Submission No 41

INQUIRY INTO CORONIAL JURISDICTION IN NEW SOUTH WALES

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Select Committee on the coronial jurisdiction in New South Wales

Submission by Michael Barnes

Sydney

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1. In making this submission I have relied upon extensive professional experience in matters of relevance to this inquiry.[1]

2. This submission is made in my private capacity as an interested member of the public.

3. In summary, the main points of my submission are:

    a. There is considerable uncertainty as to the law and policy governing coronial practice that negatively impacts its efficacy.
    b. Underfunding of the court-based aspects of coronial investigations in NSW inhibits coroners from addressing the needs of the bereaved and contributing to increased public health and safety to the to the extent they otherwise could.
    c. The various disciplines and authorities that contribute to coronial investigations are so uncoordinated that is arguably inaccurate to refer to the as constituting a "coronial system."
    d. The current structural architecture or arrangements undermine the independence of coroners and hinders the development of the expertise necessary for coroners to most effectively discharge their responsibilities

Scope of the jurisdiction

(a) the law, practice and operation of the Coroner's Court of NSW, including:

(i) the scope and limits of its jurisdiction

4. The general framework and usual outcomes of coronial investigations are well known and understood. Coroners investigate unexpected and unnatural deaths, make findings about manner and cause – that is the medical cause and the underlying causes or the circumstance of the deaths - and make preventative recommendations. Coroners find facts; they do not attribute blame or apportion liability.

5. However, because they are not bound by the rules of evidence, the Uniform Civil Procedure Rule or the rules that govern criminal proceedings – s58 *Coroners Act 2009* - there is far less certainty about how they should go about their tasks; how the limits of their jurisdiction

[1] Between 1988 – 90, while an employed solicitor with Aboriginal and Torres Strait Islander Legal Service, I represented the families of many of those whose deaths were examined by the Queensland chapter of the Royal Commission into Aboriginal Deaths in Custody.
In the years following the RCADIC I made numerous submissions to successive Qld governments on coronial law reform that led to the passing of the *Coroners Act 2003* (Qld).
Between ~2004 and 2012 I was a regular guest lecturer in undergraduate and post graduate university courses dealing with death investigation.
From 2003 – 2013 I was the inaugural Qld State Coroner responsible for operationalising the new coronial system in that state and for providing guidance of local coroners.
From 2014 to 2017 I was NSW State Coroner responsible for oversighting local coroners and attempting to reform the NSW coronial system.
I have published approximately a dozen peer reviewed journal articles dealing with various aspects of coronial law and practice.

should be defined and how they should interact with other legal processes and proceedings. This uncertainty is compounded by a dearth of judicial authority and a limited level of academic analysis against a background of very rapid change in the way the jurisdiction operates over the last 30 years. Examples of the difficulties this causes are set out below.

Jurisdiction

6. Coroners are intended to focus on suspicious, unnatural or unexpected deaths but more than half of all reportable deaths are due to natural causes. This causes unnecessary intrusion into the lives of the bereaved at a most sensitive time; consumes significant resources of an under-funded system; delays the finalisation of matters more appropriately dealt with by a coroner; and serves little worthwhile purpose. For more a detailed discussion of this issue and possible remedies see *Intake rigor: ensuing only reportable deaths become coroners' cases.*[2]

Concern for the bereaved

7. If a primary objective of the coronial system is to improve public health and safety and if undertaking internal autopsies and retaining organs and tissue may contribute to medical research that results in medical advances that saves lives, why should bereaved families be able to prevent autopsies from being undertaken or organs being retained?

8. Either explicitly or by practice, coroners frequently embrace therapeutic jurisprudence – meeting with family members in chambers; addressing family members in the gallery (even when they have a lawyer at the bar table); allowing unsworn family statements in court – without articulating how they avoid diminishing procedural fairness to others whose conduct might be scrutinised by the inquest.

9. Similarly, concern for their impact on bereaved families frequently leads coroners to shrink from making suicide findings even when the evidence supporting such a finding is compelling.

10. It is not suggested that coroners should not give primacy to the impact of their procedures on bereaved family members or abandon their pursuit of facts relevant to improving public health and safety; rather, it is submitted the legislation or procedural rules should give guidance as to how these competing interests should be ranked or resolved. Absent such guidance, inconsistent practice will continue.

Procedural ambiguity

11. The various coronial statutes authorise coroners to give police officers directions as to how an investigation is to be carried out - e.g. see s. 51 (2) *Coroners Act 2009* (NSW) - but the legislation and the law is silent as to how a dispute should be resolved if the coroner wants something done that the investigating officer considers might compromise a criminal investigation of the death in question or is simply unnecessary. A similar problem arises when the brief is delivered to the coroner and he/she is inclined to share it with the family

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[2] Barnes M, Carpenter B, Kirkegaarde A, *Intake rigor: ensuing only reportable deaths become coroners' cases,* (2014) 21 JLM 572

while the police would prefer it remain confidential so as not to negatively impact their criminal investigation.

12. Because of the different standard of proof and admissibility of evidence a person acquitted of murder on the basis that the prosecution could not satisfy the jury that the accused caused the death can be found by a coroner to have caused the death in circumstances that do not indicate any defence.

13. Most coronial statues seek to restrict the coroner's intrusion into the criminal jurisdiction by proscribing findings that "a person is or may be guilty of an offence" (s45(5) Qld, s69 Vic); "indicate or in any way suggest that an offence has been committed by any person" (s81(3) NSW). However, a finding that a named person sent a bomb to the office of a law enforcement agency intending to kill or main the officers who investigated his criminal offences is permitted. [3]

14. For 800 years investigating suspicious deaths as part of the process leading to a criminal trial was a key function of coroners. In NSW until 1962, an inquest was mandatory *before* an accused in custody went to trial. On what basis is it now considered their involvement is unwarranted? Certainly the ever growing number of unresolved suspicious deaths/disappearances would not support a suggestion that the police don't need assistance.

15. Conversely, there is concern that if coroners play a role in determining whether criminal proceedings are commenced, inquests will become committal hearings focussed on whether a particular individual should be prosecuted, rather than open inquiries seeking to establish the manner and cause of death and how similar deaths might be avoided in future.

16. It is submitted that the unnecessarily convoluted processes set out in s 78 of the NSW Act ignore the reality that in some cases the identity of the person(s) involved in causing the death, or the circumstances in which the death occurred, are inextricably interwoven with issues that will need to be determined to resolve criminal responsibility.

17. The interaction between coronial proceedings and criminal proceedings should be clarified. In those small number of cases in which the real issue to be determined is whether charges should be brought to establish criminal liability for the death in question, the coronial proceedings should be conducted in such a way that the rights of the person of interest are protected while the central issue of whether charges should be brought can be resolved.

When to inquest and what issues

18. The scope of an inquest is determined by reference to causation – what factors may have caused or contributed to the death. However the leading cases are either lacking in precision or are contradictory – see *Harmsworth v the State Coroner* [4], *Conway v Jerram*[5] and *Lucas-Smith v ACT Coroners Court*.[6]

19. The "common sense" test of causation used to limit responsibility for harm or damage caused by negligent acts involves, according to the High Court, "*the making of value*

[3] *Perre v Chivell* (2000) 77 SASR 282
[4] [1989] VR 989
[5] [2010] NSWSC 371
[6] [2009] ACTSC 40

judgments and the infusion of policy considerations."[7] It is effective because of *stare decisis* and the myriad of authorities that spell out those polices and values and put factual flesh on the doctrinal bones. Coroners have neither theory nor cases to guide their "common sense" when considering which factors can be held to have caused a death.

20. Consequently, inquests are frequently unduly narrow in their focus and occasionally too broad. These somewhat quixotic decisions are rarely challenged for reasons of cost.

21. Most coronial statutes now recognise the importance of preventative recommendations but there is little or no guidance as to the extent to which recommendations can be made. For example, is it appropriate for a coroner to recommend that a law be changed or is that intruding into the exclusive domain of the legislature?

22. How should the discretion to convene an inquest be exercised when the manner and cause of death are clearly established but there are concerns about the circumstances in which a death occurred?

The way forward

23. Each of these issues could be addressed in isolation. Indeed that's what happens in practice: coroners either muddle their way through the challenges these issues throw up or elegantly resolve concerns with careful analysis and finely argued reasons.

24. However, in many cases there seems to be little regard had to any overarching theory or even reference to clearly articulated policy principles. Would it not be better to establish the essential purposes and attributes of a coronial investigation by reference to the values that underpin it? Without a comprehensive theoretical framework coroners are likely to continue to do as little or as much as they can without being challenged. That is hardly a satisfactory mechanism for regulating such an important function.

25. An overarching theoretical framework can only emerge if coronial issues are discussed in principle, rather than just in practice and there is sufficient discourse among the professions and disciplines that contribute to coronial practice and those who use its services.

26. It is respectfully submitted that this inquiry should seek to fill the gaps and resolve the conflicts referred to above so that long overdue legislative reform could result in a more fit for purpose coronial system.

Resources

(ii) the adequacy of its resources
(iii) the timeliness of its decisions

26. New South Wales funds its coronial system at about one half of the per capita rate of Queensland and Victoria. No one with any insight into the workings of the coronial systems in those latter two states has suggested that their systems are overly funded or wasteful. There is no basis on which to hope that NSW could achieve efficiencies of operation that would compensate for the different rates of funding. Consequently, the only conclusion is that the NSW system is underfunded.

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[7] *March v Stramare* [1990 – 1991] 171 C.L.R. 506

27. That underfunding manifests itself in all aspects of coronial practice. Investigations are truncated, matters that should go to inquest are instead dealt with "on the papers" and opportunities for the making of preventative recommendations are forgone.

28. Coroners make excuses for inadequate investigations to dissatisfied family members. Inquests are dispensed with when a hearing is warranted. Requests from local coroners to transfer files to a fulltime coroner in Sydney are refused by the State Coroner. These unmeritorious decisions are made necessary by inadequate funding of the coronial system because the compounding delay in finalisations that would result were the more appropriate courses taken would be unsustainable.

29. If the system were better funded more time could be spent responding to the concerns of bereaved family members; more analysis could identify trends in various types of deaths and more effort could be devoted to understanding the factors contributing to them and their prevention.

Institutional arrangements

(c) the most appropriate institutional arrangements for the coronial jurisdiction in New South Wales, including whether it should be a standalone court, an autonomous division of the Local Court, or some other arrangement.

Problems with current arrangements

30. Each configuration suggested in this ToR has advantages and disadvantages. The current arrangements in NSW are neither a standalone court nor an autonomous division of the Local Court. Those arrangements are flawed in many respects.

31. There is no Coroners Court in NSW, a glaring anomaly. The Chief Magistrate has the authority to make decisions impacting the workload of individual coroners and the manner in which individual cases are resolved, undermining the independence of the coroner. Parliament makes no budgetary appropriation for the jurisdiction – it gets whatever amount the Chief Magistrate of the day chooses to allocate to it.

32. In regional areas, Local Court magistrates, who in some cases have very limited experience in coronial matters, are required to discharge the role of coroner.

33. Some of those Local Court magistrate coroners have little feeling for the jurisdiction and have difficulty vacating an adversarial mindset to adopt the inquisitorial approach required to effectively resolve coronial matters.

34. Many Local Court magistrates have high criminal caseloads that prevent them dealing with coroner's cases in a timely and thoughtful manner. They are frequently required to make rushed decisions in court breaks about matters in which they lack sufficient background and understanding.

35. In all other aspects of a magistrate's caseload, the parties determine whether a matter proceeds to hearing. The magistrate cannot require a defendant to plead guilty to a criminal charge or a plaintiff to settle their claim. The coronial caseload is the only body of work in which the decision whether to proceed to hearing or dispense with any further proceedings is made by the judicial officer.

36. Unfortunately, but perhaps understandably, over-burdened regional coroners too frequently elect not to proceed to hearing and dispense with an inquest.

37. Magistrates in regional courts spend a significant amount of time driving between court centres which can create logistical challenges to the smooth processing of coroners cases in the crucial period immediately after the death is reported. The body can be in one centre, the coroner's clerk in another, and the coroner in a third. Communication technology is often inadequate. Poor decision making can result.

38. The current arrangements mean that there is in effect in NSW a two tiered coronial system: deaths that are reported to a metropolitan coroner are dealt with by a full-time specialist who does not have to juggle a general court list. Deaths that are reported to a regional coroner may well be dealt with by a person with limited experience in the subtleties of the jurisdiction and inadequate time to make the inquiries necessary for the nuanced decision making required to address the competing interests many cases throw up.

An autonomous division of the Local Court

39. To overcome the problems with the current arrangements outlined above, the creation of an autonomous coronial division in the Local Court would need to involve the removal of the Chief Magistrate from operational decision-making. The State Coroner would be solely responsible for the supervision and professional development of coroners.

40. It would also require the creation of a greater number of full-time coroner positions so that only those with sufficient expertise and commitment to the role would undertake the work.

41. Unless the Coroners Division were given a discrete budget by Parliamentary appropriation, the division could be subject to funding constraints at the whim of the Chief Magistrate.

42. The selection, retention and rotation of coroners to fill the full-time roles proposed could prove challenging. If the Chief Magistrate and the State Coroner had a mutually respectful professional relationship and a shared vision of the role and function of coroners, these challenges could be overcome. However, these preconditions create a single point of failure for the proposal, dependent as they are on personalities that cannot be mandated in legislation. The issue of how to attract and retain suitable coroners is dealt with in each of the subsequent proposals.

A standalone court

43. A standalone Coroners Court has the advantage of being independent, expert and available.

44. A standalone court would have a head of jurisdiction who was fully committed to the coronial system with no obligation to juggle its needs against the competing priorities of another court.

45. It would be constituted by full-time coroners would have or would develop:
    - an understanding of the relevant esoteric legal principles
    - an understanding of the mores relating to death in diverse ethnic communities
    - an approach to decision making guided by intuitive synthesis
    - a working knowledge of the relevant aspects of forensic medicine and incident investigation
    - professional relationships with practitioners in the other professions that constitute the coronial system
    - work flows that enable the making of informed decisions that best support coronial values.

46. Possible weaknesses of a standalone court are the challenges to find suitable practitioners who are content to remain working in the jurisdiction throughout their career and a mechanism to manage those who are found after appointment to be unsuited.

47. It can be argued that the role of a coroner is more taxing than other judicial officer roles. Visiting death scenes, witnessing autopsies, constant exposure to the detailed accounts of violent deaths and dealing with the needs and demands of bereaved relatives is different in nature to the stress encountered by those presiding over criminal and civil courts.

48. Further, these differences are less likely to be appreciated by those who might apply for appointment as coroners, whose exposure to the coronial system is almost exclusively via their participation in inquests which involve an essential but only a small part of the role.

49. An advantage of the coronial jurisdiction being an autonomous part of the Local Court would be that magistrates could be rotated in and out of the role of coroner with the agreement of the Chief Magistrate and State Coroner. Those who the State Coroner concluded were not suited, or whom themselves came to the conclusion that they would prefer to preside elsewhere could transition to the general bench either permanently or for a period. The autonomy of the Coroners Division would need to include a mechanism which prevented the Chief Magistrate transferring a coroner out of the division when the State Coroner and the coroner in question wished to continue in the role.

50. A risk of making appointments exclusively to a standalone Coroners Court is that coroners who were found to be not suited would have nowhere else to go. This occasionally happens in the criminal and civil courts but it is less likely to occur because the nature of the role of

those presiding over those courts is more readily apparent to practitioners who seek appointment.

51. The Coroners Court of Victoria addresses this challenge by appointing coroners for fixed terms – usually 5 years. That approach has two flaws. First, it is a fundamental principle of the independence of all courts that judicial officers are not able to be removed until retirement age, absent proven misconduct. Requiring coroners to seek reappointment periodically risks undermining at least the appearance of that independence and gives the head of jurisdiction influence over the members of the court not available in other courts. Second, in theory a State Coroner could recommend that a coroner who he or she had concluded was not suited not be reappointed. However, in practice, when the acceptance of such a recommendation would result in the coroner in question becoming unemployed, many heads of jurisdiction would feel uncomfortable making the recommendation. Far easier to send an unsuited coroner back to the general list than to the unemployment lines.

A hybrid court

52. An arrangement similar to the Childrens Court of NSW could be the best model for the coronial jurisdiction for the following reasons. It would entail a court led by a State Coroner who was also a District Court Judge, and constituted by as many magistrates as necessary to discharge all coronial work throughout the state on a full-time basis. Those full-time magistrate coroners would be subject to the supervision of the State Coroner while attached to the Coroners Court but would revert to the usual relationship with the Chief Magistrate if they were to return to the Local Court.

53. This arrangement would deliver the same advantages of expertise as set out in paragraph 45 above.

54. Parliament would determine the court's budget. A head of jurisdiction at the same level in the judicial hierarchy as the Chief Magistrate would preserve the independence of the coroners. The Chief Magistrate would have no authority to intervene in coroner's cases. The State Coroner would consult and negotiate with the Chief Magistrate as an equal.

55. That would be necessary because of the advantages of making the appointment to the office of magistrate and coroner coterminous. Those advantages include having a magistrate coroner in all Local Court districts so that urgent orders can be made even if a full-time coroner is not available and to provide surge capacity if high demand overwhelms the contingent of full-time coroners.

56. Another advantage is the flexibility the arrangement would give to recruiting and retaining coroners. As coroners would simultaneously be sworn in as magistrates of the Local Court, if a coroner or the State Coroner came to the conclusion that an individual was struggling to adequately discharge coronial functions, or it was considered that an individual would benefit from some "time out", the coroner concerned could assume duties in the Local Court and be replaced by a magistrate from that court.