 40(1) *Alternative Law Journal* 50, 50 <https://doi.org/10.1177/1037969X1504000112>; *Civil Procedure Act 2010* (Vic) ss 3 (definition of

which empowers parties to decide on their own outcomes in a more therapeutic setting,[111] and it is not confined to a rights-based process,[112] where all evidence and decisions must fall within the parameters of the relevant legislation. Despite these features, mediation is not currently a systematic aspect of case management of judicial review and related proceedings in most Australian Supreme Courts.[113] This may partly be a result of the constraints placed upon administrative decision-makers who are bound by the *Hardiman* principle and as such are unable to be contradictors in a litigation process and, for the same reasons, nor are they able to exercise an active negotiating role in a mediation.

There is little published evidence about the use of ADR in the specific context of coronial litigation, but its potential as a preventative measure (and in a very limited and qualified way at a superior court level), is compelling.[114] To maximise their effectiveness, such processes should be co-designed with BFMs, pathologists, coroners, lawyers, judges and others who have participated in coronial processes involving disputes. It is critical that the design of ADR processes accommodate the motivations of BFMs and other parties, and explores features that might meet parties' objectives in more fitting and less expensive ways than through superior court proceedings. The *Council Appeals Review* notes that principles which underpin various forms of therapeutic jurisprudence are already a focus in some Coroners Courts.[115] It seems likely, however, that ADR is not a suitable default mechanism for resolution of all coronial litigation, which is further evidence of the distinct nature of this sort of litigation, as compared with civil litigation, where parties can avail themselves of the ADR 'off-ramp'. Nevertheless, in addition to preventative ADR at a Coroners Court level, superior court case management triage processes to gauge suitability of ADR between BFMs and active respondents, could be an important addition.

VI STUDY STRENGTHS AND WEAKNESSES

This study offers a range of valuable new insights into coronial litigation, including the characteristics of the applicants and cases and the outcomes achieved. It is a strength of the study that the cases were drawn systematically from publicly available material from all superior courts in Australia over a defined period to

'overarching purpose'), 7.

111 Glen Cranwell, 'Therapeutic Jurisprudence and Mediation: Natural Partners in Dispute Resolution' (2023) 32(3) *Australasian Dispute Resolution Journal* 185, 185.

112 Lola Akin Ojelabi and Tania Sourdin, 'Using a Values-Based Approach in Mediation' (2011) 22(4) *Australasian Dispute Resolution Journal* 258, 262–5 <https://doi.org/10.2139/ssrn.2721546>.

113 An informal survey of court websites and communication was conducted by Naomi Burstyner on 23 November 2023 with the registries of each state and territory indicates that Western Australia is the only jurisdiction with an established court-based mediation program in these cases: see Supreme Court of Western Australia, *Consolidated Practice Directions*, 14 February 2025, para 4.2.1. The Supreme Court of Tasmania offers referral to mediation as part of the standard procedures in civil disputes, subject to the urgency of the matter.

114 Bondy et al (n 106) 1–3.

115 *Council Appeals Review* (n 17) 36.

map the landscape of these proceedings over time. We were able to identify a greater number of cases than previous efforts to undertake this work,[116] and our findings are likely to be of use to Coroners Courts, superior courts, parties and policy makers in the field of coronial litigation.

The chief limitation of the study is common to projects involving content analysis of judicial decisions: judgments cannot be treated as comprehensive accounts of the facts, so it is possible that some data is missing.[117] We sought to mitigate this risk by focusing on variables that were reported consistently across judgments and did not require significant exercise of subjective judgment. Where there were exceptions to this (for example, in relation to the circumstances of deaths and the claim types), we took care to develop and refine the variables to enhance the accuracy of the data collection. It is a particular absence that we were unable to conclusively identify whether there were First Nations participants in the study cases because this information was not reported consistently or systematically in the judgments. In view of the research evidence on the challenging experiences Indigenous Australians have in coronial processes,[118] exploring their experiences in coronial litigation is an important area for future research. Additionally, as our study used decided cases, we are unable to comment on the number and characteristics of cases that might have been commenced and then abandoned or settled. Further work is required to explore coronial litigation that is commenced and abandoned, and the reasons why this occurs.

Given the dearth of research in this area, the use of content analysis in this study helps to provide an empirical foundation for future research and analysis.[119] As such, it is important to acknowledge the limits of this approach. One can make findings about the patterns of data in the cases, but it is not possible for us to draw conclusions about what the families and other parties felt about these experiences.[120] For example, we assume that lengthy waiting times between coronial events and judgment impacts negatively on parties and families, but other research methods are required to explore these matters. Future research involving direct engagement with parties who have been involved in coronial litigation would provide a more

116 See ibid 14 [1.15]. The *Review* provides an incomplete list of cases appealed to the Supreme Court of Victoria in the timeframes of 1991–2002 (at 92–3 app G), and 2011–17 (at 91 app F). This was determined by cross-checking all cases with those in the study (gleaned from AustLII) which demonstrated that some cases appearing on AustLII were not referred to in these lists.

117 Hall and Wright (n 50) 95–6.

118 See, eg, George Newhouse, Daniel Ghezelbash and Alison Whittaker, 'The Experience of Aboriginal and Torres Strait Islander Participants in Australia's Coronial Inquest System: Reflections from the Front Line' (2020) 9(4) *International Journal for Crime, Justice and Social Democracy* 76.

119 Karen A Jordan, 'Empirical Studies of Judicial Decisions Serve an Important Role in the Cumulative Process of Policy Making: Comments on a Paper by Professor William Sage' (1998) 31(1) *Indiana Law Review* 81, 88 <https://doi.org/10.18060/3280>; Hall and Wright (n 50) 83.

120 For example, there is a possibility that coronial litigation proceedings may, in some circumstances, be used to distil evidence which could be used to test the viability of civil litigation. Our study did not encounter evidence of this in the judgments analysed. Importantly, the motivations of parties engaging in coronial litigation fall outside the scope of our research, which is centred on the judgments as a data source. This consideration does not affect the study's findings or conclusions.

comprehensive picture of the impact of coronial litigation on participants and affected persons.

VII CONCLUSION

Coronial litigation is an important means of access to justice for stakeholders in the coronial process. Crucially, through their work, coroners are able to support the overarching goal of this jurisdiction, which is saving lives through prevention measures catalysed by recommendations based on sound and high-quality investigations. Coronial systems, like all legal systems, require appeal and review mechanisms to promote accountability. Such mechanisms provide means to refine, correct or simply examine decisions and findings to ensure their fairness, consistency and accuracy. As such, coronial litigation complements the goals of coronial jurisdictions. In practice, Coroners Courts can 'sometimes be forums of disappointment and anger' because of the life and death questions they deal with.[121] Against this backdrop, understanding the characteristics of coronial litigation is important for informing the way these cases are managed as well as the design and evaluation of improvement initiatives.

By exploring the characteristics of coronial litigation, our research identified opportunities to review the management of these cases by courts (including referrals to legal advice) and the potential relevance of ADR. Cases involving BFMs appear to be the leading contenders for those kinds of interventions, on the basis of our findings in addition to what is already known about family experiences in the coronial context more broadly: that 'despite the therapeutic ideal, many families and communities experience the coronial process and its aftermath as neither fair nor healing'.[122] Our findings indicate that BFMs are increasingly engaging in coronial litigation and achieving outcomes that are likely to be costly and unsatisfying from their perspective.

Coroners Courts, Supreme Courts, interested persons, practitioners and the broader community could benefit from further attention to coronial litigation as an important and public part of the coronial process. As Freckelton has argued in connection with inquests, there is value in exploring how coroners (who may inevitably become respondents in coronial litigation) might be able to have a positive impact on the applicant families.[123] We argue that the therapeutic prerogative of coroners and coronial bodies should be considered in the context of the design and operation of coronial processes. Given that coronial litigation follows on from disputes which arise on the bases of coronial decisions or findings, it is sensible to consider how both Coroners Court and superior court processes might be adjusted

121 Philip Chung, Andrew Mowbray and Graham Greenleaf, 'Making Coronial Law Accessible: The Australian Coronial Law Library' (Research Paper No 23, UNSW Law and Justice Research Series, 18 July 2023) 1 <https://doi.org/10.2139/ssrn.4514700>, quoting former NSW Deputy Coroner Hugh Dillon, from his correspondence with the authors, Chung, Mowbray and Greenleaf.

122 'Saving Lives' (n 75) 17.

123 See generally Freckelton, 'Counter-therapeutic Effects of Coronial Investigations' (n 39).

to better assist all stakeholders, and especially BFMs. Candidate improvements could include the establishment of more comprehensive sources of legal advice for those contemplating coronial litigation to advise on prospects of success and risks regarding costs; case management practices; provision of estimates about case durations; and the development of ADR mechanisms (including restorative justice processes at certain junctures) designed to address the interests of all stakeholders and potentially prevent or facilitate early resolution of disputes before they lead to litigation. Such measures could provide valuable information for applicants before they embark upon coronial litigation, as well as alternative and additional avenues for resolution of their disputes, which might be better suited to meeting the needs of all involved.

Appendix A – Appeal Rights in Relation to Coronial Decisions and Findings in Australian State and Territory Jurisdictions

Act	Section	Superior court appeal type or grounds	Time limit	Who can appeal
Coroners Act 2008 (Vic)	78(1)	Appeal against decision that the death was not reportable	28 days	The person who reported the death
	79(1)	Application against direction for an autopsy	48 hours	Senior next of kin
	79(3)(a)-(b)	Appeal against a refusal to direct an autopsy (once requested)	48 hours	Senior next of kin or person who originally requested autopsy
	81(1)	Appeal against direction to exhume body	48 hours or further period specified by Court	Senior next of kin or any person who has been informed by a coroner about decision to direct exhumation
	81(3)	Appeal against refusal to authorise exhumation (once requested)	3 months	Any person who originally requested exhumation
	82(1)	Appeal against refusal to hold inquest (once requested)	3 months	The person who originally requested inquest
	83(1)	Appeal against the findings of an investigation	6 months	A person with sufficient interest in the investigation
	83(2)	Appeal against the findings of an inquest	6 months	An interested party
	84(1)	Appeal in the interests of justice: against refusal to reopen an investigation and set aside some/all of findings (once requested)	90 days	Person who originally requested to set aside some/all of findings
	85(1)	Appeal against decision to release the body or terms of that release (once requested)	48 hours	Person who originally applied to have the body released to them
	87(1A)	Appeal on a question of law: that the weight of evidence is such that no reasonable coroner could have made that finding	6 months	Senior next of kin or person with sufficient interest (specified in section 87A(1))

Act	Section	Superior court appeal type or grounds	Time limit	Who can appeal
Coroners Act 2009 (NSW)	84(1)(a)	Request that an inquest be held	No apparent limit	The Minister or any other person
	85	Application that an inquest or inquiry be quashed and a new inquest or inquiry be held (in the interests of justice)	No apparent limit	Minister or any other person
	96(4)(b) and 97(1)	Appeal against decision to conduct autopsy (including once requested that no autopsy be done)	48 hours	Senior next of kin
Coroners Act 1996 (WA)	24(2)	Appeal against refusal (or 3 months no response) to direct an inquest (once requested)	7 days	Person who requested the inquest
	36(3)	Appeal against refusal to direct post-mortem (once requested)	2 working days or subject to extension of time by Court	Person who requested post-mortem
	37(3)	Appeal against decision to direct post-mortem (once it has been requested not to direct post-mortem)	2 working days or subject to extension of time by Court	Senior next of kin
	38(7)	Appeal against decision to direct exhumation (once it has been requested not to direct exhumation)	2 working days or subject to extension of time by Court	Senior next of kin
	52(1)	Appeal that some or all findings from inquest are void	No apparent limit	Any person

Act	Section	Superior court appeal type or grounds	Time limit	Who can appeal
Coroners Act 1995 (Tas)	3B(1)	Appeal against decision regarding who is senior next of kin	No apparent limit	A person
	26(2)	Appeal against decision not to direct an inquest	14 days	Senior next of kin
	26A(2)	Appeal against decision to direct an inquest	14 days	Senior next of kin
	27(3)	Appeal against refusal to direct an inquest (once requested)	14 days	The person who requested inquest
	37(3)	Appeal against refusal to direct autopsy (once requested)	48 hours	The person who requested the autopsy
	38(3)	Appeal against decision to direct autopsy (once it has been requested that no autopsy be performed)	48 hours	Senior next of kin
	39(4)	Appeal against decision to direct exhumation (once it has been requested that no exhumation take place)	48 hours	Senior next of kin
	58(7)	Appeal against refusal to reopen investigation (once requested)	No apparent limit	The person who requested the reopening
	58A(1)	Application that all or any of the findings of the inquest are void	No apparent limit	Any person
	63	Appeal of Coroner's order to maintain an article which a person has claimed ownership over	No apparent limit	Director of Public Prosecutions or person who claims ownership of article

Act	Section	Superior court appeal type or grounds	Time limit	Who can appeal
Coroners Act 1997 (ACT)	64(8) or s 90	Appeal against refusal to conduct hearing (once requested)	30 days	A person with sufficient interest who made the initial request
	91	Appeal in the interests of justice: application for a hearing to take place	No apparent limit	A person
	92(1)	Appeal in the interests of justice: application for an inquest to take place	No apparent limit	Attorney-General or any person
	93(1)	Appeal on basis of public interest or interests of justice: that an inquest or inquiry be quashed and another inquest or inquiry be held	No apparent limit	Attorney-General or anyone else
Coroners Act 2003 (SA)	27(1)	Appeal against the findings of the inquest	1 month	Attorney-General or a person with sufficient interest
Coroners Act 2003 (Qld)	11A(2)(b)	Appeal against decision about whether death is reportable	No apparent limit	A person dissatisfied with the decision
	11A(3)	Appeal against decision about whether death is reportable (once a submission regarding reportability status has been made)	14 days	The person dissatisfied with the decision who originally made a submission regarding reportability
	30(4)(b)	Appeal against refusal to hold an inquest (once requested)	14 days	Person who requested inquest originally
	50(1)	Appeal to set aside findings of inquest (on evidence related grounds)	No apparent limit	A person dissatisfied with findings

Act	Section	Superior court appeal type or grounds	Time limit	Who can appeal
Coroners Act 1993 (NT)	16(2)	Appeal against decision not to hold inquest	14 days	Senior next of kin or any person
	21(3)	Appeal against refusal to direct an autopsy (once requested)	48 hours	The person who originally requested autopsy
	23(3)	Appeal against decision to direct an autopsy	48 hours	Senior next of kin
	24(4)	Appeal against decision to direct exhumation	48 hours	Senior next of kin
	44(1)	Application that some or all of the findings of the inquest are void	No apparent limit	A person