State Coroner’s Guidelines 2013

Chapter 1

Introduction and the scope of the coroner’s role

1.1 Introduction 1
1.2 The scope of the coroner’s role 2
In principle 2
In practice 2
Summary 3
1.3 Further reading 3

1.1 Introduction

In order to ensure best practice and consistency in the coronial system the state coroner is obliged by s.14(1)(b) of the *Coroners Act 2003* to issue guidelines to local coroners stipulating matters to be taken into account when the discretions vested in them are being exercised. Guidelines may also be issued to any persons carrying out a function under the Coroners Act – s. 14(4).

When investigating a death, a coroner must comply with the guidelines and any direction issued to the coroner to the greatest practicable extent – s. 14(5).

These are those guidelines. They are intended to assist coroners to discharge their responsibilities. They will undoubtedly change over time and comments or suggestions from those working in or with the coronial system are always welcome.

The office of coroner is ancient and its development fascinating. It can be traced at least to 1194, although the role has obviously changed extensively in the intervening years. For those interested in this history the references below will assist. It is important to note, however, that unlike the position in say, NSW, the common law is expressly overridden by s. 104 of the Coroners Act which is in effect a codification of the law. The Coroners Act creates the jurisdiction and governs the powers and duties of coroners.

The *Coroners Act 2003* emphasizes:

- the desirability of a more consistent, efficient and transparent coronial system
- the right of family members to be involved in coronial investigations
- the need for coroners to seek to contribute proactively to a safer and more just community.

The Act seeks to facilitate the attainment of these objectives through various mechanisms including the appointment of a state coroner with power to issue guidelines and give directions to local coroners; an obligation on coroners to consult with and inform family members about key decisions; greater emphasis on coroners making preventative recommendations; and the centralisation of data collection.

The primary focus of coronial investigations is not whether someone should be held criminally or civilly liable for a death, although that may be an eventual outcome in some cases. Rather, more effort will be devoted to identifying the root cause of the incident that precipitated the death with a view to analysing systemic failures that contributed to the death and designing remedial responses.

The rigour, diligence and thoroughness with which coroners scrutinize unexpected deaths are a vindication of the value of life. Commitment to a just outcome and a meticulous approach to its pursuit are essential, but do not ensure success because coroners need to try to balance and reconcile competing interests. For example, the resolution of forensic questions must be tempered with reference to deeply held personal, religious and cultural beliefs that may come to the fore in times of tragedy: sometimes a coroner will forgo seeking to establish all of the facts relevant to understanding the circumstances of a death if there is no basis to suspect a serious wrong has occurred and the family of the deceased believe further investigation would be unduly intrusive. The coronial counsellors can assist mediate these and other issues with family members.

The identification of avoidable risks and recommendations designed to ameliorate them provides an opportunity for something positive to come from calamity. However, when analysing current practice and designing preventative recommendations the tendency to extrapolate from the single incident under investigation without sufficient regard to the frequency with which good outcomes are secured by the status quo must be avoided. Recommendations must have a sound evidentiary basis. The section on inquests contains suggestions about how this might be achieved.

The coronial system is inter-disciplinary: it depends on the cooperation and expertise of professionals from numerous agencies and organisations. That a coroner can not have personal knowledge of all matters relevant to a coronial investigation was elegantly explained 140 years ago by the great novelist George Eliot who wrote:-

> *'In my opinion,' said Lydgate, 'legal training only makes a man more incompetent in questions that require knowledge of another kind….A lawyer is no better than an old woman at a post mortem examination. How is he to know the action of a poison?'*
>
> *'You are aware I suppose, that it is not the coroner's business to conduct the post mortem, but only to take the evidence of the medical witness?' said Mr Chrichely, with some scorn.*
>
> *'Who is often as ignorant as the coroner himself,' said Lydgate.*[1]

However the coroner is at the centre: he or she is primarily responsible for ensuring the other participants play their parts appropriately. Hopefully these guidelines will assist coroners to do that.

Above all, coroners must ensure that familiarity with the processes of death investigation does not lead to their forgetting that for most people, involvement in the coronial system is a uniquely distressing experience. Compassion and patience in all dealings with those affected by the deaths investigated is essential.

1.2 The scope of the coroner's role

In principle

The role of a coroner is to:

- supervise the investigation
- direct the inquiry to ensure all necessary evidence is gathered
- preside over an inquest
- make the findings required by the Act and any appropriate preventative comments.

In practice

A coroner is in control of a death investigation from the time a death is reported under s. 7 until the coroner stops investigating the death and makes the necessary findings. While the investigative steps may be undertaken by police officers, pathologists or other forensic experts, they are acting as the coroner's agents and are subject to the coroner's direction.

[1] Eliot G, *Middlemarch*, ch 16

In an *inter partes* matter, it is the parties' role to determine the scope of any pre-trial inquiries, what witnesses are called and what information is put before the judicial officer who remains aloof from that part of the proceedings and adjudicates upon the evidence put forward by the parties after having regard to their submissions.

In an investigation and/or inquest commenced when a death is reported under the Coroners Act there is no such separation of function. The coroner identifies the issues to be investigated and the means by which that should happen. The coroner determines whether an inquest will be held, who will be given leave to appear and what witnesses will give evidence. It is appropriate for the coroner to consult on these issues with the family member and other parties who may have an interest in the inquiry. However, it is the coroner who is principally responsible for directing the course of the investigation and/or inquest and for ensuring the gathering of all information necessary for a thorough examination of the cause of death and of the means by which the likelihood of similar deaths can be reduced. It is the coroner on whom the Act places the responsibility of making the findings set out in s. 45.

When one considers that a coroner can issue and execute search warrants, instruct police on what inquiries should be made, require witnesses to answer even incriminating questions, obtain reports from experts of their choosing, is not bound by the rules of evidence, there can be no doubt the role is very different from that discharged by a magistrate adjudicating in civil litigation or criminal charges. It is essential the different purposes this system is designed to achieve are vigorously pursued and the different role the coroner plays is recognised and acted upon.

Even though a coroner can no longer commit a person to trial, as was authorised by earlier Acts, it would be disingenuous to suggest the criminal justice system and the coronial system are completely separate and discrete. Indeed the Act makes specific provisions for coroners to refer information to prosecutors - see s. 48. Similarly, although the Act in s. 45(5) and s. 46(3) prohibits a coroner from purporting to determine questions of civil liability, it is common for litigants to seek evidence for use in such proceedings via the coronial process. Approaches coroners might utilise to reduce the likelihood of their proceedings becoming focussed on issues that should better be contested in other proceedings are discussed in chapters 7 and 9 which deal with investigations and inquests. However, in some cases complete separation or compartmentalisation of the coronial, civil and criminal aspects of a death investigation is not possible or desirable. Coroners are required to find 'how' the person died; a question that is often central to civil or criminal proceedings. Evidence discovered by coroners will often be crucial to civil or criminal cases. This overlap should not discourage coroners from discharging their statutory duties.

Summary

Coroners need to be involved in determining what issues should be investigated and how they should be pursued, guided by the experts with whom they collaborate. The focus is on establishing as far as is reasonably possible, the circumstances of the person's death and considering whether changes could reduce the likelihood of similar deaths or to otherwise contribute to public safety or improvements in the administration of justice.

1.3 Further reading

Jervis on Coroners 12th ed

Halsbury's Laws of England Vol 9(2) (2006 Reissue), paras [903]-[904]

Knight, B. (1999) *History of the Medieval English Coroner System*. http://www.Britannia.com/history/coroner1.html

McKeough J, *"Origins of the Coronial Jurisdiction"* (1983)6 UNSWLJ 191

Freckleton I & Ranson D, *Death Investigations and the Coroner's Inquest* Oxford UP, Melbourne, 2006, pp 35ff.