

THE STATUTORY FUNCTIONS OF THE CORONER

ARRANGEMENTS FOR THE CORONIAL SERVICES IN NEW SOUTH WALES.

The Office of NSW State Coroner was established in 1988. Prior to its establishment, the coronial system comprised a Sydney City Coroner, a Westmead Coroner (and before that, Parramatta, Penrith and Campbelltown Coroners) along with coroners in most country towns. These country coroners were never magistrates and were rarely legally qualified, being either private persons as local dignitaries, or clerks of the Local court. Even cities such as Newcastle and Wollongong lacked a coroner who was also a Magistrate.

The position today is that the coronial system in NSW comprises the State Coroner and 4 Deputy State Coroners. One Deputy State Coroner is stationed at Westmead. They are the only full-time coroners in NSW. At Newcastle, Wollongong and now Gosford, a magistrate sits as coroner part-time. In country towns and cities Registrars of the Local Court serve as coroner. All magistrates are also commissioned as coroners but until recently, rarely sat in the jurisdiction. By arrangement with the NSW Chief Magistrate¹, all country magistrates conduct inquests in all but the shortest and most straightforward of cases. *Section 33AA, Coroners Act 1980* (Akin to S.128, *Evidence Act 1995*) prohibits non-magistrate coroners from granting certificates, hence the need for magistrate coroners to conduct most inquests in country towns.

Section 13AB has now come into operation. It provides that only the State and Deputy State Coroners may examine certain child and disability deaths.

¹ Protocol between Chief Magistrate and NSW State Coroner providing that magistrate/coroners conduct all country inquests of 2-5 days in length and all one day inquests where the issue of a S.33AA certificate may be in issue. State Coroner/Deputy State Coroners conduct all inquests over 5 days.

As I have indicated, recent amendments to the *Coroners Act 1980*² have meant that magistrates in rural NSW are now required to sit as coroners more often. Some years ago, the former Chief Magistrate, Patricia Staunton, AM, decided to mirror the Newcastle-Wollongong situation on the Central Coast at Gosford – one of the magistrate their sits as Central Coast Coroner.

The advent of the office of State Coroner has been important to the provision of coronial services for several reasons. Firstly the office has an educative role. We lecture and generally assist the general magistrates and country coroners. We provide forensic advice to them and regularly take over the most difficult country cases. We are often requested to lecture groups such as yourselves, nurses, medical practitioners, legal associations such as the college of law or the NSW Forensic Society and occasionally NSW Police Service trainee's. Secondly we provide a supervisory role in respect of all NSW coroners. We are sent details of all NSW coronial cases and later, details of their ultimate conclusion. NSW coronial data is presently now part of a national database and the State Coroner, along with other State and Territory Coroners has seen to the development of that database³. As the statistics have increased numerically, the benefit of the database has become more apparent.

We have a close working relationship with the Department of Forensic Medicine (Central Sydney Area Health Service) and the Institute of Clinical Pathology and Medical Research (Westmead) including the services of forensic pathologists, forensic pharmacologists, forensic odontologists, forensic anthropologists and even forensic entomologists. I cannot speak for the other coroners, but personally find it a great advantage to share a building with the DOFM. That enables me, personally, to speak almost on a daily basis with pathologists and others. Paper is saved and time is saved. From time to time I do go to the autopsy suite to watch an interesting case and discuss it with the pathologist.

² Section 33AA.

³ Called the *National Coronial Information System (NCIS)* and administered from Victoria on behalf of the Australasian Coroners' Society, data can be purchased by research organisations, government instrumentalities and other interested parties.

Occasionally a pathologist will suggest that I watch unusual or interesting cases. If out of court we try to attend homicide autopsies. The advantage of that is that we can talk to investigation detectives and physical evidence (crime scene) police and thus get a real feel for the case.

The State Coroner also plays a consultative role in matters such as the provision of forensic medical services. For some years, we were attempting to convince the NSW Government to establish a NSW Forensic Pathology Authority so that there will be state-wide control of all coronial autopsies and their standard. The Government only recently rejected that proposal, of course, on the basis of costs. It is sad that it has done so, as that model would have worked. Similarly, the Institutions I have referred to, and a similar one at Newcastle has a close working relationship with the office of the State Coroner. Firm links have been established with other Australian coronial jurisdictions and those of New Zealand, Papua New Guinea and the Solomon Islands.

The State of Queensland, some years ago, finally established its own state coronial system. It is fair to say that all States and Territories now have systems akin to NSW, be the jurisdictional head a State Coroner (New South Wales, Victoria, Queensland, South Australia, Western Australia), a Territory Coroner (Northern Territory) or Chief Coroner, (Tasmania, Australian Capital Territory).

One only has to consider an unfortunate event such as a 'disaster' to realise the necessity for a coordinated coronial service. Coroners tend to class disasters as incidents (other than private motor vehicle incidents), which involve the death of five or more persons. The proper coordination of disaster identification can be an enormous undertaking. The proper investigation of a major disaster will inevitably be time consuming and difficult.

Clearly the events of September 11 and more recently, Kuta, Bali, the Tsunami and the Nias helicopter incident illustrate the extraordinary breadth in terms of sheer size that a disaster can take. Disaster Victim Identification and

the actual investigation can take many months – even years, to conclude. When done well, as in recent bus and ‘tube’ bombings in England, identification of the dead can be effected quite quickly. I would now expect that to happen in this country.

With the real and obvious threat of death through terrorist activities and particularly the popularity of ‘suicide bombing’ the Australian Government has been forced to look holistically at the issue. Forums regularly meet to consider how best to conduct inquests and investigations in cases with national, rather than State/Territory ramifications. It may be that eight Coroners Acts will be amended to enable, by agreement, one Coroner to take jurisdiction in a case where a number of other jurisdictions might ordinarily also have jurisdiction.

THE STATUTORY FUNCTIONS OF THE CORONER.

Section 12A deals with the obligation to report certain types of death. In effect any person with reasonable grounds to believe that a death or suspected death would be examinable by a coroner⁴, must report the death to a member of the police force, who in turn has an obligation to report it to the coroner. That coroner must inform the State Coroner

The purpose of the inquest is to inquire and make a finding, if possible, as to a number of issues set out in *Section 22, Coroners Act 1980*, which reads:

*“22(1) The coroner holding an inquest concerning the death or suspected death of a person shall, at its conclusion or termination, record in writing his findings or, if there is a jury, the jury’s verdict, as to **whether the person died and if so –***

*(a) his **identity;***

*(b) the **date and place of his death;** and*

⁴ Viz: Deaths falling within Ss. 13, 13A and 13AB.

(c) *except in the case of an inquest continued or terminated under Section 19 or 21; the manner and cause of his death.....*"

The section goes on and involves inquiries into non-fatal fires and explosions, but in essence the coroner must find, if possible, to the balance of probabilities, the **fact of death, identity, date, place, manner and cause of death**. If there is an inquiry into a fire or explosion, cause and origin of it. There is also a common law jurisdiction to inquire onto the finding of treasure trove.⁵

Obviously many types of cases lead to the assumption of jurisdiction. The relevant sections of the act are *Section 13, 13A and 13AB*. Examples of 'Section 13' deaths include violent or unnatural deaths; sudden deaths of unknown cause; deaths in suspicious or unusual circumstances; where a medical practitioner will not give a death certificate; where a medical practitioner cannot give a death certificate; deaths under, as a result of or within 24 hours of an anaesthetic; deaths within one year and a day of an accident where the cause of death may be attributable to that accident; and deaths of persons in or temporarily absent from certain types of establishments in which the person has been receiving care and treatment (*Mental Health Act 1990 institutions*). Some of these aspects eg. anaesthetic are the subject of Amendments to the Act soon to go to Parliament.

The coroner, of course, is not a medical practitioner. He or she relies on two 'arms' of investigation. Once completed, the two arms, together, become the brief of evidence. The first of these arms is the forensic investigation characterised by the post mortem examination. To some degree most post mortem examinations will include some toxicology, histology and neuropathology details – and importantly their interpretation usually in lay terms. The second arm is characterised by the police 'brief of evidence'. In plain terms, police are the coroner's 'agents in the field'. I can tell you more of their tasks if you are interested.

⁵ See *'The (Petty Sessions) Review'* Vol One at P.249 (Inquest 149/1961(Ryde). The inquest involved an inquiry into the finding of a quantity of sovereigns and half sovereigns under a house at Woolwich.

In the vast bulk of these cases the *statutory issues* referred to above are quite clear to the coroner and in those circumstance an inquest can usually be dispensed with. That, in fact, is the *schema* of the 1980 act. It is vastly different from the 1960 act. Suicides, for example, generally do not require an inquest, nor do many types of accidental death by misadventure. Many deaths turn out, after all to be by way of natural cause.

Certain deaths must go to inquest – unsolved homicides⁶, deaths as a result of administration of an anaesthetic⁷, and those cases where the statutory issues to which I have referred are not clear to the balance of probabilities in particular, manner of death. In additional, *Section 13A Coroners Act 1980* provides that deaths in custody, and during, or as a result of police operations, must go to inquest and that either the State Coroner or a Deputy State Coroner must conduct the inquest. An annual report to the NSW Parliament is furnished in respect of deaths which fall within *Section 13A*⁸.

The relatively new jurisdiction section, *Section 13AB* provides for certain child and disability deaths to be reviewed by one of the five senior coroners in order to determine whether or not there are issues, which might warrant an inquest⁹.

From time to time, although an inquest can be dispensed with, one or more interested parties may still request the holding of one and if cogent reasons are given it is usual in this State to conduct a hearing, particularly in relation to any issues raised. From the point of view of counsel for the family, it is worth noting that an inquest may even be conducted where strictly unnecessary, as an integral part of the grief process. Resources are limited and there must be some triaging of such cases these days.

⁶ *Section 14B(a)*.

⁷ *Section 14C(1)*.

⁸ Even 'natural cause' deaths of persons in custody require the holding of an inquest. 'Custody' includes custody of the Department of Corrective Services, NSW Police and the Department of Juvenile Justice, whilst escaping from such custody and whilst *en route* to or from such custody. *Section 13A* extends the 'death in custody' scenario to include deaths 'as a result of in the course of police operations' – shooting by police, of police. In front of police, police pursuits etc.

⁹ Viz: children in care; children who have been subject of a DOCS notification in the three years prior of death; siblings of such children; children whose death is due to abuse, neglect or that occurs in suspicious circumstances; persons who at the time death were living in or temporarily absent from residential care provided pursuant to the *Disability Service Act 1993* etc.

For example, a young woman, not on the Methadone Program, dies of an overdose of the drug Methadone. The manner and cause of her death are clear to the coroner. Her parents, however, indicate that they are concerned about aspects of the NSW 'take away' Methadone program. They are also concerned that the boyfriend of the deceased may have supplied her with his Methadone. The coroner, in those circumstances, decided to conduct an inquest. He took the view that as a NSW Government program was being looked at, the relevant Statutory Authority should be given the opportunity to be heard as an 'interested party'. There was an element of 'public interest' in conducting the inquest. Whilst on one view the coroner's jurisdiction or ambit may appear quite narrow, in another sense the word 'manner' (for example) evokes a concept that may be quite wide¹⁰.

His honour, Judge Barry Thorley said in his report into the *Azzopardi Injury*, paraphrasing 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 administration of institutions and matters of public and private interest."

That is a fair summary of the points I have been making.

However, whilst 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, the process should never amount to a 'de facto Royal Commission' in order to air controversies or disputes which do not relate directly to the statutory issues under consideration. In this regard, the Victorian Case of *Harmsworth v The State Coroner (1989) VR 989* is worth reading. In *Harmsworth* a former

¹⁰ In the example given above, the Methadone was 'illicit' and the coroner looked as closely as possible at how the young woman came to have in her system, a drug not prescribed for her. Not only did he look closely at how she came to have the drug, and whether there was sufficient evidence to amount to an indictable homicide against another person (supplier), but also whether the system of dispensing Methadone in NSW was adequate. He found in the negative on both questions (insufficient evidence that a friend had given his Methadone; the system of dispensing 'take away' Methadone was inadequate. As a result of coronial recommendations the protocols for delivery of 'take away' doses were improved and tightened.

Victorian State Coroner purported to embark on a wide-ranging inquiry into Victorian prisons following a death in custody – the power to comment must relate to the obligation to make findings.

At times there is an expectation that the coroner can hear evidence and conduct a 'criminal trial' in a matter. Of course, such an expectation will always be inappropriate. The 'person of interest' does not know the precise nature of any allegation and often will have little or no opportunity to prepare a defence. The proceedings are firmly inquisitorial in nature with the rules of evidence relaxed. Coroners, of course, are bound to provide procedural fairness so that in a murder inquest, the 'person of interest' is entitled to be given an opportunity to see the evidence against him or her at a time that will enable that person to make submissions and generally combat the evidence.

THE NEXUS BETWEEN THE INQUEST AND THE CIVIL CLAIM.

Legal practitioners will often seek to use the inquest as a source of evidence for future civil proceedings. This is not the purpose of the inquest as coroners frequently point out. However it has often been said that the inquest is a useful vehicle for the gathering of information whilst it is fresh and available. The inquest is impartial and so the evidence should normally be reliable. The whole process may result in the clarification of issues, which might be expected to be raised at the civil proceedings. For these reasons, coroners normally permit some questioning which may not go strictly to the statutory issues set out in the Act¹¹. Coroners will, of course, notify lawyers once the bounds of relevance in statutory or forensic terms have been stretched beyond reasonable limits.

My view is that the inquest and the civil proceedings are interrelated. We sometimes say in court that the inquest is not to be used as a 'fishing expedition' to garner evidence for the later claim. To an extent this has to be said with tongue in cheek, as it is often impossible to draw a diving line between a legitimate series of questions going to, say, *manner or cause of*

¹¹ *Coroners Act 1980, Section 22.*

death for the purposes of Section 22, and a series going beyond that and aimed firmly at assisting with the civil claim. It really is a matter for the coroner to decide when a line of questioning is no longer of assistance in the carrying out of his or her forensic or statutory duty.

There is seldom argument with the bar table as to whether a line of questioning should be allowed or disallowed. Counsel usually understands the coroner's function and takes care not to question so as to go much beyond the achieving of that function. The rules of evidence as such, do not apply.

APPEARING AT A CORONIAL INQUEST OR INQUIRY.

Applying for an inquest.

A coroner has wide powers to dispense with the holding of an inquest, but before doing so will naturally consider any representation made to him or to her. In making representations a lawyers should perhaps consider:

- (a) Are any of the Section 22 'statutory issues' (*fact of death, identity, time, place, manner or cause*) not clear to the required standard of proof?¹² Is there any other private concern held by a near relative, which should be satisfied?
- (b) Is there a public interest to be served by the holding of an inquest?

The submission, if not accepted by the coroner may be repeated to the State Coroner or even the Minister.

¹² In missing persons (no body) cases, Waller states in *'Coronial Law and Practice in NSW (3rd Edn)* at P.64: "It is suggested that, because of the importance of the matter, the standard of proof appropriate to a finding that death has occurred should be the higher degree of the balance of probability referred to in *Briginshaw v Briginshaw (1938) 60 CLR 336*". I applied this standard in *Disappearance of Tegan Lane (2006 – John Abernethy)*.

Appearing before a coroner as an advocate

There is no automatic right of appearance before a coroner, so the advocate does not announce his appearance but seeks leave to appear. The announcement by the advocate for the party for whom he or she wishes to appear will generally be sufficient to disclose that there is a 'sufficient interest' within the meaning of *Section 32, Coroners Act 1980*.

Examples of persons usually permitted to be represented at inquests or inquiries are:

- a) A person whose actions caused a death – a person of interest;
- b) Relatives of the deceased;
- c) Employer of the deceased where death occurred in an industrial situation;
- d) An insurance company interested in a fire;
- e) An insurance company where a fire occurred;
- f) A person connected with the causation of the fire who might be suspected of starting it, whether deliberately or by accident; and
- g) A person likely to be a crucial witness
- h) WorkCover
- i) Other court bodies eg. Police, Health, SES.

A witness before a coroner cannot in general terms be compelled to incriminate him or herself,¹³ and appearance is often sought mainly to protect that right¹⁴. S133AA allows the Coroner discretion to provide a certificate of immunity if it is considered appropriate.

Counsel assisting the coroner

A police coronial advocate may perform the task of assisting the coroner, though in the more complex or important cases the Coroner arranges for the

¹³ *Coroners Act 1980, Section 33, S.33AA.*

¹⁴ See also S.33AA; *Decker v State Coroner of NSW (1999) 46 NSWLR 415.*

NSW Crown Solicitor to instruct private counsel. This must happen in matters where officers of the NSW police Service are involved in the death (deaths during or as a result of police operations; deaths in police custody). It also occurs where an interested party is making allegations against police and in matters of major public interest such as Kovco, the East Timor case, or Brimble.

The task of counsel assisting is to ensure that all relevant witnesses are called and that all relevant information is obtained from them. All Counsel, like anyone else appearing before a coroner must seek leave to appear and can ask leading questions if it is thought fit. In many cases that course of action may be forensically inferior to the usual practice of allowing the evidence to flow in the traditional adversarial manner.

Counsel assisting a coroner when addressing, makes submissions as to what he or she genuinely believes is reflected by the evidence. Counsel assisting is not arguing a cause but is assisting an inquisitorial process. In other words, counsel is not a prosecutor, nor does she/he represent any party.

Thus, a number of important contrasts can be made between proceedings at inquest and adversarial proceedings. The inquiry is that of the coroner who will often proceed in quite an informal manner. To function effectively the coroner must be able to discuss the case at anytime with counsel assisting and, it appears, other persons such as the police officer in charge of the case, and one or more of those representing interested parties. Recently, in the country, a short S.13A inquest was conducted. The police operation involved a search for a person who ultimately shot himself. The parents had no concern with the police operation but rather with one consultation their son had with a psychiatrist six months prior to his death. We called the psychiatrist and the inquest proceeded most informally with the parents asking the psychiatrist all the questions they felt they needed to ask. At the end of the process they no longer had concerns.

Procedure before a coroner

The coroner is not bound by the rules of evidence, and the procedure is informal.¹⁵ No person with leave to appear has a right to call a witness. The correct procedure is to ask the coroner to arrange for a witness to be called and where possible provide the coroner or counsel assisting the coroner with a proof of that witness' evidence.

Statements of witnesses have usually been made available to those appearing beforehand and their evidence in chief is, in the main, swearing to the truth of the statement, with such further questions as the advocate assisting the coroner may see fit to ask. All persons granted leave to appear may 'examine and cross examine' any witness. Again it will usually be more effective if counsel does not lead the witness. Counsel assisting may re-examine, but in reality that may take the form of further cross-examination, or simply further examination. There is always certain flexibility in the procedures so that if counsel for any of the interested parties wishes to ask further questions, leave can be sought. It is not uncommon to alter the order of bar table examination depending on whose witness is giving evidence.

The coroner does have a power to restrict the questions of an advocate to matters relevant to the interest represented. If the advocate refuses to obey the coroner, he or she would be at risk of losing the leave to appear. At the end of the evidence I personally invite short, succinct addresses. In the more complex and lengthy cases, written submissions are commonplace, through these too should be succinct. It is unusual for the adversarial 'cross submissions' to apply.

Most inquests are reasonably short and are determined in one or two days. Some are very short and may be finalised in a matter of hours or even minutes. Occasionally, however, inquests may take weeks or months to conclude. The *Sydney – Hobart Yacht Race* inquest involved eight weeks of

¹⁵ Section 33.

evidence culminating in a 350-page judgment, which included some 15 coronial recommendations. The *Dalamangas – Star City Casino* inquest heard five weeks of evidence by a coroner and jury of six. A police shooting near Tumut, *Hallinan*, was heard over eight weeks, again with a jury and Kovco took 8 weeks with a jury.

Representing a 'sufficient interest'

As in all advocacy it is necessary for the advocate to decide beforehand the objectives sought to be achieved. Every question asked carries a risk and should be only asked if the likely advantage will exceed the risk. Sometimes of course, risks have to be taken. Sometimes it may well be in the interests of the party represented to know the truth as early as possible. The usual rules of 'good advocacy' apply equally in the coroner's court.

Protective compared with investigative appearances.

The protective appearance

An advocate appearing for the person who caused a death, whether deliberately or accidentally, or who may have been concerned with starting a fire, is interested to protect his client against non-indictable prosecutions (eg: negligent driving causing death) or civil proceedings. Further the advocate may be concerned that the coroner may form a view in respect of indictable criminality against the client¹⁶. The advocate may be concerned to protect the general reputation of the client. The task is to see that the client is not questioned unfairly, that if necessary there is time to answer properly, or give complete answers and that re-examination elicits that which may be necessary to explain the cross-examination.

¹⁶ Section 19.

In many cases the advocate should advise the client to refuse to answer questions that might incriminate the client¹⁷. This may lead to some questioning of the client, though the coroner will be concerned to ensure that the fundamental right of the client against self-crimination is preserved. Where an unrepresented witness elects to answer incriminating questions, it is common for coroners to remind that person of his or her fundamental right.

If a witness has already made a statement, or record of interview to police, (as is common in indictable traffic matters) that statement will be admitted into evidence at inquest. Where a witness exercises the right against self-incrimination at inquest it is usual not to attempt to have such statement adopted by the witness as such adoption may encroach upon the right against self-incrimination.

In September 2000, following the decision of the Supreme Court of NSW¹⁸, *Section 33AA* was enacted. The Section, in similar terms of *Section 128, Evidence Act 1995* provides for the giving of a Certificate by *coroners who are also magistrates*, in circumstances where the coroner has required the giving of incriminating evidence, so that the evidence cannot be used later against the witness in court proceedings.

There will always be the temptation to take advantage of the right against self-incrimination at inquest. Such a course has all the attraction of safety. However, for certain persons in the community, to take such a course may subject the client to considerable criticism within that person's professional calling (medical practitioners refusing to describe how a procedure was performed by them; police officers refusing to describe their part in a death, say, by shooting during a police operation). It is therefore appropriate to take great care when advising the client whether or not to exercise the right against self-incrimination. Although the recourse to the right against self-incrimination

¹⁷ *Section 33.*

¹⁸ *Decker v State Coroner of NSW (1999) 46 NSWLR 415.*

cannot be published or commented on by the media without permission of the coroner, that permission may well be given¹⁹

The investigative appearance

The advocate in this position is seeking information and of course it is information that may well be contrary to the interests of the witness being examined. Often the advocate has indefinite and vague instructions raising suspicion, but no more. The advocate should be looking for clarification, but care must be taken to avoid asking questions and making accusations that cannot be justified by the instructions.

Of course, if reasonable instructions can be obtained justifying serious accusations, then the advocate, if it is in the client's interests, must be fearless.

CORONERS ACT 1980 – IMPORTANT PROVISIONS AND HOUSEKEEPING SUGGESTIONS.

Some important sections.

I have already referred to *Sections 13 and 13A*, which deal with jurisdiction. *Section 22* refers to those statutory issues with which the coroner must be concerned in returning a finding. Findings must generally be made to the *balance of probabilities*. There is, however, a *rebuttable* presumption against suicide under our law so that findings of suicide are to be made to the higher standard of proof.²⁰

Section 22A empowers the coroner to make recommendations.

Sections 48, 48A and 48B may be of importance to the practitioner. *Section 48* empowers the coroner to order a post mortem examination and to carry

¹⁹ Section 45(3)(b).

²⁰ See Footnote 11.

out tests. Almost every coronial case will involve an order pursuant to section 48. Whilst the supreme court of this state has always had jurisdiction to order that a post mortem examination not be carried out, or not be carried out as directed by a coroner, *Sections 48A and 48B* have now codified the area of objection to post mortem examination. In *Seemah Morris v Derrick Hand*²¹ the NSW Supreme Court quite succinctly expressed what coroners believe to be the law in relation to the ordering of post mortem examinations: -

“ The religious matters and sensibilities which would have been brought to the attention of the coroner are matters which are taken into account, but do not of themselves displace the duty of the coroner to ensure that the manner and cause of death be established”

Over approximately the last five years, there has been a marked increase in objections to autopsy. In an effort to be entirely open, police handling coronial death cases are required to canvass with families their wishes in relation to post mortem examination. Three ‘*Coronial Information and Support Officers*’ (CISP) have now been appointed. When the coroner is deciding on autopsy, they make contact with the family. Happily discussions with families usually prove fruitful to the extent that the Supreme Court has not had to entertain an objection case in recent years, despite the heavy increase in initial objections.

Section 19: Coroners deal with many cases of ‘unsolved homicide’ or ‘unsolved arson’. In the main there will usually be evidence of the crime but insufficient evidence to charge a known person. Once the police investigation (on behalf of the coroner) is completed, the matter, if a homicide, must go to inquest²² and the evidence reviewed. If, at anytime during the course of the inquest or inquiry the coroner is of the opinion that, having regard to all the (admissible in a court of law) evidence given up to that time, the evidence is both capable of satisfying a just beyond reasonable doubt that a known person has committed an indictable offence is one in which the question whether the known person caused the death, the coroner must suspend the

²¹ (SC.300XX/1997 – Per Dowd J.)

²² Section 14B(1)(a)

S19 inquest. The coroner then forwards the depositions taken at inquest together with a statement specifying that name of the known person and the particulars of the offence(s) to the Director of Public Prosecutions. *Section 19* is thus similar to current legislation dealing with committal for trial.

Recently, the Act was amended to substitute 'suspend' for 'terminate'. This was in order to ensure that it might be re-opened once any criminal proceedings are dealt with to finality.

Some housekeeping suggestions.

It is suggested that you establish clearly in your mind the basis of the interest to be represented, and be ready with the necessary argument to justify leave to appear.

It is also suggested that you try to decide, so far as possible, the objectives of the appearance – whether 'protective' or 'investigative' and what is hoped to be achieved.

If yours is a 'Sydney' case, it is usually possible to obtain copies of most of the statements in the brief through a group of police seconded to the office of the state coroner. Called the *Coronial Advocacy Team*, they are stationed either at Glebe or Westmead and assist the coroners in most cases. In country centres, the local police prosecutor will usually be involved in a similar way. These officers are expected to be co-operative with the profession generally. They like to see people legally represented. In certain complex cases, and cases where the police actions are likely to be criticised or scrutinised closely (as in police shooting and police pursuit cases) the NSW Crown Solicitor, and perhaps private counsel will be involved. Again co-operation with the profession is expected.

The present executive Coroners will not tolerate surprises and other gamesmanship during an inquest. There is little place for that in the inquisition. The role of the coroner, and counsel or 'advocate' assisting is

quite different to that of the magistrate and police prosecutor. So not only will you generally be provided with a copy of the brief of evidence, you will be shown photographs, plans and other likely exhibits usually not contained in the brief. Advocate or Counsel Assisting will generally be more than happy to confer with you, as will the coroner should it be necessary or useful. In general terms, coroners only canvass those issues, which need canvassing. We do like to know what those issues of interest are before hand. In fact, in view of the nature of coronial proceedings, we like to know all that we possibly can about a case before a word of evidence is heard. It follows that we believe that proceedings should usually be entirely open. To that end, we like to ensure that interested parties and their legal representatives are apprised of the entirety of the brief of evidence beforehand²³. Conversely, if you, the advocate, have a witness you wish to call, the coroner will expect to be advised beforehand, and provided with a proof of that witness's evidence. From what I am saying it should be clear that you wouldn't have the latitude to go off on a 'frolic' of your own. If there are issues, witnesses, experts etc that you feel ought to be called then contact us in an open manner to maximise your chances of getting what you wish.

In the more complex matters it is commonplace to conduct conferences and court mentions with the interested parties prior to listing a matter for inquest hearing. This will enable all to focus on the issues at inquest. More recently we have been tending to conduct 'direction hearings;' in complex cases – mentions if you will – in court and recorded.

The various Area Health Services, Department of Forensic Medicine and its Westmead counterpart have close links with the Coroner's Court. The forensic pathologist involved in your case, with some notice, will be more than happy

²³ It was believed that parts of a brief may be withheld in homicide/serious crime inquests (*Musumeci v Attorney General of NSW & Anor (2002) NSWSC 425 (Hidden J)*), provided procedural fairness was accorded. However the full Court of Appeal held in 2003 (*Musumeci v Attorney General of NSW & Anor (2003) 57 NSWLR 193*), 'procedural fairness' in that particular case required disclosure at the start of the inquest to enable the cross-examination of other witnesses. It was also held by the majority (Beazley and Ipp, JA, (Young CJ in Eq., dissenting) 'While it might be open to a coroner to withhold material in the interests of the integrity of the investigation... in this case there was nothing to suggest that withholding disclosure of the material would bear on the integrity of the investigation'. The Court also commented that the pursuit of a forensic advantage on the part of a coroner is not a sound basis for refusing to disclose material.

to discuss aspects of a finding at post mortem with you should that assist you and your client. Again this can often be arranged by the police officer assisting the coroner, or where private counsel is performing that task, through the instructing solicitor. Sometimes a conversation with the pathologist on the day of court will be very useful to explain matters not readily apparent to the layperson. For example a surprising number of lawyers do not realise that heroin (diamorphine) very quickly metabolises on entering the body so that analysts invariably give a 'morphine' reading. The question is thus too often asked; "How would he have got the *morphine* and overdosed?"

The post mortem examination is a completely impartial procedure performed by highly skilled and qualified specialist medical practitioners – forensic pathologists who normally possess advanced training in morbid anatomy and other relevant fields of pathology. They are certainly not servants of the police. They are fiercely independent and can be of great assistance of the practitioner.

The *Coroner's Act 1980* does provide for a requesting of a jury²⁴. Occasionally juries of six are empanelled to hear an inquest, five in the last 20 years including Kovco. The process has been found to be quite cumbersome but can be useful where next of kin are suspicious of the system. As the brief of evidence cannot really be taken into the jury room, the evidence has to be led *viva voce*, quite a time consuming exercise. Significantly the jury will return a finding as to the identity, date, place, a manner and cause of death only. It will not provide a detailed summing up of the matter, as is normal coronial practice. The question of indictable criminality remains one for the coroner and not the jury. A proposed amendment either abolishing juries or giving the State Coroner a power of veto are with the Attorney General's Department at present.

Magistrate Mary Jerram
New South Wales State Coroner

With thanks to former State Coroner, John Abernethy.

²⁴ Section 18.