Recommendation-to-Reform Mapping

A method for tracing the policy influence of coronial recommendations

JUSTICE METHODS 14, OCTOBER 2026

Introduction

Coronial investigations play an important role in identifying risks and recommending measures to prevent future deaths. In many jurisdictions, coroners are empowered by statute to make recommendations to governments, regulators, organisations and other actors, In New South Wales, for example, this power arises under s.82 of the Coroners Act 2009.

Despite the central preventive purpose of coronial systems, existing research has predominantly examined the characteristics of coronial recommendations, formal government acceptance rates, and compliance with mandatory response requirements.[1-5] These approaches commonly evaluate recommendations by examining whether governments or organisations formally accept or implement them, often within mandatory response frameworks.

While researchers have recognised the challenges of tracking complex social, economic, health, environmental and systems impacts of coronial recommendations, there are limited examples of research methods that can capture the non-linear nature of these relationships. They implicitly frame the influence of coronial recommendations as a question of implementation; whether a recommendation was adopted, rejected, or partially implemented by the agency to which it was directed. This distinction reflects a broader tension in public administration, between formal compliance and substantive accountability. Mulgan[6] and Bovens[7] distinguish accountability as a narrow reporting obligation, from accountability as a more demanding standard requiring genuine responsiveness to scrutiny. Parker[8] similarly argues that regulatory compliance is better understood as a graduated, evolving relationship than a binary outcome. Simply tracking the acceptance rates of coronial recommendations risks conflating the two, but compliance does not signal substantive accountability.

Establishing that a recommendation has led to substantive reform, rather than mere formal acceptance, is itself only part of a broader analytical task. Even a genuine policy reform does not necessarily demonstrate that outcomes have improved as a result. Assessing whether reforms are associated with measurable reductions in preventable deaths requires complementary quantitative analysis such as mortality trends drawn from the National Coronial Information System (NCIS).[9]

In practice, policy development rarely follows a linear pathway. Reforms addressing risks identified in coronial investigations may emerge through a range of processes including government reviews, research initiatives, regulatory consultation, incremental policy development or legislative reform occurring several years after the original recommendation. Recommendations may contribute to policy change indirectly by shaping policy agendas, informing research, prompting further

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investigations or reinforcing concerns raised through other policy processes.

The visibility of institutional responses to coronial recommendations varies across policy instruments. Legislative and regulatory reforms are typically identifiable through publicly accessible sources such as legislation databases, parliamentary debates and regulatory instruments. In contrast, organisational policy changes and internal operational reforms may be less visible where documentation is not publicly available. As a result, analyses of coronial influence often rely more heavily on legislative and regulatory developments, while recognising that additional institutional changes may occur within organisations but remain undocumented in public sources.

Evaluation approaches that focus narrowly on implementation or acceptance rates may fail to capture the broader ways in which coronial recommendations contribute to policy development and institutional learning.

This paper proposes a structured method, termed Recommendation-to-Reform Mapping, to address this gap. The method provides a systematic approach for tracing how coronial recommendations may influence policy development across legislative, regulatory, programmatic and research responses over time. Rather than focusing solely on implementation, the method reconstructs policy pathways linking recommendations to subsequent reforms, recognising that influence may be direct, indirect, or conceptual.

The method integrates elements of documentary policy analysis, policy sequence analysis and process tracing to reconstruct the sequence of policy developments that occur following coronial recommendations. Documentary policy analysis is used to identify recommendations, policy developments and reforms recorded in official sources. Policy sequence analysis is then used to map the sequence of policy developments that follow. Elements of process tracing are applied to examine documentary evidence linking recommendations to subsequent policy activity.

By systematically identifying recommendations, policy reforms and the documentary evidence connecting them, Recommendation-to-Reform Mapping enables researchers to examine the broader policy trajectories through which coronial investigations may contribute to systemic reform and governance change. This provides an evidentiary basis for assessing a core function of the coronial system's contribution to access to justice[10,11]: whether the findings and recommendations arising from an inquest into a death translate into a systemic response rather than concluding with the delivery of coronial findings alone.

Although developed for analysing coronial recommendations, the method may also be applicable to other investigative and oversight institutions that produce recommendations intended to prevent the recurrence of harm, including accident investigation bodies, public inquiries and regulatory reviews. Royal Commissions, for example, face a comparable challenge in establishing whether recommendations are acted on. A recent study tracked 444 recommendations across six Australian Royal Commissions to assess implementation[12], pointing to the same underlying challenges this method is designed to address.

In the study described in this paper, Recommendation-to-Reform Mapping was developed and applied as one strand of a broader mixed-methods design project, alongside a quantitative analysis of mortality trends drawn from the National Coronial Information System (NCIS). The quantitative method and results from the study are reported separately; this paper describes the Recommendation-to-Reform Mapping method only.

Theoretical foundations

Recommendation-to-Reform Mapping is grounded in three established methodological traditions used to analyse policy development.

First, **documentary policy analysis**[13] provides the foundation for systematically examining legislative records, policy documents, government reports and other institutional sources in order to identify policy developments and their contexts.

Second, **policy sequence analysis**[14] recognises that policy change occurs through evolving sequences of policy events, rather than through single decisions or interventions. This perspective emphasises the importance of reconstructing policy timelines and identifying how policy issues develop over time.

Third, **process tracing**[15-18] provides a methodological approach for identifying plausible causal mechanisms linking events within policy processes. Process tracing relies on documentary evidence to identify the extent to which earlier events or decisions may have contributed to subsequent policy developments.

Each of these traditions addresses a different methodological requirement, and no single approach is sufficient on its own. Documentary policy analysis provides a systematic basis for identifying relevant recommendations and policy events from official sources but does not by itself provide a framework for organising these events into a coherent trajectory over time or for assessing the relationships between them. Policy sequence analysis provides that temporal framework, recognising that policy change unfolds through evolving, non-linear sequences of events, but does not itself specify how such events should be identified or how a causal relationship between them might be inferred. Process tracing was designed to address this gap, providing tools for assessing whether documentary evidence plausibly supports a causal link between earlier and later events. Combining these three traditions allows Recommendation-to-Reform Mapping to move from systematic identification of relevant material, through the reconstruction of policy trajectories over time, to a defensible assessment of whether and how earlier recommendations may have contributed to later reforms.

The method also recognises that policy responses to risks identified through coronial investigations typically operate across multiple institutional levels, including government, regulators and operational organisations. Reforms addressing these risks may therefore occur through a range of policy instruments and institutional actors.

Importantly, policy responses to fatal incidents may occur during the coronial investigation process itself, before recommendations are formally issued. Comparable dynamics have been documented empirically: Sutherland, Kemp[3] found that over a third of coronial recommendations to Victorian organisations were “supplanted” by action already taken, often prompted by an internal investigation conducted independently of the coronial process. This paper terms such pre-recommendation policy activity “early-response reforms”. Because these reforms form part of the broader policy trajectory associated with coronial investigations, the Recommendation-to-Reform Mapping framework incorporates reforms occurring both during the investigation stage and following the issuance of coronial recommendations.

The Recommendation-to-Reform Mapping method

Recommendation-to-Reform Mapping is a structured method for analysing how coronial recommendations may contribute to policy development over time. The method reconstructs policy trajectories linking recommendations to subsequent policy events and reforms using documentary evidence drawn from legislative records, policy documents, government reports and other institutional sources.

The approach combines documentary policy analysis with policy sequence analysis and process tracing in order to identify the sequence of developments through which risks identified in coronial investigations may lead to policy change.

The method involves five analytical stages:

1. Defining the policy domain
2. Identifying and coding coronial recommendations
3. Identifying relevant policy developments and reforms
4. Constructing policy timelines
5. Assessing linkages between recommendations and reforms.

Together these stages enable reconstruction of policy trajectories through which coronial recommendations may influence policy responses to prevent future deaths.

UNIT OF ANALYSIS

The primary unit of analysis is the individual sub-recommendation.

Coronial recommendations frequently address more than one discrete action or target actor within a single recommendation statement. Where a recommendation encompasses multiple distinct components, each component is disaggregated and coded as a separate sub-recommendation. This allows policy translation to be captured at the level of the specific action proposed.

Each sub-recommendation is analysed separately in order to capture variations in how recommendations are translated into policy processes. Sub-recommendations arising from the same coronial investigation, or from the same original recommendation, may follow different trajectories: some may be implemented directly, others may influence reforms indirectly, while others may not be taken up.

Analysing sub-recommendations individually allows these divergent pathways to be captured. Where relevant, sub-recommendations may also be aggregated to the level of the original recommendation, the coronial investigation, or the broader policy domain, to assess cumulative influence across multiple cases.

Analytical procedure

The following section describes how the method was developed and applied in order to examine whether, and how, recommendations made by the NSW Coroner in relation to rock-fishing deaths made their way to policy reforms.

The Recommendation-to-Reform Mapping method was applied through a structured analytic procedure designed to systematically identify coronial recommendations, trace policy developments and assess linkages between recommendations and subsequent reforms.

STAGE 1 DEFINING THE POLICY DOMAIN

A policy domain was defined by identifying a specific category of preventable deaths or risk factors examined within coronial investigations. Defining the policy domain establishes the scope of both recommendation identification and policy reform analysis.

Domains may be defined by:

- type of incident (e.g. drowning, workplace fatalities, road safety)
- environment or behavioural risk factors
- regulatory or institutional responsibility.

Domain definition enables systematic identification of both relevant coronial recommendations and subsequent policy developments addressing the same risk.

STAGE 2 IDENTIFYING & CODING CORONIAL RECOMMENDATIONS

Coronial findings within the defined policy domain were systematically reviewed to identify relevant recommendations.

Each recommendation was extracted and recorded as a discrete analytical unit. Where a recommendation contained multiple distinct components addressing different actions or target actors, each component was disaggregated and coded as a separate sub-recommendation, consistent with the unit of analysis described above.

The following variables were coded:

- Year of recommendation
- Jurisdiction
- Risk or problem identified
- Mechanism proposed to address the risk
- Target agency or institutional actor
- Type of intervention proposed.

Coding these variables allows sub-recommendations to be compared across cases and facilitates linkage with later policy developments. See "Table 4: Recommendation coding" on page 13 coding in the Appendices section for more detail.

STAGE 3 IDENTIFYING POLICY DEVELOPMENTS & REFORMS

Policy developments relevant to the risk domain were identified through systematic documentary analysis. These included reforms occurring after coronial recommendations as well as early-response reforms introduced during the investigation process prior to the issuance of recommendations.

Sources included:

- legislation and legislative amendments

- regulatory instruments
- government policy documents
- parliamentary debates
- government inquiries and reviews
- regulatory guidance and standards
- programmatic initiatives
- infrastructure or operational changes.

These materials were reviewed to identify actions that addressed the risk factors identified within coronial recommendations. See "Table 5: Policy event and reform coding" on page 13 in the Appendices section for more detail.

Policy developments identified through documentary analysis were recorded as policy events within the policy domain. Not all such events constitute policy reforms. Some represent intermediate steps in policy development, such as commissioned research, government reviews, consultation processes or standards development. Recording these events allows reconstruction of the policy trajectory, linking coronial recommendations to subsequent reforms while distinguishing between preparatory policy activity and substantive policy change.

STAGE 4 CONSTRUCTING POLICY TIMELINES

A chronological timeline was constructed mapping:

- coronial recommendations
- research and review processes
- government consultations
- regulatory developments
- legislative and policy reforms.

Timeline construction allows the sequence of policy developments to be examined and provides contextual information necessary for assessing possible linkages between recommendations and subsequent reforms.

This stage also allows identification of periods in which policy attention to a particular issue intensified, including clusters of reforms occurring after coronial findings (or during inquests).

STAGE 5 ASSESSING LINKAGES BETWEEN RECOMMENDATIONS & REFORMS

The final stage assessed whether identified reforms could be causally linked to earlier coronial recommendations. Elements of process tracing methods were applied to examine documentary evidence of the policy processes through which recommendations influenced subsequent policy development and reform. See "Table 6: Recommendation - event linkage" on page 14 in the Appendices section for more detail.

Linkages were assessed along two analytical dimensions: linkage type and strength of evidence.

Linkage type describes the pathway through which a sub-recommendation influenced policy development. This was assessed by examining whether documentary evidence indicated that a sub-recommendation:

- was directly implemented through legislative, regulatory or policy reform
- informed policy development processes that subsequently led to reform (e.g. reviews, working groups or consultations established in response to the recommendation)
- contributed to recognition, framing or prioritisation of the policy issue within government decision-making processes
- showed no identifiable link to a subsequent policy development event or reform, notwithstanding a documented government response.

Strength of evidence reflects the degree of documentary support for a causal relationship between the recommendation and the reform. Consistent with process tracing approaches to causal inference, documentary sources were examined for observable traces of policy processes linking recommendations to reform. Each identified positive linkage was classified using a graded confidence framework (Strong,

Moderate or Low) reflecting the strength of evidentiary support.

Interpretive safeguards

Two interpretive safeguards were applied to maintain the transparency and conservatism of the linkage assessment process.

First, where a government response to a recommendation, or a subsequent policy document, explicitly attributed a reform to the recommendation without independent corroborating evidence, the linkage was not automatically classified as Direct with Strong confidence. Self-attributed linkages of this kind were capped at Indirect linkage type with Moderate confidence, unless corroborating documentary evidence, such as an independent policy review, parliamentary record or regulatory document supported the claimed relationship. This safeguard reduces the risk that government or agency assertions of responsiveness are accepted uncritically.

Second, sub-recommendations for which no policy development event or reform could be identified were not treated as data gaps or omissions. Where a documented government response existed but no subsequent policy event addressing the identified risk could be located, a two-step check was applied: first, confirming that documentary review of the relevant policy domain and timeframe was complete; and second, assessing whether the absence reflected a genuine absence of policy action rather than an undocumented or difficult-to-locate reform. Sub-recommendations satisfying both checks were coded as showing no identifiable link and reported as substantive findings regarding the limits of policy translation, rather than excluded from analysis.

Coding reliability

Given that linkage type and confidence level classifications involve interpretive judgement, coding reliability was assessed to ensure consistency across the research team.

All coded sub-recommendations and their associated policy events were independently double-coded by two members of the research team (100 per cent double-coding), beginning with the rock-fishing domain and applied consistently across subsequent domains. The first coder's classifications were concealed from the second coder, who coded independently from the same documentary sources before the two sets of classifications were compared.

The coding dictionary was developed prior to data collection, informed by the research questions and documentary policy analysis, policy sequence analysis and process tracing traditions underpinning the method. Category definitions were subsequently refined iteratively during coding, as ambiguous or borderline cases were identified and resolved through team discussion.

Inter-rater agreement was assessed for each coded variable using percentage agreement and Cohen's kappa, with kappa values interpreted using the benchmarks proposed by Landis and Koch[19]: values of 0.81-1.00 indicating almost perfect agreement, 0.61-0.80 substantial agreement, 0.41-0.60 moderate agreement, 0.21-0.40 fair agreement, and below 0.20 slight agreement. Kappa values are reported as a descriptive indicator of coding consistency rather than as a pass/fail threshold. Every discrepancy identified through double-coding was addressed directly, irrespective of the overall level of agreement.

Disagreements identified through the double-coding process were resolved through discussion between coders, with reference to the coding dictionary and the underlying documentary evidence until full agreement was reached. Where disagreement persisted, a third researcher adjudicated. The proportion of cases requiring adjudication and the nature of recurring disagreements are reported alongside the study findings as an indicator of the interpretive difficulty of particular coding distinctions.

Applying the Recommendation-to-Reform Mapping method

The application of the Recommendation-to-Reform Mapping method is illustrated using a single sub-recommendation from the rock-fishing safety policy domain in New South Wales, tracked through each of the five analytical stages. Four inquests between February 2011 and July 2015[1] identified recurring risks associated with rock-fishing fatalities in this domain, including the need for lifejackets when fishing at hazardous coastal platforms.

Stage 1: Defining the policy domain. The policy domain was defined as rock-fishing safety in New South Wales, encompassing risks associated with recreational rock-fishing, including behavioural risk factors such as non-use of lifejackets and environmental risk factors such as hazardous access to coastal platforms.

Stage 2: Identifying and coding the sub-recommendation. Within this domain, a coronial finding issued in 2015 recommended mandatory lifejacket use by those engaged in rock-fishing. This recommendation was extracted and coded as sub-recommendation R03.

TABLE 1: IDENTIFYING AND CODING THE SUB-RECOMMENDATION

Recommended ID	Year	Recommendation text	Target actor	Mechanism proposed	Response date	Government response	Response classification
R03	2015	Legislation – requirement for mandatory lifejackets by those engaged in rock-fishing	Minister for Justice and Police	Behavioural re-quirement	24/05/2016	Rock-fishing working group established to identify high risk locations for mandatory lifejacket use	Accepted

Stage 3: Identifying policy developments and reforms. Systematic documentary review of the rock-fishing safety domain identified the subsequent policy event connected to R03: the Rock Fishing Safety Act, which introduced a mandatory lifejacket requirement (E09, 2016). A rock-fishing working group assessment was referenced in the Act's second reading speech which is treated as evidentiary support for the linkage between R03 and E09. See Table 2: Rock-fishing policy event and reform below for an example of this coding.

1 Inquests by Magistrate MacMahon, 25 February 2011 and 13 May 2011; Magistrate Buscombe, 09 June 2011; and Magistrate Forbes, 2 July 2015

TABLE 2: ROCK-FISHING POLICY EVENT AND REFORM

Pair ID	Year	Event description	Event classification	Policy	Responsible actor	Risk factor addressed	Timing relative to coronial process	Evidence base
E09	2016	Rock Fishing Safety Act 2016	Reform	Legislation	NSW Government	Drowning risk in rock-fishing	Post-recom-mendation	Rock Fishing Safety Act 2016; Second reading speech

Stage 4: Constructing the policy timeline. R03 (2015) preceded E03 (2016), which preceded E09 (2016), establishing the sequence required for linkage assessment. R03 (2015) → E09 (2016).

Stage 5: Assessing linkages between recommendations and reforms. Documentary evidence, including the text of the Rock Fishing Safety Act and its second reading speech (which referenced the prior working group assessment) indicated that the legislative reform directly addressed the risk identified in R03. On this basis, the linkage between R03 and E09 was classified as Direct, with strong confidence, reflecting explicit documentary evidence connecting the recommendation to the reform.

TABLE 3: LINKAGE

Pair ID	Sub-recommendation ID	Event ID	Event year	Linkage type	Confidence level	Evidence basis
P102	R03	E09	2016	Direct	Strong	Rock Fishing Safety Act 2016; Second reading speech

This example demonstrates how the five analytical stages operate together to trace a single sub-recommendation from initial coding through to a documented policy outcome. The same procedure was applied systematically across all sub-recommendations identified within the rock-fishing safety domain, producing a complete coded dataset. Applying the stages consistently in this way allows the method to move beyond a single illustrative pathway, to a structured account of how recommendations across an entire policy domain may or may not translate into reform.

Strengths of the method

Recommendation-to-Reform Mapping offers several advantages for analysing the influence of coronial recommendations.

First, the framework moves beyond implementation-based evaluation approaches that assess recommendations primarily in terms of whether they were formally accepted or implemented by the agency to which they were directed. By reconstructing policy trajectories over time, the framework recognises that policy change may occur through indirect, cumulative or delayed processes.

Second, the method enables systematic reconstruction of policy developments using documentary evidence across multiple institutional sources, including legislation, regulatory instruments, government reports and policy documents. This allows researchers to identify reforms addressing risks highlighted in coronial investigations even where those reforms do not explicitly reference the original recommendation.

Third, the framework is also adaptable across policy domains. Where reforms occur primarily through legislation or regulation, publicly available legislative materials provide a clear evidentiary basis for analysis. In domains where organisational policy changes are more prominent, the framework can incorporate additional documentary sources such as agency reports, internal policy statements or regulatory guidance where these are available.

Fourth, the framework provides a structured coding approach that allows recommendations, reforms and policy linkages to be compared across policy domains, jurisdictions and time periods. The coding structure supports consistent identification of reform types, institutional actors, intervention mechanisms and risk factors targeted by reforms.

Fifth, by incorporating classification of recommendation-reform linkages and confidence assessments based on documentary evidence, the framework provides a transparent approach to assessing the strength of plausible relationships between coronial recommendations and subsequent reforms. The self-attribution rule and treatment of non-translation findings as substantive results (see Interpretive safeguards) further guard against overstating the influence of coronial recommendations.

Finally, the framework can be integrated with outcome-focused analyses, including time-series analysis of mortality or injury data. This enables researchers not only to reconstruct policy trajectories but also to examine whether reforms associated with coronial recommendations are followed by measurable changes in preventable deaths. In the study described in this paper, this integration was achieved through a parallel quantitative analysis of mortality trends using NCIS data, reported separately.

Limitations

Several limitations should be acknowledged.

First, Recommendation-to-Reform Mapping relies primarily on documentary evidence. Policy influence may occur through informal processes that are not visible within official documents. A related limitation concerns the different visibility of policy instruments. Legislative and regulatory reforms are generally well documented and publicly accessible, whereas internal organisational policies, operational procedures and administrative changes may not be publicly available in sufficient detail to allow systematic analysis. Consequently, analyses using this framework may capture legislative and regulatory reforms more readily than internal organisational changes.

Second, attribution of policy change to specific recommendations is inherently uncertain. Policy reforms often emerge from multiple sources of influence, including research, advocacy and broader political developments.

Third, reforms may address risks identified in coronial recommendations without explicitly acknowledging the recommendation itself.

Finally, the framework is designed to identify policy trajectories rather than evaluate the effectiveness of specific policy interventions. Assessing the effectiveness of reforms requires complementary analytical approaches, including statistical analysis of mortality or injury trends.

Conclusion

Recommendation-to-Reform Mapping offers a structured alternative to compliance-focused evaluations of coronial recommendations. It traces the documentary pathways through which recommendations may contribute to reform over time rather than treating formal acceptance of recommendations as an endpoint in itself. The worked example included in this paper illustrates how the method's five stages operate together to produce a transparent, evidence-based account of whether and how a specific recommendation translated into policy change. Although developed for the coronial context, the method is readily adaptable to other institutions that issue recommendations intended to prevent the recurrence of harm.

The framework offers auditors, public managers and oversight bodies a more rigorous basis for assessing whether external recommendations are shaping government action, beyond what acceptance rates can provide. Establishing whether such reforms occurred is, in turn, a necessary precursor to the broader question of whether they are effective: whether reforms associated with coronial recommendations are followed by measurable reductions in preventable deaths. Recommendation-to-Reform Mapping therefore provides the documentary foundation on which quantitative assessments of policy effectiveness, such as analysis of mortality trends, can be built.

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Appendices

CODING FRAMEWORK

An open-text notes field was included in each dataset to record contextual information, coding decisions and relevant policy details that could not be fully captured within the structured variables.

TABLE 4: RECOMMENDATION CODING

Variable	Description
Sub-recommendation ID	Unique identifier (e.g. R01a-R01d for distinct components of a single original recommendation)
Case / Inquest	Coronial matter
Year issued	Year of recommendation
Recommendation text	Summary of recommendation
Target actor	Agency addressed
Risk domain	Safety domain
Mechanism proposed	Behavioural requirement Infrastructure / environmental change Public education Enforcement Information / warning Evidence generation / review
Government response	Summary of official response
Response classification	Accepted Partially accepted Noted Rejected

TABLE 5: POLICY EVENT AND REFORM CODING

Variable	Description
Event ID	Unique identifier
Year	Year of event
Event description	Name or description of policy event or reform
Event classification	Recommendation Policy development event Reform

Variable	Description
Policy instrument / event type	Research initiative Agency review or report Policy review or inquiry Legislation Regulation Legislative proposal (not passed) Public education campaign Policy or program initiative Infrastructure or environment change Enforcement initiative
Responsible actor	Organisation or portfolio responsible
Risk factor addressed	Safety risk targeted
Intervention mechanism	Behavioural requirement Public education Enforcement Infrastructure / environmental modification Information / warning Research / evidence generation
Timing relative to coronial process	Pre-existing Early-response Post-recommendation Later policy development
Evidence source	Legislation Report Policy document Parliamentary record

TABLE 6: RECOMMENDATION - EVENT LINKAGE

Variable	Description
Linkage ID	Unique identifier
Sub-recommendation ID	Sub-recommendation being assessed
Event ID	Policy or reform event
Linkage type	Direct Indirect Conceptual or agenda setting No identifiable link
Confidence level	Strong Moderate Low
Evidence basis	Documentary evidence supporting linkage

TABLE 7: CODING DICTIONARY

Event classification	
Recommendation	A formal recommendation issued in a coronial finding or inquest report
Policy development event	Policy activity that contributes to policy development but does not itself constitute a substantive reform. Examples include commissioned research, policy reviews, consultation processes, or agency investigations
Reform	A substantive policy change intended to address identified risks. Reforms typically involve legislative, regulatory, programmatic, enforcement or environmental interventions
Policy instrument / event type	
Research initiative	Commissioned research or study examining the safety risk or policy options
Agency review or report	Review, report or investigation conducted by a government agency or authority
Policy review or inquiry	Formal review, inquiry or consultation process examining policy responses
Legislation	Statutory law enacted by parliament
Regulation	Subordinate legislation, regulatory rule or mandatory requirement introduced under legislation
Legislative proposal (not passed)	Bill or legislative proposal introduced but not enacted
Public education campaign	Public awareness or behavioural change campaign aimed at improving safety
Policy or program initiative	Government program or administrative policy initiative designed to address the risk
Infrastructure or environmental change	Physical modification to infrastructure or the environment intended to reduce risk (e.g. barriers, signage, access change)
Enforcement initiative	Compliance activity, enforcement program or increased regulatory oversight
Event timing	
Pre-existing	Policy, regulatory or operational measures already in place before the coronial investigation began, forming part of the baseline context against which subsequent policy developments are assessed
Early-response	Policy activity occurring during the coronial investigation process before recommendations are formally issued
Post-recommendation	Policy activity occurring after recommendations have been issued
Later policy development	Policy activity occurring substantially later in the policy cycle and not immediately linked to the investigation period
Intervention mechanism	
Behavioural requirement	Intervention requiring individuals to comply with a mandated behaviour (e.g. mandatory lifejacket use)
Infrastructure or environmental modification	Intervention involving physical changes to infrastructure or environmental design to reduce risk
Public education	Awareness or behavioural change initiatives aimed at influencing individual behaviour

Enforcement	Monitoring or enforcement mechanisms designed to improve compliance with safety rules
Information or warning	Provision of information intended to alert individuals to hazards (e.g. signage or warnings)
Evidence generation / review	Research, investigations or reviews undertaken to generate evidence or inform policy development
Linkage type	
Direct	Documentary evidence indicates that the policy event or reform was undertaken in response to a specific coronial recommendation or findings
Indirect	The policy event or reform addresses risks identified in the recommendation but without explicit documentary evidence that the recommendation directly prompted the action
Conceptual or agenda setting	A recommendation contributes to broader recognition of a policy problem or informs subsequent research or policy debate without being directly implemented
No identifiable link	A documented government response exists but no policy development event or reform addressing the identified risk could be identified, following completion of the completeness and substance check described under interpretive safeguards
Confidence level	
Strong	Explicit documentary evidence links the recommendation to the policy event or reform
Moderate	Moderate documentary evidence indicating the recommendation informed policy processes leading to reform
Low	Indirect or circumstantial evidence suggesting the recommendation contributed to issue recognition or agenda setting
Mechanism proposed (recommendation coding)	
Behavioural requirement	Recommendation proposes introduction of rules mandating behaviour
Infrastructure or environmental change	Recommendation proposed modification of infrastructure or the physical environment
Public education	Recommendation proposed public awareness or behavioural change campaigns
Enforcement	Recommendation proposes monitoring or enforcement activity
Information or warning	Recommendation proposed provision of warnings or safety information
Operational procedure/organisational practice	Changes to internal procedures, operational protocols or staff practices intended to reduce risk
Evidence generation or review	Recommendation proposes research, investigation or policy review. Where recommendations request a review or investigation, coding reflects the substantive intervention under consideration rather than the administrative review process itself

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