

AIJA MAGISTRATES' CONFERENCE

Brisbane, 13-14 September, 2002

CURRENT ISSUES IN CORONERS' COURTS

Preamble.

Those of you who are erudite magistrates will of course know the reference in *Les Reportes Del Cases 176 - 177* (found in *Holdsworths History of the English Law, Vol 5, p 209:-*

“Let all men take heede how they complayne in wordes against any magistrate, for they are gods.”

Many magistrates throughout the country, though coroners themselves, are unfamiliar or not closely familiar with the work of coroners.

If, as is suggested in “*Holdsworth*”, magistrates are gods, then magistrates should sit particularly well as coroners. In his book “*Uncommon Law*” being a collection of sixty-six Misleading Cases, the author *A. P. Herbert* (whom I believe to be required reading for all of us) said this about the office of Coroner:-

“The office of Coroner is ancient, odd, anomalous, and perhaps unnecessary. (He points out that the Procurator Fiscal does the job admirably in Scotland). It is of interest to note (he goes on to say) that as far back as the thirteenth century the Coroner had gained a reputation for interfering in matters which did not properly concern him. In Magna Carta it was thought worthwhile to include a chapter restraining his activities, and this was later re-enacted in the (English) Coroners’ Act of 1887.”

Coroners have been around for about 800 years. The king in those days was not only interested in the due administration of criminal justice, but also in the revenue derived from such administration (seizure of felons’ property, confiscation of wrecks and treasure trove and the like). Coroners were for awhile a type of tax collector but quite early became more like they are today - inquisitors into certain types of violent and unnatural death.

In my State, New South Wales of one looks at *Volume I, “The Petty Sessions Review”* you will see that as recently as 1961, a magistrate/coroner sitting at Ryde conducted an inquest into treasure trove found under a house in suburban Sydney (122 gold sovereigns and 35 half sovereigns). He determined that, according to law, the treasure trove should go to the NSW Treasury - Mr. Chick, SM was clearly a coroners coroner.

Coronial work, of course, is substantially different from that of the magistrate. Whilst most magistrates spend their day working within the framework of the adversarial system, coroners are inquisitors and not subject to the rules of evidence. In fact, were Coronial work to involve a similar adherence, for example, to the law of evidence, the jurisdiction simply would not function efficiently. For coroners must find, by almost any means available, as to those “*statutory issues*” set out in each of the eight Australian Coroners’ Acts. I say “almost” as there is no doubt that coroners must observe concepts such as “procedural fairness” (*Musumeci -v- Attorney General of New South Wales & Anor (2002)NSWSC 425.*)

For example, in my State, New South Wales, in any given case, we must find as to the *fact of death, the date and place of death, and the manner and cause of death*. Generally these must be ascertained to the balance of probabilities, though the fact of suicide, to the “*Briginshaw*” standard (very likely) for there is a rebuttable presumption at law against suicide. Similarly it is generally accepted that in “no body” cases that a similar standard of proof applies. The other States and Territories differ very little in terms of these statutory obligations.

In *Musumeci* (above) Hidden J of the NSW Supreme Court usefully referred to *R -v- South London Coroner; Ex parte Thompson* (*The Times*, 9 July, 1982 - per Lord Lane):-

“Once again it should not be forgotten that an inquest is a fact finding exercise and not a method of apportioning guilt. The procedure and rules of evidence which are suitable for one are unsuitable for the other. In an inquest it should never be forgotten that there are no parties, there is no indictment, there is no prosecution, there is no defence, there is no trial, simply an attempt to establish facts. It is an inquisitorial process, a process of investigation quite unlike a trial where the prosecutor accuses and the accused defends, the judge holding the balance or the ring whichever metaphor one chooses to use.”

I have remained in the coronial jurisdiction simply because I find the work positive indeed. *Thorley, DCJ* when compiling his report into the Azzopardi Inquiry, paraphrased *Bowen, JA.*, in *Bilbao v Farquhar* (1974) 1 NSWLR 377:-

“The purposes underlying coronial inquiries include the satisfaction of legitimate concern of relatives, the concern of the public in the proper administrations of institutions and matters of public and private interest.”

The Australian Jurisdiction.

There is in place a Coroners Act in each of the six States and two Territories of the Commonwealth. The Acts are anything but uniform except in the most general sense.

The State/Territorial Coronial Systems.

The office of Coroner is ancient indeed and for centuries coroners in England and Wales (the Procurator Fiscal in Scotland) acted locally and fiercely independently of each other. It was not until the mid 1980's that Australian legislators were able to see that there might be singular value in “State Coronial Systems”. Victoria, New South Wales, South Australia and Western Australia each have a State Coroner, and sometimes a Deputy or Deputies. The Northern Territory has its Territory Coroner. In Tasmania and the Australian Capital Territory, both modest jurisdictions, the Chief Magistrate doubles as the Chief Coroner in a very much “hands on” way. In this State, Queensland, whilst a State Coroner is being considered, as I understand it the Chief Magistrate is also the Senior Coroner and the Brisbane City Coroner, a magistrate acting as a coroner.

I am an unabashed advocate of the “State Coronial” system. To me it provides my State with a means of co-ordinating Coronial services state-wide, thus raising the standard of Coronial work generally. In Victoria, as I understand it, full-time magistrate/coroners do

most, if not all Coronial work. I would love to see our third most populous State implement a similar system - the opportunity is there for it to utilise the best aspects of the other State systems.

The Australasian Coroners' Society.

The disparate jurisdictions, all dealing as best they can with the important social issue of Coronial death, saw the need some years ago, to come together regularly in order to learn more of each other's system and legislation. Hal Hallenstein and Kevin Waller pioneered and oversaw the foundation of the Australian Coroners' Society. The Society met annually in one or other of the eight States and Territories for three days, dealing with a range of issues of interest, not only to coroners, but to those in walks of life which deal regularly with coroners (forensic pathologists, police, clerks in coroners' offices, grief counsellors, forensic scientists and others.)

In recent years New Zealand and Papua-New Guinea coroners have been attending our conferences and last year the Society re-formed itself into the Australasian Coroners' Society, admitting members from those countries. It is hoped to hold next year's Annual Conference in New Zealand.

This year the Conference will be held in Manly, a suburb of Sydney in October. It's keynote topic will be "*Disaster Victim Identification*" - surely very relevant in view of the events of September 11th last year. The keynote speaker will be a coroner from London who became involved in DVI in New York last year.

Other topics will be "Cultural Change in Hospital Safety and Critical Incident Reporting, Current Issues in the investigation of Medical Adverse Events, Cultural Practices and Values in Australasian Suicide (This by Professor Colin Tatz who has published a written study on aboriginal and Torres Straight Islander suicide), Forensic Pathologist and the Coroner, Forensic Anthropology in Australia: What can the Anthropologist Deliver, Comparative Coronial Systems.

The State and Territory coroners always meet at the Conference venue the day before the Conference opens and we attempt to meet during the middle of each year in some other State or Territory in order to discuss issues relevant to the Australian jurisdiction generally. We have become friendly and find we always benefit from the regular exchange of information and ideas.

Current Issues in Coroners Courts.

Perhaps more importantly, this coming together under the auspices of a properly constituted Society has enormously enhanced each and every one of the jurisdictions for the benefit of all Australians. Two examples are worth explaining.

The National Coroners' Information System.

In this country there are over 7,500 unnatural deaths per annum. These deaths arise from workplace incidents, motor vehicle trauma, suicides, drug use, medical adverse events,

homicides, fires, drowning, firearm misuse and sporting accidents. Many, many deaths initially reported to coroners are sieved early as natural cause deaths.

In about 1990 the fledgling Society decided to investigate the feasibility of setting up a national Coronial data base. The hope was that each jurisdiction could use the cases of the eight jurisdictions to enhance our own investigations. Obviously with eight disparate jurisdictions it was quite a task and for some years our steering committee appeared to make little headway. Then Monash University expressed interest and finally the Australian Government, through the *Standing Committee of Attorneys General* became involved in the project and about three years ago it commenced receiving data. The data is not merely of statistical value, but includes brief synopses or narratives of case facts, full autopsy reports, Coronial summings up, findings and recommendations. As the *National Coroners Information System* pamphlet says:

“The core data set for the NCIS, that is the data common to all cases stored in the NCIS, consists of the following: Case Demographics (name, date of birth, usual residential address, sex, occupation etc), Incident Information (time, location, activity at time of death, mechanism and object contributing to death) Cause of Death (medical) Police Summary of Circumstances, Standard Text Reports (pathology/post mortem, toxicology, Coronial finding).”

The *National Coroners Information System* is the initiative of the Society and is managed by the *Monash University National Centre for Coronial Information (MUNCCI)*. It is supported on a national basis by a range of public sector agencies with an interest in death and injury prevention. In effect it has been designed as a valuable hazard identification system and research tool that will contribute to a reduction in the incidence of unnatural death and injury in this country. It is capable of giving up to date statistical information, whereas the Australian Bureau of Statistics, the former sole generator of such information can take up to two years to release its statistical data.

It operates quite simply. Stakeholders and others, researchers and the like, go through application to make use of the System. Each application is approved by a Committee chaired by one of the country's senior coroners. Once approved, the data used is paid for by the applicant. Privacy considerations have held up the system but finally seem to have been resolved. In essence, bona fide users are given the identifying data and cull it themselves for publication of research. In general terms the 4th Estate cannot use the system, though individual coroners may permit limited access to the press, for example, for a bona fide documentary.

NCIS is a world first and the information is provided by all States and Territories except, I am afraid to say, Queensland since 1 July, 2000. Queensland Coronial information is now being entered on the system though a licence agreement has still to be finalised. Access to the data is via the Internet and is available to coroners, Coronial investigators and third party organisations.

My colleague, Graeme Johnstone, *Victorian State Coroner* has been particularly closely involved in the project, along with Professor Stephen Cordner, the Director of the *Victorian Institute of Forensic Medicine*.

NCIS recently issued the first edition of a periodical called *“Fatal Facts”* (a document for coroners and coroners court registrars) summarising findings on the data base in the last

three months. Included were pertinent case summaries, including recommendations. Examples were, deaths involving post hole augers, several deaths in custody, transport related deaths, hospital deaths and work related deaths. MUNCCI has a research element and has just published a report on plastic bag asphyxia deaths for the purpose of demonstration to the Department of Health and Ageing. It I also looking at agricultural vehicle roll-overs. Recently a coroner requested a search of the data base in order to identify whether we were seeing deaths from a new anti-psychotic medication.

Medical Adverse Events.

A clinical team has recently been established in Victoria to assist the coroner in the investigation of potential medical adverse events. The intention of the team (clinicians and nurse investigators) is to develop investigatory standards for these types of cases; improve the early identification and targeting of those cases which need increased investigatory attention; improve the quality of the investigatory material for the coroner; identify systemic issues; help distribute coroners' findings to the health areas that need the information; ensure that coroners better understand how the health sector works and vice versa - this has not happened in the 800 year history of the office of coroner.

All information collected during each investigation will be stored on a Victorian data base for trend identification and analysis, research and so on. The Victorians have also set up a *Coroners Health and Medical Advisory Committee* (made up of representatives from the various medical colleges). This will provide liaison between the coroner and the health sector.

Multiple Inquests - dealing with systemic issues.

Coroners have begun dealing with issues more effectively by hearing a number of cases involving the same issue, together, or *seriatim* at least. Three deaths involving mistake in the transfusing of blood were recently heard by the one coroner in New South Wales, as were several psychiatric hospital suicides and several scuba diving deaths. I hope to deal with a number of lorry deaths involving ingestion of drugs, mainly amphetamines, by drivers. This method of dealing with issues has been in vogue in Victoria for some time. In my view it enables us to look at such matters in more death and, hopefully, to provide the State with more relevant Coronial recommendations for consideration.

Of course, there are problems with this approach. Using the lorry deaths, for example, they invariably occur on rural roads which can make it difficult to conduct inquests together, particularly in the larger States and Territory - the tyranny of distance. Ultimately it is a matter for the individual coroner, the parties and the public interest.

Forensic Pathology.

There is a world-wide shortage of forensic pathologists. They are simply not paid anything like their brothers and sisters in the private sector. There is also a lack of resources in the area. Coroners throughout the country are attempting to deal with the problem as best they can. For example in my State, NSW Institute of Forensic Medicine will ensure that most Coronial post mortem examinations are carried out by forensic pathologists as opposed to experienced general practitioners. This is particularly important in rural areas where GP's still perform Coronial post mortems in many places. I am satisfied that the NSW Health

Department knows of the problem and will do all it can to attract practitioners to this exacting but worthwhile work.

Grief Counsellors - dealing with the public.

Grief Counsellors have long been an integral part of the Coronial systems, at least in the larger, more populous States. Their work is incredibly important. Traditionally they deal with the bereaved at the time help is most needed. They provide counselling, assist with viewings and so on.

In recent times they have been called on to assist in dealing with the public on issues such as objection to post mortem examination and organ retention as part of the autopsy. In some cases, particularly in my State they have felt that such work compromises the counsellor/client relationship.

With that in mind, and with the increased counselling work involved in autopsy objection cases and organ retention cases, the NSW Attorney General's Department is in the process of employing counsellors specifically for that type of work.

Australian Transport Safety Bureau.

The federal body charged with investigating air crashes, BASI, became the ATSB (Air Transport Safety Bureau) and is now the Australian Transport Safety Bureau. As I understand it ATSB will now investigate train and marine incidents as well as air incidents.

The Australasian Coroners' Society, primarily through Jacinta Heffey, coroner Victoria (our President) and Arnold Schott, Tasmanian Chief Magistrate/Coroner has been for some years now in negotiation with the federal body to produce a Memorandum of Understanding between the States and Territories on the one hand and the Commonwealth on the other. The Commonwealth legislation is draconian and coroners have historically been unable to get hold of important evidentiary documentation and information (cockpit voice box recordings for example - though usually a transcript will be provided). Further, relationships between State/Territory police, investigating for the coroner, and federal investigators, can range from cordial to poor, depending on the case. That is still the situation. Our MOU was just about finalised when the new Transport Safety Investigation Bill 2002 was introduced into the Federal Parliament on 20 June, 2002. It is presently adjourned for debate in this sittings and Regulations have to be drafted.

Fortunately Mr. Kym Bills, Executive Director ATSB appears to want to have State/Territory/Commonwealth co-operation and has given coroners input into the Act and shall into the Regulations. Whilst we can do little, at the end of the day, about the problem of the Commonwealth overriding the States, it is hoped that this new air of co-operation will minimise the problems which have been occurring until now.

New Technology.

Late in 2000 I completed my inquests into the deaths of the six yachtsmen who died during the 1998 Sydney - Hobart Yacht Race. The race is, of course, world famous and one of the toughest blue water races on the planet. I heard about 10 weeks of evidence, some of it the most interesting, indeed gripping, that I have heard in my judicial career - I am no yachtsman. There were many issues in that case and ultimately a 350 page judgment was

written and 14 *Recommendations* made pursuant to *Section 22A, Coroners Act 1980*. It became apparent during the writing of the judgment that there was a deal of international interest in the judgment. The *New York Times* and the *Guardian*, for example would regularly telephone to ascertain the likely date of publication. Because of this interest, and because of the particularly technical nature of the inquest and its interest to yachtsmen and women, yacht clubs and those involved in yachting, I decided to publish the judgment in book form. As an afterthought, the *transcript* and virtually all *paper exhibits* were placed onto a CD Rom which was inserted into a sleeve on the cover of the judgment. So, those interested can read my decision and go to the transcript itself to settle their own mind as to whether I was correct or incorrect on a given aspect.

This was a definite “first” in my State.

In NSW we still occasionally sit with juries of six. Two recent jury cases, both lengthy were the Star City Casino Case (*Dalamangas*) in 2000 and a rural police shooting case (*Hallinan*) this year. In those cases we used *virtual reality* technology.

For example, in the *Star City* case, the action (the taking down and restraining of patrons by security staff) occurred throughout the gaming floor of the Casino, but it culminated in an area inside and just outside the main doors of the Casino, near some escalators. Being a Casino, the whole area was covered by many video cameras. These were utilised by technicians to create videotapes of all aspects of the case. For example, witnesses standing on a balcony above the foyer and beside the escalators could actually see themselves on video and at the same time could see the action of interest to the coroner and jury. Similar technology was used in *Hallinan* but collated by police technicians going to a number of pre set locations of the scene and videoing on a 360 degree basis. These were then collated and used for a similar type of interaction between witnesses, coroner and jury.

Conclusion.

Those of you who have not had the chance to sit as coroners are missing out on a different, exacting but exciting jurisdiction.

(John Abernethy)
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