

THE ROLE OF THE CORONER AND CORONERS COURT.

(A paper presented by the NSW Deputy State Coroner, Magistrate Carl Milovanovich at the State Legal Studies Teacher's Conference, On the 30th March, 2006, at the Carlton Hotel, Parramatta. NSW.)

It might be of interest to you to know that when I completed my secondary education in 1967, the first Higher School Certificate under the Wyndam Scheme, my desire was to matriculate and undertake tertiary studies with a view of becoming a school teacher with my interest being in Modern and Ancient History. That I should end up a Bachelor of Legal Studies is perhaps prophetic as the law, as you know, is very much a study of historical precedents such as Judge made law and statute law.

What I would like to do today is give you an insight into the role and function of a Coroner and how the jurisdiction works in NSW today. Coroners have been around for about 800 years and it is probably the oldest judicial role that still survives from medieval times. According to the cornerstone English text, Jervis on Coroners (11th Edition – 1993)

*“No-one is quite sure what were the origins of the ancient office of coroner. Although there is some evidence that the office of coroner existed before 1194, it is only because of Article 20 of the Articles of Eyre of that year that the office can be conclusively established. The Eyre system was the means by which Royal power (including justice) travelled the whole country in the 12th Century. The Articles of Eyre set out the matters of financial interest to the king in local affairs, almost like a checklist for the itinerant justices. Article 20 provides for the election of three knights and clerks by every county as “keepers of the pleas of the Crown”: in Latin, *custos placitorum coronae*. The role of these “coroners” was in looking after the records of cases in which the Crown was interested, to have regard to the financial interests of the King”.*

The King in those days was not only interested in the due administration of criminal justice, but also in the revenue derived from such administration (seizure of felons' property, confiscation of wrecks and treasure trove and the like). Coroners were then a type of tax collector. After a while Coroners became more like they are today, inquisitors into certain types of violent and unnatural deaths. Today in NSW Coroners operate under the provisions of the NSW Coroners Act, 1980, as amended and the role of the Coroner is very much a statutory function as set out in that legislation.

As Legal Studies teachers you will no doubt have some grasp of the role of a modern Coroner, however, it is amazing even in this day and age, possibly due to shows like Quincy (I hope I am not showing my age) and more recently the plethora of CSI type shows, that even with a well informed public a perception exists that as a Coroner I attend Crime Scenes in a white jacket and then proceed to perform Post Mortem examinations. I trust I will put that myth to bed be the end of this session.

The New South Wales Coroner.

I have restricted my discussion to the legislation in NSW, however, it might be of interest to you that in all other States of Australia the appointment, role of the Coroner and the legislation is almost identical. That goes back historically to our colonial days and the reception of English Law. Since Federation each State has tailored its Coronial Laws according to the States needs, however, the distinctions are minor.

In NSW the Coroners Act, 1980, as amended sets out the powers and functions of a Coroner. The preamble to the Act states "*An Act with respect to the holding by Coroners of Inquests into deaths and suspected deaths and inquiries into fires and explosions*". The Act also provides the machinery provisions, rules and regulations.

Appointment of Coroners.

In NSW there are three types of Coroners. In country locations, such as Dubbo the Registrar of the Local Court will usually be also appointed as a Coroner and with some limitations can perform all the functions of a Coroner under the Coroners Act. There are also Assistant Coroners who generally speaking only deal with natural cause deaths and every non-metropolitan Magistrate is also commissioned as a Coroner when appointed as a Magistrate. In the metropolitan area there are four State Coroners, the State Coroner, currently Mr John Abernethy and 3 Deputy State Coroners. The State Coroner and two Deputy State Coroners have their offices at the Coroners Court, Parramatta Road, Glebe and I am the Deputy State Coroner for Westmead. The State is divided into a geographical area with my area taking all deaths that occur in a line west of Bowral to the Brooklyn Bridge and the areas of Katoomba, Lithgow, Bathurst, Orange and Cowra. The rest of the State falls under the jurisdiction of Glebe.

Under the Coroners Act, the State Coroner and Deputy State Coroners must be Magistrates under the Local Courts Act and their appointment as Coroners is for a fixed term by the executive appointment of Parliament.

The exclusive Jurisdiction of a State Coroner.

As previously indicated all Coroners have jurisdiction to perform the roles and duties as set in the Coroners Act, with the exception that **only** a State Coroner can preside over an Inquest which involves a death in custody, a death in a Police Operation or a Police Pursuit and all deaths reportable to the Coroner under Section 13AB of the Coroners Act. Section 13AB deals with the deaths of children who are State Wards or have, or one of their siblings have, been subject to a notification to the Dept of Community Services within a period of 3 years immediately before the death of the child. Similarly under Section 13AB all deaths of persons who are at the time of their deaths residing in an aged care facility, for which assistance is provided under the Dept of Aged and Disability, must be reported to a State Coroner and only a State Coroner can preside over an inquest into such a death.

The Coroners Jurisdiction in relation to deaths, fires and explosions.

Section 12B of the Coroners Act states that a medical practitioner must not give a certificate as to a cause of death if the death is reportable to a Coroner. A death is reportable to a Coroner under Section 12B if the person died in any of the following circumstances;

- (a) the person died a violent or unnatural death,
- (b) the person died a sudden death the cause of which is unknown,
- (c) the person died under suspicious or unusual circumstances,
- (d) the person died having not been attended by a medical practitioner within the period of months immediately preceding his or her death,
- (e) the person died while under, or as a result of, or within 24 hours after the administration of, an anaesthetic administered in the course of a medical surgical or dental operation or procedure or an operation or procedure of a like nature, other than a local anaesthetic administered solely for the purpose of facilitating a procedure or resuscitation from apparent or impending death,
- (f) the person died within a year and a day after the date of any accident to which the cause of his or her death is or may be attributable,
- (g) a person died while in or temporarily absent from a hospital within the meaning of the Mental Health Act, 1990, and while the person was a resident at the hospital for the purpose of receiving care, treatment or assistance,
- (h) the person died in circumstances that are examinable as referred to in Section 13A (Deaths in Custody, Police Pursuit etc, previously referred to),
- (i) the person died in circumstances that are examinable as referred to in section S.13AB (child or disability deaths as previously referred to).

Under Section 13B the Coroner does not have jurisdiction unless a death occurred in the last 100 years. In view of our indigenous past, it is still not uncommon for bones to be at times located which are then sent to a Forensic Anthropologist to determine the age and race of the remains. If it transpires that the remains are more than 100 years old and of indigenous background appropriate arrangements are made with the National Parks & Wildlife and the tribal elders for the particular area of discovery for the remains to be returned.

The jurisdiction of a NSW Coroner, generally speaking relates to deaths that occurred in NSW, however, under Section 13C the Coroner can assume jurisdiction if a person has died outside of NSW providing the deceased person had a sufficient connection with the State of NSW at the time of death. A sufficient connection is described in the Coroners Act, under Section 13C(2) as being that the person was ordinarily a resident of NSW when the death occurred or at the time of death was on a journey to or from NSW. Under this Section a Coroner can deal with death on the high seas if the person was a NSW resident and travelling either from or to NSW. Similarly, in the recent Bali Bombings and the Tsunami the NSW Coroner was able to assume jurisdiction for NSW residents who died overseas on the basis of their residency and that they were either travelling from or to NSW. Some of you may have seen media coverage of an Inquest which is still pending which concerns the death of a woman on a cruise ship, the Coroner had jurisdiction as the person was both a resident of NSW and travelling either from or to NSW. It may be of interest to those who remember, that the death of 5 journalist “known as the “Balibo Five” in East Timor in the early 1970’s is subject to a Coronial Inquest which will be conducted by the State Coroner in the near future, again an example of the jurisdictional power of Section 13.

Missing Persons.

Under Section 13 of the Coroners Act, 1980, a Coroner has jurisdiction to investigate, the death *or suspected* death of a person. Accordingly it is under the provisions of this Section that Coroners will assume jurisdiction. In NSW about 9000 people go missing each year, all but about 45 to 50 each year are either located or found deceased. After exhaustive checks by the Missing Persons Unit if a person can not be located alive and checks determine that they have not left the country, have not accessed bank accounts or services (eg, taxation, centre link, RTA etc) the Police are required, if they suspect that the person is deceased, to report the suspected death to the Coroner. In those cases, and I am sure you will recall many old and recent examples (Juanita Nielson, the recent Tegan Lane case etc) the Coroner will direct the Police to prepare a brief of evidence and it is then mandatory for a Coroner to hold an Inquest and make a finding as to whether the Coroner is satisfied that the person is deceased or not.

The Coroners Statutory Function under the Coroners Act in regard to an Inquest into a death.

In every Inquest into a death or suspected death the Coroner must be satisfied as to the identity of the deceased, the date of death, the place of death and make a finding as to the manner and cause of death. In some cases, (such as missing persons) the Coroner may form the view that the person is deceased, however, is not able to determine the place, date or manner and cause of death. That does not preclude the Coroner from returning a finding and usually the finding is referred to as an open finding as to date, place, manner and cause of death.

Under Common Law there is a presumption against suicide and when a Coroner is examining the circumstances of death the evidentiary test is slightly higher than the civil standard, being the balance of probabilities and lower than the criminal standard of beyond reasonable doubt. The evidentiary standard has been referred to as the Briginshaw Test (Briginshaw –v- Briginshaw (1938) CLR 336) which is the test in paternity cases. Similarly, in missing person's cases the Coroner must be reasonably comfortable that the missing person is deceased and apply the Briginshaw test when returning a finding that the person is deceased.

Dispensing with Inquests.

Section 14 of the Coroners Act, 1980, is the pivotal section, which permits a Coroner to dispense with an inquest. The power to dispense applies to all deaths except those which require a mandatory inquest, such as deaths in custody (Section 13A), Section 13AB deaths and all cases of suspected death and homicide. The mechanics of forming the view to dispense are that the Coroner will examine the brief of evidence which is presented by the Police. If the Coroner forms the view that the identity of the deceased has been established, the date of death, the place of death and the manner and cause of death AND there is no public interest in holding an Inquest, the Coroner may dispense with the holding of a formal Inquest. What that means is that the Coroner performs a quasi judicial/administrative role in Chambers and closes the file after being satisfied as to those formal requirements. In some cases,

notwithstanding that the Coroner is satisfied as to identity, date, place, manner and cause of death, a interested party, usually a family member may still request an formal Inquest. In many cases the family simply want an Inquest because they may not accept some of the findings in the Police investigation, sometimes they may have an agenda of attempting to use to the Coronial jurisdiction as a sounding board for civil action. In cases such as that the Coroner will make a decision on a case-to-case basis, and usually the wishes of the next of kin will be accommodated. When a Coroner refuses to grant a formal Inquest, an interested party may make application to the State Coroner for the Inquest to be held, or they can make an application seeking a Declaration from the Supreme Court.

Post Mortem Examinations.

All cases which are reported to a Coroner are cases in which a death certificate can not issue. As the role of the Coroner is to determine the manner and cause of death, it is usually the case that the Coroner will order under Section 48 of the Coroners Act that a post mortem examination be conducted. The post mortem examination is conducted by a Forensic Pathologist employed by the Department of Health. At Westmead I have 4 Forensic Pathologist who work full time conducting Post Mortem and special examinations. A post mortem examination is usually a three cavity examination of the abdomen, chest and cranium as well as taking blood and other tissue samples for analytical examination. In some cases there may be a need to retain the brain for fixation and when this is required, Forensic Counsellors will liaise with the family in regard to the options for the disposal or return of the brain.

Under the provisions of Section 48 of the Coroners Act a next of kin may object to a post mortem examination. In most cases where the Coroner feels that a post mortem is necessary and gives the reasons why, the objection is withdrawn by the family. There are, however, a number of cases each year where the family insist on no post mortem and in those cases, the Coroner is required to serve a notice on the objector giving reasons for the post mortem examination and indicating that a hold on the post mortem has been put in place for a period of 48 hours. It is incumbent then on the objector to seek relief in the Supreme Court.

In recent years, perhaps due to the multicultural nature of our society, objections are becoming more common, particularly from the Jewish and Muslim communities, who see post mortem examinations as contrary to their religious beliefs. Supreme Court Justice Dowd in the case of *Seemah Morris v. Derrick Hand* (1997) (former State Coroner) said *“the religious matters and sensibilities which would have been brought to the attention of the Coroner are matters which are taken into account, but do not of themselves displace the duty of the Coroner to ensure that the manner and cause of death be established”*.

In some cases where elderly people die in hospital and it becomes a Coroners matter, simply because the person died within 24 hours of the administration of an anaesthetic, a post mortem may not be required. Although there is no death certificate, the Forensic Pathologist will often be requested to undertake a Forensic Review of the medical records and the patient's history. In most of those cases, a cause of death can be determined without the need for a post mortem. I have also in some cases, such as suicide by hanging, where there is a religious objection to post

mortem, and being satisfied that there are no suspicious circumstances, order an external examination of the deceased and bloods for toxicology.

Organ Donations.

Most of you would be aware that a person could nominate on their drivers license that they consent to certain or all organs being donated. You may not be aware, however, that the indication on the license is not legally binding and in any death, Coroners case or otherwise, the senior next of kin can lawfully object, notwithstanding that it may have been the deceased wish to donate. In Coroners cases there is a further impediment in that even where the deceased has given consent and the senior next of kin agree, organ donation cannot proceed without the consent of the Coroner. The reason for this is that the deceased body is within the jurisdiction of the Coroner and if it is a case where certain organs may need to be examined for forensic purposes, organ removal will not be approved by the Coroner. Usually the Coroner will be guided by the views of the Forensic Pathologist. In some cases permission may be granted for certain organs to be removed but not others.

Privilege in respect of self-incrimination.

Section 33AA of the Coroners Act, 1980 provides that no person who has been called as a witness is required to give evidence that may intend to criminate them. If a witness objects to giving evidence on that basis, the Coroner may direct that the witness must answer or give the evidence. In such cases the Coroner is required to issue a Certificate under Section 33AA which provides that witness with protection in that the evidence given at the Inquest can not be used in other criminal or civil proceedings.

An example of this section in operation can perhaps be best explained in relation to a recent Fire Inquiry which I conducted. Two witnesses were considered as persons who had deliberately set fire to a Heritage Home. One of the witnesses was the son of the owner of the property who had lodged a development application and that application was refused on the grounds of the homes Heritage listing. The property owner wanted to demolish the home and build a new one. His son and a friend were suspected of lighting the fire from evidence of witnesses who saw a vehicle leaving the scene. They were both interviewed by Police and denied the allegation and provided an alibi for each other. By the time the matter came to Inquiry before the Coroner there had been a falling out between the two men and an indication was given to the Police and the Coroner that one of the witnesses now wished to change his story and tell the truth. In essence that witness got into the witness box, took an objection to giving evidence that would incriminate him, was directed to answer and told the court under oath that he and other fellow deliberately set fire to the premises. I then granted this witness a Certificate under Section 33AA, which meant that his evidence could not be used against him. His evidence, however, could be used against the other person involved and that matter is currently with the Director of Public Prosecutions with a view of instigating criminal charges.

Coroners attending fatal accident scenes.

As a general rule, Coroners do not attend fatal scenes. This role is left to the Police and their specialist agencies such as Crime Scene Investigators, Forensic Services Group etc. In cases of homicide and other critical incidents, a standard protocol exists between the Coroner and the Forensic Pathologists that they will attend the scene. Particularly in cases of homicide it is very important that the Forensic Pathologist, who will invariably be undertaking the Post Mortem examination, attends and views the body in situ and conducts an examination at the scene. There are some cases in which it is desirable for the Coroner to attend, thankfully they are few. The State Coroner has a policy in place which, subject to logistics, would require a State Coroner to attend a the scene of a death in police custody, police shooting or police pursuit. The reason being is that a death in those circumstances will result in a mandatory inquest and there is some benefit in viewing a scene in person. A State Coroner will also attend the scene of any major incident, such as multiple murder/suicide, explosion, bus, train or air crash, and again the reason is to get a first hand picture of what invariably will be played in Court many months and sometimes years later.

SUMMARY.

I hope my presentation today has given you a little more insight into the role of a State Coroner. It is a very interesting and challenging jurisdiction and one that I am sure would be of interest to Legal Studies students. It may also be of interest to you as teachers to consider obtaining a copy of the ABC production, "A Case for the Coroner". That programme shows actual cases and how the Coroner performs his/her function in Court and reaches the findings required under the Act.

Magistrate Carl Milovanovich.
NSW Deputy State Coroner.
Westmead.
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