COMMONWEALTH OMBUDSMAN

FACT SHEET

Principles for good practice in responding to coronial recommendations

Coronial inquests are fundamentally connected with improving public safety and reducing fatalities. Coroners frequently make recommendations directed to government agencies in light of lessons learned from the investigation during a coronial inquest. Such recommendations aim to improve processes, policies and legislation to prevent similar deaths in the future.

Agencies whose legislation and policies directly or indirectly affect people on matters of public safety may receive recommendations directed to them from time to time by a coroner following an inquest.

There is presently no legislative requirement for an agency to acknowledge or respond to a coroner when it receives a recommendation directed to it. However, in the interests of transparency, good public administration and an overarching commitment to public safety, an agency should hold itself responsible for considering and potentially implementing recommendations made to it by a coroner following an inquest.

This guide outlines a number of principles that agencies may employ in dealing with a recommendation directed by a coroner to it or to a delegated body over which it has oversight. Following this, the guide provides some general steps an agency may take to increase its participation in the coronial process and to better manage the process of handling a recommendation.

Principles of good practice

Participate in the coronial process

An agency should make it its business to be aware of coronial inquiries that may concern it, even if the agency has not been called as a witness to the inquest. This principle is embodied in an agency maintaining awareness of coronial inquests being heard which may give rise to recommendations directed to it.

In many cases, an agency may deliver services which impact the public all over Australia. It is prudent and reasonably simple to keep track of upcoming inquests being held in each of the state coroners' courts.

Be responsive and transparent

Despite there being no legislative requirement to respond to coronial recommendations, it is good administrative practice to do so. It is also in the interests of public confidence of the work of the agency to be seen to be publicly responding to recommendations made to it, particularly considering that coronial recommendations are generally made publicly available by way of the inquest findings published on the coroner's website.

Agencies should avoid using privacy laws to avoid responding to coronial recommendations fully or to avoid accepting recommendations. Instead, agencies should work within the guidelines of the *Privacy Act 1988* to reasonably address the concerns raised by the coroner through the recommendations made.

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This guide outlines a number of principles that agencies may employ in dealing with a recommendation directed by a coroner to it or to a delegated body over which it has oversight.

Where an agency intends to reject a recommendation, it should provide clear reasons to the coroner and the public with evidence of the decision-making process employed.

Use recommendations to identify and drive improvement in agency work

Recommendations can occasionally be couched as criticism of the agency to which they are directed. Agencies can demonstrate their commitment to continuous improvement in public safety and administration of their policies by placing value on recommendations made by coroners for the purpose of improving public safety and reducing the likelihood of fatalities.

The improvements gained through the thoughtful consideration of coronial recommendations benefit the agency's reputation and administration and recommendations should be received in this spirit.

Be timely

Agencies should provide responses and information about decisions to coroners and other stakeholders in a timely fashion. The expected timeframes for finalisation of the process should be established and communicated to all relevant parties and updates should be provided where these timelines look to be exceeded. Clear reasons for any delays should be provided as soon as practicable, ideally when information comes to light that timeframes are likely to be exceeded.

Procedural guide for receiving, considering, implementing and reviewing coronial recommendations

- **Acknowledge** the recommendation
- **Assess** the recommendation and give it priority for implementation
- **Plan** the intended implementation action and determine the associated parties
- **Implement** the recommendation
- **Respond** to the coroner and inform the public of action taken
- **Review** the action taken to assess its effectiveness and **consider** if there are any systemic issues arising from the implementation of the recommendation.

1. Acknowledge the recommendation

An acknowledgement should be sent to the coroner's office and if possible, a notice should be placed on the agency's website to acknowledge that recommendations were made to the agency and that the agency is considering these.

In some cases an agency may be prevented from publishing details of its planned consideration of a recommendation, due to privacy laws or matters being before a court. In other cases, an agency will be disinclined to disclose the details of its internal consideration of the relevant policies and processes that may be affected by the potential implementation of a recommendation.

In either case, publicly acknowledging receipt of the recommendation and advising that it will be considered for acceptance and implementation is sufficient to demonstrate the agency's awareness that the recommendation was made and its commitment to the intent behind the recommendation to improve public safety.

The acknowledgement should outline the intended consideration and implementation process and should provide the name and contact details of a contact person. As far as possible, it should also note how long it is likely to take to complete the process and when the coroner will be informed of the outcome of the agency's decision regarding accepting the recommendation or not.

Where an agency intends to reject a recommendation, it should provide clear reasons to the coroner and the public with evidence of the decision-making process employed.

In some cases an agency may be prevented from publishing details of its planned consideration of a recommendation, due to privacy laws or matters being before a court.

2. Assess the recommendation and give it priority for implementation

The assessment should be carried out by a person or team that specialises in the field or domain to which the recommendation is related. Further preliminary assessment by other specialised staff might be required if the recommended change is complex or requires the involvement of several areas of the agency.

In some cases, there may be legislation or existing policy that will impact whether the kind of change recommended by the coroner can be achieved. Issues of this kind should be considered during this part of the process to determine whether the recommendation is likely to be accepted and implemented.

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Some recommendations might not be easy to implement—for example, a matter requiring major policy, legislative or procedural change. In these instances, it is important that consideration be given to whether the gains achieved by implementing the recommendation warrant the work involved in the implementation process.

Above all, the decision-making process regarding the assessment of the recommendation should be documented thoroughly.

Additionally, it is important to explain to the coroner and the public why a recommendation has not been accepted. A thorough documentation of the decision-making process will assist in this regard.

3. Plan intended implementation action and determine associated parties

A written plan should be produced. The plan should define:

> the processes and parties that implementation will affect

> the steps involved in implementing the recommendation

> any other possible remedies or solutions that could be implemented instead of the original recommendation (i.e. whether the coroner's original recommendation will be accepted in whole or in part), and

> any special considerations that apply to the process of implementation—for example, whether there are any matters before the court which relate to the inquest, whether there are any privacy considerations relevant to the matter, if there is any sensitive or confidential information that needs to be safeguarded.

A written plan will focus attention on what is to be implemented and the parties it will affect. This will ensure that important matters are not overlooked and that the implementation process does not wander off course.

This is especially important if the implementation cannot be completed by the original officer or team to which the project was originally allocated. A common source of inefficiency and delay in administrative processes is responsibility for actioning tasks being passed from one officer to another with inadequate handover or planning.

Planning and executing the implementation of a recommendation is a dynamic and ongoing process. It is not always possible to know at the outset how such processes will develop, and more complex processes can take a long time.

It is important to revisit the implementation plan regularly and make adjustments as circumstances change and new information becomes available.

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4. Implement the recommendation

Each recommendation should be considered with an open mind, and the relevant issues should be weighed objectively.

It is not always possible to resolve each recommendation by accepting and implementing it. Thought should be given to whether the matter which gave rise to the recommendation could be resolved by implementing a change not suggested by the coroner.

If a decision is reached to adopt a different course of action that espouses the essence of the coroner's recommendation, the matter can still be considered to be resolved and the outcome should be communicated to the coroner making the recommendation.

5. Respond to the coroner and inform the public of action taken

When consideration and implementation of a recommendation is completed, the coroner should be informed of the decision reached and actions taken. If a recommendation has been made that the agency has not implemented, this should be explained in the response to the coroner.

In the interests of transparency and to increase public confidence in the agency's commitment to the coronial process, the public should also be informed of the agency's decision in relation to accepting the recommendation or not.

Depending on the number of recommendations made to an agency in a calendar year and how long it usually takes the agency to resolve and implement recommendations, the agency may prefer to publicly respond to the recommendation twice—when a decision is made whether to accept the recommendation, as well as at the point the recommendation's implementation is completed.

Alternatively, if the agency decides immediately to accept and implement a recommendation and this process is completed within a short time period (a few weeks, for example), the agency might choose to publish its response to the recommendation when the recommendation is implemented.

Finally, agencies can summarise the recommendations made to it by coroners using its annual report. An agency can provide a brief overview of the action taken to address recommendations made by coroners as well as reporting on the time taken to resolve implementation processes.

6. Review the action taken to assess its effectiveness and consider if there are any systemic issues arising from the implementation of the recommendation

Responsibility for business improvement usually lies elsewhere in the agency, rather than with the legal unit to which the recommendation was made. It is therefore important that issues and trends are reported to and analysed by executive and senior managers. Where the agency has set up a unit or committee to consider coronial recommendations, the committee should be comprised of or at least have membership of senior executive officers of the agency.

If a recommendation has been made that the agency has not implemented, this should be explained in the response to the coroner.

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