State Coroner's Guidelines 2013

Chapter 9

Inquests

9.1 Introduction

An inquest is the coroner's "public face", an open and transparent inquiry that scrutinises the events leading to a reportable death and provides an opportunity for coroners to make comments that can be powerful catalysts for broad systemic reform. Despite the common misconception that all reportable deaths proceed to inquest, inquests are held only into a small percentage of the total number of reportable deaths reported to Queensland coroners each year.

This Chapter explains when inquests should be held and the matters a coroner should take into account when considering whether to hold an inquest, either on his or her own initiative or in response to an application for an inquest to be held. It outlines the inquest process and strategies for managing the preparation for, and conduct of, an inquest. It provides an overview of the role of counsel assisting and the basis on which leave to appear is granted. It explains the standard of proof applicable in the Coroners Court and how incriminating evidence and potential referrals under s48 are dealt with. It provides guidance about the making of inquest findings and comments. Finally, it outlines the avenues by which a coroner's decision not to hold an inquest or the coroner's inquest findings can be reviewed and how inquests can be re-opened.

9.2 When should an inquest be held?

Legislation

Coroners Act
Sections 27, 28, 29, 33, 45(2)

In principle

An inquest **must** be held whenever:-

- there is a death in custody
- the circumstances of a death that happened in the course of or as a result of police operations raises issues that warrant the holding of an inquest
- a death in care raises issues about that care
- the Attorney General directs an inquest be held
- the District Court upholds an appeal against the decision of a coroner not to hold an inquest
- the State Coroner directs one be held.

An inquest should be held whenever there is reasonable doubt about the cause or circumstances of the death or it is in the public interest to do so.

An inquest must not be held, or must be postponed if already commenced, when someone is charged with a criminal offence in connection with the death.

In practice

Mandatory inquests

The mandatory inquest categories are generally clear cut except the death as a result of police operations and "*death in care*" categories. Chapter 3 *Reporting deaths* explains these categories of reportable death.[1]

Deaths as a result of police operations

The Act mandates an inquest for these deaths only if the coroner considers the circumstances of the death warrant an inquest. In practice, an inquest should be held when the death raises concerns about the police involvement in the event leading to the death and/or highlights inadequacies in police policy and operational procedures.

Deaths in care

This category of reportable death recognises the vulnerability of persons who meet the death in care criteria because of their disability, youth or mental health status. The coroner's investigation should focus on whether the welfare of the deceased was being properly attended to by those who have been charged with supplementing the deceased's ability to care for him or herself. If there is any evidence that sub-optimal care contributed to the death or that a different approach to caring for the deceased may have avoided the death, an inquest should be held.

Discretion to hold an inquest

The discretion to hold an inquest should be exercised with reference to the purposes of the Act and with regard to the superior fact finding characteristics of an inquest compared to the fault attributing role of criminal and civil trials. The wide scope of the coroner's inquiry as outlined in Chapter 7 *Investigations* should also be considered as should a family's right to know the circumstances of their relative's demise. It may be entirely appropriate to hold an inquest even if the medical cause of death can be established without one and no family member is insisting on one being held.

Factors for consideration when assessing whether an inquest should be held include, but are by no means limited to, the following:

- can all of the findings required by s45(2) be made without an inquest? Are chambers findings sufficient? If not, why not? Is an inquest likely to assist?

- Is there such uncertainly or conflict of evidence so as to justify the use of the judicial forensic process?

- are there suspicious circumstances that have not been resolved or resulted in criminal charges?

[1] See sections 3.1.8 (deaths in care) and 3.1.10 (deaths as a result of police operations)

The interplay between the criminal and coronial processes is far from clear in some cases. In theory, inquests should not be used as quasi-committals but in practice it can be more difficult to maintain a discrete and complete distinction.

In a small number of cases there is a suspicion the death may be the result of a crime but the police are unable to gather sufficient evidence to charge the suspect. Usually, in those cases the police request the coroner to convene an inquest so the versions can be better tested or witnesses who have refused to cooperate with the police can be required to give an account. Compelled answers, even if incriminating, are only inadmissible against the witness who gives them; they can be used against co-accused or others.

Establishing criminal liability frequently largely depends on proving precisely how the death occurred which is also what a coroner is obliged to find. While it is clearly inappropriate for a coroner to determine whether charges should be laid, it is entirely reasonable for the coroner to establish with some precision how the death occurred. For example, whether the driving that caused the death amounts to dangerous driving is purely a criminal law question; however, the speed of the vehicle, what precipitated the crash etc are questions a coroner should answer.

In cases where family members believe someone is criminally responsible for the death and no charges have been laid, inquests are commonly requested. Unless a coroner can demonstrate the suspicions are baseless the request will usually be granted. As the determination of criminal culpability is the motivation for the inquest, it is essential that the coroner gives reasons if he/se concludes no referral to the DPP is warranted.

If there is evidence that the death might have been intentionally caused by another person it is difficult to see how a coroner could discharge his or her duties under the Act without fully investigating that via an inquest if that is what is needed to clarify how the death occurred.

- is there a need to exclude the involvement of a third party procuring or failing to prevent an apparent death form self-harm?

- did an apparent failure by an individual to discharge a legal/moral duty allow an otherwise preventable death to occur, for example, by permitting abuse or neglect or failing to seek medical attention?

- did an apparent failure by a public official or agency to adequately discharge its responsibilities allow an otherwise preventable death to occur?

- is there a likelihood that an inquest will uncover important systemic defects or risks not already known about?

- are there issues of public health and safety and/or controversy that should be investigated by way of an inquest to allay public concern?

- did the incident result in multiple fatalities?

- is the identity of the person in control of the vehicle, vessel or craft involved in a fatality in question?

- does the death when grouped with others that have occurred in similar circumstances indicate there may be an unexpected increase in danger in a particular location, area, family, industry or activity?

- has the family requested an inquest and provided cogent reasons for one to be held?

- is it likely an inquest would address or allay reasonable fears or suspicions held by the family?

- do the circumstances of the death raise issues of public health and safety that have not been adequately addressed by other processes or proceedings?

- is it likely preventative recommendations would be made if an inquest was held?

- have previous inquests dealt with similar deaths and made recommendations for reform that have not been adopted?

- is there potential for publicity from an inquest to generate fresh useful evidence?

- as a matter of fairness to persons involved in the event leading to the death, should they be given a public opportunity to address adverse publicity or potential coronial criticism?

In decisions arising from applications made pursuant to s.30(6) the District Court has agreed that[2]:

- relief should be granted rarely or sparingly, and that regard should be had to the specialist nature of the Office of the State Coroner, including resourcing issues

- the phrase "in the public interest" involves a discretionary value judgement of the kind identified in *O'Sullivan v Farrer* (1989) 168 CLR 210.

[2] *Gentner v Barnes* [2009] QDC 307; *Lockwood v Barnes* [2011] QDC 084

In each case the District Court has considered evidence not available to the State Coroner when the decision under review was made.

There is also judicial recognition that, in assessing whether there is a public interest in the holding of an inquest, regard can be had to other forensic avenues by which the circumstances surrounding a death might be investigated or examined. In *Dupois v Barnes* [2012] QDC 306 it was found that the Health Quality and Complaints Commission would be a more appropriate forum in which to examine allegations of medical malpractice which had been made on the basis of the observations of a lay person.

9.3 The right to request an inquest

Legislation

Coroners Act
Section 30

In principle

Any person has a right to request an inquest be held, to receive reasons if the investigating coroner declines and to appeal that decision to the State Coroner and/or the District Court. Significant weight should be given to requests for inquest made by someone with a legal or other real interest in the investigation.

A response must be given to such requests within 6 months, unless the coroner requires longer to obtain relevant information, for example additional witness statements or an independent expert report, to inform his or her decision.

In practice

In most cases it is apparent from the Form 1 Police report of a death to the coroner and the autopsy results that the investigation will not need to proceed to inquest, and that subject to some straightforward inquiries being made, the final autopsy report being received and the family confirming they have no concerns that warrant further coronial investigation, chamber findings can be done.

Families will routinely be given 14 days notice of a coroner's intention to finalise an investigation without an inquest. This can prompt an application under s30.

It is not uncommon for a family's request for an inquest to be based on the misapprehension that an inquest is held into every reportable death.

Giving appropriate weight to requests for inquests requires the balancing of considerations that are difficult to reconcile.

If the coroner considers that the findings required by s45 can be made without an inquest and the criteria outlined in section 9.2 above do not indicate an

inquest is called for, the obligation to husband resources appropriately suggests that a request for an inquest which is not based on any new evidence should usually be refused. Further, in some cases, an inquest can provide a forum for publicising baseless but damaging allegations against individuals or institutions.

On the other hand, if after providing the family member or other interested party with a detailed explanation of why the coroner considers that an inquest is not warranted, the requester continues to insist, the following factors may support a decision to hold an inquest:

- an important purpose of the coronial system is the maintenance of public confidence in public health and safety and the justice system. An unwillingness to conduct an inquest in the face of persistent demands by a person with a real interest in the death may be counter-productive to this goal.

- the savings achieved by not holding an inquest could well be off set by the time and resources consumed by participating in an appeal to the District Court.

- an appeal to the District Court involves the risk that the Court, which will have little opportunity to develop a detailed appreciation of the function and practice of the coronial system, may in reaching its decision in a particular case make a ruling or comment that will significantly limit the discretion of coroners to determine which cases should be subject to inquest.

9.4 Communicating decisions to hold/not hold an inquest

In principle

All individuals and agencies with a real interest in the death should be advised of the decision as to whether an inquest will be held. Family members should be given reason for the decision and advised of the right to seek a review of a decision not to convene an inquest by the State Coroner or the District Court**.**

In practice

The decision as to whether an inquest will be held should be recorded on Form 26. If the decision is not to hold an inquest the form should set out detailed reasons for the decision.

The Form 26 should be sent to:-

- the Office of the State Coroner
- the Queensland Police Service
- any other investigative agency that has provided reports to the coroner or conducted an investigation into the death in discharge of its statutory

duty, for example, the Office of Fair and Safe Work Queensland or the Mining Safety Inspectorate.
- the senior family member
- any other party who has made submissions to the coroner concerning the holding of an inquest.

The form sent to the family should be under cover of a letter that provides sufficient details of the evidence to enable the basis of the decision to be fully appreciated and should advise the family member of their right under s30 to have the decision reviewed by the State Coroner or the District Court.

9.5 The role of Counsel Assisting and seeking approval to brief external counsel

In principle

In short, the role of Counsel Assisting at inquest is to impartially and fairly present the evidence to the coroner, identify issues for examination, call and examine witnesses, explore the range of possibilities open on the available evidence, explore possible options for preventative recommendations and make submissions about the findings and comments open to the coroner. Coroners may ask Counsel Assisting to assist in the preparation of findings by providing a summary of the evidence, outline of relevant legislation and case law. However, it remains the coroner's responsibility to weight the evidence and make appropriate findings and comments.

Chapter 2 *The rights and interests of families* discusses the role of Counsel Assisting at inquests when the family is not represented.[3]

Freckleton and Ranson's *Death Investigation and the Coroner's Inquest* contains a useful discussion of the role of counsel assisting.[4]

In practice

Each coroner is supported by in-house lawyers whose role is to assist the coroner to manage complex investigations and inquests and appear as Counsel Assisting at inquest.

However, if it is anticipated that an inquest may be complex, protracted or contentious, it may be desirable to brief external counsel. An application for approval funding for the briefing of external counsel should be made to the State Coroner setting out reasons, an estimate of the duration of the matter and an indication whether any particular counsel is preferred.

9.6 Notification of inquests

Legislation

Coroners Act

[3] See section 2.11.4 (Role of Counsel Assisting when family not separately represented)
[4] See p.p.564-5

Sections 32, 34(2) & (3)

In principle

All people with a legitimate interest in an inquest must be notified of the date, time and place it will commence. There must also be a general public notice of the commencement date published in the newspaper.

In practice

Inquest notice

A notice giving details of the commencement of all inquests should be published in the *Courier- Mail* at least 14 days prior to the commencement of the inquest or pre-hearing conference. Although it is not mandatory to do so, it is desirable for the inquest notice to be published prior to the pre-inquest conference.

The inquest notice must outline the issues proposed to be examined at the inquest. It is important for the issues to be articulated in sufficient detail to indicate the scope of the inquest. The notice is prepared by Counsel Assisting and settled by the coroner.

This information is also published on the Office of the State Coroner website.

Balancing confidentiality of child protection information

The Child Protection Act contains stringent confidentiality provisions aimed at preventing the identification of a child as a child in care or the subject of a child safety investigation or as a child harmed or at risk of harm by a member of their family. These provisions also extend to protect the identity of people who make a child protection notification, as well as information obtained by child safety officers in the performance of their duties. These provisions operate, subject to limited exceptions, to prevent the recipient of this information from disclosing it. Strictly applied, these restrictions could be seen to impinge on the transparency and rigour of the coronial process.

For an inquest into the death of a child in care under s9(1)(d), it is appropriate for the pre-inquest and inquest notice to name the deceased child. Where the circumstances of the child's death raise issues about their care arrangements, the notice is to include references to the fact that the child was in care within the meaning of section 9(1)(d) and that the actions of Child Safety Services are being examined by the inquest.

Additional notification

Additionally, written notice of the commencement date should be given to the senior family member and the inquest should not commence unless the coroner is satisfied that the family member has been notified.

If the deceased person is an Aborigine or a Torres Straight Islander, notice of the commencement should also be given to the local Aboriginal and Torres

Straight Islander Legal Service unless another legal practitioner has indicated that he/she is acting on behalf of the family or the family has indicated that they don't intend to be represented at the inquest.

Counsel Assisting must ensure any person who is potentially the subject of adverse findings and/or a s48 referral is given notice of this possibility, with the recommendation that he or she seek legal advice about their participation in the inquest.

9.7 Preparing for an inquest

Timely identification of inquest issues and witness and proper preparation is essential to the efficient conduct of an inquest.

Prior to the pre-inquest conference, Counsel Assisting should prepare a proposed issues and witness list for the coroner's consideration. Once settled by the coroner, the proposed issues and witness list and the brief of evidence should be provided to the family and any other person who has indicated an intention to seek leave to appear at the inquest.

It is appropriate for Counsel Assisting and the coroner to meet with the family prior to the inquest being notified, if the family requests it. This meeting should canvas the inquest process and explain the scope of the inquest. It is important that neither the coroner nor Counsel Assisting express any view about the evidence. While it is appropriate for Counsel Assisting to meet with the family in the lead up to and during the inquest, the coroner should not participate in these meetings.

It is appropriate for Counsel Assisting to liaise frequently with the coroner in the lead up to the inquest as this ensures relevant evidence is gathered prior to the hearing to enable proper examination of all relevant issues at the hearing.

9.8 Pre inquest conferences

Legislation

Coroners Act
Section 34

In principle

Pre-hearing conferences should usually be convened before inquests unless there is a reason not to do so. Although not mandatory, pre-inquest conferences assist greatly in ensuring a focussed and efficient inquest.

In practice

The following matters are routinely dealt with at the pre-inquest conference:

- Counsel Assisting opens the evidence, tenders the brief of evidence and discusses previously circulated issues and witness lists

- applications for leave to appear and limited leave to appear are determined

- those granted leave to appear should be invited to make submissions regarding proposed issues and/or witnesses either at the pre-inquest conference or in writing within 14 days

- Counsel Assisting raises any outstanding material, for example witness statements, expert reports etc and timetables set for the production of this material, followed up with a Form 25

- Counsel Assisting makes submission as to venue and the need for a view and the coroner makes appropriate rulings

- submissions about the making of non-publication orders under s41 of the Act are heard and determined

It is preferable that applications for leave to appear and challenges to the scope of the inquiry etc be determined prior to the hearing commencing so that if any party wishes to challenge that ruling or persuades the court that more time is needed to consider matters the witnesses will not have needlessly been summoned to attend a hearing that will then not proceed. This also assists with estimations as to the likely duration of the proceedings and the settling of the witness list. Two days to a week is long enough for most inquests.

If the inquest is to proceed on the day it is set to commence it is important for the parties to be given timely access to the brief of evidence. A pre-hearing conference enables the coroner to authorise the release of the investigations documents to parties granted leave to appear and to impose conditions on access and stress with the parties the seriousness of any breach of such an order.[5]

Although not bound by the rules of evidence, coroners are obliged to ensure that the principles of procedural fairness are applied.[6] One consequence of this is that if evidence adverse to any party is led, that party must be given an opportunity to respond. If the leading of such evidence has not been anticipated and the party whose conduct is criticised has not been involved from the outset of the inquest it will be necessary to adjourn the inquest and allow that party time to obtain representation and familiarise him/herself with all of the evidence that has been given. At a pre-hearing conference counsel assisting can outline the issues that will arise during the a hearing and if any party affected by that evidence has not sought leave to appear a direction can be given by the coroner that they be contacted and invited to seek such leave

[5] See s55(2) The maximum penalty is 100 penalty units or 2 yrs imprisonment
[6] *Harmsworth v State Coroner* [1989] VR989 at 994. For discussion see Freckelton, I in the *The Inquest Handbook*, Selby H. (ed), Federation Rules, Sydney, 1998

from the outset or for so much of the proceedings as may be relevant to their interests.

Pre-hearing conferences also provide a convenient forum for the exchange of expert witness reports. Arrangements can be made for these witnesses to meet and discuss their competing views with a view to isolating any points of substantial difference; often this may result in agreement among these experts on all but a few salient points.

Balancing confidentiality of child protection information

For inquests into a death in care under s9(1)(d), it is appropriate for the child's name to be used during the pre-inquest conference and the inquest hearing. However, coroners are to give consideration to making a non-publication order under s41 of the Act to ensure the child's name is not reported in the media.

9.9 Leave to appear

Legislation

Coroners Act
Section 36

In principle

All parties with sufficient interest should be given leave to appear. The Act was amended in 2009 to clarify the standing of public interest interveners who have specialist expertise in matters on which the coroner may make comments under s46.

In practice

The Act does not define 'sufficient interest'. In *Barci v Heffey*[7], Beach J held that standing was a question of fact to be determined after a consideration of the circumstances surrounding the death. His Honour identified that following persons as having sufficient interest:

- persons closely related to the deceased - in this regard, s36 specifically recognises family members as having sufficient interest to appear at an inquest

- Any person whose actions may have caused or contributed to the death, where there is a reasonable prospect that the coroner may make a finding or comment adverse to that person's interest.

  Employers, treating doctors, supervisors, professional accreditation bodies, government welfare agencies and regulatory agencies are examples of parties that may not be directly implicated in the death but who may have sufficient interest to be given leave to appear and be heard on an issue affecting them before any finding is made.

[7] Unreported Supreme Court of Victoria, 1 February 1995)

It is appropriate to discuss this question with counsel assisting before the pre-trail conference is convened so that parties can be invited to attend the pre-hearing conference to hear the issues that are likely to be raised during the inquest outlined by the counsel assisting. They can then seek leave to appear if they wish. Some parties may only have an interest in some of the issues that will be canvassed at the hearing and may therefore be granted leave only to the extent necessary for them to protect those interests.

Those given leave to appear have a right to examine witnesses and make submissions, unless they have been granted leave to appear as a public interest intervener under s36(2), in which case, the right of appearance is limited to examining witnesses only with the leave of the coroner and making submissions only on those matters on which the coroner ma make comments under s36.

9.10 Scope and conduct of an inquest

Legislation

Coroners Act
Sections 31, 35, 37, 38, 40, 41, 42, 43, 44

In principle

In inquest is bound by the principles of natural justice and procedural fairness. Although coroners are not bound by the rules of evidence or procedure, the guiding principles regarding admissibility of evidence will be relevance and fairness only.[8]

It well established that "*the scope of inquiry under section 45 is extensive and is not confined to evidence directly relevant to the matters listed in section 45(2)*".[9]

Despite the breadth of the scope of a coroner's inquiry under sections 45 and 46, the coroner may only rely on evidence that is relevant to, and logically probative of, matters within the scope of coronial inquiry, as defined by sections 45(2) and 46(1).[10] In *Doomadgee v Clements*, Muir J stated the test as follows[11]:

> ..the decision must be based upon material which tends to logically show the existence or non-existence of facts relevant to the issue to be determined, or to show the likelihood or unlikelihood of the occurrence of some future event the occurrence of which would be relevant.

[8] *Annetts v McCann* (supra)
[9] *Doomadgee v Clements* [2006] 2 Qd R 352 at 360 [28], citing *Atkinson v Morrow & Anor* (ibid) and *Queensland Fire & Rescue Authority v Hall* [1988] 2 Qd R 162 at 170
[10] *Doomadgee v Clements* at 361 [35]
[11] ibid

In *R v Doogan* (2005) 157 ACTR 1, Higgins CJ, Crispin and Bennett JJ stated the point at which the coroner's line of inquiry is drawn as follows:[12]

> A 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 determined not by the application of some concrete rule, but by what is 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; 99 ALR 423. 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.

It is important to acknowledge inquests can be stressful for not only the family but also witnesses. Participation in an inquest can be costly and those costs are not recoverable. For these reasons, it is essential that Counsel Assisting and the coroner ensure the inquest is conducted as expeditiously and efficiently as possible.

An inquest is the public facet of the coronial process. An inquest should generally be held in open court unless there is a good reason for the proceedings or part of them to be closed. Coroners should consider alternative strategies such as the use of non-publication orders or excluding persons from the court to manage the giving of sensitive evidence or vulnerable witnesses.

In practice

Evidence

The Court of Appeal considered the practical application of the power granted by the liberally worded section 37(1) in *Commissioner of Police Service v Clements*[13]

> *While the Coroners Court is not bound by the rules of evidence, the touchstone of the evidence and submissions it may receive must be relevant to the matters the Coroner is empowered to investigate, the questions on which he or she must make findings and the matters on which he or she may comment.*

The admissibility of evidence will, therefore, hinge on the scope of an inquest. In practice, arguments over the admissibility of individual documents are usually resolved by admitting them as an exhibit. This emphasises the importance, discussed earlier, of Counsel Assisting clearly identifying the relevant issues for investigation at the pre-inquest conference. Any disagreement as to the proper scope of the inquest should be settled prior to the commencement of the inquest through, if necessary, the convening of further pre-inquest conferences.

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[12] At 9-10 [29] – [30]
[13] [2006] 1 Qd R 210

In *Goldsborough v Bentley*[14] McMurdo J considered the scope ss45 and 46 in the context of admissibility of evidence and the scope of inquests. This case arose from an inquest into the drowning death of a tourist in a waterhole located within a privately operated tourist facility. In that inquest the Northern Coroner sought to investigate the reasoning behind the decision of Workplace Health and Safety Queensland ("WHSQ") not to prosecute the owner/operator. WHSQ sought declarative relief on the basis that the scope of the coroner's intended investigation was *ultra vires.* His Honour applied the reasoning of Muir J (as he then was) in *Doomadgee v Clements*[15]in determining that:

- The scope of s45 is extensive;
- There is no justification for construing s46 as being qualified by s3 (i.e. it is not the case that any comment must be directed only at preventing deaths from similar causes to the death under review);
- s46, being remedial in nature, should be construed liberally;
- The decision of an agency not to prosecute, although unconnected to the cause of death, does have a connection to the death in this case and relates to the administration of justice;
- A decision not to prosecute is something that '*…would appear to have potential relevance for a comment which the coroner might make under the power conferred by s46(1).*";
- The limitation contained in s46(3) does not prevent coronial comment on a decision not to prosecute; and
- The principle that courts should disassociate themselves from the administrative decision to prosecute is not relevant to the investigative, evidence gathering function of a coroner.

Standard of proof

The particulars a Coroner must if possible find under s45 need only be made to the civil standard but on the sliding *Briginshaw* scale.[16] That may well result in different standards being necessary for the various matters a coroner is required to find. For example, the exact time and place of death may have little significance and could be made on the balance of probabilities. However, the gravity of a finding that the death was caused by the actions of a nominated person would mean that a standard approaching the criminal standard should be applied because even though no criminal charge or sanction necessarily flows from such a finding, the seriousness of it and the potential harm to the reputation of that person requires a greater degree of satisfaction before it can be safely made.

The paragraph above was specifically contemplated by the Court of Appeal[17] with apparent approval. The Court went on to state:

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[14] [2014] QSC 141
[15] [2006] 2 Qd R 352
[16] *Anderson v Blashki* [1993] 2 VR 89 at 96 and *Secretary to the Department of Health and Community Services v Gurvich* [1995] 2 VR 69 at 73
[17] *Hurley v Clements & Ors* [2009] QCA 167 at 11

> *Two things must be kept in mind here. First, as Lord Lane CJ said in* R v South London Coroner; ex parte Thompson*, in a passage referred to with evident approval by Toohey J in* Annetts v McCann*:*
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> *…an inquest is a fact finding exercise and not a method of apportioning guilt … 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.*
>
> *Secondly, the application of the sliding scale of satisfaction test explained in* Briginshaw v Briginshaw *does not require a tribunal of fact to treat hypotheses that are reasonably available on the evidence as precluding it from reaching the conclusion that a particular fact is more probable than not."*

Preventative recommendations on the other hand, do not of themselves negatively impact upon any individual or organization and a Coroner need therefore only act judicially – not perversely or capriciously – when determining the level of satisfaction required to support conclusions on which they are based.[18]

Practical considerations

Counsel Assisting plays a pivotal role in ensuring the smooth conduct of an inquest. It is recommended that Counsel Assisting confer daily with the coroner to discuss the evidence to be called and any issues or applications likely to arise.

A witness schedule should be distributed to the parties well prior to the inquest commencing and all summons issued within the required timeframes. It is preferable to call the minimum number of witnesses needed to resolve the issues to be examined by the inquest.

While it is desirable for all oral evidence to be heard in one sitting, there may be occasions when it would be advantageous to schedule a break between brackets of evidence if it is foreseen that factual evidence may be required before more expert opinion is obtained.

There is no need to have witness statements read into the record, as the brief of evidence will already have been tendered. Witnesses should be given their statements in court and asked questions about them. Consideration may be given to the appropriateness of 'stopwatch' orders or concurrent evidence. It

[18] For discussion of these issues see Freckelton I., *Inquest Law* in *The Inquest Handbook*, Selby H.(ed), Federation Press, Sydney, 1998 at p9

is generally appropriate and efficient for independent experts and policy witnesses to sit in on the examination of relevant witnesses so they can comment efficiently on those witnesses' evidence.

Invariably some witnesses involved in the events leading to the death will have been significantly traumatised. Counsel Assisting should explore a range of options to assist vulnerable witnesses to give evidence. This may involve obtaining reports from treating doctors about the extent to which the experience of giving evidence may affect the witness' physical or mental health and ways in which that impact can be minimised, for example, giving evidence in closed court or using a screen or arranging for family members to hear the evidence from outside the court.

Coroners have power to make non-publication orders in respect of information arising from a pre-inquest conference or inquest. The circumstances in which these orders may be appropriate include when the inquest relates to confidential child safety information, the information could identify a minor or publication of the information could prejudice ongoing police investigations into the death.

It is helpful for Counsel Assisting to confer with the coroner about the submission he or she proposes to make, in the final days of the inquest. Counsel Assisting's submissions should foreshadow any adverse findings or comments, preventative recommendations or s48 referrals open to the coroner.

Generally oral submissions should be made at the close of the oral evidence. However, in complex and lengthy matters, it may be necessary to adjourn the inquest for submissions to give parties access to the transcript in order to make written submissions.

Submissions are not evidence but only the opinions of lawyers or parties. For this reason, and in order to protect the legitimate interests of the parties, submissions should be tendered so coroners can make use of non-publication orders and refrain from releasing written submissions until after the findings have been published.

Family participation

Chapter 2 *The rights and interests of families* details the ways in which families can participate in inquests, even if they do not seek leave to appear.[19]

9.11 Power to compel witnesses

Legislation

Coroners Act
Section 39

[19] Section 2.11 (Involvement in inquests)

In principle

Consistent with the inquisitorial nature of the coronal jurisdiction, the Act expressly abrogates the common law privilege of protection against self-incrimination and enables coroners to compel a witness to give self-incriminating answers. However, it does so at the cost of preventing evidence given under direction or evidence derived from it being used against the witness in any other proceeding. Before issuing a direction under s39, coroners must be satisfied it is in the public interest for a direction to be given.

The power to compel incriminating answers is designed to ensure a coroner gets all information relevant to finding how the person died and what caused the death. Such information must not be included in a referral to the DPP under s48 (discussed below).

Freckelton and Ranson's *Death Investigation and the Coroner's Inquest* provides a useful discussion of this issue.[20]

In practice

Section 39 allows a coroner at an inquest to require a person to give oral evidence that would tend to incriminate the witness. The coroner can only do this if the coroner is satisfied that it is in the public interest for the witness to do so.

The evidence is not admissible against the witness in any other proceeding other than a proceeding for perjury. Nor is derivative evidence (namely any information, document or other evidence obtained as a direct or indirect result of the evidence given by the witness). Compelled answers, even if incriminating, are only inadmissible against the witness who gives them; they can be used against co-accused or others.

Factors which may help divine what is in the "public interest" in the context of an inquest are discussed above.

Issuing a direction pursuant to section 39 can potentially have serious ramifications for the course of an investigation. A direction should only be made if the coroner is satisfied that there is a reasonable apprehension a witness may incriminate him or herself. Experience shows that counsel will sometimes seek a s.39 direction for their client in the absence of reasonable grounds due to an overly conservative approach.

9.12 Inquest findings and comments

Findings

Chapter 8 *Findings* details the considerations coroners must take into account when making findings.

[20] See pp.578-585

The making of comments – preventive recommendations

Legislation

Coroners Act
Section 46

In principle

The coroner's power to make preventative recommendations is a powerful tool for furthering the death prevention objectives of the Act. As acknowledged by Freckleton and Ranson,[21]

> *coroners' comments and recommendations can be of profound importance to manufacturers, distributors, industrial entities, health institutions, government instrumentalities and many others. They are frequently publicised extensively by the media and can result in considerable embarrassment and financial disadvantage for those who are the subject of them*.

The coroner can only make comments if an inquest is held but can not hold an inquest for the sole purpose of making preventative recommendations.

Section 46(1) empowers coroners to comment, whenever appropriate, on any anything connected with the death that relates to public health or safety, the administration of justice or ways to prevent deaths from happening in similar circumstances in the future.

Recent Queensland authority supports a broader than direct connection between any matter on which comment is made and the death under investigation.[22]

The power to comment under section 46 is ancillary to, not independent of, the coroner's power and obligation to make findings under section 45(2).[23] Section 46 does not make coroners '*roving Royal Commissioners empowered to make findings and recommendations in respect of the matters described in paragraphs (a), (b) and (c) of section 46*' – any matter on which comment is made must relate to one or more of those of matters and must be connected with the death.[24]

In order to properly achieve the Act's death prevention objectives, preventative recommendations must be realistic and workable. Consequently it is vital that Counsel Assisting and coroners give careful consideration to possible recommendations well prior to the inquest commencing and ensure the inquest is informed by input and evidence from agencies that may be required to implement those recommendations.

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[21] *Death Investigation and the Coroner's Inquest*, p.662
[22] *Doomadgee v Clements* (supra) at 360 [29] & [33]; affirmed in *Thales Australia Limited v The Coroners Court & Ors* [2011] VSC 133
[23] *Harmsworth v The State Coroner* (supra) at 996; *R v Doogan* (supra) at 6, 7, 9-10; *Doomadgee v Clements* (supra) at 360 [28]; *Walter Mining Pty Ltd v Hennessy* [2010] 1 Qd R 593 at 597
[24] at 360 [28]-[29]

In practice

Informing preventative recommendations

Once the coroner decides to hold an inquest, early consideration should be given to possible recommendations, with a view to inviting input from relevant agencies for examination during the inquest. This will ensure that agencies to whom possible recommendations may be directed are identified and given an opportunity to participate in the inquest, either by seeking leave to appear or providing information or written submissions about the practicality of any proposals under consideration.

Depending on the circumstances of the death, consideration should be given to seeking input from relevant government agencies, statutory authorities, regulatory authorities, professional or industry representative bodies or public interest groups.

The National Coroners Information System[25] is another valuable resource for coroners when considering whether and how systemic issues have been dealt with by other coronial jurisdictions.

It is preferable that this response gathering process is commenced prior to the inquest to allow sufficient time for all parties to consider the responses, and for arrangements to be made for relevant witnesses to give evidence. Parties should be actively encouraged to suggest areas where the coroner may consider making recommendations.

It is desirable for experts to be given an opportunity to comment on the appropriateness of proposed recommendations either before or during their evidence at inquest. There may be merit in other witnesses being examined about the workability of the proposals under consideration. It may also be necessary to call agency representatives to give evidence.

Counsel Assisting's submissions should address possible comments open to the coroner so the family and other parties have an opportunity to respond to those proposals.

Framing strong recommendations[26]

The most effective recommendations are arguably those which involve low implementation effort but achieve high impact.

When framing a recommendation, coroner should consider the ways in which and how likely the recommendation could fail. Clearly, input from agencies who will be required to consider whether and if so how the recommendation can be implemented is pivotal to this exercise.

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[25] www.ncis.org.au/

[26] These comments draw on a presentation given to the Australia Pacific Coroners Society Conference 2011 by Dr Jill-Ann Farmer, Queensland Health Patient Safety and Clinical Improvement Service: *Fluoride for Recommendations: making them strong so they don't decay!* *www.courts.qld.gov.au/__data/assets/pdf_file/0009/163791/osc-asia-pacific-conference-15-farmer-jillann.pd*

For example, a general recommendation that "*all maternity units should ensure there are clear guidelines and instructions for midwives as to when to refer to obstetricians*" could fail for reasons including implementation of different guidelines in different maternity units, guidelines not being readily accessible or known to the staff who need to apply them and staff forgetting or ignoring the detail of the guidelines. A more effective alternative of achieving the intended outcome would be for the recommendation to *require Queensland Health facilities to implement a standardised clinical pathway that is used by all staff in the documentation of intrapartum care*.

Ideally, coroners' recommendations should make clear the intended objective and allow the agency to which they are directed some flexibility to assess how best to achieve that objective. For example, rather than recommending that there be mandatory inspections of residential rental properties with decks of a certain age, the recommendation may be more appropriately framed to direct that consideration be given to legislative amendment to ensure rental properties meet the standards required under the legislation governing residential tenancies, and that this exercise incorporate a cost-benefit analysis of a mandatory inspection model and consultation with relevant industry stakeholders.

Responses to coronial recommendations

Although the Act does not require the Government to respond to coronial recommendations, the Government has implemented an administrative arrangement whereby government agencies are required to report publicly on their response to recommendations directed to them. This process was implemented in 2008 in response to the Queensland Ombudsman's Coronial Recommendations Project Report which identified the need for a coordinated system for ensuring appropriate action was taken by public sector agencies in response to coronial recommendations.[27] The agency responses are tabled in Parliament annually by the Attorney-General and accessible on the Department of Justice and Attorney-General website.[28]

Dissemination of findings and comments

Chapter 8 *Findings* explains how inquest findings and comments are to be disseminated.

No findings of criminal or civil liability

Chapter 8 *Findings* explains the prohibition on coroners' findings and comments making an explicit statement reflecting on a person's guilt or liability.[29]

[27] www.ombudsman.qld.gov.au/Portals/0/docs/Publications/Inv_reports/Coronial_Recommendations_Project.pdf
[28] www.justice.qld.gov.au
[29] Section 8.8 (No findings of criminal or civil liability)

9.13 Management of s. 48 referrals

Legislation

Coroners Act
Section 48

In principle

For at least the 137 years prior to the commencement of the Coroners Act 2003[30], coroners in Queensland presided over inquests at which submissions were made about whether people should be committed for trial and coroners gave reasons as to why, or why not, that was to happen. If a person was committed for trial, Crown prosecutors determined whether an indictment would be presented.

One of the most significant changes made by the 2003 Act was to abolish the coroner's committal power and replace it with an obligation for coroners to given information to the Director for Public Prosecutions or other prosecuting authority in the coroner reasonably suspects an offence has been committed.

The Act obliges referral of a suspected offence and gives coroner discretion to refer official misconduct, police misconduct or professional conduct issues to the relevant regulatory authority for further investigation. Coroners should ensure a person who may be the subject of a possible referral is given an opportunity to be heard before the referral is made.

The referral mechanism reflects a shift to a coronial regime in which prevention of future deaths is central and coroners are unable to find that a person is or may be guilty of an offence.

In practice

Chapter 7 *Investigations* discusses the application of s48 to non-inquest investigations.[31]

Submissions on and statements about section 48 referrals

The effect of section 45(5) is that the coroner must not include in his or her description of the particulars of the death required by section 45(2) statements that a person is or may be guilty of a criminal offence. Similarly, when a coroner is making comments under section 46, no such statement can be made.

However, referral under section 48 is another and discrete function of a coroner who has investigated a death. It imposes a duty on the Coroner to refer information to the DPP in certain circumstances, whether or not an inquest has been held. There is in section 48 no limitation similar to that

[30] *An Act to abolish Coroners' juries and to empower Justices of the Peace to hold inquests* was passed in 1866. s8 provided a coroner or JP who held an inquest could commit a person for trial for homicide. However it is likely that colonial coroners acting under the common law were already doing that from when the first was appointed in 1819.
[31] Section 7.2

contained in section 45(5). Indeed, it would be internally inconsistent and contradictory to do so.

If a coroner gathers information during an investigation that concludes with findings on the papers - that is, without an inquest being convened - and he or she concludes a s48 referral is mandated, the coroner is encouraged to give the subject of such a referral the right to be heard. It follows then that submissions should be heard on a possible referral pursuant to section 48 where an inquest is concerned. Coronial proceedings should be as open and transparent as reasonably possible. There is a presumption they will be held in open court. It would be contrary to these principles to require the section 48 function that arises and is triggered during an inquest to be hived off from the inquest and dealt with in private.

Further, that approach would offend against the obligation to give any person who might be adversely affected by a coroner's decision the right to be heard before such a step is taken.

On the basis of the same principles of openness and transparency espoused above it is appropriate and proper that the decision on whether a referral has been made under section 48, and the basis for it, be set out clearly at the conclusion of the findings. Being informed that the coroner intends referring the material to prosecutorial or disciplinary bodies for further consideration, and if not why not, is an essential part of a coroner's function. Bereaved family members and members of the public expect at the end of the inquest to know what happens next. If the answer is "nothing", they will want to know why.

Although this approach involves a risk to reputation, that can be ameliorated by the coroner making clear the low threshold on which the obligation to refer arises and referring to the role of the DPP in determining whether charges should be brought.

It follows that the right to make submissions would be confined to Counsel Assisting and counsel for the person or organisation subject to possible referral.

9.14 Review of inquest findings and reopening inquests

Legislation

Coroners Act
Sections 50 & 50A

In principle

The Act establishes mechanisms for administrative review of inquest outcomes including a right to review inquest findings or to re-open an inquest. These avenues of review are intended to provide an efficient and cost-effective means of examining concerns about the way in which a death has been investigated or the basis of the coroner's findings.

In practice

Section 50 provides for the reopening of inquests either on application to the State Coroner or District Court.

A person may apply to the District Court even if an unsuccessful application based on the same or substantially the same grounds has been made to the State Coroner. A person may not apply to the State Coroner if an unsuccessful application based on the same or substantially the same grounds has already been made to the District Court.

The State Coroner may set aside the finding if satisfied:

- new evidence casts doubt on the finding; or
- the finding was not correctly recorded.

If the finding is set aside the State Coroner can reopen the inquest to re-examine the finding or hold a new inquest (or direct another coroner to do either of these things).

The District Court may set aside the finding if satisfied:

- new evidence casts doubt on the finding; or
- the finding was not correctly recorded; or
- there was no evidence to support the finding; or
- the finding could not be reasonably supported by the evidence.

If the finding is set aside the District Court may order the State Coroner to re-open the inquest to re-examine the finding or hold a new inquest (or direct another coroner to do either of these things).

In a reopened or new inquest conducted pursuant to section 50 the Coroner may accept any of the evidence given, or findings made, at the earlier inquest as being correct.

There is no statutory right to review coronial comments.

The Act was amended in 2009 to allow the coroner who held an inquest, or the State Coroner, to reopen an inquest, or hold a new inquest, on his or her own initiative. Section 50A provides that the State Coroner has the same powers as he or she would have on receipt of an application under section 50 without it being necessary for such an application to first be made. In acting this way on his or her own initiative the State Coroner's power to reopen or hold a new inquest is extended so that it can be exercised if such further inquiry is thought to be in the "public interest". In that sense regard can be had to the earlier guidelines relating to the public interest test embedded in section 28.