TOWARDS A NEW SOUTH WALES CORONIAL SYSTEM FOR THE NINETIES[1]

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INTRODUCTION

Coronial law and practice have received considerable attention over the past decade. We have had a series of very controversial inquests such as those into the deaths of Warren Lanfranchi and at the Hilton Bombing, and the firing of Eddie Azzopardi's garage to name a few. We have two Royal Commissions inquiring into deaths that had or should have been dealt with by the coronial system — those of Aboriginal people in custody and from so-called 'deep sleep' treatment and Electro-Convulsive Therapy. The presence of two speakers at this seminar from the Commissions itself indicates that all has not been well with the coronial system. Many of these cases were followed by public agitation by families, lawyers and members of Parliament out of concern with the original coronial investigations and hearings. From another angle, there is a now a network of counselling and bereavement groups that have come together under the banner — *Coalition for Change in the Coronial System* — drawing up a Charter of Rights of the Bereaved.

In terms of official attention, we have had the scathing 1987 Report of the Taskforce on Services to Victims of Crime, a Working Party report on forensic services in 1989, and an Inter-Departmental Committee considering matters arising from the Royal Commission into Aboriginal Deaths in Custody.

We saw this Government come to power with a commitment in its platform to reform the coronial system. A number of legislative and administrative changes have followed; more are in the pipeline. In 1988, the Attorney promised a thorough review of the coronial system. The Public Interest Advocacy Centre (PIAC) has pushed for this to be a comprehensive and consultative exercise. The State Coroner has recently put to the Attorney some further proposals to alter the *Act*, and PIAC has gladly welcomed an invitation to respond to the recommendations. Last year, a Private Members Bill with amendments to the *Coroners Act* was prepared for introduction by the Australian Democrat, Elizabeth Kirkby.

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1 Paper delivered at a public seminar entitled "Coronial Inquiries", convened by the Institute of Criminology at Sydney University Law School, 10 October 1990.

2 The Public Interest Advocacy Centre (PIAC) is a public interest litigation, policy and research centre based in Sydney. The Centre is an independent and non-profit organisation. It was established in 1982 as an intitiative of the Law Foundation of New South Wales, with the support of the New South Wales Legal Aid Commission. PIAC receives the continuing support of these two bodies. It also generates income with project and case grants, by recovering costs in successful legal actions and by donations. PIAC has received funding from the Law Foundation of New South Wales to undertake a major Project on the New South Wales Coronial System.

More recently, we have had some very public inquests into the Davis Gundy killing, the Newcastle earthquake, bus and truck crashes, and boating and hostel fire disasters.

This seminar is indicative of the importance and the public interest in the coronial system. It is a timely opportunity to consider some of the system's strengths and weaknesses, and to consider what sort of coronial system we require. This paper presents PIAC's tentative view of a coronial system appropriate for the 1990s.

PIAC'S INTEREST

PIAC's interest stems from its case and policy work in this area. Since 1984, PIAC's solicitors have been involved in various of the proceedings initiated by victims of Chelmsford, including representing family members in the second Francis Inquest, and a number of patients, families, nurses and the Citizens Committee for Human Rights before the Royal Commission. We have also acted in other coronial matters concerning deaths in public hospitals and a police shooting.

Since 1987, PIAC has taken a strong policy interest in coronial law and practice. In view of the cases in which it has acted, and the criticisms generated by other cases referred to above, PIAC determined to address some of the structural issues — legislative and organisational — that needed attention and possible reform. Early in 1988, a Preliminary Submission was made at the invitation of the Attorney General. This was also subsequently submitted to the two Royal Commissions.

Also in 1988, a submission for funding was made to the Law Foundation of New South Wales to undertake a detailed review of the law, administration and procedures of the New South Wales coronial system, and compare them with other systems in Australia and overseas. The Centre's aim was to come up with practical suggestions for reform. This was begun a year ago, with five main aspects — a series of interviews and surveys with families (40) and those (53) who work in or with the system (coroners, police, lawyers, pathologists, forensic assistants and counsellors), an Issues Paper for consultation with key individuals and associations, an exhaustive literature review, a comparative legislative analysis and a booklet for bereaved families and friends. To date, the surveys have been completed; the Issues Paper distributed (see Appendix); an Annotated Bibliography prepared; and an Information Booklet is ready for publication. The Report is expected in November 1990. The views expressed to us in large part support, and will greatly assist us to develop further, our preliminary views.

The following comments draw upon this work. It does not give a conclusive position, but identifies the key issues, presents some preliminary findings and makes some tentative proposals. Before making the critique of the current system, it is worth considering some of the fundamental issues that need to be addressed.

First, we must consider what is the proper role of the coronial system? To what extent should it be investigative? To what extent should it be preventative? What should

we learn from the differences and the reforms in other jurisdictions? What should its objects be? Should they be articulated as in Saskatchewan? How should it achieve them?

Secondly, what are the strengths and weakness of existing law and practice? How explicit should the law be in regulating the powers, procedures and activities of the coronial system?

Thirdly, what structures and resources are necessary for the coronial system to appropriately fulfil its functions? How does it compare to other investigative/educative bodies — the ICAC, Ombudsman, Judicial Commission, etc? Could the massive resources expended on further inquests, the royal commissions, judicial reviews, official attention, and on-going agitation been saved by a properly equipped coronial system?

Finally, how responsive and accountable is the system to the situation and needs of its users — the bereaved families and friends, the staff and the other professionals who deal with it, and to the public interest?

A GENERAL CRITIQUE

In my view the coronial system has never had the status it deserves. It has been the proverbial 'poor relation' in the administration of justice in New South Wales. It was trapped in a residual role — no longer investigative in orientation as it once was, and relying largely on clerks of local courts, police and the health department, for whom coronial work was of no great priority or interest. It became a processing mechanism, quite efficiently doing the paper work on unusual deaths for the Registrar of Births, Deaths and Marriages. It occasionally went beyond this to focus public concern and official attention on particular problems or regulatory deficiencies, such as the need for fencing around swimming pools.

As PIAC's Preliminary Note to the Attorney General points out, the nature and history of the office of the coroner makes clear that it is a public mechanism by which deaths in suspicious circumstances are to be accounted for. A particularly important role of the coroner is in relation to deaths involving state agencies. This has long been recognised in case law, legislation and official reviews. Such terms as 'an independent check' and 'public examination', have been used to describe that role. References are also made to the public's 'legitimate curiosity', the 'felt risks of the facts being suppressed', and to 'public disquiet'. The New South Wales Chief Justice's Law Reform Committee referred in 1964 to it as "an opportunity for the public examination of the thoroughness or otherwise of the police investigation"; and elsewhere it described the inquest as an "independent check" on the opinion of the police.[3]

The underlying principle has been the 'public interest' in the investigation and inquiry into such deaths. To give that notion any meaning, PIAC's position has been that

3 Chief Justice's Law Reform Committee, *The Powers and Procedures of Coroners at Inquests and of Magistrates at Committee Proceedings*, Interim Report No6 (1964) para 3.

the purpose of the coronial system is to provide full and open scrutiny and accountability. Yet this too requires elaboration. Criteria must be articulated to determine whether, in any case, and generally, the coronial system ensures scrutiny and accountability. Those criteria should be independence, impartiality, fairness and efficacy.

There are legitimate questions as to the adequacy of the existing legislative framework and organisational arrangements to ensure that the coronial system meets those criteria. Our Preliminary Submission expressed the view in strong terms that the New South Wales coronial system had too often not provided sufficient scrutiny and accountability of the circumstances of a death.

Moreover, the coronial system itself must be accountable. That accountability should be manifested at various levels: to its 'users', to the public generally, to the executive government, to parliament, and to the justice system. Further measures than currently exist are required to guarantee that the coronial system satisfies the 'public interest'. It is a question of both the substance and appearance of justice. There should be no room for concerns that the system is a cover-up, is providing partial immunity, or is glossing over the context of such deaths. This is not an attack on the integrity of those running the system. With few resources, and some exceptions, the magistrates and clerks have done their job well. It is a matter of what we expect of them and what we give them to do it.

We should acknowledge the significant changes that have taken place in recent times — the appointment of the State and Deputy State Coroners, the improvements in training programmes, the expansion of counselling services, and the procedural reforms. We must now determine what else needs to be done.

There are still significant problems of a general nature that will be not be solved by piece-meal amendments to the legislation. These relate both to its legislative framework and organisational arrangements. The 1980 legislation, even as amended, is by no means a codification of the law. It is silent on many specific matters; it is too narrow or too vague on others. Of the diverse roles of the coronial system, only the judicial aspect — the conduct of inquests — is regulated to any significant extent. The administrative, investigative, preventive, and educative roles lack an appropriate legislative base.

In terms of its organisation, the system is still not structured or resourced to undertake the broader brief that the community needs, and increasingly expects, from it. The steps toward greater central co-ordination and control with the appointment of the State Coroner are most welcome. But do they go far enough? Can we afford not to treat the system as a major public institution, with significant management, resourcing, staff development, data, liaison, information and public education needs.

Despite the improvements in counselling services, particularly in relation to disasters, the system is not yet thoroughly 'user friendly'. The needs of bereaved families and friends of the deceased and other interested persons in relation to notification of deaths, access to the deceased, the conduct and explanation of forensic examinations, the manner of notification of other key points in the system's dealing with the deceased, their

participation in key decision-making processes, their rights in relation to investigations and formal hearings, and their access to advocacy and support in and outside the system are outstanding issues.

Finally, the representation of the 'public interest' is inadequate. The coroner exercises his or her role for the 'public interest', but is that sufficient to guarantee that due regard is paid to it. Coroners come from a context that is not usually investigative or inquisitorial. The judicial role in local courts is as a passive recipient and adjudicator of evidence presented by competing parties. Those attending inquests, at least in contentious matters, while not strictly 'parties', are nonetheless in an adversarial situation. In all cases, too much responsibility to represent interests other than those of the individuals or agencies involved in the death falls on the existence, willingness and resources of relatives of the deceased.

This is too great a burden. It is itself a cause for concern without even considering all the specific limitations within the coronial process which inhibit full participation by non-state 'parties'. The imperative for those with some connection with the death to deny culpability, is too strong for the contesting of the versions of those directly interested — especially when the death is of someone in a public institution — to be left so equivocal and subject to circumstances. This is even more worrying when there is evidence of police and others actively dissuading relatives from attending inquests. The 'public interest' cannot be guaranteed given this situation. At present there is no mechanism for independent or official public interest representation in cases raising issues of major public concern.

SPECIFIC PROBLEMS

(a) Administrative arrangements

In our 1988 Preliminary Submission, we argued that the failure to provide for any express, comprehensive, and structured responsibility for the coronial system was a serious flaw in the legislation. The legislation is no longer silent on the matter of administrative arrangements. The statutory position of State Coroner, with clearly expressed responsibilities and powers, goes a long way toward an institutional structure. However, the complex and fractured pattern of administrative responsibility, with different parts of the coronial system currently split between the Attorney General's Department, the Health Department and the Police Department, is not resolved. The State Coroner does not have budgetary and managerial control over the system.

There is not a body in a corporate sense. There is no New South Wales Coronial Service as in Victoria, no statutory authority, commission, or office. Perhaps we should look to the structures provided to the bodies mentioned previously — the Office of the Ombudsman, the Judicial Commission and the Independent Commission Against Corruption (ICAC). Unlike the Victorians, we have not created an independent Institute of Forensic Pathology, with a board provided for in statute.

The decentralised nature of the system — with clerks of local courts having the role of coroner as another of their myriad functions — is a particularly difficult issue to resolve. The problems for uniformity, capacity and co-ordination are only partially overcome by the existence of the State Coroner, even with the reporting requirements to, and powers to give directions and guidelines by, the State Coroner. While there are considerable benefits of accessibility in the use of local justice officials, other options need to be considered. The State Coroner has flagged the possibility of differentiating their ranks by designating new or inexperienced clerks as Assistant Coroners and more experienced ones, based in larger towns, as Supervising Coroners. In Victoria, coroners must be stipendiary magistrates or solicitors or barristers. Another option would be Regional Coroners as in Ontario. If it is good enough for there to be specialised coroners' courts at Glebe, Westmead, Newcastle and Penrith, why not Wollongong, Lismore, Tamworth, Dubbo and Wagga?

There is also room for improvement in the training and resourcing needs of coroners. Professional training courses have now been introduced, but only for new recruits. For years, coroners were given only a copy of Mr Waller's book, essentially an annotated Act, and not much else. The distribution by the State Coroner of a regular bulletin has improved the situation, but as yet there are no collected reports, guides, handbooks or other resources. The second edition of Waller is now well out of date.

In 1987 a Task Force on Services to Victims of Crime reported on the information and counselling needs of the bereaved. It uncovered endemic and systematic problems which they found to actually make matters worse for grieving families and friends. Some, but not all, of its recommendations have been implemented. There are now three counsellors in the system instead of one, but the service they can offer is limited, especially for country people.

Another neglected area of the coronial system is its educative and research role. Notwithstanding the best efforts of the State Coroner, and the small administrative staff, without specialist officers with the skills and contacts to undertake these tasks, the system will not adequately fulfil its role of educating either the public or those agencies regulating the areas or activities in which deaths occur. In recent years, the collection and collation of coronial statistics has been up-graded by the Bureau of Crime Statistics and Research, and by the State Coroner himself, but there has been very little qualitative research or evaluative monitoring of coronial information. It has taken years for basic computer systems to be installed. Why aren't there state, and even nation-wide coronial information systems, so that patterns of deaths, such as the propensity of certain types of tractors to tip over, can be determined quickly?

As for means of ensuring accountability to Parliament and the public, what about a coronial council as in Ontario? Why shouldn't the State Coroner make annual reports to be tabled in Parliament, as recommended in Hong Kong and like the Ombudsman and ICAC here, or even special or public reports on matters arising from important, or a series of, cases.

(b) The investigation

In our 1988 Preliminary Submission, we put forward the view that:

> the current arrangements for the investigative part of the coronial system are likewise characterised by a deficient legislative base and bureaucratic structure.

One significant problem stemmed from the uncertainties surrounding the investigative functions of the coroner. For most of the long history of the office, the coroner's role was essentially investigative. That function waned with the development of police forces, the formalisation of the coroner's procedures, and the (uneasy) incorporation of the coroner into the judicial hierarchy. Legally and practically those powers have fallen into disuse.

The *Coroners Act* provides limited recognition of investigatory powers. Section 13 makes certain deaths "examinable" by a coroner; and s25 empowers the coroner to authorise the examination of any place, including the taking of measurements and photographs. The new section 17B allows the State Coroner to give directions to coroners and to members of the Police Service regarding investigations to be carried out. However, uncertainty as to the investigative powers of coroners themselves has not been resolved. Do their common law powers persist? Why is there no obligation on coroners to investigate into all relevant matters and with due diligence? Why no powers to authorise the seizure of relevant documents? Why no requirements to stipulate findings when inquests are dispensed with? Where are the criteria for the dispensing of an inquest? Unlike the reforms in Victorian and Canadian legislation, the New South Wales system is yet to be re-orientated to an investigative body.

In relation to investigations, the coroner is very much dependent on police for the conduct of coronial investigations, even in cases when other police are involved in the death. Police play a central role in the coronial system. This may be practical, but it makes problematic the extent to which an inquest is supposed to be a supervisory mechanism over the police, especially since inquests take place in only a small proportion of cases. Their functions include informing the coroner of a death, conducting the investigations into the death (including interviewing witnesses, and delivering specimens), preparing the brief for the inquest, assisting the coroner and securing the attendance of witnesses.

Again, questions of expertise, commitment and independence have only been partly addressed. For most police, coronial duties are regarded as unpleasant and of low priority, for which they receive little training. The typical focus of police on criminal responsibility must necessarily be narrower than the ambit of an inquest. In cases involving state agencies, there is also the potential for real or perceived conflicts of interest, for structural, ideological, and cultural reasons.

The secondment to the Attorney General's Department of the police-staffed Coronial Investigation Unit (CIU), deals with these issues to some extent. However, the desirability of multi-disciplinary investigative teams — with legal, health and financial expertise — such as exist in other bodies like ICAC, the Ombudsman's Office and the Health Complaints Unit, needs to be considered. What about full-time legal counsel, as recommended in Hong Kong?

The other main aspect of the investigative phase of a coronial matter is the forensic investigations. Here the problems are considerable. Delays in the production of reports for certain tests are lengthy, and a cause of tremendous grief to families and difficulties for coronial personnel. These were considered by a working party of officials from the relevant departments in 1989, but the recommendations of their report remain for the most part still to be acted upon. The one week course now offered to Government Medical Officers does only a little to overcome the problem caused by the continued use of GPs, rather than forensic or even nonforensic pathologists, to conduct post-mortems. For expert medical opinion, the CIU has a very modest budget to pay for consultant's reports.

Are the resources for forensic services enough? What about a Chief Medical Examiner, to give us a mixed model (as in Saskatchewan) that adopts something of the medical examiner systems that have replaced coroners in much of the USA?

(c) The inquest

The judicial aspects of the coronial process have been legislated for to a greater degree than the administrative and investigative parts of the system. As noted earlier, the *Coroners Act* is concerned primarily with the conduct of inquests. The inquest is certainly the most obvious and public part of the coronial system.

Our 1988 Preliminary Submission made many comments about the problems with the ways in which inquests are regulated, in particular, the lack of certainty as to the ambit of an inquest, the broad discretions given to coroners, the insufficient guidance given to their exercise, the lack of guidance with respect to the determination made at the conclusion of the inquest, and the few rights of those appearing before the coroner. Few of these have as yet been addressed.

First, the provisions concerning the character of an inquest are ambiguous and unduly restrictive. The ambit or scope of an inquest, and its terms of reference, are of primary importance. However, the *Act* provides little help. Where a death is "examinable" pursuant to s13(1), a coroner has "jurisdiction to hold an inquest". However, at no place in the legislation are the meanings of the terms defined or adequately elaborated. The definition in s4(1) of "inquest" refers to it as meaning "an inquest concerning the death or suspected death of a person". This is an obviously circular definition. It results from the partial implementation of the recommendations of the Chief Justices' Committee and of the New South Wales Law Reform Commission, in particular, from the failure to include in the definition a reference to "circumstances".

There is no guidance to be found in any "terms of reference" for the inquest either. The only indication of the matters which the inquest should address is to be found in the section of the legislation which provides for the "recording" of a coroner's findings, or if there is a jury, its verdict. Section 22 suffers the same deficiency as that which previously applied to the definition of an inquest. At present, it is confined to whether the person died; if so, his or her identity; the date and place of death; and the manner and cause of death.

Unfortunately, in the absence of positive statements of the properly broad ambit and concerns of an inquest, coroners have frequently tended to look to s22 as a de facto indication of the scope and focus of an inquest. Accordingly, too often the inquest fails to fulfil its proper function because of the narrow and restrictive interpretation of its character adopted by coroners. There are no such injunctions as those in the Scottish system, that require attention to such matters as:

- any incident resulting in the death and the causes of the incident;
- the cause or causes of such death and any incident resulting in the death;
- the reasonable precautions, if any, whereby the death and the incident resulting in the death might have been avoided;
- the defects, if any, in any system of working which contributed to the death or such incident; and
- any other facts which are relevant to the circumstances of the death.

Perhaps we need an obligation to inquire thoroughly and with due despatch into all relevant and ascertainable; the definition of inquest expanded to include "circumstances"; and a list of minimum matters to be reported upon (together with a proviso that this is not to be taken to limit the proper scope of an inquest).

Given the public interest in deaths involving state agencies, it is surprising that the requirement for mandatory inquests does not cover all instances of deaths in which state agencies are involved. There should be no room for arguments that someone was not actually in custody (such as in the Gundy case) when killed, for example, in a car chase or police shooting.

As in other areas, the legislative framework for the procedural and related aspects of the inquest is found to be wanting. Here it is a case of the legislation not providing guidance to coroners, and being unduly restrictive of participation of those appearing. The coroner has unparalleled discretions in relation to inquests compared to other judicial officers. In relation to the issue of standing, there is no right to appear as such, as it is a matter of the coroner's discretion. No reasons need be given for a refusal, nor is review available.

The lack of adequate provisions for disclosure of, and access to, information amounts to one of the most important barriers to the effective participation of relatives, friends and others at an inquest. In non-controversial cases, access to medical and other reports prior to or during an inquest will usually be granted upon request. The 1980 *Coroners Act* makes provision for such with respect to forensic reports (only) pursuant to s51. At present, parties to an inquest have no right of access to the information to be put before the coroner, unlike in Victoria. Just because an inquest is supposed to be inquisitorial doesn't mean that the participation of others should be on the basis of "one hand tied behind their backs".[4]

4 Ward, T., "Speaking for the Dead" (August, 1984) *Legal Action Bulletin* 7.

The traditional proclamation of an impending inquest "invites all the world to come forward and tell what they know". In New South Wales, however, the common law concerning witnesses has been substantially narrowed by the relevant legislative provisions and the usual practice adopted at inquests. The coroner has exclusive control over the attendance of witnesses, although the influence of the police over the pre-inquest process should be kept in mind. There is no provision for persons appearing to call or even request that witnesses be brought forward, or for reasons to be given for failure or refusal to do so.

The provision for juries at inquests is one of the most enduring and endearing features of the coronial system. From its very beginnings, the coronial process has involved to some extent a judgment of a deceased's peers as to the circumstances of the death. The provision for juries is a clear manifestation of the public interest in deaths occurring in questionable circumstances. Furthermore, juries are, at least potentially, a significant check on the coronial process, a means of ensuring that both the police and the coroner adequately perform their functions. Unfortunately, the ability of a jury to be such a check is limited in a number of respects.

The first problem concerns whether or not a jury will even be empanelled for an inquest. At present, a jury is not mandatory in cases of deaths involving state agencies. In the United Kingdom, both the Broderick Committee and the Home Affairs Committee recommended that juries be mandatory in cases of deaths in custody, and given effect to in an amendment in the 1982 UK *Administration of Justice Act.* Why should this not also be the case in New South Wales?

Another area of concern is the problematic nature of the role of the jury. This is evident in a number of ways. It is unclear both in law and practice in New South Wales whether juries can ask questions, request the recall of witnesses, or request the reception of evidence of persons not so far called. Also, while it is accepted that a jury may add a rider to its verdict, this has no statutory basis. Further, there is little guidance given to them to assist such a function. In Victoria, there are express provisions about the role of a jury in inquests.

The question of the relationship between the coronial system and the criminal justice system is a vexed one. This arises from the coroner's powers to terminate an inquest and refer the papers to the Attorney General for a decision whether to prosecute a known individual. Prior to the 1989 amendments, the coroner was supposed to terminate as soon as a prima facie case arose. This led to a number of problems and was not always complied with. The old section 19 was subject to not-so-muted criticism by the Court of Appeal in *Attorney General v Maksimovich and Anor*,[5] in which the Court considered the scheme of sudden termination without reasons, the secret transmission of decisions to the Attorney General, and secret decisions about whether to lay charges, as arguably in breach of the public interest and natural justice. The Court felt compelled by the statutory language to uphold the scheme. The section was amended last year to allow an inquest to

5 *Attorney General v Maksimovich and Anor* (1985) 22 A Crim R 392.

run its full course. It is my tentative view that coronial and criminal jurisdictions should be entirely separated.

When an inquest runs its full course, the coroner is obliged to make findings or, if there is a jury, a verdict, as to the matters listed in s22. The narrow terms of the section have already been addressed. Another defect relates to the lack of legislative guidance as to the types of verdicts available. They are nowhere set out in the legislation, let alone the standards and bases upon which they are to be established. Furthermore, the coroner is under no obligation to disclose the reasons for his/her findings, nor to specify what evidence was or was not relied upon, and what weight was given to evidence accepted. The coroner is thus much less accountable than other judicial officers. It seems reasonable enough that the relatives, witnesses and public are entitled to know those matters.

While some guidance is to be found in Waller's book where the common law is discussed and sample findings set out, this is neither an appropriate nor adequate substitute for proper legislative guidance. This can be illustrated in one important respect. The discussion does not contain any mention of the availability of a verdict/finding of "lack of care". This is most important in the context of deaths in care or custody, or through related activities, for example, in a situation of failure to supervise or to seek medical attention. The verdict/finding of "lack of care" is available in the United Kingdom, why not here? It need not transgress the prohibition against a finding of civil negligence on the part of an individual.

Finally, the potential for coroners to make recommendations or juries adding riders is an old and most important one. However, again the law is silent, and the potential often unrealised due to the propensity of coroners to restrict the scope of an inquest. It is via a recommendation or rider that comment may be legitimately made as to the general context of a death — the regimes, conditions, powers and procedures which give rise to it. The State Coroner's recent public position in relation to the state of our highways perhaps indicates a greater willingness to perform one of their most important functions, the prevention of similar deaths. Inquests need not become royal commissions to address or draw attention to these matters. Why not consider appointing Assessors to sit with coroners, as in Ontario?

A further point arises as to the notification and enforceability of recommendations or riders. There is no statutory procedure for that purpose in New South Wales. Some jurisdictions have gone so far as to put on a statutory basis powers and procedures allowing the coroner to notify, follow-up, supervise and even enforce such recommendations. Such measures warrant serious appraisal in New South Wales.

(d) Judicial review

Finally, judicial review of coronial decisions is not common in New South Wales, at least not compared to the United Kingdom. This is due to a number of problems — the restrictive statutory bases for review, some narrow old precedents, uncertainty as to the availability of traditional writs (such as *ad meilium inquirendum*), the permissiveness of the coroners statutory powers and lack of rights of interested persons, the

unadventurousness of lawyers (both counsel and the judiciary), and the barriers to appellate actions (such as legal aid, costs, etc.).

These could be remedied by framing the legislation in terms of duties and rights; specifying where review is available; giving an express right of appeal against a finding to the District or Supreme Court; broadening the grounds for review to decisions that are defective as a breach or abuse of their powers and duties on grounds of illegality, irrationality or impropriety; and by express application of the principles of natural justice.

CONCLUSION

What then should be the shape or features of a reformed and restructured coronial system for the nineties? The existing statutory framework for the coronial system in New South Wales is clearly inadequate. The 1980 *Coroners Act* contains anomalies, uncertainties, gaps and other weaknesses in many respects. This will not be remedied by clause-by-clause reform. Maybe its time for a new statutory framework, comprising express principles and objects, and comprehensive provisions regulating each of the main aspects of the system.

We should consider a significant up-grading of the organisation of the coronial system to make it more structured, autonomous, centralised and specialist. More emphasis could be given to its investigative, preventative and educative functions. It must be become more 'user friendly'. Finally, it is only with sufficient resources that we will get from the coronial system a mechanism that can fulfil its public mandate, and be a cost effective means of dealing with questionable deaths and ensuring that the lessons to be learnt are applied as well.

This agenda will take a greater commitment from all of us — politicians, coroners, lawyers, the media, doctors, police, counsellors, officials and others — to see that the coronial system gets all the attention it deserves. That is, due official, financial, parliamentary and judicial attention, and not just critical attention from royal commissions, activists, research projects and seminars such as this.

APPENDIX

PIAC ISSUES PAPER ON THE NEW SOUTH WALES CORONIAL SYSTEM October 1989[6]

PART A INTRODUCTION

1. PIAC CORONIAL PROJECT

PIAC's Coronial Project will look into the law, administration and procedures of the current coronial system in New South Wales, and compare them with other systems in Australia and overseas. The Centre's aim is to come up with practical suggestions for reform.

The Project will result in a written report to the Law Foundation, which will also be the basis of detailed submissions to the relevant Government Ministers, authorities, and various Royal Commissions. In addition, the Project will also produce information on the laws and procedures of the coronial system, and the rights of families and friends, to be available to those in contact with the system.

2. THE STAGES OF THE PROJECT

The Project has three main stages:

- an exhaustive literature review and review of materials and critiques of the New South Wales and other coronial systems;
- interviews and questionnaires with families, coroners, lawyers, police and others with experience of the coronial system; and
- production of accessible information on the coronial system for families and friends of the deceased.

PIAC is particularly keen to get the views and ideas of those who work or have an interest in the coronial system, and of members of the public that have had experiences, good and bad, with the system. The Centre will be conducting surveys of relatives, coroners, doctors, lawyers and police to obtain the views of the participants in the system. It is important that the Government knows what the community expects and needs in this area.

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6 Any written comments about the issues in this Paper, or relevant materials, would be greatly appreciated and, if requested, will be treated in strict confidence. These should be sent to: Coronial Project, PIAC, PO Box A236, Sydney South, NSW, 2000 or DX 643 Sydney.

3. OBJECTIVES OF THE PROJECT

The purpose of PIAC's Coronial Project is to review and seek reform of the New South Wales coronial system. The specific objectives are to:

- report on the perspectives, experiences and ideas of coroners, coronial officials, relatives, lawyers, doctors and police;
- provide input from members of the public about the coronial system;
- compare the New South Wales with alternative arrangements in other jurisdictions;
- review the relevant literature on the system;
- assess the accuracy of existing critiques of the system;
- contribute constructive proposals for legal and administrative reform;
- enhance public knowledge of and access to the coronial system.

4. UNDERLYING ISSUES

The underlying issues to be considered in the Project are:

- the desirable changes to the existing laws, policies and procedures of the coronial system, and;
- the extent to which the objects and elements of the coronial system should be made explicit in the law;
- the manner in which the law should regulate the structure, powers and activities of the coronial system;
- the policies and procedures necessary to achieve the principles underlying, and the objects of, the coronial system;
- the resources necessary to achieve reform of the coronial system; and
- the process for implementation of proposed changes.

5. THE ISSUES PAPER

The following parts of this Paper set out the range of potential issues that arise in relation to the constitution and workings of the coronial system. The purpose of this Paper is to seek feedback as to what are the priorities or problem areas in New South Wales and other states. Given our limited resources, not all of these will be dealt with to an equal degree, and we must focus on those matters of most importance or concern. Your ideas would be greatly appreciated.

PART B SPECIFIC ISSUES

6. THE ROLE OF THE CORONIAL SYSTEM

6.1 What should we learn (if anything) from the history of the coronial system?

6.2 What are the roles of the coronial system?

6.3 What should be the principles underlying the system?

6.4 What are the interests with which the system deals?

6.5 Should the objects of the system be given statutory expression?

7. THE STRUCTURE OF THE CORONIAL SYSTEM

7.1 Should the coronial system have a more independent (separate from existing departments and the judiciary) and integrated (bringing all aspects together) structure?

7.2 Should the coronial system be based on a primarily legal model (as at present) or a medical one, or a combination?

7.3 What should be the components of the coronial system?

7.4 What should be the role of the State Coroner?

7.5 What should be the powers, qualification, resources and training of coroners?

7.6 How many coroners should there be?

7.7 How should the coronial system be accountable to Parliament, Ministers, and Courts?

7.8 What are the direct and indirect costs of the coronial system?

8. THE TIME OF DEATH

8.1 Are the existing rules for the signing and review of death certificates adequate?

8.2 Who should have a duty to inform the coroner and in what circumstances?

8.3 By whom, how and what information should the relatives be notified regarding a death?

8.4 What policies and facilities should there be for the viewing and release of the body?

8.5 Are special measures required depending on the cultural background of the deceased?

9. THE CORONIAL INVESTIGATION

9.1 Should the coronial system be more investigative?

9.2 Who should supervise the investigation?

9.3 Should police, medical examiners, lawyers or others conduct coronial investigations?

9.4 What is the proper scope or ambit of the investigations?

9.5 What should be the rights of the bereaved in relation to investigations?

9.6 What protocols or guidelines are necessary for coronial investigations?

9.7 What relationship should there be between coronial investigations and other investigative agencies?

9.8 What reports should go to the coroner?

9.9 What should be the role of the police (General Duties, the Coronial Investigations Unit, and other specialist officers) in coronial investigations?

9.10 Are police instructions relating to coronial investigations adequate?

9.11 What should be the composition of the Coronial Investigation Unit?

9.12 Should the Coronial Investigation Unit be centralised or de-centralised?

9.13 What should be the relationship of the Coronial Investigation Unit with the coroner?

10. FORENSIC MATTERS

10.1 Should post-mortems be mandatory or discretionary?

10.2 What should be the time frame within which a post-mortem should be performed?

10.3 What could be done to reduce delays in the provision of forensic reports?

10.4 What approach to postmortems is appropriate?

10.5 Who is/should be entitled to be present at the post-mortem?

10.6 What standards (if any) are appropriate and how are they to be developed?

10.7 What rights should families have in relation to post-mortems?

10.8 To what extent should the positions of the Health Department's Discussion Paper on Forensic Services be adopted?

10.9 Should there be a New South Wales Institute of Forensic Pathology?

10.10 Are special measures required depending on the cultural background of the deceased?

11. INFORMATION, SUPPORT AND ADVOCACY SERVICES

11.1 What information services should be provided within the coronial system?

11.2 What counselling services should be provided within and external to the coronial system?

11.3 What rights and access to legal representation do interested individuals, special interest groups and public interest agencies have?

11.4 Are rules for legal aid for inquests adequate?

11.5 Should specialist advocacy services be available in relation to inquests?

11.6 Should there be an Office of the Public Advocate to represent the "public interest" in inquests?

11.7 What training, resources and manuals are required by advocates and lawyers?

12. THE INQUEST

12.1 Are the present laws adequate for when an inquest is mandatory?

12.2 What should be the criteria for, and checks upon, dispensing with inquest when discretionary ?

12.3 What rights to an inquest should relatives have ?

12.4 What is the preferable time frame in which an inquest should be held?

12.5 Are too many or too few inquests held?

12.6 What should be the objectives of an inquest?

12.7 Is a statutory definition of an inquest necessary?

12.8 Are terms of reference for inquests necessary?

12.9 Is there a need for statutory guidance as to extent of inquiry — whether the coroner's duty in determining manner and cause of death extends to inquiring into the circumstances surrounding or leading up to the death?

12.10 By whom, when and how should the relatives be informed of the date of the inquest, their right to attend and to be represented, and their rights in relation to the conduct of inquests?

12.11 Is notification of the next of kin enough?

12.12 Should it be the clerk of the Coroners Court and/or the social worker and/or police who has the duty of liaising with relatives?

12.13 Should a right of appearance at the inquest be at the discretion of the coroner?

12.14 Should specific provision be made for representation of public interest matters?

12.15 Should the inquest be open to the public?

12.16 When should there be counsel or police prosecutors assisting the coroner?

12.17 Should there be an instructing solicitor?

12.18 Should the proceedings be inquisitorial or curial in nature?

12.19 Should it be possible to conduct an inquest by oral evidence and/or by affidavit, and what criteria might there be for determining to do so?

12.20 Is there a need for a pre-inquest directions hearing to discuss the course of the inquest and other procedural matters?

12.21 Are any changes required in relation to procedural aspects (access to documents, witnesses, evidence, juries, adjournments, costs etc) of inquests?

12.22 Are any changes required in relation to the termination and re-commencement of inquests?

12.23 Are any changes required in relation to the available findings?

12.24 Should the jury's power to add riders be formalised?

13. PREVENTION

13.1 Are any changes required in relation to the powers to make recommendations?

13.2 Are any changes required in relation to the capacity to make recommendations?

13.3 Are any changes required in relation to the notification of recommendations?

13.4 Are any changes required in relation to the followup of recommendations?

13.5 Are any changes required in relation to the reporting of recommendations?

13.6 What use of the media should be made to publicise recommendations?

13.7 Should the coronial system maintain a data base?

13.8 What research should be done either routinely or periodically within and in conjunction with the coronial system?

13.9 What policy making assistance should be provided to the State Coroner?

14. JUDICIAL REVIEW

14.1 What decisions of the coroner should or should not be subject to review?

14.2 What are the barriers to judicial review?

14.3 To what extent have case law developments been incorporated in the legislation?

14.4 Should the legislation be framed as far as possible in terms of rights and duties?

14.5 Should express recognition be made of the application of the rules of natural justice?

14.6 Should there be express recognition of the inherent jurisdiction of the Supreme Court?

14.7 Should the coroner be able to state a case to the Supreme Court on questions of law?