Queensland Public Interest Law Clearing House Incorporated

CORONIAL INVESTIGATIONS AND INQUESTS:

A Guide for Lawyers and Interested Persons to the Queensland Coroners Court

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1. OVERVIEW

The *Coroners Act 2003* (Qld) commenced on 1 December 2003 and codifies changes in the coronial role. This development is reviewed in Section 2 of this guide.

The remainder of the guide deals with the operation of the new Act. In particular, it provides a general outline of the coronial process and the practice and procedure of the Coroners Court in holding an inquest. It canvasses issues of interest to persons who may wish to be heard before the coroner, or who may be called to give evidence at a coronial inquest.

2. CONTEMPORARY DEVELOPMENTS

2.1. Background

Under the *Coroners Act 1958* (Qld) Queensland's magistracy had responsibility for coronial investigations[1] and was heavily criticized for "lagging well behind the rest of Australia"[2]. "The difficulty in Queensland is that there is no State Coroner."[3] Instead, investigations were conducted by Magistrates with no particular expertise in coronial investigation[4]. Local magistrates had to "squeeze the coronial inquests in around their other work"[5]. Mistakes were more easily made and recommendations more easily ignored[6]. "Key medical groups ... also warned that patterns emerging from deaths that happened in a similar way would continue to go undetected until a state coroner was appointed and was able to co-ordinate the data."[7] Both Victoria[8] and New South Wales[9] had had State Coroners Offices for many years. It appeared that while other jurisdictions were taking a pro-active approach to looking for systemic causes of death and making meaningful recommendations, Queensland's coroners were not so enthusiastic[10].

Following this increasing criticism of Queensland's 1958 coroner's legislation, the Queensland Government released a draft Coroners Bill 2000[11] for public consultation. Over 90 submissions were received from advocacy groups, medical colleges and associations, private citizens, academics, the funeral and crematoria industry, the State Coroner for Western Australia and the Queensland Law Society.

The Coroners Bill 2002 received royal assent on 9 April 2003. The majority of the provisions in the *Coroners Act 2003* (Qld) commenced on 1 December 2003.

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[1] *Coroners Act* 1958 (Qld), s 6
[2] Qld Shadow Attorney-General Lawrence Springborg, 'Coroners Reform 18 Months Overdue: Springborg', *Qld Government Shadow Attorney-General Media Release* (7 March 2002)
[3] Malbon J, 'Coroner's Death-Defying Decisions', Transcript of *ABC Radio National The Law Report* (10 October 2000)
[4] Malbon J (10 October 2000)
[5] Malbon J quoted by Gregory J in 'Suspicious deaths risk slipping by undetected' in *Courier Mail* (27 March 2002) at 8
[6] Malbon J (10 October 2000)
[7] Gregory J (27 March 2002) 'Suspicious deaths risk slipping by undetected' in *Courier Mail* (27March 2002) at 8
[8] See http://www.magistratescourt.vic.gov.au/text/StateCor.htm
[9] See http://www.lawlink.nsw.gov.au/lc.nsf/pages/coronersindex
[10] Malbon J (10 October 2000)
[11] Qld Attorney-General Matt Foley, 'Draft State Coroners Bill 2000 Released at Conference', *Qld Government Attorney-General's Department Media Release* (22 November 2000)

The 2003 Act emphasises:

> "• the need for Coroners to seek to contribute proactively to a safer and more just community;
> • the desirability of a more consistent, efficient and transparent coronial system; and
> • the rights of the family member to be involved in decisions concerning the deceased."[12]

2.2. Preventative Role

In Victoria the coroner's role is seen essentially as one of prevention[13]. Australia-wide more than 7000 violent, unnatural deaths occur every year and only about 400 of those are homicides[14]. A significant number occur in "so-called accidental circumstances" and are preventable[15]. "Really the Coroner should be about seeking to find out why deaths have occurred, particularly in a systemic situation, and to make recommendations to prevent similar deaths occurring in the future."[16]

In respect of a coronial investigation into deaths in custody in Australia, it was said:

> "Each unnatural death examined by coroners represents the tip of an iceberg of injuries and other high-risk circumstances. A proactive strategy therefore has the potential to prevent many deaths as well as to make a significant reduction in risks to health and safety generally."[17]

In discussing developments in the coroner's role in Victoria, Tasmania, Northern Territory and the ACT, Ian Freckelton said:

> "What is revolutionary in respect of these changes is the introduction of an obligation on the part of people affected or the subject of coroners' findings to respond in some way to what coroners have found to be the cause of death or other phenomena.

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[12] State Coroner's Guidelines – Version 0 (Dec 2003) at 1.1 - http://www.justice.qld.gov.au/courts/coroner/pdfs/guidelines.pdf
[13] Johnson G, Victorian State Coroner, 'Coroner's Death-Defying Decisions', Transcript of *ABC Radio National The Law Report* (10 October 2000)
[14] Johnson G (10 October 2000) and Gregory J (27 March 2002)
[15] Johnson G (10 October 2000)
[16] Malbon J (10 October 2000)
[17] Halstead B 'Coroners' Recommendations and the Prevention of Deaths in Custody: A Victorian Case Study' in *Deaths in Custody Australia* (November 1995) Australian Institute of Criminology at 1.

> Such a transformation of the coroner's role has major repercussions in terms of rendering the coroner into an entity with the capacity to have a substantial impact on reducing the incidence of avoidable death and injury."[18]

Under previous legislation, coroners in Queensland could only explore the direct cause of a person's death with a view to identifying persons who may be criminally responsible[19]. The making of riders, although a long held function of coroners in Queensland, was seen as subordinate to the findings.[20]

In order to address this issue, the Royal Commission into Aboriginal Deaths in Custody recommended[21]:

- all deaths in custody be the subject of formal inquests by the State Coroner conducted in public and with a full record of evidence taken;
- coroners make recommendations with a view to preventing further custodial deaths when inquiring into a death in custody;
- copies of findings and recommendations and responses be provided between the coroner and the State Attorney-General, the relevant representative of the Crown, and other appropriate departments and persons;
- copies of findings and recommendations be provided to all parties appearing at an inquest; and
- establishment of a uniform database to record details of all deaths in custody.

As discussed in section 2.4 below, these recommendations have been more or less been implemented in the *Coroners Act 2003*.

The extent to which coroners should be permitted or required to act outside of their traditional role as fact gatherers and make recommendations regarding prevention has been widely debated. Indeed, "some commentators have viewed with suspicion any deviation from the realm of fact into the realm of opinion"[22]. The basis for this criticism stems from the fact that:

- the coronial process is inquisitorial rather than accusatorial;[23]

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[18] Freckelton I 'The evolving institution of coroner' (1999) 24 (3) Alternative Law Journal 156 at 157.

[19] *Coroners Act 1958* (Qld), s 24. See 'Call for Coroner's Act to be Updated' in *The Courier Mail* (8 March 2002) at page 10.

[20] State Coroner's Guidelines – Version 0 (Dec 2003) at 8.13

[21] See Johnston E, 'Post-Death Investigations' in *Royal Commission into Aboriginal Deaths in Custody National Report – Overview and Recommendations* (1991) Australian Government Publishing Service, Canberra at http://www.atsic.gov.au/issues/law_and_justice/rdiadic/overview_and_recommendations/recommendations6-40.asp

[22] Halstead B (November 1995) at 3

[23] Halstead B (November 1995) at 3

- formal rules of evidence do not apply;[24]
- a focus on prevention will mean drawing attention to omissions or blameworthiness of a person, which may do an injustice to that individual;[25]
- the publicity surrounding such comments "is extremely damaging, both for morale and in respect of its likely generation of civil claims for damages"[26];
- coroners may be forced to decide whether preventative action is required without having all the necessary information. [27]

The utility of such comments have also been questioned: "The problem is that such comments may be of a desultory and possibly moralistic nature, ill fashioned to accomplish a real reduction in repetition of dangerous activity."[28]

It is suggested, though, that there is never a better time for recommendations about health and safety to be made than during an investigation into a preventable death[29]. The fear coroners' recommendations could be based on only limited information is overcome by the lack of enforceability of such recommendations[30]. Further, it is also said that blame-free investigatory systems "tend to also miss the point, because they don't delve deeply enough"[31].

Much of the debate about coronial reform is characterized by the tension between coroners' role in fact-finding on a case-by-case basis and in taking a more holistic focus on prevention[32]. Arguably, a balance of the two is probably best[33]. "The quest for a preventative response to problems is likely to move beyond 'blame' and look towards a critical assessment of the adequacy of systemic responses to problems"[34].

2.3. Role of Families

One of the other major criticisms of Queensland's former coronial process was the lack of involvement and consideration accorded to families of the deceased person. Under the 1958 Act, Queensland persons with a sufficient interest were entitled to attend an inquest, examine and cross-examine witnesses and address

[24] Halstead B (November 1995) at 3
[25] Halstead B (November 1995) at 3
[26] Freckelton I, 'Expert Proof in the Coroner's Jurisdiction' in *The Aftermath of Death: Coronials* (1992) The Federation Press, Sydney at 44
[27] Halstead B (November 1995) at 3
[28] Freckelton I (1992) at 41
[29] Halstead B (November 1995) at 3
[30] Halstead B (November 1995) at 4 and 6.
[31] G Johnson (10 October 2000)
[32] Halstead B (November 1995) at 4
[33] Johnson G (10 October 2000)
[34] Halstead B (November 1995) at 7

the coroner on points of law[35]. The limitation to legal issues was arguably restrictive.

> "The family has enormous potential in relation to contributing to the investigation. The family can raise issues with us that they're concerned about. Often they know things that we will never find out unless they inform us"[36].

Further, while the legislation allowed interested parties to participate to a limited extent, it did not require family members to be consulted or informed[37]. "Australian laws aren't guaranteeing families a prominent role in Coroners' inquests, so some families can spend thousands hiring a barrister, just to make sure their voices are heard."[38] Indeed the recommendations of the Royal Commission into Aboriginal Deaths in Custody included that[39] –

- No inquest should proceed in the absence of appearance for or on behalf of the family of the deceased except in certain circumstances; and
- The family of the deceased should be entitled to legal representation at the inquest provided through legal aid.

In Ontario, Canada, it is common practice, within a legislative framework not unlike Queensland's, for the coroner to speak at length with the families of the deceased within a few weeks of the death. "It means that the families are involved at a very early stage, they feel that something is being done, and often they're content, even if there isn't a formal inquest held"[40].

2.4. Reforms for Queensland

The *Coroners Act 2003* contains a number of major changes to Queensland's coronial processes.

Section 3 sets out the object of the Act to

- Establish the position of the State Coroner;
- Require the reporting of particular deaths;
- Establish procedures for investigations, including by holding inquests;

[35] *Coroners Act 1958* (Qld), ss 31 and 40
[36] Johnson G (10 October 2000)
[37] See *Coroners Act 1958* (Qld), ss 40 and 43
[38] Richards C, 'Coroner's Death-Defying Decisions', Transcript of *ABC Radio National The Law Report* (10 October 2000)
[39] Johnston E (1991) at http://www.atsic.gov.au/issues/law_and_justice/rdiadic/overview_and_recommendations/recommendations6-40.asp
[40] "Coroner's Death-Defying Decisions", Transcript of Law Report program by C Richards of Griffith University with Malbon J (10 October 2000)

- Help prevent deaths from similar causes happening in the future by allowing coroners at inquests to comment on matters connected with the deaths;[41]

The Office of State Coroner is established under s 70 to provide a single point of accountability and central coordination for the Queensland coronial system.[42] The State Coroner will ensure the coronial system operates efficiently and that reportable deaths are investigated to the appropriate extent. He or she will be the central point to facilitate Queensland's ongoing participation in the national coronial information system. In addition, he or she will be able to issue guidelines in relation to specific inquests and must issue guidelines about how coroners perform investigations generally to ensure administrative consistency and best practice. The State Coroner is required to report annually to the Attorney-General about the operation of the Act.

In respect of coroners' focus on preventative action, the Act provides that a coroner may, whenever appropriate, comment on anything raised in an inquest relating to public health or safety, the administration of justice, and ways to prevent deaths happening in similar circumstances[43]. This appears to be somewhat narrower than the proposal in the draft Coroners Bill 2000 which made appropriate comment mandatory and extended to any situations that may be of public interest[44]. Otherwise, the Act has generally implemented the recommendations of the Royal Commission into Aboriginal Deaths in Custody in that:

- An inquest must be held in open court, unless otherwise ordered by the coroner (s 31);
- Any proceeding in the Coroners Court (except for pre-inquest conferences) must be recorded and, subject to the Act and the *Recording of Evidence Act 1962*, anyone is entitled to obtain a copy of that recording (s 38);
- All deaths in custody are to be the subject of formal inquests by the State Coroner or the Deputy State Coroner (ss 11(7) and 27);
- Copies of findings and comments are to be provided to the family of the deceased, any person who appeared at the inquest and the State Coroner (ss 45 and 46);
- Copies of comments are also to be provided to the Minister administering the relevant government entity and the chief executive officer (s 46);
- Copies of findings and comments in relation to deaths in custody must be provided to the Attorney General, the appropriate chief executive and the Minister administering the relevant Act (s 47).

[41] *Coroners Act 2003* (Qld) s 3 (Object of the Act)
[42] Coroners Bill 2002, Second Reading Speech, Hon RJ Welford, 3 Dec 2002 at 5222
[43] *Coroners Act 2003* (Qld), s 46(1)
[44] Coroners Bill 2000 (Qld), s 46(1)

- A coroner must keep a record of the coroner's findings and comments and the State Coroner must establish a register of all deaths or suspected deaths investigated under the Act. The Minister may enter into an arrangement with an entity, which maintains a National Coronial database, for information obtained under the Act to be included in the database (ss 51, 92 and 93).

The Act also recognises the stress caused to families by lengthy coronial investigations and the importance of families being able to access information quickly. As noted above, copies of findings and comments are to be provided to the family of the deceased. Other examples include:

- The Act allows persons who the Coroners Court believes have sufficient interest to appear, examine witnesses and make submissions at an inquest. Families are expressly provided for in the Act as an example of persons who may have a sufficient interest. Interested parties' rights to legal representation are also confirmed (s 36).
- Before ordering an internal examination of the body, the coroner must consider the distress caused to the deceased person's family, for example, because of cultural traditions or spiritual beliefs, and any concerns raised by a family member or anyone else with a sufficient interest (s 19(4)).
- Before allowing a person to observe an autopsy, the coroner must consult with and consider the views of family members (s 21).
- Family members and other persons with sufficient interest may access investigation documents about a death directly from the coroner (s 54).

In addition, the State Coroner's Guidelines (2003) states the following policy (at 3.24):

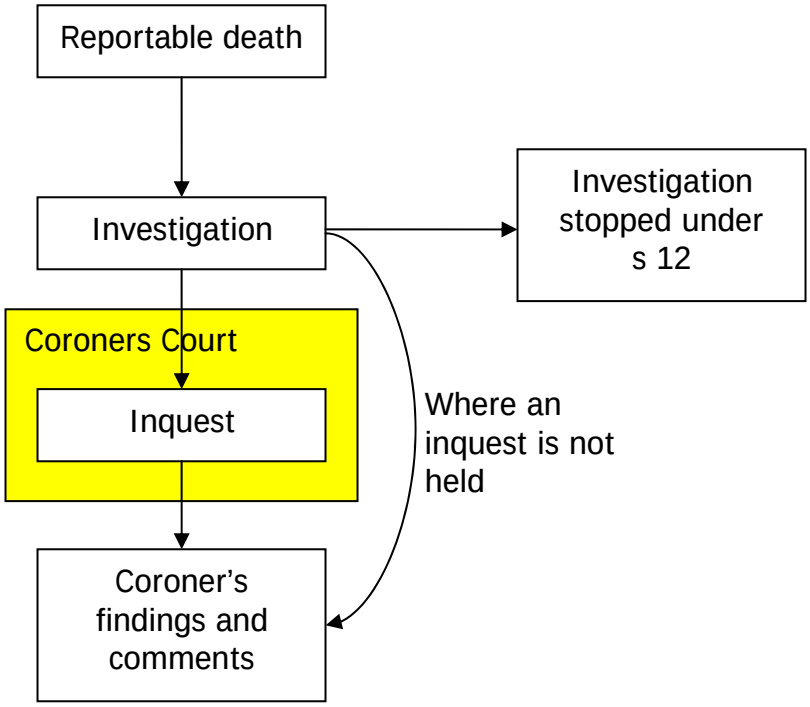
> "Families of deceased persons should not be denied information about the death just because it has been reported to a Coroner. The general principle is that families are entitled to any and all information concerning the death as soon as it is available unless there is a basis for suspecting that to release the information may compromise a criminal investigation."

3. CORONERS ACT 2003 – THE CORONIAL PROCESS

3.1. Overview

Figure 1 outlines the general process of a coronial investigation under the *Coroners Act 2003*.

Figure 1: Process of a coronial investigation



The Coroners Court only plays one part of the coronial investigation process, that is, the holding of inquests. Before examining the practice and procedure of the Coroners Court, it is important understand the events leading up to and following an inquest.

3.2. Who is the coroner?

The coroner is:

- The State Coroner – a magistrate appointed by the Governor in Council for a term of not more than 5 years, with one option to renew for a term of not more than 5 years, currently M.A. Barnes (s 70);
- The Deputy State Coroner – a magistrate appointed by the Governor in Council for a term of not more than 5 years, currently C.A. Clements (s 78);
- A local coroner – every magistrate is a local coroner (s 82); or

- An appointed coroner – a person appointed by the Governor in Council who has been a lawyer for at least 5 years (s 83).[45]

The role of the coroner is to:

- Supervise investigations into reportable deaths;
- Direct the inquiry to ensure all necessary evidence is gathered;
- Preside over an inquest, if one is required; and
- Make the findings required by the Act and any appropriate preventative comments.[46]

The coroner has the same protection and immunity afforded to a Supreme Court judge when performing a function of a coroner under the 2003 Act or another Act (s 88).

Office of the State Coroner

The Office of the State Coroner is established by s 70.

The State Coroner has the following functions (s 71(1)):

- to oversee and coordinate the coronial system;
- to ensure the coronial system is administered and operated efficiently;
- to ensure deaths reported to coroners that are reportable deaths are investigated to an appropriate extent;
- to ensure an inquest is held if—
  - the inquest is required to be held under this Act; or
  - it is desirable for the inquest to be held;
- to be responsible, together with the Deputy State Coroner, for all investigations into deaths in custody;
- to issue directions and guidelines about the investigation of deaths under this Act; and
- any other function given to the State Coroner or a coroner under the 2003 Act or another Act.

The State Coroner has the power to do all things necessary or convenient or in connection with the performance of the State Coroner's functions (s 71(2)).

The State Coroner must consult with the Chief Magistrate about resources necessary for efficient administration, amount of work conducted by magistrates as coroners and any guidelines or practice directions that the State Coroner wishes to make (s 76). The State Coroner is also obliged under the Act to produce an annual report that contains the State Coroner's guidelines, a

[45] *Coroners Act 2003* (Qld), Schedule 2
[46] State Coroner's Guidelines – Version 0 (Dec 2003) at 2.2

summary of the investigation into each death in custody and a summary of the types of directions the State Coroner has given to coroners under s 14 (see "Powers of Investigation" under section 3.4 below) (s77).

3.3. Reportable Deaths

A reportable death is one which:

- is connected with Queensland pursuant to s 8(2) in that:
  - the death happened in Queensland; or
  - although the death happened outside Queensland—
    - the person's body is in Queensland; or
    - at the time of death, the person ordinarily lived in Queensland; or
    - the person, at the time of death, was on a journey to or from somewhere in Queensland; or
    - the death was caused by an event that happened in Queensland; and
- meets one of the criteria under s 8(3), that is:
  - it is not known who the person is;
  - the death was violent or otherwise unnatural;
  - the death happened in suspicious circumstances;
  - the death was not reasonably expected to be the outcome of a health procedure; or
  - a cause of death certificate has not been issued, and is not likely to be issued, for the person; or
  - the death was a death in care; or
  - the death was a death in custody.

A person who becomes aware of an apparent reportable death, and who reasonably believes the death has not been reported, must immediately report the death to a police officer or coroner. If the death is a death in custody, the death must be reported to the State Coroner or Deputy State Coroner (s 7).

A police officer to whom a death is reported must report the death to a coroner in writing (s 7(3)). A coroner to whom a death is reported must report the death to the State Coroner in writing (s 7(5)).

The rationale for these provisions is set out in the State Coroner's Guidelines (2003) as follows (at 3.1):

> "Deaths in which the cause is uncertain, violent (including deaths that are the result of any trauma) or suspicious or that occur in circumstances that warrant their receiving special attention must be reported to a Coroner for scrutiny."

If a death is reported to the coroner, the coroner should make a finding as to whether a death is reportable or not as soon as possible, since the exercise of the coroner's powers under the 2003 Act hinges on the fact of the death being reportable. If the coroner exercises his or her powers and it is found the death was not reportable "the intrusion into the grief of the family and the interference in how they might otherwise choose to respond to the death would be reprehensible."[47]

The 2003 Act modernises the categories of deaths that have to be reported. In particular, "deaths in care" and "deaths in custody" are expressly defined (ss 9 and 10 respectively) and must be reported.[48] The State Coroner's Guidelines (2003) provides detailed discussion on the scope of each category (see sections 3.1.3 to 3.1.9 of the Guidelines).

3.4. Investigation

The coroner must investigate a death (or suspected death) if:

- the coroner considers the death is a reportable death (whether or not the death was reported under s 7) and is not aware that any other coroner is investigating the death (s 11(2)); or
- the State Coroner directs the coroner to investigate the death (s 11(3)) or suspected death (s 11(5)).

A death in custody must be investigated by the State Coroner or Deputy State Coroner (s 11(7)) and there must be an inquest.

Unless directed otherwise by the Minister, a coroner must not investigate a death if:

- the death happened in another State and has been reported to a non-Queensland coroner; or
- the death happened outside Australia (s 12(1)).

The scope of the investigation will be determined by reference to the findings the coroner must make under s 45 and any comments made under s 46 (see section 4.6.1 and 4.6.2 below). That is, a coroner should ensure that all inquiries, inspections, tests and examinations necessary to secure the evidence needed to support the findings and comments are made. The State Coroner's Guidelines (2003) provide:

> "Any temptation to assume the death is from natural causes or self inflicted must be resisted until the cause of death and the circumstances of it have been established.

[47] State Coroner's Guidelines – Version 0 (Dec 2003) at 3.2
[48] Coroners Bill 2002, Second Reading Speech, Hon RJ Welford, 3 Dec 2002 at 5221

> ...
> The investigation must extend beyond the simple medical cause of the death and seek to establish the circumstances that contributed to the death occurring and consider whether any changes to law or practice would reduce the likelihood of deaths occurring in the future."[49]

Investigation into deaths in custody are given special attention in both the legislation and guidelines "because of the responsibility of the state to protect and care for people it incarcerates, the vulnerability of people deprived of the ability to care for themselves, the need to ensure the natural suspicion of the deceased's family is allayed and public confidence in state institutions is maintained. Further, a thorough and impartial investigation is also in the best interests of the custodial officers."[50]

Stopping the investigation

Under s 12(2), a coroner must stop investigating a death if –

- the coroner's investigation shows that the body is indigenous burial remains; or
- the coroner's investigation of one of the following types of death shows that an autopsy of the body is not necessary and the coroner decides to authorise a doctor to issue a cause of death certificate—
  - a death that was a violent or otherwise unnatural death; or
  - a death that happened in suspicious circumstances; or
  - a death that was not reasonably expected to be the outcome of a health procedure; or
  - a death that was a death in care; or
- an autopsy of the body, ordered by the coroner, shows that the body is that of a stillborn child; or
- the State Coroner directs the coroner to stop the investigation; or
- the coroner becomes aware that the death happened in another State and has been reported to a non-Queensland coroner, or occurred outside Australia, unless the Minister otherwise directs.

Powers of investigation

A coroner who is investigating a death under the 2003 Act may, among other things:

- make any examination, inspection, report or test that the coroner considers is necessary for the investigation (s 13(2));

[49] State Coroner's Guidelines – Version 0 (Dec 2003) at 7.3 and 7.7
[50] State Coroner's Guidelines – Version 0 (Dec 2003) at 7.5

- direct police officers, as part of their duty to assist the coroner in the performance of a function or exercise of power under the *Coroners Act* (s 447A);
- issue a search warrant under the Police Powers and Responsibilities Act 2000, s 371AD(1)[51] (s 13(3)) and be present while a police officer exercises powers under the search warrant (s 13(4));
- seek the help of a lawyer or other person who the coroner reasonably believes can help the coroner investigate the death (s 15(1));
- direct police officers to assist in the investigation, as part of their duty to help the coroner as stated in the *Police Powers and Responsibilities Act 2000* (Qld), s 447A[52]; and
- require a person to give the coroner information that is relevant to the investigation (s 17).

The State Coroner may issue directions in relation to a particular investigation and must issue guidelines about the performance of investigations generally (s 14(1)). Coroners must comply with any directions and guidelines to the greatest practicable extent (s14(4)). The current State Coroner's Guidelines (2003) can be found on the Department of Justice and Attorney-General's website at http://www.justice.qld.gov.au/courts/coroner/pdfs/guidelines.pdf.

Autopsies

Unless a coroner has stopped investigating a death under s 12(2), a coroner must order some form of autopsy to be performed and is obliged to state the type of examination that is to be conducted (s19).

The decision not to order any autopsy has the effect of ending the coronial process.[53] Under the State Coroner's Guidelines (2003) (at 5.1), an autopsy should only be ordered when it is necessary to allow the death to be registered or for the coroner to make the findings under s 45(2) (see section 4.6.1 below).

There are different types of autopsies, with varying levels of intrusiveness:
- an external examination of the body;
- an external and partial internal examination of the body; or
- an external and full internal examination of the body (s 19(2)).

[51] Section 371AD(1) of the *Police Powers and Responsibilities Act 2000* (Qld) provides: "A coroner may, on his or her own initiative, issue a search warrant for a place if the Coroner reasonably suspects that there is evidence at the place that may be relevant to the Coroner's investigation.
[52] Section 447A of the *Police Powers and Responsibilities Act 2000* (Qld) provides: "(1) It is the duty of police officers to assist Coroners in the performance of a function, or exercise of a power, under the Coroners Act 2003, including – (a) the investigation of deaths; and (b) the conduct of inquests; (2) Without limiting subsection (1), it is the duty of police officers to comply with every reasonable and lawful request, or direction, of a Coroner."
[53] State Coroner's Guidelines – Version 0 (Dec 2003)

The State Coroner's Guidelines (2003) (at 5.5) provide that the least intrusive examination that will resolve the issues in doubt should be ordered.

Before ordering an internal examination of the body, the coroner must, whenever practicable, consider at least:

- the distress it may cause to the deceased's family, for example, because of cultural traditions or spiritual beliefs;
- any concerns raised by a family member or another person with a sufficient interest (s 19(4)).

If internal examination is still ordered, despite concerns being raised, then the coroner must give a copy of the order to the person who raised the concern (s 19(5)). An aggrieved person may seek review under the *Judicial Review Act 1990* (Qld) of the coroner's decision to order the autopsy.

The coroner may also order that particular tests be carried out (s 23) or that medical reports be provided to the doctor conducting the autopsy (s 22).

3.5. Inquests

Part 3, Division 3 of the Act deals with court powers during inquests.

An inquest must be held where:

- the death is a death in custody,
- the death is a death in care in circumstances that raise issues about the deceased person's care;
- the Attorney-General directs for an inquest to be held;
- the State Coroner orders an inquest to be held;
- the District Court on application under s 30 orders an inquest to be held (see section 4.5.1 below) (s 27).

The State Coroner's Guidelines (2003) (at 8.2) provide that an inquest must also be held if consideration of the investigation report and any other evidence does not enable the coroner to make the findings required by s 45 to the required civil standard of proof.

An inquest may be held into a reportable death if the coroner considers it desirable to hold an inquest, having regard to:

- the extent to which drawing attention to the circumstances of the death may prevent deaths in similar circumstances happening in the future; and
- any guidelines issued by the State Coroner (s 28).

The State Coroner's Guidelines (2003) (at 8.3) provide that "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 with the fault attributing role of criminal and civil trials." That is, it is in the public interest to hold a hearing. The guidelines go on to list some categories of cases in which an inquest should usually be held.

An inquest must not be held where a person has been charged with an offence in which the relevant death is at issue. If an inquest has already commenced, it must be adjourned pending outcome of the proceedings for the offence (s 29).

Applying for Inquest

Under s 30, persons may apply to the coroner to hold an inquest. The coroner is required to answer such a request within 6 months and give written reasons for the decision. Appeal of a coroner's refusal to hold an inquest must take place within 14 days after receiving the coroner's reasons, either to the State Coroner, if the coroner is not the State Coroner, or to the District Court if the request was refused by the State Coroner. The State Coroner or District Court may order that an inquest be held if it is satisfied it is in the public interest to hold the inquest.

The State Coroner's Guidelines (2003) (at 8.5) provide the following direction in relation to the considerations the State Coroner should take into account in determining whether to hold an inquest pursuant to a request under s 30:

> "Due weight must be given to request for an inquest from those with a legal or other real interest in the investigation. There are obvious public benefits in allaying the concern of those affected by sudden deaths and there are practical imposts in litigating a challenge to a decision not to convene an inquest."

Notification of inquest

There is no specific requirement in the *Coroners Act 2003* that the family be notified that an inquest into a death is to take place. The only obligation on the Coroners Court is that they must publish in a daily newspaper notice of the matter to be investigated at the inquest and the date, time and place of the inquest, at least 14 days before the inquest is to be held (s 32). The State Coroner may direct that the notice not be published (s 32(3)).

However, the State Coroner's Guidelines (2003) provide that all individuals and agencies with a real interest in the death should be advised of a decision to hold an inquest and that family members should be advised of the right to seek a review of a decision not to convene an inquest (at 8.5).

It also provides that written notice of the commencement date of the inquest 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 (at 8.7).

Inquest practice and procedure

Further details of the practice and procedure of an inquest are provided in section 5 below.

3.6. Findings and Comments

Coroner's Findings

Section 45 provides:

> (1) A coroner who is investigating a suspected death must, if possible, find whether or not a death in fact happened.
> (2) A coroner who is investigating a death or suspected death must, if possible, find—
> (a) who the deceased person is; and
> (b) how the person died; and
> (c) when the person died; and
> (d) where the person died, and in particular whether the person died in Queensland; and
> (e) what caused the person to die.
> (3) However, the coroner need not make the findings listed in subsection (2) if—
> (a) the coroner is unable to find that a suspected death in fact happened; or
> (b) the coroner stops investigating the death under section 12(1).

Whether or not an inquest is held, a coroner investigating a death or suspected death must make, if possible, the findings listed at s 45(2) above. Findings are recorded in a standard form (Form 20). If an inquest is held, the form is attached to detailed reasons for the findings.

The findings need only be made to the civil standard (balance of probabilities) but on the sliding *Briginshaw* scale. That is, the standard of proof is the civil standard, but on a scale that slides toward the criminal standard depending upon

the seriousness of the findings made. [54] Therefore, a criminal act need only be proved on the balance of probabilities but proof must be "clear, cogent and exact and when considering such proof, weight must be given to the presumption of innocence."[55]

Identification of the deceased (s 45(2)(a)) is possibly the most crucial aspect of a coronial investigation. The evidence used to support identity should be the most reliable and least intrusive of the methods set out in the State Coroner's Guidelines (2003) in Section 3.3. [56]

Coroner's Comments

Section 46 provides:

> (1) A coroner may, whenever appropriate, comment on anything connected with a death investigated at an inquest that relates to—
> (a) public health or safety; or
> (b) the administration of justice; or
> (c) ways to prevent deaths from happening in similar circumstances in the future.

Preventative comments and recommendations should be made whenever there is evidence that the death was preventable and an evidentiary basis for such recommendations.[57]

The standard of proof required to support comments is simply that which is necessary for the coroner to have acted judicially, not perversely or capriciously.[58]

Dissemination of findings and comments

The coroner must give a written copy of findings and comments to:

- The family of the deceased;
- All parties who appeared at the inquest;
- If the deceased person was a child – the Children's Commissioner; and
- The State Coroner (s 45(4) and s 46(2)).

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[54] State Coroner's Guidelines – Version 0 (Dec 2003) at 8.14. See also *Anderson v Blashki* [2994] 2 VR 89 at 96 and *Secretary to the Department of Health and Community Services v Gurvich* [1995] 2 VR 69 at 73

[55] Freckelton I, "Inquest Law" in The Inquest Handbook, The Federation Press

[56] State Coroner's Guidelines – Version 0 (Dec 2003) at 3.19

[57] State Coroner's Guidelines – Version 0 (Dec 2003) at 8.12

[58] State Coroner's Guidelines – Version 0 (Dec 2003) at 8.14

In addition, the coroner must give a written copy of comments to:

- The Minister responsible for any government entity which deals with matters to which the comments relate; and
- The Chief Executive Officer for that entity (s 46(2)).

Wider dissemination provisions apply to findings and comments in relation to a death in care or a death in custody (s 47).

Statements regarding a person's guilt or liability

In making findings and comments, the coroner must not include any statement that a person is, or may be, guilty of an offence or civilly liable for something (ss 45(5) and 46(3) respectively).

This is narrower than the 1958 Act provision which prohibited the framing of findings "in such a way as to appear to determine any question of civil liability or as to suggest that any particular person is found guilty" of any offence.

The reason for this change is stated in the State Coroner's Guidelines (2003) (at 8.14) as follows:

> "Accordingly, there is no impediment to Coroners providing a full and complete narrative of the circumstances of death nor stating their conclusions as to the responsibility of individuals or organizations for the death provided they refrain from using language that is applicable to decisions made by criminal and civil courts when they adjudicate upon the same issues."

If, from information obtained while investigating the death, the coroner reasonably suspects a person has committed an offence, the coroner must give the information to the Director of Public Prosecutions for an indictable offence or to the chief executive of the relevant department for a non-indictable offence. Similarly, the coroner may give information about official or police misconduct, or misconduct in relation to a profession or trade, to the relevant disciplinary body (s 48).

4. PRACTICE AND PROCEDURE OF THE CORONERS COURT

4.1. Constitution of the Coroners Court

Section 64 of the *Coroners Act 2003* establishes Queensland's Coroners Court, constituted by a coroner, as a court of record.

The Coroners Court may be held at any place or at more than one place at the same time (s 66).

4.2. General powers and duties of the Coroners Court

An inquest must be held by the Coroners Court in open court, unless the coroner orders the court be closed while particular evidence is given (s 31(1)).

The Court may order a person be excluded from an inquest if the court considers it is in the interests of justice, the public or a particular person to do so (s 43). The legislation gives 2 examples of circumstances where a person may be excluded from an inquest:

- A person who commits an offence by publishing information relating to an inquest in contravention of an order made by the coroner pursuant to s 41;
- A person who is to give evidence at an inquest may be excluded until he or she has given evidence.

The law relating to contempt under s 50 of the *Magistrates Court Act 1921* (Qld) applies to proceedings before the Coroners Court (s 42).

Section 104 expressly provides that the Act overrides the common law duties and powers of a coroner of the Coroners Court. This changes the proposal that was raised in s 81 of the Coroners Bill 2000 which allowed operation of the common law where the Bill was silent[59].

4.3. Pre-inquest conference

The Coroners Court investigating a death may hold a pre-inquest conference:

- To decide
  - What issues are to be investigated at the inquest;
  - Who may appear at the inquest
  - Which witnesses will be required at the inquest
  - What evidence will be required at the inquest
- To work out how long the inquest will take;
- To hear any application regarding the disclosure of confidential information under s 17

[59] *R v Bristol Coroner; Ex Parte Kerr* [1974] QB 652; [1974] 2 All ER 719.

- To otherwise ensure the orderly conduct of the inquest (s 34(1)).

In practice, pre-hearing conferences should be convened unless there is a reason not to do so, as they increase the likelihood of an orderly inquest.[60]

4.4. Right of appearance

Persons assisting the coroner, including lawyers and police officers, the Attorney-General and any person the Court considers to have a "sufficient interest" in the inquest may appear or be represented at an inquest, examine (and cross examine) witnesses and make submissions (s 36).

"Sufficient interest" is not clearly defined in the legislation, although the following examples are provided to give guidance:

- Family members;
- Representatives of departments;
- Representative of a company that manufactured a product that is believed to have killed the deceased person.

4.5. Evidence

The Coroners Court is not bound by the rules of evidence and may inform itself in any way it considers appropriate (s 37(1)).

The Act specifically provides for certain evidence gathering powers of the Coroners Court. For example, the Court may:

- Require a person to produce a document to the court before the start of the inquest (s 37(2));
- Inspect anything produced at an inquest, copy it, or keep it for a reasonable period (s 37(3));
- Order a person to attend an inquest to give evidence or to produce something (s 37(4)(a));
- Issue a warrant for the person's arrest if the person fails to attend an inquest as ordered (s 37(7)).

A person must comply with an order of the Coroners Court unless he or she has a reasonable excuse (s 37(6)).

Incriminating evidence

The coroner may require a person to give evidence that would incriminate a person if it is in the public interest to do so (s 39(2)). This power is given so the

[60] State Coroner's Guidelines – Version 0 (Dec 2003) at 8.8

Coroners Court "can find out what really happened to cause the death and make meaningful recommendations to prevent it happening again."[61]

The power can only be exercised at an inquest (not at a pre-inquest conference) and is not admissible against the witness in any other proceeding, other than a proceeding for perjury (s 39(3)).

Further, any information, document or other evidence obtained as a direct or indirect result of the evidence given by the witness cannot be used against the witness in a criminal proceeding (s 39(4) and (5)).

Recording of evidence

Apart from the pre-inquest conference, all proceedings in the Coroners Court must be recorded under the *Recording of Evidence Act 1962* (s 38(2)). Such a record includes a transcription of the record (Schedule 2).

In relation to pre-inquest conferences, the Court may decide whether or not to record the proceedings (s 38(1)).

Subject to an order made by the coroner prohibiting the publication of information relating to an inquest under s 41 and the requirements of the *Recording of Evidence Act 1962*, any person is entitled to obtain a copy of the record (s 38(3)).

The coroner as a witness

The Act provides that a coroner cannot be called as a witness in a proceeding about anything coming to the coroner's knowledge in the performance of the coroner's functions under the Act (s89).

4.6. Immunity of coroners, representatives, and witnesses

Under s 88, coroners, legal representatives, and witnesses have the same protection and immunity as:

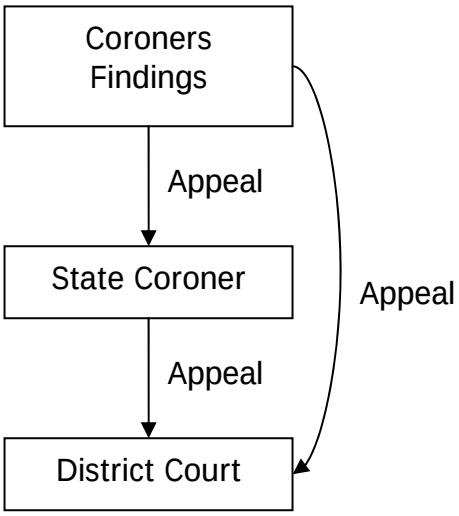
- For a coroner in the performance of his/her functions – a Supreme Court judge in a judicial proceeding in the Supreme Court;
- For a representative of a party before the Coroners Court – a lawyer appearing for a party in a judicial proceeding in the Supreme Court; and
- For a witness before the Coroners Court – a witness appearing in a judicial proceeding in the Supreme Court.

[61] Coroners Bill 2002, Second Reading Speech, Hon RJ Welford, 3 Dec 2002 at 5222

4.7. Appeals and Review

A person dissatisfied with a finding at an inquest may apply to the State Coroner or District Court to set aside the finding (s 50(1)). A person may apply to the District Court on an application based on the same or substantially the same grounds or evidence already put before a State Coroner. However, the person cannot put such an application to the State Coroner which has already been heard before the District Court (s 50(2) and (3)).

Figure 2: Appeals process



Appeals before the State Coroner

The State Coroner may set aside a finding if satisfied:

- New evidence casts a doubt on the finding; or
- The finding was not correctly recorded (s50(4)).

If the State Coroner sets aside a finding, the State Coroner may, or may direct another coroner to:

- Reopen the inquest to reexamine the finding; or
- Hold a new inquest (s 50(6)).

Appeals before the District Court

Like appeals before the State Coroner, the District Court may set aside a finding if satisfied:

- New evidence cases a doubt on the finding; or
- The finding was not correctly recorded (s 50(5)).

In addition, the District Court may set aside a finding if it is satisfied:

- There was no evidence to support the finding; or
- The finding could not be reasonably supported by the evidence (s 50(5)).

If the District Court sets aside a finding, the District Court may order the State Coroner to, or the State Coroner to direct another coroner to:

- Reopen the inquest to reexamine the finding; or
- Hold a new inquest (s 50(7)).

Reopened and new inquests

A coroner who reopens or is holding a new inquest may accept any of the evidence given, or findings made, at the earlier inquest as being correct (s 50(8)).