THE OFFICE OF THE STATE CORONER[1]

Derrick Hand
Acting State Coroner

The appointments of State Coroner and Deputy State Coroner in August 1988 have revolutionised coronial law and practice in the State of New South Wales. The innovation was modelled upon the Victorian system, and in effect makes the State Coroner responsible for the oversight of all coroners and their cases within the State itself. The functions of the State Coroner are:

(a) to oversee and co-ordinate coronial services in New South Wales;

(b) to ensure that all examinable deaths and fires are properly investigated;

(c) to ensure that an inquest or inquiry is held whenever it is desirable to do so;

(d) to issue guide-lines to coroners; and

(e) to exercise such other functions conferred or imposed.

A system has been set up whereby all deaths reported to coroners in this State are notified to the State Coroner, and this is now a statutory requirement. The State Coroner has power to assume jurisdiction in any case, and the result is that he or his Deputy make regular visits to other courts where they hear inquests or inquiries into the more difficult and lengthy cases reported to coroners. Most deaths in custody are dealt with in this way, and there were 25 of those in 1989. In the first six months of 1990, the State Coroner or the Deputy State Coroner heard cases at a number of country centres.

The Coroners Court at 40-46 Parramatta Road, Glebe, is also a Local Court, and the State Coroner and Deputy sit there as magistrates hearing committal proceedings where persons are charged with murder or manslaughter, unlike their Victorian counterparts whose duties relate solely to matters coronial.

The *Coroners Act* 1980 gave coroners far greater power to dispense with the holding of an inquest than was possessed previously. The 1988 statistics of Coroners Courts, prepared by the Bureau of Crime Statistics and Research, show that of all deaths reported to coroners, only one in nine was decided by a formal inquest. At Glebe, in 1989, that statistic was one in 18. The result is that fewer inquests are held, but those which are determined in the court contain issues which are important and far-reaching in effect, or which are very controversial. The spate of disasters which overwhelmed New South Wales in the second half of 1989 resulted in the office becoming extremely high profile. There were two motor vehicle accidents which created new Australian records for the number of persons killed, the first deaths ever to occur from earthquake in Australia, plus deaths from a fire, a boating tragedy and a train crash (early on 1990) which have highlighted the existence of the Office of State Coroner and the application of the laws of the coroner

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generally. The hearing of the inquests also demonstrated that the coroner is prepared to explore beyond the mere formal taking of evidence relating to the manner and cause of death, and will hear expert evidence at length directed at the making of recommendations which will have the effect, if implemented, of substantially reducing the number of similar deaths in the future. It is emphasised that these recommendations must arise out of the circumstances of the particular death itself, and must be based on evidence actually heard and tested, not upon the personal opinions of the coroner himself or herself. The system has been adopted of forwarding copies of findings and recommendations to the Minister of the Department concerned, and requesting a response setting out what action has been taken consequent upon the recommendations.

A coroner wants to find out what happened, why it happened, what role did anyone play in causing it to happen and whether it can be prevented from happening again. He or she may not make a finding that a person has committed an offence (s22(3) of the *Coroners Act*) but may refer a matter to the Director of Public Prosecutions if appropriate (s19(2) of the *Coroners Act*).

A coronial inquiry is not concerned with allocating blame to any person or body or with finding anyone liable for what happened. These may result as a consequence of the inquiry but they are not the reasons why a coroner decides to hold an inquiry. A coroner decides to hold an inquest or inquiry either because the *Coroners Act* requires that it be held or because there is some features of the matter which warrants the holding of an inquest or inquiry. The coroner may wish to have the opportunity to examine the witnesses and test their evidence. He or she may think that the facts are such that the public should be alerted to some danger or they are the source of controversy and should be put to public scrutiny.

Coroners and the public also need to be educated as to the limits of the Coronial jurisdiction. A coroner is mainly concerned with those matters contained in s22 of the *Act*. However, as mentioned in the report of His Honour B.R. Thorley in the Azzopardi Inquiry, paraphrasing Bowen JA in *Bilbao v Farquhar* (1974):[2]

> the purposes underlying coronial inquiries include the satisfaction of legitimate concern of relatives, the concern of the public in the proper administration of institutions and matters of public and private interest.

It is generally agreed that one role of the coroner is to alert the community and public authorities to the existence of perils or dangers which have been revealed in the course of an inquest or inquiry. However, on occasion, parties may attempt to use the inquest or inquiry as a de facto Royal Commission or other such inquiry in order to air controversies or disputes which do not relate directly to the matters under consideration. This is outside the jurisdiction and responsibilities of a coroner. If such an inquiry or Commission is warranted, the parties should seek to have it set up in the appropriate way, with accurately defined terms of reference and adequate resources for the proper conduct of the inquiry.

2 *Bilbao v Farquhar* (1974)1 NSWLR 377.

On other occasions, there has been an expectation that the coroner can hear evidence and conduct a criminal trial in a matter. This is not appropriate for several reasons. The coroner, if not a magistrate, is not empowered to deal with any such purported prosecutions. The alleged defendant does not know the precise nature of the charge and will often have no opportunity to prepare any defence. As a coroner is not bound by the rules of evidence applicable in a criminal trial, he or she may receive information which would not be admissible at a trial.

It is often sought by legal practitioners to use an inquest as a source of evidence for future civil damages proceedings. This is not the purpose of an inquest, as coroners frequently point out. However, it has often been said that the inquest is a useful vehicle for the gathering of information while it is fresh and available. The coroner's inquiry is impartial and so the evidence collected is normally reliable. The whole process should result in the clarification of issues which might be expected to be raised at a damages hearing. For these reasons coroners normally may be expected to permit some relaxation in the rules of relevance to permit those issues to be explored, and will notify lawyers once the bounds of relevance are stretched beyond the limit.

In the Interim Report of the Royal Commission into Aboriginal Deaths in Custody, Muirhead J said, *inter alia*:

> The value of the Coroner's role must now be recognised, the responsibilities of that office require recognition of the Coroner's true status, the provision of adequate and co-ordinated facilities. In my view the Coroner should be the person basically in charge of investigation of deaths within his or her jurisdiction and those responsibilities should be recognised. The terms and conditions attaching to Senior Coroner or State Coroner's office should certainly be not less than that of a Judge of a District or County Court. The office represents the only tribunal which can investigate circumstances fairly and quickly, before memories fade or perhaps before reconstruction rather than memory influence the minds of witnesses.
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> A first class and co-ordinated coronial system is of tremendous value to the law, both in criminal and civil spheres, and constitutes a continuing monitor of public safety, be it on our roads or in industrial and other spheres. And it must be a system which retains public confidence. As I mentioned earlier in this report, coronial investigations appear to have been thorough since the establishment of the Commission, but Coroners who are not themselves associated with the investigative role can do little, save perhaps comment, concerning investigative procedures and practices.

INVESTIGATIONS

Investigations on behalf of the coroner are carried out by Police. While it is sometimes suggested that a body other then police should perform this function, no one has indicated from where this force would be recruited. The Police Force is a disciplined body with well-established lines of authority. It has access to vast resources, including finance, transport, (land, sea and air), manpower, expertise (fingerprinting, ballistics, document examination, criminal records) and special purpose squads. In most cases it is the best and indeed the only body able to carry out a proper investigatory role.

A difficulty arises where the death results from actions by a member of the Police Force. The criticism is then often made that investigating Police may "cover up" for the member involved in the death. It is said that whether there has been a cover up or not, the suspicion that such a thing took place will forever remain. The Police have taken steps to allay suspicion (for example, in a shooting case a squad is formed of detectives not involved in the operation during which the fatality is suffered, and from a different region), but such a system is not perfect. Some people would never be satisfied that the inquiries were genuine and thorough. It is the responsibility of the coroner to do all he can to ensure that the investigations are fair, competent and thorough. There has never been brought to our attention any satisfactory way of forming a Coroner's Squad or similar body under his direct control. There are other considerations as, for example, in the case of a violent death, Police would have to be brought in anyway to look into the possibility of a crime having been committed, while the Coroner's Squad was gathering evidence on behalf of the coroner. Waste and duplication would result, and one would anticipate a substantial degree of rivalry and hostility generated.

A step in the direction mentioned has been taken by the formation of the Coronial Investigation Unit (CIU). This Unit commenced with the appointment of one Police officer, and has now grown to six. These officers are seconded to the Attorney General's Department. The result of this is that they remain Police for the purposes of salary, leave, promotion and the supply of equipment, but are under the direction and control of the State Coroner so far as their activities are concerned. They dress in plain clothes, carry no weapons, and investigate mainly medical and hospital deaths and industrial accidents, and have a supervisory role where deaths occur in prisons or police cells. In the course of their duties they have established relationships with many medical experts who give independent reports of enormous value in hospital and medical cases, usually for no fee. They get expert evidence from university organisations in industrial cases, usually at a very substantial fee. The CIU does not inquire into deaths where a crime may have been committed.

CORONERS' EDUCATION

One of the main areas of concern in the Coronial jurisdiction has been the lack of training and inexperience of some coroners, who are required to deal with sometimes very complex and controversial matters with little knowledge of how to conduct the inquest or inquiry and no idea of where to turn for advice. This problem has been addressed to a large extent by the creation of the State Coroner's Office and the introduction of a mandatory training course. However, it is apparent that more will need to be done to answer the concerns raised, particularly those raised by the Royal Commission into Aboriginal Deaths in Custody. Further proposals in this regard have been made and will in due course, be circularised to interested bodies for their comment. In the meantime the State Coroner attends to his educational responsibilities by addressing coroners at Local Court conferences in person or through his Deputy, and by the distribution of circulars to all coroners and magistrates in the State, as well as to other interested bodies.

PUBLIC EDUCATION

In tandem with the concept of prevention of death is that of public education. In days gone by, representatives of the media attended the Coroner's Court at Glebe every day. This court not only hears inquests, but the coroners are also magistrates who determine committal cases for murder, manslaughter and culpable driving, all newsworthy matters. In more recent times, though, attendance has fallen away and journalists only appear now whenever something of a more sensational kind is listed. The result is that coroners may issue warnings about electrocution, drowning and the like which go unpublished and so unnoticed.

A system is now being introduced whereby the State Coroner or Deputy State Coroner will issue press releases through the Attorney General's Department to ensure that unusual dangers are brought to the attention of the public.

The Coroners Court complex also provides education by way of lectures, court attendances and supply of written materials to potential coroners, nurses, the Police and medical students. The Division of Forensic Medicine, which is part of the court complex, provides tuition to country doctors who perform autopsies for their local coroners.

THE CONCERN OF RELATIVES

Another purpose in holding an inquest is to satisfy the legitimate concern of relatives. With this in mind, it is the almost universal practice among coroners that if a near relative of the deceased asks for an inquest, an inquest is provided. Experience shows that relatives react to sudden death in varying and unpredictable ways. Some wish to remain alone in their grief, spurning the public ventilating of surrounding circumstances; others want a full and open inquiry to either establish all the facts or to attempt to place the blame on an outside person or body for the death. This latter type of case occurs most frequently in "hospital cases", where it sometimes happens that an application for an inquest by a relative is refused. This happens when the circumstances of the death are clear, the evidence (usually including the opinion of an independent expert) shows no indication of negligence, and the holding of a formal inquiry would greatly disrupt and perhaps unnecessarily embarrass the doctors and nurses at the hospital concerned.

SOCIAL ISSUES

Especially in recent years there have been representations by pressure groups to the effect that inquests should take account of and make recommendations regarding issues of a wider social significance than are customarily considered, and beyond what appears to be envisaged by the *Coroners Act.* The targets of these proposals are the usual bodies which come under fire from such quarters, like police, prisons, doctors and hospitals. Areas of concern are the arming of police, police motor vehicle chases, use of shock treatment in psychiatric hospitals, the adequacy of medical treatment of prisoners, and such like. While one makes recommendations aimed at improving systems on a reasonably regular basis, we usually resist proposals that coroners should attempt to instigate sweeping social

change on the basis that the matters raised are not really those to be determined by a single coroner, but rather by the elected Government.

It is obvious that every coroner would not have the same social, political and psychological outlook, so that pronouncements respecting social issues would vary like "the Chancellor's foot". In other circumstances, a coroner would not know important information like the cost involved of any proposal. He would not know the competing priorities of a Government department. He does not know Government or Ministerial policy.

It is, as I have already said, a dangerous practice to draw extensive inferences from a single case. If the facts are such that they call out for remedial action, and quickly, the coroner should speak out. If the coroner hears a number of cases showing a like problem, he may feel it is his duty to bring that problem to the notice of the public or the appropriate authority. In our view he should be loathe to make public statements addressing issues which are clearly in the domain of Government.

In the fullness of time one can envisage that the State Coroner and Deputy will eventually abandon their work as committing magistrates in cases of murder, manslaughter and culpable driving and will deal with inquests and inquiries only. The Coronial Unit will be expanded, and will undertake more investigations where the consequences may save lives, especially in industrial accidents. The Coroner will become involved in civil safety programmes, like the State Emergency Services, to be on hand and lend his expertise in the event of a major disaster like a civilian aircraft crash.

The office of coroner has existed for some 800 years. The Interim Report of The Royal Commission into Aboriginal Deaths has urged that the importance of the office be recognised, supported and expanded. May it survive another eight centuries!