2016 Asia Pacific Coroners Society Conference
Perth

The Coronial Jurisdiction: Lessons for Living

address

by

The Honourable Wayne Martin AC
Chief Justice of Western Australia

9 November 2016

The Coronial Jurisdiction: Lessons for Living

by

Wayne Martin AC[1]

Introduction

It is a great honour and a pleasure to have been invited to address the 2016 conference of the Asia Pacific Coroners Society. I am very pleased to welcome all delegates to our city, and hope that you have a most enjoyable stay. Delegates not from Perth will, almost by definition, have travelled long distances to get here and I am very glad that you have taken time out of your busy schedules in order to attend this conference. I extend a particular welcome to delegates from outside Australia and express the confident hope that during your time at the conference you will be able to build or strengthen networks of communication with delegates from other jurisdictions who have a common interest in the vitally important work performed by coroners and related professions in our region.

Acknowledgment of traditional owners

I would like to commence by acknowledging the traditional owners of the lands on which we meet, the Whadjuk people, who form part of the great Noongar clan of south-western Australia and pay my respects to

[1] I am indebted to Dr Jeannine Purdy for the research which has informed this paper. However, responsibility for the views expressed and any errors is mine alone.

their elders past and present and acknowledge their continuing stewardship of these lands.

Visitors to Perth may not be aware that we meet on a place of particular significance to the Whadjuk, as we meet on land adjacent to the banks of a river named by the colonists as the Swan River because of the many black swans which made the river their home at the time the colonists arrived, but which is known to the Whadjuk as Derbarl Yerrigan. Along with other lakes and rivers situated on the coastal plain between the scarp to our east and the ocean to our west, Derbarl Yerrigan is one of the homes of the Wagyl, a serpentine creature of great significance in the dreamtime lore of the Whadjuk.

The conference topic

I have often said that the gross over-representation of Aboriginal people in the courts of Western Australia is the biggest single issue confronting those courts and tragically the Coroner's court is no exception to that observation.

I have taken the theme for my address 'Lessons for Living' from the general theme of the conference - 'Pathways to Prevention'. In this paper I will endeavour to briefly chart the historical evolution of the contemporary jurisdiction and functions of a coroner in the Australasian region, with particular reference to the vital function of contributing to the reduction in the incidence of preventable deaths in the communities served by a coroner.

Historical evolution of the coronial jurisdiction

Coroners' Courts have been described as:

> one of the most ancient parts of the English legal system, dating back to at least 1194... The coroner was an appointment originally made as *custos placitorum coronae*, keeper of the pleas of the Crown.[2]

The Coroners' Society of England & Wales has observed that:

> the role of the Coroner has adapted over the eight centuries since the office was formally established in 1194, from being a form of medieval tax gatherer to an independent judicial officer charged with the investigation of sudden, violent or unnatural death.[3]

A brief analysis of the process of evolution from medieval tax gatherer to independent judicial officer sheds some light on the characteristics of the functions performed by contemporary coroners.

The *Articles of Eyre* 1194

The office of coroner appears to have been formalised by the publication of the *Articles of Eyre* in 1194, although historians contend that the office existed before that date, albeit performing a more limited role.[4]

In medieval England an 'eyre' was a form of circuit court conducted by itinerant justices moving throughout the kingdom. The reason for formalising the role of coroner in the Articles regulating the conduct of the circuit courts has been described by McKeough in these terms:

---

[2] Gary Slapper & David Kelly, *The English Legal System* (2016) 333.

[3] The Coroners' Society of England & Wales, 'History' available at: www.coronersociety.org.uk/history (accessed 24 October 2016).

[4] Charles Gross, 'The Early History and Influence of the Office of Coroner' (1892) 7(4) *Political Science Quarterly* 656, 656-660; Jill McKeough, 'Origins of the coronial jurisdiction' (1983) 6 *UNSW Law Journal* 191, 191. Article 20 declared that: 'In every county of the King's Realm shall be elected three knights and one clerk, to keep the pleas of the Crown'.

almost certainly in order to check the increasing corruption practised by sheriffs who were royal bailiffs, the King's administrative officials at a local level.

Hubert Walter, Justiciar [the King's chief minister] during the absence of Richard I, decided that by utilising the country gentry and middle classes whom he felt he could control, certain sources of revenue could be safeguarded. Because the execution of justice depended a great deal on local knowledge and not very much on the expertise of professional judges, the county court was very important and it was here that the coroners would enrol the pleas of the Crown to be presented to the eyre upon its arrival as a record of local events as they affected the King's interests.[5]

A foot in both camps

Although the primary role of the coroner was to protect the interests of the Crown, it was the freeholders of the relevant local district who selected the person who was to perform that role. The medieval coroner's connection to both the Crown and the local community made him:

> a very prominent figure - an important link between the itinerant justices and local administration, and hence between the crown and the people.[6]

Revenue collectors

The functions of the medieval coroner have been succinctly described by the Coroners' Society of England & Wales:

> The duties of the early coroners were varied, and included the investigation of almost any aspect of medieval life that had the potential benefit of revenue for the Crown. Suicides were investigated, on the grounds that the goods and chattels of those found guilty of the crime of 'felo de se' or 'self murder' would then be forfeit to the crown, as were wrecks of the sea, fires, both fatal and non-fatal, and any discovery of buried treasure in the community which, as 'treasure trove', remains one of the coroner's duties today [in the UK],

[5] McKeough, above note 4.
[6] Gross, above note 4, 665.

> although it is likely that this particular medieval duty will finally be removed. Sudden death in the community had always been considered important since the early days of the office and was also investigated by coroners, although for reasons far different to those of today.
> After the Norman Conquest, to deter the local communities from a continuing habit of killing Normans, a heavy fine was levied on any village where a dead body was discovered, on the assumption that it was presumed to be Norman, unless it could be proved to be English. The fine was known as the 'Murdrum', from which the word 'murder' is derived and, as the system developed, many of the early coroners' inquests dealt with the 'Presumption of Normanry' which could only be rebutted by the local community, and a fine thus avoided, by the 'Presentment of Englishry'.[7]

In addition to the revenue derived from the 'Murdrum', revenue was derived by the Crown from the forfeiture of the goods of any felon who had caused a death, and from the forfeiture of any thing which had caused a death.[8] The forfeiture of goods or animals involved in fatalities was known as 'deodand' from the Latin 'deo dandum' meaning 'to be given to God' although in fact the chattels were forfeit to the Crown unless the owner paid a fine equal to the value of the goods or animals, as assessed by the coroner's jury.[9] The practice of deodand was eventually abolished by statute, although not until 1846.[10]

Magna Carta and the coroners

Last year we celebrated the 800th anniversary of the execution of Magna Carta by King John and the rebellious barons who had baled him up at Runnymede. Amongst the reasons we celebrate the execution of that document is that within its provisions, generously construed over the centuries, are to be found the seeds of the notion of an independent

---

[7] The Coroners' Society of England & Wales, above note 3.
[8] 'The Coroners and Crime' (1939) 3(2) *Journal of Criminal Law* 304.
[9] Thomas Wood, *An Institute of the Laws of England* (Book II) (4th ed) (1742) 212-213.
[10] With the enactment of *An Act for the Compensation of Families of Persons Killed by Accidents 1846* (9 & 10 Vic c93) (UK), usually called the Fatal Accidents Act or Lord Campbell's Act.

judiciary and the rule of law to which everyone, including the monarch was subject. However, perhaps predictably, more base fiscal considerations lay at the heart of the dispute between the King and the barons. The Hon James Spigelman AC has observed:

> The largest number of clauses of the *Magna Carta*, in all versions, were those directed to preventing the King's abuse of incidents of feudal tenure and social structure to raise revenue.[11]

Given the role of the medieval coroner as a collector of revenue for the Crown, in that context it is not surprising that one of the provisions of the charter limited the role of the coroner, and other local officials in relation to legal proceedings and confined those functions to the judiciary, providing a form of limited guarantee of the rule of law, at least viewed in the context of a feudal society.

The process of evolution

The evolution of the role of the coroner in England and Wales between the 13th and 19th centuries has been succinctly described:

> The Coroner system continued to adapt over the centuries, but in the nineteenth century major changes relating to the investigation of death in the community occurred. In 1836, the first Births and Deaths Registration Act was passed, prompted by the public concern and panic caused by inaccurate 'parochial' recording of the actual numbers of deaths arising from epidemics such as cholera...
>
> There was also growing concern that given the easy and uncontrolled access to numerous poisons, and inadequate medical investigation of the actual cause of death, many homicides were going undetected.
>
> By then, the coroner's fiscal responsibility had diminished and the Coroners Act of 1887 made significant changes here, repealing much of the earlier

[11] James Spigelman, 'Magna Carta: The Rule of Law and Liberty' (Centre for Independent Studies, 15 June 2015).

legislation. Coroners then became more concerned with determining the circumstances and the actual medical causes of sudden, violent and unnatural deaths for the benefit of the community as a whole.[12]

Coroner's qualifications

The evolutionary change in the primary functions of a coroner resulted in change in the qualifications required for appointment to that office. Until 1926 in England and Wales the only qualification required for appointment to the office of coroner was land ownership,[13] continuing the traditional link between the coroner and the local community he[14] was appointed to represent, although during the 19th century it seems that medical practitioners commonly acted as coroners, given the increasing focus upon the ascertainment of the medical causes of unexplained deaths.[15]

However, in 1926 an amendment to the *Coroners Act* (UK) required that a coroner be a barrister, solicitor or legally qualified medical practitioner of not less than five years standing.[16]

Differing social and professional circumstances in colonial Australia necessitated a rather different approach to the office. Police magistrates or local justices were often used as substitutes for coroners, and coronial juries were increasingly dispensed with in all jurisdictions other than

[12] The Coroners' Society of England & Wales, above note 3.
[13] Oxfordshire County Council, 'The Coroner' available at: www.oxfordshire.gov.uk/cms/sites/default/files/folders/documents/leisureandculture/history/collections/coroner_0.pdf (accessed 24 October 2016).
[14] The first female coroner appointed in England appears to have been Miss Mary Hollowell, a solicitor, made deputy-coroner in 1946 and then coroner for North Suffolk in 1951.
[15] Lee Karen Butterworth, 'What good is a coroner? The transformation of the Queensland office of coroner 1859-1959' (PhD theses, Griffith University, School of Humanities) (2012) 80-81.
[16] *Coroners (Amendment) Act 1926* (UK), s 1.

New South Wales.[17] The fact that legal officials were used more commonly in Australia than in the 'mother country' during the 19th century should not be taken to support an inference of a more legalistic approach to the function in the colonies, because very often police magistrates and local justices in Australia were not legally trained. Indeed, in Western Australia it was not common for lawyers to appear regularly in coronial inquiries until the 1990s.[18]

Today in most Australian jurisdictions, coronial functions are overseen by specialist coroners appointed with a status equivalent to that of either a judge or a magistrate (depending on the jurisdiction). However, in some jurisdictions, including Western Australia, coronial responsibilities can and do devolve to regional magistrates who do not have extensive specialised training in the performance of the function, although more significant cases will usually be dealt with by the State Coroner's office.

The role of a coroner in Australasia today

The evolution of the contemporary role of a coroner which I have briefly described explains why that role is somewhat anomalous. While coroners are independent judicial officers who must conduct inquiries in accordance with the principles of procedural fairness,[19] coronial hearings are inquiries, not trials between adversaries, and a number of the

---

[17] Carol Grech, 'Coronial Inquiries into Fatal Adverse Events in South Australian Hospitals: From Inquest to Practice' (PhD thesis, University of Adelaide, Faculty of Heath Science) (2004) 89, but see the *Coroners Act 2008* (Vic). The *Coroners Act 2009* (NSW) retains the option of a jury trial but only if the State Coroner directs (s 48). Juries are retained for a broader range of inquests in England (*Coroners and Justice Act 2009* (UK) s 7), but nevertheless are now only used in a minority of inquests (457 out of 35,473 inquests conducted in 2015-16) (Chief Coroner, *Third Annual Report 2015-16* (2016) 15-16).

[18] Len Roberts-Smith, 'The Conduct of Coronial Inquiries in Western Australia: A Practitioner's Guide' (1994) 24 *WA Law Review* 172, 172.

[19] ***Annetts v McCann*** [1990] ACA 57; (1990) 170 CLR 596.

functions of a coroner have an administrative rather than a judicial character. The key points of distinction between a coronial inquest and a trial were succinctly identified by Lord Lane CJ and more recently cited with approval by Toohey J in the High Court of Australia:

> Lord Lane CJ in *The Queen v South London Coroner; Ex parte Thompson* said:
>
> > Once again it should not be forgotten that an inquest is a fact finding exercise and not a method of apportioning guilt. The procedure and rules of evidence which are suitable for one are unsuitable for the other. In an inquest it should never be forgotten that there are no parties, there is no indictment, there is no prosecution, there is no defence, there is no trial, simply an attempt to establish facts. It is an inquisitorial process, a process of investigation quite unlike a trial where the prosecutor accuses and the accused defends, the judge holding the balance or the ring, whichever metaphor one chooses to use.
>
> What was said by Lord Lane in *Ex parte Thompson* holds good for coronial inquiries in Western Australia. It is true that the court of a coroner has been regarded historically as a court of record: see *Garnett v Ferrand* (1827) 6 B and C 611, at p 625 (108 ER 576, at p 581). But that is for certain purposes; it remains an inquisitorial body.[20]

The inquisitorial character of the coronial jurisdiction is exemplified not only in the search for the cause of death, but also in the function most relevant to the theme of this conference - that of making recommendations or 'riders' as they were known, and which is a function of an administrative character.

<u>Recommendations (Riders)</u>

The practice of adding 'riders' (recommendations) to findings with respect to the cause of death has been identified at least as early as 1821,

[20] ***Annetts v McCann*** [1990] HCA 57; (1990) 170 CLR 596 [12], [15].

in the form of recommendations from a coroner's jury.[21] The development of this practice during the 19th and 20th centuries has been described by Moore:

> This preventative potential was recognised as early as 1842 in England by the Registrar General of Births, Deaths and Marriages. In 1915, an English medical practitioner and barrister, Dr William Brend, highlighted that coronial data could be deployed for public health purposes and concluded that '[i]f prevention of deaths is not now regarded as the main purpose to be served by inquests, the inquiry becomes of relatively little value'.[22]

Tension emerges

However, the perceived tension between the judicial function of finding facts which establish the cause of death, and the administrative function of making recommendations for preventative action has given rise to controversy, conveniently described in the following passage from a case study undertaken by the Australian Institute of Criminology in 1992:

> The heart of the coronial process has been to gather facts about the who, what, when, where and why of unexpected deaths. Some commentators have viewed with suspicion any deviation from the realm of fact into the realm of opinion. This is partly a response to the fact that coronial processes are inquisitorial rather than accusatorial, and that the formal rules of evidence do not apply. Brodrick [Chair of the Committee which reviewed the coronial system in England and Wales in 1971] expressed anxiety that in drawing attention to omissions or the blameworthiness of individuals for a death 'he may be doing an injustice to the person criticised'. Furthermore:
>
>> Comments on the morals, ethics or professional standards of those who have no opportunity to answer back made by someone who speaks from a position of privilege are reprehensible and we should like to see them discontinued.

[21] Jennifer Moore, *Coroners' Recommendations and the Promise of Saved Lives* (2016) 76.
[22] Ibid.

> Moreover, it was considered that the 'decision whether any further action is required may depend on many factors of which the coroner will know nothing and we think these matters would be best left to the expert authorities concerned'.
>
> Thus, there has been vigorous debate about the authority of coroners to make recommendations and their appropriate status. Jervis, in the 8th edition of *On the Office and Duties of Coroners*, was clear about his view of the significance of recommendations (which are sometimes known as riders):
>
> > the addition is no part of the verdict, but is mere surplusage. A recommendation is no part of the verdict and the coroner may refrain from recording it, or, he may allow it to be written in the margin of the inquisition, of which it is not part.
>
> These comments were echoed in Pilling's review of the Brodrick Report, endorsing the proposed removal of 'the irritation of riders and animadversions'.
>
> In summary, there were fears that the coroner might inadvertently make suggestions which could have the potential to make a bad situation worse. The Brodrick Committee recommended that the right to attach a recommendation should be abolished and that, in order to prevent recurrence of the fatality, the coroner should have 'the right to refer the matter to the appropriate body or public authority, and he should announce he is doing so'. Following the release of the Brodrick Report, the power of the coroner to attach a recommendation to the verdict was abolished in England and Wales in 1980. Waller, in his text on *Coronial Law and Practice in New South Wales* echoes a similar concern when he cautions that 'there are dangers that coroners will make definite recommendations without being fully aware of the ramifications, or of competing priorities in a Government department'.[23]

As noted in this passage, these tensions reached their zenith in 1980, when the *Coroners Act 1980* (UK) dispensed with the preventative aspect of the coroner's role. However, that dispensation was short-lived, and four years later the *Coroners Rules 1984* (UK) provided coroners with 'a power to report a matter to a relevant authority where a coroner

[23] Boronia Halstead, 'Coroners' Recommendations and the Prevention of Deaths in Custody: A Victorian Case Study' (*Australian Deaths in Custody No 10*, Australian Institute of Criminology) (1992) 3.

believed action should be taken to prevent the recurrence of fatalities similar to the one under inquest.'[24]

The tension emerges in Australia

In Australia this tension has surfaced in a series of judicial decisions relating to the ambit of a coroner's jurisdiction. It is beyond the scope of this paper to analyse those decisions in detail, and sufficient to record that they are not entirely consistent and turn to some extent upon the precise terminology used in the legislation defining the coroner's powers in the relevant jurisdiction. So, for example, in Victoria and the ACT, courts have taken a narrower approach to the ambit of a coroner's jurisdiction to inquire into systemic issues associated with the cause of death than in Queensland.[25] In the cases taking a narrower approach, courts tend to emphasise that the coronial function does not provide an opportunity for an open-ended inquiry into the merits of government policy, the performance of government agencies or private institutions in a manner akin to that of a royal commission. In those cases in which a broader view is taken, emphasis is placed upon the statutory jurisdiction which expressly empowers a coroner to comment on 'on anything connected with a death investigated at an inquest that relates to … ways to prevent deaths from happening in similar circumstances in the future'.[26]

---

[24] Moore, note 21 above, 32.

[25] ***Harmsworth v State Coroner*** [1989] VR 989; ***R v Coroner Doogan; ex parte Peter Lucas-Smith & Ors*** [2005] ACTSC 74; cf ***Atkinson v Morrow*** [2005] QSC 353; ***Doomadgee & Anor v Clements & Ors*** [2005] QSC 357.

[26] *Coroners Act 2003* (Qld), s 46(1)(c). The Law Reform Commission of Western Australia (LRCWA) recommended that similar provisions be included in the *Coroners Act 1996* (WA) (recommendations 49 and 84) but those recommendations have not yet been implemented. Note

The preventative role triumphs

Despite the narrow view taken by the courts in some of the cases to which I have referred, it is I think clear that recognition of the importance of a coroner's preventative role is now the ascendant view. That role has been described in the following terms:

> while the determination of certain particulars may be the coroner's primary function, other purposes have been recognised as valid to pursue. Of these, the promotion of public health and safety and, specifically, the prevention of death may be the most vital. Twenty years ago, the Royal Commission into Aboriginal Deaths in Custody ('RCIADC') noted this capability, observing that '[i]n the final analysis adequate post death investigations have the potential to save lives.'
>
> In contributing to the prevention of death, the principal strategy available to a coroner is their power to make recommendations at the conclusion of an inquest. These recommendations 'represent the distillation of the preventive potential of the coronial process. The action taken in response to such recommendations carries the promise of lives saved and injury averted.' Utilising the evidence as to the circumstances surrounding the death, the expertise of the coroner, and, perhaps, the submissions of those appearing at an inquest, such recommendations can offer possible 'remedies' to avoid future deaths. It is this potential that underpins the frequently quoted motto of the coroner: 'We speak for the Dead to protect the Living'.[27]

In the case study conducted by the Australian Institute of Criminology, referred to previously, in which the concerns associated with a coroner's recommendations were succinctly identified, the author went on to rebut those concerns in the following passage:

---

however that the recommendations also restrict the coroner's power to comment or make recommendations to only deaths investigated at an inquest and recommendation 85 requires that a coroner must consider the extent of the evidence presented at the inquest in determining whether to make comments or recommendations (LRCWA, *Review of Coronial Practice in Western Australia: Final Report* (2012)).

[27] Raymond Brazil, 'The Coroner's Recommendation: Fulfilling its Potential? A Perspective from the Aboriginal Legal Service (NSW/ACT)' (2011) 15(1) *Australian Indigenous Law Report* 94, 94.

> As Johnstone points out, however, these arguments do not take account of the fact that the coroner can call experts to provide testimony on the details of any relevant matter; that coroners' suggestions are frequently very general in nature; and that, most importantly, 'there is never likely to be a better time' to make a recommendation. Moreover, the coroner has no power to require formally that any suggested action be carried out. It is always open to the agency to ignore or reject coronial recommendations, either explicitly or implicitly, and with or without communicating the reason for choosing such a course of action.
>
> Johnstone points out that as far back as 1907, the potential role of the coroner in the prevention of deaths and injury was acknowledged. He cites the early writings of William Brend, who argued that the Coroners' Court was poorly adapted for the detection of crime; that claims for compensation were settled in other courts and that the only valuable role left to the coroner was a preventive role.
>
> This potentially preventive role has been marginalised in some coronial practice through the emphasis on unpacking the facts of individual cases, rather than the systematic identification of patterns of death and injury. This emphasis reflects the over-riding modus operandi of the legal profession as a whole, which has concerned itself solely with dealing with events on a case by case basis, closing the file at the conclusion of each. A preventive focus requires additional steps: identifying patterns; identifying remedial responses; making recommendations to implement the response; ensuring that problematic situations are remedied.[28]

A similar approach was taken in a recent review of coronial practice in Western Australia conducted by the WA Law Reform Commission, which embraced the preventative role of the coroner in many of its recommendations. Chief among those recommendations was its primary recommendation, which was to amend the Act so as to feature a clause which provided that the primary objects of the Act include:

> to contribute to a reduction in the incidence of preventable deaths and injury by the findings, comments and recommendations made by coroners and by the timely provision by coroners of relevant data to appropriate authorities and research bodies.[29]

---

[28] Halstead, above note 23, 3.

[29] LRCWA, above note 27, recommendation 1. The recommendation has not yet been implemented however.

NCIS

Coroners who are members of the Society presenting this conference have recognised the importance of the systematic identification of patterns in death and injury by creating the National Coroners Information System (NCIS) in 1997. The creation of that system has been explained:

> Apart from acting as a safety valve for high-running public emotions, and on occasion allaying suspicion, the coroners' system could be said to serve little other purpose, the criminal and civil jurisdictions having whittled away at what history left of its ancient functions. Even so forensic pathology still allows itself to be hamstrung by the legal adversarial paradigm which emphasises the individual and has less interest in the community. However, in September, 1997, the Australian Coroners Society unanimously endorsed a plan from Monash University to administer a National Coroners Information System...
>
> That proposal was based on the premise that coroners can be more effective if they can learn from and apply the experience of coroners who have dealt with the same type of case. More importantly, policymakers and researchers wanting up-to-date national data on classes of deaths reported to coroners will now be able to access such data through the system.[30]

The concurrent jurisdiction of the WA Ombudsman

The deaths of vulnerable children

Despite the creation and implementation of this important system for the development of a database relating to the causes of death, perhaps it was concern about the capacity of diverse coroners conducting independent and separate inquiries to identify systemic patterns which led the initial establishment of a Child Death Review Committee in WA in 2003, to 'provide quality assurance mechanisms of particular departmental cases

---

[30] Stephen M Cordner & David L Ranson, 'Grim new role for forensic pathologist' (1997) 350(suppl III) *Lancet* 6.

where a child has died',[31] in response to a recommendation by the Gordon Inquiry.[32] In my view, it is of some significance that the Gordon Inquiry was itself prompted by:

> the coronial inquest into the death of 15-year-old Susan Ann Taylor at the Swan Valley Nyoongar Community (SVNC) in Lockridge in 1999. The Coroner's report included allegations of physical and sexual abuse at the community, and raised questions, such as the mandatory reporting by health officials of sexually transmitted diseases and the practices of various government departments and other agencies.[33]

The Child Death Review Committee that was established carried out reviews of the operation of relevant policies, procedures and organisational systems of the then Department for Child Protection, at the request of the Minister or Director General, in circumstances where a child known to the Department had died.[34]

Subsequently the legislature of Western Australia conferred this jurisdiction upon the Ombudsman, on the basis that the Ombudsman was an independent parliamentary officer with wide powers of investigation that were not available to the Committee.[35] The legislation conferred power on the Ombudsman, in relation to the death of children in the care of, or who had come to the attention of the Department for Child Protection, to:

---

[31] The Committee was to seek to understand why children in the care of child welfare authorities had died, determine whether departmental procedures had an impact on events and make recommendations to improve policy and practice (Find & Connect website, 'Western Australia – Organisation, Child Death Review Committee (2003 - 2008)' (2013), available at: https://www.findandconnect.gov.au/ref/wa/biogs/WE01095b.htm#tab5 (accessed 4 November 2003)).

[32] Gordon S, Hallahan K & Henry D, *Putting the picture together, Inquiry into Response by Government Agencies to Complaints of Family Violence and Child Abuse in Aboriginal Communities* (2002) Recommendation 146.

[33] Ibid, xxi.

[34] Ibid, 412.

[35] Western Australia, *Parliamentary Debates*, Legislative Assembly (19 March 2009) 2182b (Mr CJ Barnett, Premier).

- review the circumstances in which and why the deaths occurred;
- to identify any patterns or trends in relation to the deaths; and
- to make recommendations to any department or authority about ways to reduce or prevent such deaths.[36]

In other words, in respect of such children, the Ombudsman has been given jurisdiction which is almost exactly concurrent to that of the coroner.

Of course I mean no disrespect to the Ombudsman when I observe that this appears to me to be a very strange – although not unique[37] – conferral of jurisdiction. The primary function of an Ombudsman traditionally has been to investigate complaints of maladministration by government agencies. Investigations are not undertaken in public, nor is there any specific obligation to publish the outcome of such investigations. By contrast, a coroner is an independent judicial officer who is obliged to undertake an inquest into the death of a person held in care[38] transparently and in accordance with the principles of procedural fairness, and to publish the findings made together with any recommendations - on the face of it, a procedure which might be thought to be well aligned with the investigation of the deaths of vulnerable children. If concerns were held about the efficacy or limits of the coroner's role in relation to the deaths of such children, in my respectful

---

[36] *Parliamentary Commissioner Act 1971* (WA), ss 19A, 19B.

[37] See for example, *Community Services (Complaints, Reviews and Monitoring) Act 1993* (NSW), s 36. Other jurisdictions appear to have conferred similar jurisdictions on other non-curial bodies.

[38] *Coroners Act 1996* (WA), ss 3, 22(1).

view the preferable course would have been to enhance and adequately resource that role rather than duplicate it.[39]

Deaths due to suspected family or domestic violence

I would respectfully make the same observations with respect to the administrative arrangements which have been made, without specific legislative backing, for the WA Ombudsman to review all fatalities due to suspected family and domestic violence. These are described as being undertaken 'to identify key learnings that will positively contribute to ways to prevent or reduce family and domestic violence fatalities.'[40]

The recent public attention directed to the scourge of family violence is entirely appropriate and long overdue. Given the importance which our community rightly attaches to the need for effective action to reduce family and domestic violence, I would have thought that increasing the powers and resources available to independent judicial officers with training and expertise in the investigation of fatalities and the power to make public recommendations to reduce preventable death might have had much to commend it. I note that where inquests are conducted, the coroner proceeds through open and transparent hearings at which all may be required to give evidence. This appears to me to be preferable to a review conducted by an official behind closed doors, an official whose powers are limited to the investigation of government agencies,[41] and whose powers of recommendation are limited to circumstances in which

[39] See for example LRCWA, above note 27, recommendation 83.
[40] Ombudsman Western Australia, *Annual Report 2015-16* (2016), 89.
[41] *Parliamentary Commissioner Act 1971* (WA), ss 4A, 13(1).

a finding which may be loosely described as 'maladministration' has been made.[42]

I have no doubt that the WA Ombudsman reviews the deaths of vulnerable children and fatalities caused by family and domestic violence diligently and in good faith. Nonetheless, when account is taken of:

(a) the obligation of a coroner to conduct an inquest openly, transparently and in accordance with the principles of procedural fairness (as compared to the administrative review conducted by the Ombudsman[43]);

(b) the broader potential range of a coronial inquiry (not limited to public administration); and

(c) the limited nature of the Ombudsman's powers to make recommendations (at least in respect of deaths due to suspected family or domestic violence);

it might be asked what purpose is served by this division of powers and resources.

There is much to be said for the view that these critically important functions would be best performed by a coroner's office with augmented powers and resources. The recommendations made by the LRCWA appear to me to provide a good model of the way in which the coroner's powers and resources could be augmented to perform these functions

---

[42] *Parliamentary Commissioner Act 1971* (WA), s 25.

[43] Although I note that, as would be expected, the Ombudsman is subject to the requirements of procedural fairness in relation to any reported comment that is defamatory or adverse to any person (*Parliamentary Commissioner Act 1971* (WA), s 25(7)).

effectively, and without need for duplication by another agency (such as the Ombudsman).

Medical research

The NCIS provides a database potentially available to researchers interested in the cause of death. Individual coroners are also in a position to provide extremely valuable information to those engaged in medical or epidemiological research. That capacity would be enhanced by the adoption of objects clauses of the kind recommended by the Law Reform Commission WA (LRCWA) in all relevant legislation, augmented by legislative provisions empowering coroners to provide information and copies of documents not only to interested agencies but also to those conducting bona fide research.[44] In the same vein, the LRCWA recommended that a prevention team be established within the office of the WA State Coroner employing sufficient research and systems information staff to:

- perform various functions, including the analysis of coronial data to identify insipient trends in deaths and opportunities for preventative activities;
- conduct consultations with stakeholders to inform the proposed formulation of coronial recommendations; and

[44] See, for example, s 115(2) of the *Coroners Act 2008* (Vic).

- liaise with and provide relevant coronial information to approved death prevention bodies, researchers and special interest advocacy groups.[45]

It is difficult to contest the wisdom of these recommendations.

Responses to coronial recommendations

More controversial has been the question of whether an obligation should be imposed upon persons or organisations the subject of coroners' recommendations to respond to those recommendations within a particular time period. For example, in the UK, such persons and agencies must respond to the recommendation within 56 days and in most cases both the report and the response are published. The LRCWA recommended that a similar statutory obligation be imposed upon statutory authorities or public entities the subject of a coronial recommendation, although such agencies would be given three months within which to respond. Under its recommendations, unless the State Coroner ordered otherwise, the State Coroner would be obliged to publish the response on the internet as soon as reasonably practicable after its receipt. The LRCWA also recommended that the government give consideration to the question of whether private entities performing public functions should be subject to the same obligation.[46]

The role of the media in the coroners' preventive function

The media has a pervasive role in contemporary society, and the capacity to dramatically influence the actions of public agencies and

[45] LRCWA, above note 27, recommendation 83.
[46] Ibid, recommendation 87.

private organisations. A question arises as to the extent to which coroners should conduct their inquiries and frame their recommendations in such a way as to utilise the beneficial influence of this powerful tool in bringing about change likely to reduce the incidence of preventable deaths. The attractions of such an approach are obvious but, at the risk of undertaking the metaphorical equivalent of attempting to teach a group of grandmothers how to suck eggs, I would recommend great caution before undertaking any strategy involving use of the media.

There are a number of reasons for this caution and I will mention just some. First, modern media is a particularly unruly horse involving many facets and forms of communication. The advent of the internet has provided a multitude of publishers who are not governed by journalistic ethics or the responsibilities which flow from being a major trading organisation with a substantial balance sheet. Whatever the benefits, and there are many, the likelihood of undisciplined and uninformed commentary has multiplied exponentially in the modern media environment.

Second, I am sure I do not need to remind this audience of the vital importance of appropriately respecting the interests of the family and others affected by a death. There is a real risk of those interests not being given due regard by every media outlet, with some aggressively pursuing a storyline which will attract public attention.

Third, if the primary purpose of the preventative function is to bring about informed systemic, institutional, organisational or regulatory change, a febrile media campaign may have precisely the opposite effect. Individual agencies and organisations under intense media scrutiny, especially in cases where death has been caused, may well be inclined to respond to that scrutiny by public vindication and defence of their actions and systems. That defensive position would be undermined by change, which is therefore resisted.

In my respectful view, legislative provisions along the lines of those recommended by the LRCWA, emphasising the importance of the preventative function, supported by the provision of appropriate resources and systems and augmented by the capacity for appropriate disclosure of documents and data together with a regime of mandatory responses to coronial recommendations is likely to be more effective in bringing about changes likely to reduce the incidence of preventable deaths.

Conclusion

In this paper I have endeavoured to demonstrate the manner in which the important preventative function of the coroner developed in the context of the historical evolution of the office of coroner generally. Although the preventative function, and its performance, has occasioned controversy from time to time, recognition of the importance of that function is now, appropriately, ascendant. If coroners are provided with the legislative backing and appropriate resources to properly perform

that function, the community is likely to benefit through the reduction of the incidence of preventable deaths, which can only be a good thing.