Inquest Hearings in Western Australia

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Introduction

In the year 2010-2011 2,243 deaths were referred to the Coroner's Court. The number of deaths ultimately determined to be reportable was 1,994. In respect of each of the reportable deaths it was necessary for the coroner investigating the death to make findings pursuant to section 25 of the Coroner's Act 1996.

In the same year only 40 deaths were inquested. While this was largely a factor of the under-resourcing of the Coroner's Court at the time, even if approximately 100 deaths had been inquested, this would have still only comprised 5% of the total number of reportable cases.

It is clear, therefore, that the number of deaths which are inquested are only a small fraction of the total number of reportable deaths and inquest hearings are a relatively small part of the work of the Coroner's Court.

Section 3 of the Coroner's Act 1996 (the Act) defines what is meant by a "reportable death" as:

> "**reportable death"** means a Western Australian death –
>
> (a) that appears to have been unexpected, unnatural or violent or to have resulted, directly or indirectly, from injury;
>
> (b) that occurs during an anaesthetic;
>
> (c) that occurs as a result of an anaesthetic and is not due to natural causes;
>
> (d) that occurs in prescribed circumstances;
>
> (e) of a person who immediately before death was a person held in care;
>
> (f) that appears to have been caused or contributed to while the person was held in care;

(g) that appears to have been caused or contributed to by any action of a member of the Police Force;

(h) of a person whose identity is unknown

(i) that occurs in Western Australia where the cause of death has not been certified under section 44 of the *Births, Deaths and Marriages Registration Act 1998;*
or

(j) that occurred outside Western Australia where the cause of death is not certified to by a person who, under the law in force in that place, is a legally qualified medical practitioner.

In respect to (d), there are no "prescribed circumstances."

Reportable deaths include all suicides, motor vehicle deaths, accidental deaths, industrial deaths, deaths as a result of adverse events in a medical setting and unexpected natural cause deaths as well as unexplained deaths.

The Jurisdiction to Hold an Inquest

(a) Mandatory Inquests

Section 22 of the Act deals with the jurisdiction of a coroner to hold an inquest into a death. This section provides for mandatory inquests in the case of deaths of persons in custody, persons whose deaths were caused or contributed to by the action of a police officer or other deaths of persons held in care.

Section 22 also provides for mandatory inquests when the Attorney General so directs, when the State Coroner so directs or when the death occurred in "prescribed circumstances"

The Attorney General has never given such a direction and there are no "prescribed circumstances".

Importantly an inquest must be held when a person is missing and the State Coroner has reasonable cause to suspect that the person has died and that the death was a reportable death (section 23). In these cases the State Coroner may direct that the suspected death of the person be investigated, in which case an inquest must be held into the circumstances of the suspected death of the person, and if the death is established beyond all reasonable doubt, into how the death occurred and the cause of the death.

(b) Discretionary Inquests

Section 22(2) provides that a coroner who has jurisdiction to investigate the death may hold an inquest if the coroner believes that it is "desirable."

The term "desirable" has been interpreted broadly and the common law relating to when to hold an inquest "depended largely upon a good measure of common sense."[1]

The Purpose of Holding an Inquest

An inquest provides the following benefits over an investigation simpliciter:

- An open and public investigation.
- An opportunity for the coroner to call and question witnesses and for interested parties to question witnesses. A coroner at an inquest has the power to compel witnesses to attend and to answer questions, which may assist in making findings of fact (sections 46, 47).
- Interested parties can suggest witnesses to be called at an inquest and the public nature of the inquest may lead to additional witnesses coming forward.
- The publication of the inquest findings may resolve any uncertainty or conflict of evidence regarding the circumstances

[1] ***Clancy v West*** [1996] 2 VR 647 @ 651.

of the death and may uncover important systemic defects or risks not already known about.

- An inquest may provide the coroner with an opportunity to make comments and recommendations designed to prevent similar deaths, contribute to public health and safety, or the administration of justice.

The 1971 *Broderick Report* into the English coronial system identified five purposes that a coroner's investigation should serve:

(i) to determine the medical cause of death;

(ii) to allay rumours or suspicion;[2]

(iii) to draw attention to the existence of circumstances which, if unremedied, might lead to further deaths;

(iv) to advance medical knowledge; and

(v) to preserve the legal interests of the deceased person's family, heirs or other interested parties.[3]

In the Shipman Inquiry (Dr Shipman was an English doctor who was found to have killed at least 215 of his patients), Dame Smith suggested that the purposes of a modern inquest include:

- to inform interested bodies and the public at large about deaths which give rise to issues relating to public safety, public health and the prevention of avoidable death and injury
- to provide public scrutiny of those deaths that occur in circumstances in which there exists the possibility of an abuse of power.[4]

As Ashley J explained in ***Domaszewicz v State Coroner***

[2] While a coroner cannot investigate every rumour or suspicion, the coroner must not prematurely conclude that rumours or suspicions cannot hope to be confirmed. Instead, the coroner must assess whether there is a reasonable evidentiary basis to warrant investigation and, if so, call relevant evidence to investigate the rumour or suspicion. **See *Re Hemsworth*** [2009] NIQB 33 at [35]-[36]; ***Re Ramsbottom*** [2009] NIQB 55 at [17].

[3] United Kingdom, *Report of the Committee on Death Certification and Coroners,* Cmnd 4810 (1971), paragraph 14.19 *(the Brodrick report*). The report noted, however, that preserving legal interests will never be a primary purpose of an investigation. Instead, it may be an "incidental by-product of the system and not intrinsic to it" (at 14.24).

[4] United Kingdom, *The Shipman Inquiry: Third report: Death Certification and the Investigation of Death by Coroners,* Cmnd 5854 (2003) at 9.84.

> An inquest is not a proceeding *inter partes*. It is part of an investigative process which is concerned, inter alia, to set the public mind at rest where there are unanswered questions about a reportable death.[5]

A coroner must not confuse the purpose of an inquest with the purpose of other proceedings. A coronial investigation does not exist to investigate possible criminal conduct and compile a brief of evidence in preparation for a future criminal trial.[6] Similarly, an inquest does not exist to provide a "dummy run" for future civil litigation.[7] Instead, the purpose of an inquest is to establish the findings required by section 25 of the Act and to make such comments or recommendations as are appropriate in the circumstances of the case.

When it is "desirable" to hold an inquest (section 22(2))

One of the first matters a coroner will need to consider when deciding whether to conduct an inquest is whether the material available raises any doubts concerning the cause or circumstances of the death. If so, the coroner should determine the most appropriate means of further investigating the matter. In many cases information can be obtained through further police investigations, the obtaining of medical reports or otherwise seeking documentary evidence. In other cases, however, the coroner may need to conduct an inquest.

There are at present no Western Australian guidelines relating to this topic though it is anticipated guidelines will be produced following the outcome of the current Strategic Review of the Office of the State Coroner and the government response to the recent *Law Reform Commission of Western Australia Final Report, Review of Coronial Practice in Western Australia* (2012).

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[5] ***Domanszewicz v State Coroner*** [2004] VSC 528 at [28].
[6] ***Maksimovich v Walsh*** (1985) 4 NSWLR 318 at 330 per Kirby P.
[7] See United Kingdom, *Report of the Committee on Death Certification and Coroners,* Cmnd 4810 (1971), paragraph 16.34 *(the Brodrick report*).

Coroner's Courts in other jurisdictions have produced useful guidelines on when to conduct an inquest. The Queensland guidelines state that the coroner should hold an inquest into:

- Any death where there is such uncertainty or conflict of evidence as to justify the use of the judicial forensic process.
- Any death in which there is a likelihood that an inquest will uncover important systemic defects or risks not already known about.
- Any deaths in which the views of the family or other significant members of the public are such that an inquest is likely to assist maintain public confidence in the administration of justice, health services or other public agencies.
- Any death that when grouped with others that have occurred in similar circumstances indicates that there may be an unexpected increase in danger in a particular location, area, family, industry or activity.
- Any workplace death in which industrial processes or activity is implicated.
- Any disasters involving multiple deaths.
- Any death from self harm in which it is not possible to exclude the involvement of a third party in procuring the death or in failing to prevent it.[8]

New Zealand Coronial Guidelines advise coroners to consider the following four issues:

- Would an inquest be likely to provide information that has not already been disclosed by information available to the coroner?
- Does the death appear to be unnatural or violent? If so, does it appear to be from the actions or inactions of others?

[8] State Coroners Guidelines, Queensland, December 2003, 8.3. See also ***Chiotelis v Coate*** [2009] VSC 256; ***Conway v Jerram*** [2010] NSWSC 371; United Kingdom, *Death Certification and Investigation in England, Wales and Northern Ireland: The Report of a Fundamental Review* (the Luce Report), Cmnd 5831 (2003), 80.

- Are there any allegations, rumours, suspicions or public concerns about the death?
- Are there any other matters the coroner considers relevant?[9]

The following matters may also be relevant when determining whether to hold an inquest:

- Whether the inquest will provide the opportunity to compel a reluctant witness to give evidence, using section 46.
- Whether the family or another person has requested an inquest.
- The existence of conflicting expert opinions on the cause of death or the circumstances of death.
- The danger that interested parties will seek to use the inquest as a 'political platform' or a platform for making damaging or baseless allegations.
- Whether drawing attention to the death may prevent other similar deaths.
- Whether drawing attention to the death may increase the risk of similar deaths, especially in suicide cases.
- Whether there is a reasonable prospect that examination of witnesses may help establish the cause of death or circumstances surrounding the death, where there are some doubts on either of those issues.

A coroner should not allow an inquest to be used for an improper purpose. For example, an inquest is not:

- An opportunity for family members to perpetuate a family dispute.
- An opportunity to gather or test evidence in preparation for a civil claim.[10]

[9] *Coroners Bench Book 2007,* New Zealand, 166.

[10] ***Clancy v West*** [1996] 2 VR 647; United Kingdom, *Report of the Committee on Death Certification and Coroners,* Cmnd 4810 (1971), paragraph 15.24 (*the Brodrick report*),

Applications for an Inquest

While a coroner may unilaterally decide to hold a discretionary inquest, many of these inquests are conducted following a successful application for an inquest into a death.

Section 24 of the Act provides that a person may ask a coroner to hold an inquest into a death which a coroner has jurisdiction to investigate, in which case the coroner may either hold an inquest or ask another coroner to do so; or refuse the request and give reasons in writing for the refusal to the person and to the State Coroner within a reasonable period after receiving the request.

Section 24(1a) provides that a request under subsection (1) is to be made in writing and to contain reasons for the request.

While any person may make a request under section 24 and the Act does not impose any standing or sufficient interest requirement, the coroner would be expected to consider the nature of the applicant's connection to the death and the deceased, as this may bear on the appropriateness of an inquest.

In the case where a coroner has refused to hold an inquest, or a reply has not been given within 3 months after a request was made, the person who made the application may apply to the Supreme Court for an order that an inquest be held.

The Supreme Court may make an order that an inquest be held if it is satisfied that it is necessary or desirable in the interests of justice (section 24(3)).

Clearly an application for an inquest should address the important purposes for holding an inquest.

Most applications for an inquest are made by family members or their lawyers or other representatives but these applications can also be made by other persons concerned about the circumstances of a death.

An application for an inquest would not normally be granted prior to the Coroner's Court receiving the results of the police investigation or any other important investigations relevant to the case. It is rarely, therefore, useful to make an application for an inquest until the police investigations have been completed.

When police investigations have been completed an application may be made by the family or their legal representatives to access the investigation file with a view to determining whether any additional investigation is required and identifying issues which could best be addressed by the holding of a public inquest.

It is important that the applications to hold an inquest clearly articulate the main issues which it is perceived the inquest could best address, and, to the extent practicable, identify suggested witnesses to give oral evidence. The latter is important as in the event that a coroner decides that an inquest should be held, the next step will be the identification of witnesses who should be subpoenaed to give oral evidence (from the other witnesses whose statements or reports alone will suffice) and to make a realistic estimate as to the anticipated length of the inquest hearing to enable appropriate listing to take place.

Any legal representatives of a person seeking an inquest should ensure that the Coroner's Court is informed of the above matters and if any changes take place, such as the identification of additional witnesses, that information is promptly communicated to the Coroner's Court.

Parties to an Inquest Hearing

Section 44 of the Act provides that an interested person may appear, or be represented by a barrister or solicitor, at an inquest and examine or cross-examine witnesses.

Regulation 17 of the Coroners' Regulations 1997 provides a list of the persons who are interested persons for the purposes of the section as follows:

> **17 Interested persons for the purposes of section 44(3)**
>
> The following persons are interested persons for the purposes of section 44(3) of the Act—
>
> (a) a spouse, de facto partner, child, parent or other personal representative of the deceased person;
>
> (b) any of the deceased person's next of kin under section 37(5) of the Act;
>
> (c) a beneficiary under a policy of insurance issued on the life of the deceased person;
>
> (d) an insurer who issued such a policy of insurance;
>
> (e) a person whose act or omission, or the act or omission of an agent or servant of that person, may in the opinion of the coroner have caused, or contributed to, the death of the deceased person;
>
> (f) a person appointed by an organization of employees to which the deceased person belonged at the time of death, if the death of the deceased person may have been caused by an injury received in the course of employment or by an industrial disease;
>
> (g) the Commissioner of Police appointed under the *Police Act 1892*.

The fact that a determination has been made that a person may appear, or be represented, at an inquest does not mean that the person or the legal representative can examine or cross-examine all witnesses. The coroner may, for example, limit the person's involvement to only questioning certain witnesses, or only making submissions. This will

mean that the person does not receive the full range of rights normally granted to interested parties.

While parties at the inquest will normally be provided with copies of the brief prepared for the inquest hearing, there is normally a requirement for fees to be paid as required by Schedule 3 of the Regulations.

A coroner's registrar may remit payment of the fees or reduce the amount on the basis of financial hardship or the interests of justice (regulation 23).

It is not appropriate to make an application that payment of a fee be waived at an inquest hearing.

Multiple Death Inquests

Section 40 of the Act provides that the State Coroner may direct that more than one death be investigated at one inquest.

The power to conduct an inquest into multiple deaths gives coroners the opportunity to investigate significant systemic issues that contributed to a number of deaths. The coroner may investigate common elements in a comprehensive and efficient manner, rather than conducting parallel inquiries.

When deciding whether to exercise the power under section 40, relevant considerations include:

- Whether there is sufficient common elements between the several deaths to justify a single inquest.
- Whether a joint inquest will be of manageable scope.
- Whether it is fair to the interested parties to conduct a single inquest.
- Whether it is an efficient use of coronial resources to conduct separate inquests or one multiple event inquest ***Maksimovich v***

Walsh (1985) 4 NSWLR 318 and *Victorian Parliamentary Law Reform Committee, Coroner's Act 1985: Final Report,* 246-250).

In multiple death inquests it is important for a coroner to carefully consider whether to limit the role of any interested parties to the investigation into particular deaths. In a case where there is a multiple event inquest, there will likely be some interested parties that have an interest in each of the deaths, however, there may also be other interested parties, such as families of the individual deceased persons, that have limited interests.

It is important to note in this context that the inquest is part of the coroner's investigation and often there is no other individual or organisation who conducts such investigations. Particularly significant in this context are the cases of cluster suicides where it may be important to conduct an investigation and sometimes an inquest in order to address the causes of the suicides and to see whether there are common features. If this does not occur the ability of society to ever reduce the numbers of these tragic cases will be severely compromised. This fact is not often well understood by those who would criticize the conducting of such inquest hearings.

Evidence at Inquest Hearings

Section 41 of the Act provides that a coroner holding an inquest is not bound by the rules of evidence and may be informed and conduct an inquest in any manner the coroner reasonably thinks fit.

Perhaps the most striking feature of the modern inquest hearing is the way in which documentary evidence is received and the ability to avoid unnecessary calling of oral evidence so as to focus on important and contentious issues.

As the rules of evidence do not apply, oral evidence is usually only received when it is considered important to do so. This may be because of a conflict in the evidence or the importance of the witness to determinations of the coroner or for similar reasons.

There usually is no need to call continuity evidence and in most inquest hearings the bulk of the evidence is received in documentary form.

It is the practice in Western Australia to receive the inquest brief comprising the police investigation results as the one exhibit. The exhibit can be organised in a user-friendly format which will enable witnesses and counsel to readily identify any evidence to which they wish to refer.

In the recent Christmas Island inquest, for example, the ultimate brief prepared by WA Police contained a report with 25 annexures, each annexure comprising multiple lever arch files. Annexure 2, for example, comprised 9 lever arch files. The total brief comprised well over 100 lever arch files. This brief was received as one exhibit.

The brief included over 730 witness statements as well as a very large number of reports, records, emails and other documents.

While these documents were all contained in the one exhibit, that exhibit was itself organised for ease of use, with each annexure containing documents relating to a discrete topic or area of investigation.

Of course it was necessary for a number of additional documents, reports and statements to be received separately as different exhibits, but the bulk of the documentary evidence was usefully received as one exhibit at the beginning of the inquest. In that case new additional documents were added to the same exhibit where they could conveniently be placed within the existing annexures to the main report.

An important benefit of this procedure is that all counsel at an inquest have the ability to refer to any of the documents which have been obtained during the course of the investigation as each witness gives evidence. There are none of the delays or complications which adversarial courts face because of the need to prove each document prior to its admission.

That is not to say that all documents provided by any party will be received without question. Clearly a party seeking to tender a document or documents will need to satisfy the coroner that the document or documents is or are relevant to and likely to be helpful for the coroner's determinations.

At the end of the inquest it may become apparent that some of the documents are wholly or in part irrelevant, unhelpful or unreliable. This can best be determined at the end of the inquest hearing and fortunately valuable time is not wasted in debates about admissibility etc.

Unfortunately the way in which a modern inquest is conducted is often not well understood. The *Law Reform Commission of Western Australia in its recent Review of Coronial Practice in Western Australia Final Report (2012) at recommendation number 78* recommended that the section of the Coroner's Act dealing with affidavits expressly provide for the acceptance and use of affidavits at an inquest. The Law Reform Commission also recommended that the Coroners Regulations be amended to provide a form for affidavits relating to coronial investigation which could be sworn before a coroner's registrar or coroner's investigator. This was because the Commission understood that such a procedure would save time and resources and that some witnesses might have to be called if affidavits were not sworn.

It is, of course, not necessary to rely on affidavits at all. The statutory declaration format currently in routine use by WA Police is entirely appropriate and there is no need for affidavits to be sworn when statements, reports, emails, charts and a whole range of other documents are received at the beginning of each inquest.

The Role of the Coroner

The coroner's role is unlike that of a judicial officer in a criminal/civil trial. While a coroner must conduct an inquest in accordance with procedural fairness, he or she should play an active role in directing the inquest. A coroner may, for example, seek out relevant witnesses or call for submissions on points not raised by counsel and may question witnesses to an extent which would not normally be appropriate in a criminal/civil trial.

It is, also important for the coroner to, as far as practicable, make the inquest comprehensible to the media, interested parties and family members who are present. For that reason the coroner may make observations or require summaries of evidence which have been produced to be read out in open court.

When hearing appeals from coronial decisions, courts have often reiterated the following statement by Lord Lane CJ in ***R v South London Coroner;*** *ex parte Thompson:*[11]

> 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.

[11] The Times, 9 July 1982 (quoted in ***Arnetts v McCann*** (1990) 170 CLR 596 at 616).

Coroners have a wide discretion to determine the relevant issues and which evidence will be produced at an inquest. Coroners are not bound by the rules of evidence. Whether or not evidence is received which an interested party seeks to tender depends on whether the coroner considers the material useful for the purposes of the inquest.

The Effect of the Rules of Evidence in the Context of Section 41

While section 41 provides that a coroner holding an inquest is not bound by the rules of evidence, courts have consistently held that the provisions which relieve courts or tribunals of the rules of evidence do not allow courts to completely ignore the underlying wisdom of these rules. Coroners must make decisions based on rationally probative evidence and not on mere suspicion or speculation[12]

There are competing interpretations in the cases on exactly how provisions of suspended rules of evidence operate.

In reconciling the different approaches expressed in the authorities, the coroner should focus on whether the proposed evidence is relevant and reliable. Common law and statutory exclusionary rules can provide useful guides for when evidence is unreliable and may help a coroner decide whether evidence has sufficient probative value.

Hearsay evidence, for example, may be unreliable because of its nature, but in the context of a coronial investigation hearsay, particularly relating to statements made by the deceased prior to death, may be valuable and highly probative.

[12] ***Epeabaka v Mima*** (1997) 150 ALR 497 at 400; ***Pochi v Minister for Immigration and Ethnic Affairs*** (1980) 31 ALR 666 at 685.

A coroner can decide that procedural rules relating to the questioning of witnesses, such as the rule in ***Browne v Dunn***, may apply.[13] In addition, coroners would normally limit the extent to which leading questions and challenges to a witness's credibility are used, as such questions may not help the coroner perform the functions of an inquest.

Natural Justice

Coroners must conduct investigations and inquests in a fair and efficient manner, must comply with the rules of natural justice and must act judicially. The rules of natural justice are flexible and vary based on the circumstances of the case.

Section 44(2) of the Act provides that before a coroner makes any finding adverse to the interests of an interested person, that person must be given the opportunity to present submissions against the making of such a finding.

In this context a finding is one of the ultimate findings to which section 25(1) of the Act refers, that is a finding as to how the death occurred or the cause of death. This is the type of finding in respect of which any person may apply to the Supreme Court under section 52(1) of the Act for an order that the finding is void.[14]

Section 44(2), therefore, does not apply to every conclusion of a coroner which involves criticism of an individual or an organisation.

Section 44(2) reflects, in part, the effect of the decision in ***Annetts v McCann***[15] in which the majority of the High Court held that a coroner must not act contrary to a person's legitimate expectation that he or she

[13] ***R v Doogan; ex parte Lucas-Smith*** (2006) 158 ACTR 1 at 61.

[14] ***Re the State Coroner; ex parte The Minister for Health*** [2009] WASCA 165, ***Re Inquest into the death of Romuald Todd Zak; ex parte Zak*** [2006] WASC 186 at [28] (Murray J).

[15] ***Annetts v McCann (1990)*** 170 CLR 1296 at 601.

will be given an opportunity to be heard before the coroner makes findings adverse to his or her interests.

Later cases developing the principles of natural justice require coroners to accord natural justice to any person who is exposed to a risk of being subject to an adverse finding.[16]

In practice counsel assisting is expected to identify any individuals or organisations in respect of whom the available information indicates that an adverse finding may be made and provide that individual or organisation with a letter advising of the possibility of an adverse finding prior to an inquest commencing.

Counsel assisting would not normally be expected to warn of the possibility of specific adverse findings, but may in some cases refer to evidence which has been obtained which contains allegations which, if accepted, could constitute an adverse finding.

Counsel representing a party at an inquest should be alert to any statements or comments in the evidence critical of that party and should not assume that the coroner will not accept those critical statements or comments as being reliable unless the coroner has specifically indicated that he or she places no reliance on them.

Because of the information gathering nature of an inquest hearing, however, it is often only during an inquest hearing that it may become apparent that an individual or organisation may be the subject of an adverse finding. In these cases it is necessary to provide a warning of the possibility of an adverse finding and to inform the individual or organisation that submissions may be made in respect of such a finding. It would not normally be necessary for an inquest to be abandoned or restarted, but it may in some cases be necessary to provide a copy of the

[16] ***Musumeci v Attorney General of New South Wales*** (2003) 57 NSWLR 193 at [11].

transcript of relevant evidence to the individual or organisation concerned.

The rights of natural justice in this context only accrue when a coroner is considering making an adverse finding and the obligation to provide natural justice does not require the coroner to give a "running commentary" on his or her assessment of the evidence or the findings he or she is considering making. Natural justice for a person subject to the risk of an adverse finding requires the coroner to give that person an opportunity to make submissions. It does not require the coroner to warn the person that a specific adverse finding is under contemplation and invite a response.[17]

In many inquest hearings it is the person in respect of whom an adverse finding is likely to be made who is best placed to appreciate that fact, often long before counsel assisting or others involved in the inquest are alerted to that possibility. Sometimes inquests are held in order to obtain information from witnesses who are reluctant to provide statements or reports or to co-operate with investigations in any other format. In these cases it may not be known until the witness is called that the evidence will raise the potential for an adverse finding.

Counsel representing such a witness should be alert to the possibility of an adverse finding without the need for specific advice from counsel assisting or the coroner.

[17] ***Annetts v McCann*** (1990) CLR 596 at 609-610 per Brennan J.

The Scope of the Inquest

Section 25 provides, relevantly:

> **25 Findings and comments of coroner**
>
> (1) A coroner investigating a death must find if possible –
>
> (a) the identity of the deceased;
>
> (b) how the death occurred;
>
> (c) the cause of death; and
>
> (d) the particulars needed to register the death under the *Births, Deaths and Marriages Registration Act 1998.*
>
> (2) A coroner may comment on any matter connected with the death including public health or safety or the administration of justice.
>
> (3) Where the death is of a person held in care, a coroner must comment on the quality of the supervision, treatment and care of the person while in that care.
>
> …
>
> (5) A coroner must not frame a finding or comment in such a way as to appear to determine any question of civil liability or to suggest that any person is guilty of any offence.

In most inquest hearings the focus of the evidence will be on how the death occurred and the cause of death. Both of these concepts have been discussed extensively in recent authorities and it is clear that the scope of the inquiry under section 25 is extensive.[18]

How the Death Occurred

The meaning of "how the death occurred" was explored by Buss JA with whom Martin CJ and Miller JA agreed in ***Re the State Coroner; ex parte the Minister for Health:***[19]

> The dictionary meaning of the expression 'how the death occurred' is in what way or manner or by what means the death happened or

[18] ***Doomadgee v Clements*** [2005] QSC 357; [2006] 2 QdR 352.
[19] ***Re the State Coroner; ex parte the Minister for Health*** [2009] WASCA 165 [16].

took place. See *The Macquarie Dictionary* (4th ed, 2005) 694; *The Shorter Oxford English Dictionary* (5th ed, 2002) 1279.

However, 'how death occurred' in s25(1)(b) of the Act must be construed not merely by reference to its dictionary meaning, but also in the context of the other provisions of s25(1) and the Act as a whole. For example, the parliament plainly intended that a finding of 'how death occurred' within s25(1)(b) would be different from a finding of 'the cause of death' within s25(1)(c).

In my opinion, s25(1)(b) confers on the coroner the jurisdiction and obligation to find, if possible, the manner in which the deceased happened to die. This does not refer only to the means or mechanism by which the death was suffered or inflicted. It extends to the circumstances attending the death. In my opinion, a construction of s25(1)(b) which entitles and requires the coroner to find, if possible, by what means and in what circumstances the death occurred reflects the public interest which is protected and advanced by a coronial investigation (especially an investigation into deaths where one or more of the conditions in s22(1) of the Act are satisfied). Also, this construction is consistent with the decision of the Court of Appeal of Queensland in ***Atkinson*** on a comparable statutory provision.

The Cause of Death

"The cause of death" was discussed in the same case at [16] – [17]:

> Section 25(1)(c) of the Act requires the coroner to find, if possible, 'the cause of death'.
>
> The coroner, in finding, if possible, 'the cause of death', is not confined or restricted by concepts such as 'direct cause', 'direct or natural cause', 'proximate cause' or the 'real or effective cause'. Similarly, a coroner is not confined or restricted to a cause that was reasonably foreseeable. See ***WRB Transport v Chivell*** [1998] SASC 7002; (1998) 201 LSJS 102 [20] Lander J, Mullighan J agreeing).
>
> In ***WRB Transport,*** Lander J said, in the course of considering the coroner's jurisdiction under s12 of the *Coroners Act 1975 (SA)* to ascertain 'the cause or circumstances of the … death of any person …':
>
> > The Coroner … has to carry out an inquiry into the facts surrounding the death of the deceased to determine what, as a matter of common sense, has been the cause of that person's death. The inquiry will not be limited to those facts which are immediately proximate in time to the deceased's death. Some of the events immediately proximate in time to the death of the deceased will be relevant to determine the cause of death of the deceased. But there will be other facts less

> proximate in time which will be seen to operate, in some fact situations, as a cause of the death of the deceased. This is a factual inquiry which only has, as its boundaries, common sense.

His Honour added that the coroner's jurisdiction to determine the cause of a deceased's death is in addition to his or her jurisdiction to determine the circumstances of the deceased's death [22]-25]. See also ***Saraf v Johns*** [2008] SASC 166; 92008) 101 SASR 87 [18] – [19] (Debelle J).

Section 25(1)(c) does not, however, authorise a coroner to undertake a roving Royal Commission for the purpose of inquiring into any possible causal connection, no matter how tenuous, between an act, omission or circumstance on the one hand and the death of the deceased on the other. See ***R v Doogan; Ex parte Lucas-Smith*** [2005] ACTSC 74; (2005) 193 FLR 239 [28] (Higgins CJ, Crispin & Bennett JJ).

It will be necessary, in each inquest, to delineate those acts, omissions and circumstances which are, at least potentially, to be characterised as causing or a cause of the death of the deceased. This is to be undertaken by applying ordinary common sense and experience to the facts of the particular case. See ***March v E & MH Stramare Pty Ltd*** [1991] HCA 12; (1991) 171 CLR 506, 515 (Mason CJH), 522 (Deane J); ***WRB Transport*** [21]; ***Saraf*** [18] – [19]; ***Doogan*** [29].

A statement that a particular act, omission or circumstance did not cause a deceased's death is not a finding as to the cause of death.[20]

Causation and remoteness

It is clear that there must be a causal link between the death and the matter under investigation to bring the matter within the scope of an inquest. In determining that a causal relationship exists, coroners use a "common sense" test of causation limited by principles of remoteness.

In ***R v Doogan; ex-parte Lucas-Smith & Ors***, (2006) 158 ACTR 1 the Supreme Court of the Australian Capital Territory discussed this context while reviewing an inquest into the Canberra bushfires. The court stated that an inquest must examine both the initial ignition of the fire and the

[20] ***Keown v Khan*** [13]; ***Hurley*** [23]

factors that caused the fire to spread, but must not become a form of Royal Commission. The court explained at [29] that:[21]

> A fine line must be drawn at some point beyond which, even if relevant, factors which come to light will be considered too remote from the event to be regarded as causative. The point where such a line is to be drawn must be described as the "common sense" test of causation affirmed by the high Court of Australia in ***March v E & MH Stramare Pty Ltd*** (1991) 171 CLR 506**.** The application of that test will obviously depend upon the circumstances of the case and, in the context of a coronial inquiry, it may be influenced by the limited scope of the inquiry which, as we have mentioned, does not extend to the resolution of collateral issues relating to compensation or the attribution of blame.

The Court in ***R v Doogan*** **(2006)** 158 ACTR 1 demonstrated how an inquiry can spread out of control unless a test of remoteness applies:[22]

> To take but one example, it may be thought that the thickness of the vegetation at the site where the fire commenced had some causal relevance and, if the first respondent came to that view, then she would clearly be entitled to make a finding to that effect. However, that observation may evoke other questions. Why was the vegetation in that state? Was there some failure on the part of a government agency to detect its growth and embark upon fuel reduction measures? If so, was this attributable to lack of resources, public policy related to conservation of the natural environment and/or other considerations? The answers to those questions could, in turn, evoke yet others. How much does the ACT Government spend on the construction of fire breaks and other fuel reduction measures in and around Canberra? Is that amount of money appropriate having regard to the Government's competing responsibilities such as those relating to the provision of adequate funds for education, public health facilities and law and order? As a matter of public policy, has an appropriate balance been struck between the need to protect housing on the fringes of Canberra and the need to ensure that the surrounding bushland is maintained in its natural state? If not, is that because the legislature has been misled as to the relative importance of wilderness areas.
>
> Even further questions could be asked. Should people have been permitted to build houses in the areas in question? Should the New South Wales Government have taken measures to prevent fires spreading from forest or bushland into the Territory? Should the ACT building code have required houses constructed in those areas to incorporate various features

[21] ***R v Doogan***; ***Ex-parte Lucas Smith & Ors*** (2006) 158 ACTR 1 at [29]
[22] ***R v Doogan***; at [25] – [27]

> designed to ameliorate the danger posed by potential bushfires? Should fire crews have been deployed in one suburb in preference to another? Did some occupants contribute to the danger and/or the damage by failing to remove flammable materials from their yards?
>
> Each of these questions could, of course, lead to yet others and, ultimately to a virtually infinite chain of causation. Yet the scope for judicial inquiry pursuant to s.18(1) must be limited. Whilst none of these suggested issues could be said to be irrelevant, they are somewhat remote from the concept of the cause and origin of the fire, and any adequate investigation of them would involve not only substantial time and expense, but also delving into areas of public policy that are properly the prerogative of an elected government rather than a coroner or, indeed, any other judicial officer.

Similarly, in the earlier decision of ***Harmsworth v State Coroner*** [1989] VR 989 at 996 Nathan J warned that unless a coroner confines an inquest using principles of remoteness and causation, then:[23]

> Such an inquest would never end, but worse it could never arrive at the coherent, let alone concise, findings required by the Act, which are the causes of death, etc.

The need for a causal connection between the death and the subject-matter of the inquest must be applied in a common sense manner. Like other judicial proceedings, coroners should receive all relevant evidence before making findings, comments and recommendations.

Jurisdiction : Conclusions

It is clear from the above that the courts in Australia have given a broad interpretation to the words "how the death occurred" and "the cause of death". This is in keeping with the purpositive approach to statutory interpretation and section 18 of the *Interpretation Act* 1984.

In the context of both (b) and (c) of s25(1) and considerations of causation and remoteness there are no hard and fast rules and a common sense approach is required.

[23] ***Harmsworth v The State Coroner*** [1989] VR 989 at 996

It is important to bear in mind the fact that the inquest is part of an investigation and in any investigation an unduly restrictive approach is likely to be unhelpful. It is important, also, to recognise that if evidence is received which is subsequently found to be unhelpful or outside jurisdiction, that evidence can simply be ignored or rejected in the ultimate decision making process. The problems which occur in criminal cases when inadmissible evidence is wrongly received do not apply to an inquest.

The requirement that a coroner must not frame a finding or comment in such a way as appear to determine any question of civil liability or to suggest that any person is guilty of any offence.

The above requirement, contained in s25(5) of the Act, requires coroners to ensure that they do not appear to determine questions of civil liability or criminal guilt, but it does not prevent findings of fact even if the context of those findings of fact is such that a conclusion as to civil liability or criminal guilt seems almost inescapable.

In ***Perre v Chivell*** [2000] SASC 279 the court was considering findings by the State Coroner which included a finding that *"... the only reasonable inference to be drawn from the evidence is that Dominic Perre was responsible in the sense that he constructed the bomb and either posted it or arranged for someone else to post it on his behalf to Detective Sergeant Bowen."*[24]

That finding was in the context of an inquest into the death of a police officer, Detective Sergeant Bowen, who died as a result of an explosion which occurred at the office of the National Crime Authority in Adelaide caused by the bomb in question.

In that case Nyland J concluded that the statement made by the coroner that "*Perre sent the bomb*" and other similar statements were relevant

[24] ***Perre v Chivell*** [2000] 77 SASR 282 at 285

findings of fact which were reasonably open to him on the evidence and did not offend against similar provisions to section 25(5) of the Act. His Honour observed that even though the acts might not seem legally justifiable, that was, nevertheless, a different question. In the context of the case, had there been a prosecution, there were a number of elements which the Crown would have been required to prove which were not necessarily resolved in these findings.

Similar comments were made by the Court of Appeal in Victoria in the case of ***Keown v Khan & Anor*** [1999] 1 VR 69 where Calloway JA observed with a finding that the appellant killed a person in self defence was a finding as to how the death occurred while any reference to "lawful self defence" would involve the determination of a question of law.

In this context it is important to avoid use of the words like "lawful" or even "negligent", but there is no restriction to the coroner finding that a death was caused by a particular individual or individuals.

The Ability to Report to the Commissioner of Police or to the Director of Public Prosecutions

Section 27(5) of the Act provides that a coroner may report to the Director of Public prosecutions if the coroner believes that an indictable offence has been committed in connection with the death, or to the Commissioner of Police if the coroner believes that a simple offence has been committed.

It is not necessary for an inquest to be conducted for a coroner to make such a report. There may be cases where on the basis of the papers a coroner forms such a belief and a report is made.

When during an inquest the possibility that an offence has been committed in connection with the death is raised the coroner could either adjourn the inquest at that point and report the matter or, alternatively,

complete the inquest and on the basis of all of the evidence and any submissions determine whether a report should be made.

In some cases an inquest has been held after a decision has been made by police or the Director of Public Prosecutions that charges will not be laid. In these cases it is sometimes a function of the inquest to determine whether additional evidence is available or whether important evidence has been misunderstood or overlooked.

Reference to a Disciplinary Body

Section 50 of the Coroner's Act deals with reference to a disciplinary body and provides in part:

> "**Reference to a disciplinary body**
>
> (1) A coroner may refer any evidence, information or matter which comes to the coroner's notice in carrying out the coroner's duties to a body having jurisdiction over a person carrying on a trade or profession if the evidence, information or matter—
>
> (a) touches on the conduct of that person in relation to that trade or profession; and
>
> (b) is, in the opinion of the coroner, of such a nature as might lead the body to inquire into or take any other step in respect of the conduct apparently disclosed by the evidence, information or matter so referred."

Such a reference can take place even if an inquest is not held, based on information contained in reports, statements and other evidence obtained during the course of an investigation.

In the context of such a reference it is not necessary for a coroner to positively conclude that the conduct of the person in question was such as would require disciplinary proceedings or a sanction, it is only necessary for a coroner to form the opinion that the body having jurisdiction over the trade or profession should enquire into the matter and determine what action should be taken.

References are most commonly made in medical death cases to the Australian Health Practitioner Regulation Agency (AHPRA) or to the Medical Board of Australia in respect of medical practitioners or to the Nursing and Midwifery Board of Australia in respect of nurses.

In some cases it is clear that the body in question is already reviewing the conduct of the person in which case that fact may be noted in the inquest finding and may not require further attention at the inquest.

Counsel acting for a medical practitioner or nurse whose conduct may have caused or contributed to a death should be alert to the possibility of such a reference.

Comments and Recommendations

The power to comment is found in section 25(2) and (3) of the Act which relevantly provide:

> " (2) A coroner may comment on any matter connected with the death including public health or safety or the administration of justice.
>
> (3) Where the death is of a person held in care, a coroner must comment on the quality of the supervision, treatment and care of the person while in that care."

It has been accepted that the power to make a comment includes the power to make recommendations.

Section 27(3) of the Act provides that the State Coroner may make recommendations to the Attorney General on any matter connected with the death which the coroner investigated, including public health or safety, the death of a person held in care or the administration of justice. In practice recommendations have been made in the context of comments under section 25 rather than under section 27(3).

Section 25(3), which deals with deaths in care, requires comment on the quality of supervision, treatment and care of the person while in care, even if those were not factors in the death.

The section 25(2) power to comment has been the subject of a number of observations by Australian courts in recent years. Courts have warned that while the power to comment is wide, it is limited by the requirement that the matter must be "connected with the death".[25]

The words "connected with", however, may describe a range of relationships, from direct to immediate through to tenuous or remote.

The courts have further warned that the scope of an investigation is determined by the need to make the ultimate findings required by the Act and the power to comment is not a:

> Separate or distinct [source] of power enabling a coroner to enquire for the sole or dominant reason of making comment … it arises as a consequence of the exercise of a coroner's prime function, that is to make 'findings'.[26]

It is clear, however, that it was intended by Parliament that the words "connected with" should be broadly construed as it was contemplated that investigating matters connected with the death could involve coroners receiving evidence bearing on issues relevant to "public health", "safety" and the "administration of justice". It was, therefore, clearly contemplated that coroners would explore systemic deficiencies in appropriate cases.

Following the recent *Law Reform Commission Review of Coronial Practice in Western Australia Final Report* (2012) it is likely that the Act will be

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[25] ***Commissioner of Police v Halenstein*** [1996] 2 VR at 7; ***Harmsworth v The State Coroner [***1989] VR 989 @ 996.

[26] ***Harmsworth v The State Coroner*** [1989] VR 989 @ 996. See also ***R v Doogan; ex parte Lucas Smith and Ors*** (2006) 158 ACTR 1 at 41; ***Thales Australia Limited v Coroners Court*** (Vic) [2011] VSC 133

amended to contain explicit recognition of the coroner's death prevention role.

The death prevention role of the coroner is seen by many as being the most important coronial function and in that context it is important that any comments or recommendations intended to prevent deaths occurring in the future are based on reliable evidence and contain sound recommendations for future conduct.

In this context counsel who are submitting that a particular recommendation should be made, should describe the proposed recommendation with clarity. It is usually helpful if a suggested draft recommendation is prepared which will enable parties at the inquest and the coroner to address specific issues. This will also enable parties representing those who will be required to respond to the recommendation to take appropriate instructions and to have meaningful input in the process.

While the power to comment does not involve the exploration of issues unconnected with the death, in order to make meaningful comments or recommendations it will often be necessary for the coroner to make at least some enquiries going beyond the immediate circumstances of the death themselves and bearing on the validity of the proposed comment or recommendation. It would not, for example, be helpful for a coroner to make recommendations about a particular nursing home if evidence was available to indicate that since the inquest the nursing home had been closed down and so any specific recommendations directed to its management would be worthless.

The Media

In many discussions about courts and particularly Coroner's Courts the media is "the elephant in the room", important but not spoken about.

In the context of the modern Coroner's Court it is important that the role of the media is well recognised as publication of information relating to inquest hearings, comments and recommendations is fundamental for the achievement of many of the objects of the court.

While the media is often criticised for inaccurate over-sensationalism and unbalanced reporting, it is media reporting which is largely responsible for appropriate responses by government and others to recommendations of coroners.

In order to ensure that reporting is as accurate as possible, it is a common practice in the Coroner's Court in Western Australia for the opening speech of counsel assisting to be provided in written form to members of the media.

It should be recognised that media representatives in court do not have access to the papers available to counsel at the bar table and often endeavour to come to grips with complex circumstances of a case with little or no preparation as the inquest is ongoing.

In the case of an inquest into a medical adverse event, for example, evidence received at the inquest may include reference to medical terminology and to complex procedures which media representatives may find hard to summarise in a meaningful away. If the public at large are to be reliably informed about such cases, it is important that the media is provided with some assistance. The media cannot be fairly criticised for inaccurate reporting in such cases if they are not provided with at least some basic information in written form at the commencement of the inquest.

The WA Coroner's Court has experienced several cases where media misreporting has caused significant unnecessary distress to witnesses and persons involved in an inquest when the errors might have been

avoided by providing the media with the helpful summary contained in counsel assisting's opening speech at the commencement of the inquest.

Counsel appearing for parties at the inquest should also be mindful of the importance of media reporting. In the 21st Century positive media reporting can have significant beneficial results. Conversely reporting of information which is potentially inflammatory can cause harm.

The fact is politicians and other decision makers are often prompted into action by media reporting.

An example of a poor tactical approach to inquest hearings has occurred when counsel have asked the coroner in open court to provide advice as to possible adverse findings. The resulting advice unsurprisingly resulted in relatively inflammatory articles being written, when at the end of the inquest the coroner's findings did not include the adverse findings in question.

Self Incrimination: Certificates

Section 47 of the Act provides that if a person called as a witness at an inquest declines to answer any question on the ground that his or her answer will criminate or tend to criminate him or her, the coroner may, if it appears to a coroner expedient for the ends of justice that the person be compelled to answer the question, tell the person that if the person answers the question and other questions that may be put to him or her, the coroner will grant the person a certificate under the section.

This section is in very similar terms to section 11 of the *Evidence Act* 1906 and similar considerations apply to its use.

This is an important provision as witnesses whose conduct comes within the provisions of this section are not infrequently called to give evidence at inquest hearings.

It is important that counsel representing these persons are alert to the existence of this section and if a certificate will be sought advises counsel assisting. Counsel should advise their clients of the effect of the section and make the application for a certificate at the appropriate time.

The Role of Counsel Assisting

In the Coroner's Court of West Australia a lawyer usually acts as counsel assisting. Sometimes an experienced police sergeant will act as the coroner's assistant and in doing so adopts the same role.

In general the counsel assisting will conduct the procedural steps of the inquest and will introduce evidence for the coroner. This allows the coroner to focus on listening to and evaluating the evidence.

Counsel assisting in addition is expected to:

- Ensure that police officers and other investigating officers have conducted adequate investigations so that an inquest brief can be prepared. This may involve directing other avenues of inquiry, identifying witnesses and reviewing information that has been obtained.
- In some cases where police investigators have not addressed important issues adequately or at all, it may be necessary for counsel assisting to effectively conduct an investigation for the coroner, seeking reports or other evidence. This is often the case in medical related death cases where police have not sought reports from important witnesses.
- Counsel assisting is also often required to obtain expert overview opinions from experts in the relevant field who can assist the court at the inquest.
- Counsel assisting should also make an opening speech and provide closing submissions to the coroner. These should identify the key issues expected to be explored at the inquest,

findings which it is contended should be made and importantly provide the court with suggestions as to appropriate comments or recommendations which could be made. It is important to recognise, however, that the opening speech of counsel assisting can only be based on the then available information and new issues may emerge as the inquest progresses.

- Counsel assisting is expected to call and question witnesses, effectively leading the evidence in chief, although questions may be leading and in some cases it will be necessary for counsel assisting to cross-examine a witness or witnesses.
- Counsel assisting should raise and address any issues of law which arise during the inquest.
- Counsel assisting may provide chronologies or summaries of the facts for the coroner to assist in understanding the evidence and for the purposes of the finding writing process.

Differences Between a Counsel Assisting/Coroner's Assistant and Counsel in Adversarial Litigation

As with counsel assisting a royal commission, the role of a counsel assisting in a coronial inquest differs from the usual role of counsel in *inter partes* litigation.

Justice Peter Hall, writing extra curially, identified eleven exceptional features of working as counsel assisting in a royal commission. Many of these features also apply in coronial inquests:

1. The fact that counsel assisting does not have, or act on behalf of, a client.

2. The proceedings of a commission of inquiry do not arise out of charges laid against specific individuals.

3. The proceedings do not involve issues in the same way or sense as occurs in *inter-partes* litigation.

4. counsel assisting may, in appropriate circumstances, choose to examine witnesses before a commission by leading questions.

5. The right to claim privilege may be wholly or partly abrogated by statute.

6. There is, strictly speaking, no onus of proof upon counsel assisting and no specific requirement to prove any particular matter or thing.

7. There is a relationship between counsel assisting and the person or persons constituting a commission of inquiry that exists and operates both inside and outside the hearing room.

8. An investigation of unlawful or criminal conduct by a commission of inquiry does not in any sense constitute criminal proceedings.

9. There are no remedies to be awarded or final orders made at the end of the inquiry process.

10. The rules of evidence are usually not binding on a commission of inquiry.

11. There is no outcome of an inquiry which is dependent upon who establishes what.[27]

As the assistant's role is to assist the coroner, a coroner may confer with the assistant in private without counsel or any interested parties present. This would be highly irregular in adversarial litigation, but is appropriate in an inquest.[28]

The principles that apply to prosecutors in a criminal proceeding provide guidance on the obligations on the coroner's assistants. They must be independent and impartial. The assistant must not struggle unduly for a particular result. While robust advocacy and testing of alternate theories is permissible, intemperate or inflammatory language is not.

In ***R v Doogan; ex parte Lucas-Smith***, the Supreme Court of the ACT explained that:

> Whilst the duties of Crown prosecutors and counsel assisting coroners are by no means the same, we accept that both should be guided by the overriding principle that their goal is the attainment of justice rather than the achievement of a preconceived objective. However, justice is not always, nor even usually, attained by forensically passive approach in which counsel assisting eschew any responsibility to explore particular possibilities actively or to test assertions which may or may not be

[27] P Hall, Bar News: Journal of the NSW Bar Association, Winter 2005: 29, 30.
[28] ***Kotan Holdings v Trade Practices Commission***, Unreported, Federal Court of Australia, 24 June 1991, French J.

> accurate. On the contrary, coroners are entitled to expect that counsel assisting them will actively pursue the truth and that will almost inevitably involve identifying particular possibilities or tentative conclusions and testing the evidence with a view to determining whether it can be confirmed or discounted. [29]

The Role of Counsel Representing Parties at an Inquest

Counsel representing parties at an inquest should be clear as to who they represent and the extent of their role. While this may seem a self-evident proposition, counsel at inquest hearings have, on occasions, been unclear as to precisely who they represent or have asked questions which have no bearing on their client's involvement in the death.

Counsel should review the brief at the earliest possible opportunity to ensure that information of importance to their client is included in the brief. In the event that it is considered that additional information would be of assistance to a coroner, this information should be provided well in advance of the inquest so that the coroner and legal representatives of other parties have an opportunity to examine the material.

Counsel should review the witness list with a view to determining whether it would be helpful to receive oral evidence from other witnesses. If that is the case counsel should contact counsel assisting and request that the additional witness or witnesses be added to the witness list.

In the event that the party has obtained independent expert evidence which would be helpful to the coroner, copies of any reports, statements or other information obtained should be provided at an early stage. Provision of such material may avoid the need for an expert witness to give oral evidence, may result in further lines of inquiry being conducted at the inquest or may require the obtaining of additional expert evidence.

[29] ***R v Doogan; ex parte Lucas-Smith*** [2005] ACTSC 74 at [162].

Counsel who provide the court with copies of statements and large bundles of additional information on the day before the inquest or after the inquest has commenced should expect to receive some critical comment from the coroner.

In the event that the client's case involves criticism of the conduct of other individuals or organisations, this should be drawn to the attention of counsel assisting so if necessary a letter can be written to the individual or organisation advising of the possibility of an adverse finding. This is particularly important in cases where the person or organisation affected has not already obtained legal representation and may wish to be legally represented as a result.

If counsel proposes to make submissions on the law, such as a submission that the scope of the inquest should be limited, those submissions should be made at an early stage and counsel assisting and the coroner informed in advance so that the inquest is not unnecessarily interrupted. In the event that authorities are relied upon, a list of the authorities should be provided at an early stage and, if this is not possible, copies of relevant authorities provided to the court and other counsel at the time when the submissions are made.

When counsel wishes to refer to a document or documents at the inquest these should be clearly identified using the same system of identification used by the court. If a document is annexed to an exhibit, counsel should be able to refer to the annexure number. In the event that a document is contained within an exhibit, counsel should be aware of the exhibit number.

In the event that a particular document may be difficult to locate, such as one document within voluminous medical records of a deceased patient, counsel should give consideration as to how the document will be readily located by the witness and the court. In some cases it may be

appropriate to tag the document in question with a post-it or other type of removable tab. In other cases it may be helpful to provide a photocopy of the relevant page to the court, other counsel and the witness, at the same time providing clear reference to the location of the document within the exhibit.

It is most unfortunate when time is wasted as the result of counsel referring a witness to one document within a voluminous bundle which cannot be readily located.

Counsel should also give early notice of any requests which will require preparation by the judicial support officer or the court. In the event that it may be necessary to use a video link or telephone link with a witness, advice should be given to that effect in advance so that necessary arrangements can be made.

If it is proposed to put a document on a screen or to use any technical aid to view a document or other exhibit, the judicial support officer should be advised in advance so that necessary arrangements can be made. If a disc, CD rom or other such item is to be used, a copy should be provided to the judicial support officer well in advance of the time it is to be used so that there are no unnecessary delays as a result of technical or information technology problems.

In the event that a document is provided late, sufficient copies should be available to provide each counsel appearing at the inquest with a copy as well as an exhibit copy and a copy for the coroner. It is important to recognise the fact that the coroner will wish to follow questioning relating to the exhibit on his or her own copy and the coroner will have a marked brief on which reliance will be made in writing up the finding.

In the event that counsel proposes to make submissions in respect of particular recommendations at the end of the inquest, it is helpful if any

suggested recommendations are reduced to writing, even if submissions are oral. This assists with identification of particular issues and assists with understanding the precise recommendation being contended for as well as providing a useful resource for the coroner.

It is important for counsel to have meaningful communication with counsel assisting in relation to the progress of the inquest and to identify any matters which will have to be addressed which will impact on the court sitting time, the order of witnesses or the timing of the inquest. Issues such as the possibility of seeking a certificate for a witness should be discussed with counsel assisting prior to the inquest commencing if possible.

It is often helpful if counsel representing parties take an active role in the inquest, suggesting additional witnesses who may be called and presenting their own "side of the story". Parties who effectively remain silent, while others give evidence critical of their performance, should not be heard to complain if matters they have chosen not to raise are not taken into account in the coroner's findings.

Counsel : Questioning of Witnesses

Counsel in questioning witnesses should be mindful of the fact that the coronial process is inquisitional in nature rather than adversarial and that at an inquest criminal guilt or civil liability will not be determined.

It is, however, a function of the coroner's court to find out the truth about the circumstances surrounding a death, indeed for many families this is the outcome they are most seeking from the inquest.

Counsel should be alert to the fact that the family of the deceased are likely to be in court and should be respectful of the family's grief and the genuine distress many witnesses may experience in recounting the details of a death.

There is no room in the Coroner's Court for shouting at witnesses, rudeness or some of the histrionics regrettably sometimes seen in the criminal courts. It is, however, sometimes necessary for counsel to question witnesses closely and to return evasive witnesses to unanswered questions. Witnesses in the Coroner's Court can on occasions be untruthful, unhelpful and evasive as in other courts.

In the case of witnesses whose conduct has caused or contributed to death, questioning is unlikely to be a pleasant experience even if conducted properly and appropriately and this needs to be recognised.

Orders for Witnesses Out of Court

Witnesses who are waiting to give evidence usually wait inside the court unless there is a specific order for witnesses to be out of court.

Clearly the families of the deceased have an interest in the inquest and only in relatively exceptional circumstances would there be an order which would exclude a family member from sitting in court. In the event that such an order was to be made, it would be important that it be of limited duration and only apply during a period where there was real concern as to contamination of the family member's future evidence.

Clearly there will be cases when it is appropriate for an order to be made that a witness or witnesses remain out of court while some of the evidence is received. This is usually done when evidence is contentious and there is a concern that a witness will change his or her answers, having seen the evidence of another witness or witnesses.

An application for a witness or witnesses to leave the court should specify with precision which witness or witnesses should leave the court and when those witnesses should be absent. It is rarely appropriate for there to be a general order for all witnesses to remain outside the court

as some witnesses may be family members and others may need to give their legal representatives instructions in respect of matters which arise during the course of the inquest hearing.

Suppression Orders

Section 49 of the Act provides in part as follows:

> **Restriction on publication of reports**
>
> (1) A coroner must order that no report of an inquest or of any part of the proceedings or of any evidence given at an inquest be published if the coroner reasonably believes that it would –
>
> (a) be likely to prejudice the fair trial of a person; or
>
> (b) be contrary to the public interest.

This power may be exercised on application or on the coroner's own motion. It is important that suppression orders are made in open court in the presence of the media (if media representatives are attending the inquest). A copy of a suppression order, when made, will be placed on the door of the court.

In practice these orders are rarely made. It is, of course, the primary purpose of holding a public inquest that the proceedings and evidence given at the inquest should be in the public domain. If that was not the case the coroner could have proceeded to complete the investigation without holding a public inquest.

It is a fundamental principle of common law that justice should be administered in public.[30]

[30] ***David Syme and Co v General Motors Holden Ltd*** (1984) 2 NSWLR 294 per Street CJ at 300; ***John Fairfax & Sons v Police Tribunal of NSW & Anor*** (1986) 5 NSWLR 465 McHugh JA at 476-477; ***Re Bromfield, Stipendiary Magistrate; ex parte West Australian Newspapers Ltd*** (1991) 6 WAR 153 per Malcolm at 164 and Rowland at 179; ***Re Robins SM; ex parte West Australian Newspapers Ltd*** (1999) 20 WAR 511 per Ipp at 514.

The authorities are to the effect that courts should only depart from the public administration of justice where there are special or exceptional circumstances.[31]

The most common context in which applications are made pursuant to section 49 is where there is a concern that identification of an individual will put that individual at risk of harm or when a person would not be prepared to speak openly if the identity of the witness was published.

Counsel wishing to make an application pursuant to section 49 should address the terms of section 49 itself and specify whether it is contended that publication would be *"likely to prejudice the fair trial of a person"* or *"be contrary to the public interest"*.

In cases where a suppression order is granted, the media may seek to appear at the inquest to submit that the suppression order should be lifted, in which case the legal representatives of the media are usually considered to have standing as any such order impacts on the media's ability to report the inquest.

Media Access to Exhibits

As indicated earlier herein, it is the usual practice at inquest hearings in Western Australia for the entire police brief to be received as one exhibit and other documents and written information, considered to be potentially of use to the inquest, are also usually received subject to arguments relating to reliability and usefulness.

In this context unless a specific order is made, access to exhibits is not granted to the media.

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[31] ***Mirror Newspapers Limited v Waller*** (1985) 1 NSWLR 1 per Hunt at 20; ***TK v Australian Red Cross*** **(1988/90) 1 WAR 335 per Malcolm at 337;** ***Re Bromfield, Stipendiary Magistrate; ex parte West Australian newspapers Ltd*** (1991) 6 WAR 153 per Malcolm at 165.

In the event that the media wish to access a particular exhibit, reference to the request is usually made in open court so that the parties have an opportunity to make submissions as to whether or not access to the exhibit or exhibits should be granted. The media does not necessarily have standing to make submissions in respect of such a request.[32]

In some cases such a request made by the media has a legitimate basis. In order for the public to have a proper appreciation of the inquest proceedings it is sometimes important for a specified exhibit or exhibits to be made available for publication. In some cases a photograph or photographs, for example, may constitute an important part of the evidence and it is appropriate that the media have access to the photograph or photographs to enable accurate and meaningful reporting to take place.

The media should not be given access to photographs which depict deceased persons in circumstances where publication of such photographs could cause significant distress to family members and friends.

[32] ***Swan Television Radio Broadcasters Pty Ltd Trading as Channel Nine Perth*** [2005] WACC 3].