APPEARING IN THE CORONIAL JURISDICTION[1]

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1. This paper aims to provide guidance to practitioners briefed to appear in inquests in the NSW Coroner's Court. Although some reference will be made to matters of law[2], my primary purpose is to focus on matters of practice and procedure which might assist if you are fortunate enough to be briefed to appear in this interesting, and very special jurisdiction.

The purpose of Coronial proceedings and the role of the Coroner

2. It is important at the outset to understand that a Coronial inquiry is fundamentally different from ordinary "litigation". An inquest is not litigation at all. There are no "parties" and no "contest". No-one sets out to "prove" any particular allegation or proposition.

3. Rather, an inquest is an investigation, aimed at discovering the truth. It is an inquisitorial[3] exercise in fact-finding. It is this principle which drives the inquest hearing, and which generally informs the approach taken by Coroners to evidentiary and procedural matters, both prior to and during the hearing of an inquest.

4. In NSW, the Coronial process is primarily[4] regulated by the Coroners Act 2009. Coroners conduct inquiries into certain types of deaths and fires. Under the Coroners Act 2009, an "inquest" is an inquest into the death or suspected death of a person (s.4). An "inquiry" is an inquiry into a fire or explosion (s.4). The overwhelming majority of Coroner's work is in relation to deaths (rather than fires). Inquests into deaths is the primary focus of this paper. However, as most of the comments in this paper are about matters of procedure, many will apply equally to the conduct of a fire inquiry.

When might an inquest be held ?

5. The general jurisdiction to hold an inquest arises if it appears that a person has died (see s.21, s.6):-

    - a violent or unnatural death; or

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[1] Views expressed in this paper are mine, based on my own research, observations and experience, and do not represent any "standard practice" which applies in all or any Coronial proceedings.

[2] For a thorough examination of the Coroners Act 2009 & law relating to it, see Waller's Coronial Law and Practice in NSW (4th Ed) Abernethy, Baker, Dillon & Roberts (Lexis Nexis 2010).

[3] It has been said that a Coronial inquest is a hybrid of adversarial and inquisitorial elements: Musumeci v A-G [2003] NSWCA 77 at [33].

[4] It seems that the Coroners Act 2009 does not amount to a Code. The common law continues to have some operation: see Waller at I.50ff.

- a sudden death the cause of which is unknown; or
- under suspicious or unusual circumstances; or
- having not consulted a doctor in the previous 6 months; or
- where death was not the reasonably expected outcome of a health-related procedure; or
- while in or temporarily absent from a mental health facility (and while a "patient" at the facility under Mental Health legislation); or
- where a doctor has not issued a certificate of cause of death.

6. Jurisdiction is given (exclusively) to a "Senior Coroner"[5] to hold an inquest where it appears that a death has occurred in the following circumstances (see s.23 and s.24):-

    - while in the custody of police or other lawful custody; or
    - while escaping or attempting to escape from police or other lawful custody; or
    - as a result of, or in the course of police operations; or
    - while in or temporarily absent from an adult correctional centre, lock-up, or children's detention centre (or while en route to such a place); or
    - while a "child in care"; or
    - where a report has been made under NSW "care legislation"[6] about the deceased child (or a sibling) within the previous 3 years; or
    - where a child's death may be due to abuse or neglect or is suspicious; or
    - where the person was living in or temporarily absent from residential care (or was is in a 'target group' and received assistance to live in the community) under the Disability Services Act 1993.

7. Section 25 confers on Coroners a wide discretion to dispense with an inquest. In many cases where jurisdiction arises, an inquest will be dispensed with, because there is no doubt as to the identity of the deceased or the time, place, and manner and cause of death (and there is no public or family interest to be served in holding an inquest). There are however, some deaths in which an inquest must be held.

    When MUST an inquest be held?

8. There are some deaths where holding an inquest is mandatory. Section 27 says that an inquest into a death or suspected death must be held:-

    - if it appears that the death was a homicide (and not suicide); or
    - if the death occurred in police or other lawful custody (or while trying to escape); or

[5] Senior Coroner is defined by s. 4 and s.22(1) as the State Coroner or a Deputy State Coroner.

[6] That is, a report to Family and Community Services under Children and Young Persons (Care and Protection) Act 1998.

- if the death occurred as a result of or in the course of police operations; or
- if the death occurred while in, or while temporarily absent from an adult correctional centre, lock-up, or children's detention centre (or while en route); or
- if it has not been sufficiently disclosed whether the person has died; or
- if the person's identity and date and place of death have not been sufficiently disclosed; or
- if the manner and cause of death have not been sufficiently disclosed[7]; or
- where the Minister or the State Coroner directs that an inquest be held (s.28, s.29).

What are the purposes of an inquest ?

9. The primary purposes of an inquest are to determine, if possible (see s.81):-

- whether the person has died
- the person's identity
- the date and place of death
- the manner of death
- the cause of death

Manner and Cause of death

10. The phrase "manner and cause of death" is not defined in the Coroners Act 2009. However there is usually a distinction drawn between "manner" and "cause". Sometimes it can be difficult (on the facts of a particular case) to draw a clear line between the two concepts. This might arguably be because the expression "manner and cause" is a "composite phrase": see Campbell JA in Conway v Jerram [2011] NSWCA 319, at [39].

11. However, adopting the generally accepted approach to the meaning of these words, they might be explained as follows[8]:-

- *Cause* of death = the physiological event which led to the extinction of life (eg gunshot wound to the head)

- *Manner* of death = the means by which, and circumstances in which the death occurred (eg Was the shot self-inflicted? If so, was it suicide, or an accident? Or did someone else fire the shot, either intentionally or accidentally?)

12. The "cause" of death might be thought of, therefore, as the terminal event which extinguished life (eg cardiac arrest due to hypoxia[9]).

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[7] Unless an inquest has been suspended or continued under s.78.

[8] I have referred to "cause" of death first, because the concept is more narrow than "manner of death" and usually more easily understood.

13. The concept of "manner" of death can sometimes raise interesting issues. How far down the chain of causation can or should the Coroner go? In the gunshot example above, does manner of death extend to examining how the deceased came into possession of a gun? (I would say "yes"). What if the gun fired accidentally because it's safety catch was faulty – could this go to manner of death? (I would say "yes"). If the deceased held a gun licence, does manner of death extend to examining whether that licence should have been granted? (I would say "that depends on the facts[10]"). Could manner of death extend to examining whether gun licences should ever be issued to civilians? (I would say "no – too remote").

14. Determining what is relevant to manner of death will depend on the facts of the case, and requires a practical and common sense approach. An inquest is not a Royal Commission. The scope of an inquest is a matter for the Coroner, exercising proper discretion and common sense. In the usual cases, a line must be drawn at some point beyond which, even if relevant, factors which come to light will be considered too remote from the event: Young JA in Conway v Jerram (above) at [48-49].

15. In Conway v Mary Jerram, Magistrate and State Coroner [2010] NSWSC 371, (this was the first instance decision which preceded the Court of Appeal decision in Conway v Jerram above) Barr AJ said at [52]:- *"It seems to me…that the phrase "manner of death" should be given a broad construction so as to enable the coroner to consider by what means and in what circumstances the death occurred."* In that case, the plaintiff was the mother of a 16 year old girl who died from injuries received in a stolen car that crashed. The plaintiff argued that "manner" of death was not adequately disclosed by reference to the car crash, and that an inquest should be held, looking at events going back months and years into her daughter's life (in other words the path that led her to get into a stolen car). In dismissing this argument, Barr J held that these events were too remote, and said (at [61]) – *"It seems to me that the means by which and the circumstances in which the death of M occurred are explained by the circumstances set forth in the reports to the coroner made by the police officers and by the pathologist. To go any further back in time than the time at which M became a passenger in the motor vehicle driven by the young man would be to enter upon an inquiry that might never end."* An application for leave to appeal from Barr J's decision was dismissed by Campbell & Young JJA in Conway v Jerram (noted above).

Some examples of "common" inquests

16. The circumstances in which inquests are held, and the issues arising in them, are infinitely variable. In many inquests, there will be no doubt that the person has died, and no doubt as to their identity and date and place of death.

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[9] Hypoxia – A lack of oxygen to the tissues.

[10] This might be a relevant issue if, for example, the gun licence had been issued to a person with a known history of mental instability

There may still however be doubt as to the manner and/or cause of death, or there might be issues of public safety that the Coroner thinks should be examined. Some specific examples of "common" inquests, and the issues that usually arise in them are:-

- Missing persons – Is the person dead? When and where did they die? How did they die? What events led to the death? Is the Coroner of the opinion (under s.78) that a "known person" committed an indictable offence in relation to the death?

- Medical mishaps – Identity, time and place of death are usually not in issue. Questions might remain as to "cause" of death (eg did the deceased suffer a spontaneous cardiac event, or did a cardiac arrest occur due to a blockage of the patient's airway?) Manner of death might also be in question – eg if the patient suffered a spontaneous cardiac event, what led to it? Or, if cardiac arrest was due to airway blockage (and resulting hypoxia) what caused the blockage?

- Drownings – Usually (if the body has been found) there will be no issue that the person has died, nor as to their identity, and the time, place and cause of death. There might however be unanswered questions as to the "manner" of death. For example – How did the deceased enter the water? Was it suicide? Did they fall? Were they pushed? There might also be issues of public safety to be examined (eg, in 2011 a joint inquest was held into multiple drowning deaths involving rock fishing).

- Deaths during police operations or while in custody[11] – Normally there will be no issue as to identity, time, place or cause of death (eg gunshot). Frequently however there will be questions as to the "manner" of death – Was the use of a firearm justified? Was the fatal shot fired in self defence? Did the police comply with procedures? Relevant to possible recommendations[12] might be the question of whether the police officer received suitable training, or whether there should be a review of policy or procedures as to the use of firearms.

- Child deaths (where a report of risk of significant harm with respect to the child or a sibling has been made in the 3 years before the death) – Child deaths involving alleged neglect or abuse will usually raise issues as to the "manner" of death. For example - Were the child's injuries accidental, or inflicted? Was medical attention sought promptly? If medical attention was given, was it appropriate? Was appropriate action taken by authorities in response to notifications of a child being at risk of significant harm?

[11] NSW Police Force refers to a death or serious injury which occurs arising out of the actions of police in the execution of their duty as a "critical incident".

[12] Recommendations are examined further below.

- Suicides – In most cases of suspected suicide, the deceased's body will have been discovered, and the fact of death, identity, and time and place of death will not often be in issue. Questions might remain however as to the "manner" of death. For example – How did the deceased get access to a gun/tablets/rope? Were appropriate measures taken to restrict access to such means of self-inflicted harm? Should recommendations be made which might reduce the risk in the future? It should also be noted that in cases of apparent or suspected suicide, a common practice is for a Coroner (at the start of proceedings) to make a non-publication order (under s.75(1)) as to the identity of the deceased and the relatives of the deceased. Section 75(5) applies after a finding has been made of self-inflicted death, and says that a report of the proceedings must not be published after the finding, unless the Coroner makes an order permitting it.

17. These are but a few examples of the types of cases that might be encountered in the Coroner's Court. To get a better idea, you can read Coronial findings by going to http://www.coroners.lawlink.nsw.gov.au.

18. In all inquests, an important focus for the Coroner (and thus for persons granted leave to appear) will be whether any "recommendations" should be made in relation to any matter connected with the death (s.82).

Recommendations

19. The power to make recommendations is frequently exercised by Coroners (see s.82). Recommendations are usually aimed at making improvements to public health and safety. The power to make recommendations however is not open-ended. The recommendation must be "*in relation to any matter connected with the death*":s.82(1).

20. Recommendations are usually reserved for cases which involve "systemic problems". For example, a recommendation might not be appropriate where it is clear that a death was a "one-off" mishap involving an error (eg a surgeon who leaves a surgical instrument inside a patient's body, leading to fatal septicaemia). However a recommendation might well be appropriate where that error has been caused or contributed to by an inadequate system (eg where the hospital has no clear system of conducting an "inventory" or "count" of surgical instruments before closing a surgical wound).

21. In cases where the deceased died while in or under the care of a government agency (eg police, a public hospital, a prison, DoCS[13]), it is likely that the Coroner will examine the adequacy of policies and procedures of the agency, whether those policies and procedures are sufficiently well known, and whether they (or knowledge of them) should be improved.

[13] Although the former "Department of Community Services" (DoCS) is now known as Family and Community Services (FaCS), I have used here the former and better known acronym.

22. In cases where a death has occurred while a person was using a particular piece of equipment, (eg an outdoor spa, a car jack), or a particular service (eg hot air ballooning, jet-boat riding) Coroners may be interested to look at whether recommendations should be made, aimed at improving safety of that equipment or service, or warning of the risks involved.

23. If therefore you are briefed to appear for a government agency, a manufacturer of equipment, or a provider of a service (etc) you should give consideration (well before the inquest) to the types of recommendations that the Coroner might be likely to entertain. If improvements in safety can or should be made, then it is likely to reflect well on your client at inquest if it can be shown that those improvements have already been carried out (ie the Coroner does not expect your client to "sit on their hands"). Contact should also be made, at an early stage, with Counsel Assisting the Coroner, to obtain an idea of the type of recommendations that might be under consideration, so that you and your client can consider them.

Inquiries into fires and explosions

24. Part 3.3 (ss 30 to 32) sets out a regime under which inquiries into fires may be held and cases where an inquiry must be held. Section 81(2) sets out the obligation of a Coroner to record findings as to the date, place, and circumstances of the fire or explosion. As this paper is primarily focussed on inquests (which represent the majority of Coronial cases), it is not proposed to examine the various provisions of the Coroners Act 2009 which regulate fire inquiries. Suffice to say however that the comments in this paper about practice and procedure in inquests will also apply, in general terms, if you are appearing in a fire inquiry.

The Coronial investigation and preparation of a brief of evidence

The OIC

25. A police officer is assigned to be the Officer in charge (OIC) of a Coronial investigation. Section 51 of the Coroners Act 2009 empowers a Coroner to give directions to the OIC for the purposes of the Coronial investigation. In practice, what usually happens is that an OIC is appointed at an early stage, to conduct the investigation. The OIC, usually in consultation with Counsel Assisting and the Coroner, will then try to obtain statements from all relevant witnesses, and obtain all other material evidence, for the purposes of compiling a brief of evidence for the inquest.

26. It sometimes occurs that a witness will refuse to cooperate in providing a statement (or a thorough statement) to the OIC. Sometimes also, a witness will refuse to provide a statement to the OIC, but indicate that a statement will be prepared by, or in consultation with their own lawyer. There is no power in the OIC (or the Coroner) to compel a witness to provide a statement. However, it should be remembered that if an important witness refuses to provide a statement (or supplies a statement that is not

comprehensive) then it is far more likely that the witness will be placed on the witness list and subpoenaed to give oral evidence at the inquest (and is likely to spend more time in the witness box). Clients who are reluctant to cooperate in providing a comprehensive statement should be advised of this risk.

27. The OIC will ordinarily prepare (some time prior to hearing) an "OIC statement", which summarises the entire brief, and which usually includes the OIC's conclusions as to manner and cause of death, and sometimes, suggested recommendations. The "OIC statement" (which appears near the front of the brief) is usually a good place to start when reading into the brief.

28. Although the original brief given to the Coroner will usually include photos of the deceased's body (and of the autopsy), it is standard practice for these to be removed from the copy of the brief that is served. If access to this sensitive material is sought, then a specific application must be made, and a clear explanation provided as to the legitimate forensic purpose in seeking it.

29. It is standard practice for the OIC to consult with Counsel Assisting in the lead up to, and during the inquest hearing. The OIC will frequently be provided with "requisitions" by Counsel Assisting (on behalf of the Coroner), as to lines of inquiry to be followed up. If a person granted leave considers that some further inquiry should be made, then the legal representative for that person should advise Counsel Assisting (or the instructing Solicitor if there is one), rather than approach the OIC directly.

30. When the inquest hearing commences, it is usual for Counsel Assisting to call the OIC as the first witness, at which time the brief of evidence is usually tendered and admitted as an exhibit. In lengthier inquest hearings, it is not uncommon for any cross examination of the OIC (on behalf of persons granted leave to appear) to be deferred until near or at the end of the hearing (this is often a practical step, given the likelihood that, during the hearing, other lines of inquiry, and items of evidence might be suggested, and pursued).

<u>Counsel Assisting</u>

31. Coroners are usually assisted by an advocate, who takes the role of "Counsel Assisting the Coroner". In the majority of inquests, the role of Counsel Assisting is performed by police Coronial Advocates (Police Prosecutors specially assigned to conduct Coronial matters).

32. However, in more complex cases, and in cases where there is, or may be a conflict of interest for the police, Coroners will engage the NSW Crown Solicitor's Office to assist. The Crown Solicitor maintains an "Inquiries team" which consists of Solicitors and Solicitor Advocates who specialise largely in inquest work for the Coroner. The Crown Solicitor's Office usually retains either one of it's own Solicitor Advocates, or private Counsel, to advise and to appear as Counsel Assisting.

33. In cases where the Crown Solicitor's Office perceives there to be a possible conflict of interest (eg where the Crown Solicitor's Office has been retained to appear for a government agency which will be seeking leave to appear in the inquest) the NSW Department of Attorney General and Justice will take on the role of assisting the Coroner, and (usually) briefing Counsel to advise and appear as Counsel Assisting.

34. Once a brief of evidence (or a partial one) has been assembled, it is given to Counsel Assisting, to provide advice as to issues that might be considered by the Coroner, and additional evidence (including expert reports) that should be obtained. In cases where the Crown Solicitor's Office (or Attorney General and Justice) is retained, the instructing Solicitor, after briefing a Solicitor Advocate or Counsel, will liaise closely with the OIC, the Coroner, and Counsel Assisting, so as to complete all necessary enquiries, with a view to compiling a final brief of evidence.

35. This process of ongoing consultation between the Coroner and the Counsel Assisting team is an example of the inquisitorial and investigative nature of a Coronial inquest, which was mentioned at the commencement of this paper.

36. Another of the roles of Counsel Assisting (in consultation with the instructing Solicitor if there is one, and the OIC) is to prepare, for the Coroner's consideration, a "List of issues" to be considered at the inquest, and a draft List of witnesses to be called in the inquest. The List of issues, and Witness list, once settled by the Coroner, are circulated to the legal representatives for persons/organisations seeking leave to appear, shortly before the hearing.

37. Counsel Assisting will give consideration to, and consult with the Coroner about the question of which persons/organisations should be informed about the inquest. Once the relevant persons/organisations have been identified, a letter[14] is usually sent on behalf of the Coroner, informing them of the inquest, and asking whether they wish to apply for leave to appear. Such applications are often dealt with at a directions hearing.

38. It is a good idea to make contact with Counsel Assisting as soon as you are briefed, and to remain in contact throughout the inquest. This provides you a better opportunity to remain informed of the real issues in the inquest, so that you and your client can consider how best to deal with them.

39. At the commencement of the inquest hearing, it is usual (at least in more complex matters) for Counsel Assisting to deliver an opening address, touching upon the facts uncovered in the investigation to date, and the issues which are expected to be addressed during the inquest hearing.

[14] Sometimes known as a “sufficient interest” letter.

40. It is the role of Counsel Assisting to call, and to conduct the primary examination of all witnesses on behalf of the Coroner. No one else (apart from the Coroner) is entitled to call a witness (although a person granted leave to appear may *apply* to the Coroner under s.60, to have a particular witness called and examined). But even if such an application is granted, it will be Counsel Assisting who will call and examine the witness (at least initially). In many cases, if sufficient notice is given, agreement can be reached with Counsel Assisting (who will consult with the Coroner) for the additional witness to be called.

41. As the inquest is an investigation, with no "parties" as such, lawyers appearing for an interested person do not have an "entitlement" to tender evidence, or to make a "call" for a document. The correct procedure for tendering a document (or other proposed exhibit) is to hand it to Counsel Assisting (at a convenient time beforehand) and invite Counsel Assisting to tender it. Similarly, if subpoenas to obtain further evidence are thought necessary, this should be raised as soon as possible with Counsel Assisting (because, being an investigation with no "parties", the issuing of subpoenas is a matter for the Coroner). If Counsel Assisting refuses a reasonable request (eg. to tender a document or to have a subpoena issued) then of course you might need to raise the issue formally with the Coroner.

42. As the rules of procedure and evidence do not apply in Coronial proceedings (s.58(1)), the examination of a witness will usually involve leading (as in cross-examination) and non-leading questions. Because the inquest is an investigation by the Coroner, it is the expectation that (ideally) all relevant questions will be asked by Counsel Assisting the Coroner (although of course Coroners will themselves frequently ask questions too).

43. Another aspect of inquests (which distinguishes them from ordinary court proceedings) is that Counsel Assisting will usually consult with the Coroner (ex parte) at various times both before and during the hearing.

44. In cases where recommendations are being considered, it is common for Counsel Assisting to circulate (usually towards the end of the hearing) a draft of the proposed recommendations.

45. At the conclusion of the evidence, Counsel Assisting will make submissions first (sometimes in writing as well as orally) with the order of other addresses to be either agreed or directed.

The inquest hearing

46. As the Coroner's Court has a very large workload, it is common for hearings to be booked many months in advance, and to be listed for hearing on particular dates. If a hearing does not complete within the allocated days, then it usually will not "run on" – additional dates will have to be allocated.

47. Many inquest hearings are conducted at the Coroner's Court at Glebe or Parramatta. However it is also common for inquests to be held in courts out of Sydney – in or near the place where the death occurred (especially where most of the witnesses are located there, or where the death is of particular interest or concern to the local community).

48. A number of call overs and directions hearings will usually be conducted prior to the commencement of the formal hearing. These are intended to facilitate the giving of directions for service of the brief on interested persons, for interested persons to note their intention to seek leave to appear at the inquest, and to raise any preliminary issues, such as particular witnesses who might be called.

49. Under s.48, Coronial proceedings are conducted without a jury, unless the State Coroner directs it (being satisfied there are "sufficient reasons" to justify a jury). In practice, juries are very rare.

50. At the start of the hearing, the Coroner will often commence by making some preliminary comments to family members who are present. This part of the process is an acknowledgement of the special vulnerability and distress likely to be felt by members of a deceased person's family.

51. The Coroner will then take "appearances" – that is, hear and determine applications for leave to appear in person or to be represented by a legal practitioner (s.57(1)). Often, the identity of those who will be granted leave will have been sorted out at a directions hearing.

52. Counsel Assisting will usually present an opening address, outlining the facts uncovered by the investigation to date, and referring to the issues which are expected to be addressed in the inquest. As noted above, it is common for a List of issues to have been distributed some time before the hearing.

53. Counsel Assisting tenders the "formal documents" and they become an exhibit (eg "P79A Report Of Death To The Coroner"; Post Mortem (Autopsy) report; Identification statement; and any certificates of blood or tissue analysis). Counsel Assisting will then tender "the brief" (being the folder or folders of statements, photographs and other evidence gathered during the investigation). Most Coroners will have read the brief before the hearing commences.

54. Any objections to parts of the brief should be raised when it is tendered by Counsel Assisting and before it becomes an exhibit. The Coroner can then determine whether to hear the objection then and there or wait for a more appropriate point in time (eg when a particular witness is called). However, given that the rules of evidence do not apply (s.58(1)), taking objections to parts of the brief tends often to be the exception rather than the rule. This does not mean however, that objection should not be taken in an appropriate case. The focus of any such objections should not be on "technical admissibility" (which usually won't get you far), but on matters of

"relevance" (to the issues in the inquest) and to matters of procedural fairness. There is no doubt that a Coroner is required, when conducting an inquest, to comply with the requirements of procedural fairness (natural justice): Annetts v McCann (1990) 170 CLR 596; Musumeci v Attorney-General (2003) 140 A Crim R 376; [2003] NSWCA 77.

55. Counsel Assisting will then proceed to call witnesses, with the first witness commonly being the OIC. At the completion of questioning by Counsel Assisting, an opportunity is given to persons granted leave to appear to ask questions of each witness. Any questions must be restricted firstly, to the issues in the inquest (including any suggested recommendations), and secondly, must relate to the "interests" that the questioner represents. In other words, you are not entitled to cross examine "at large". Where a particular witness is legally represented, the usual practice is for the lawyer appearing for that person to "go last" if he or she wishes to ask any questions.

56. Another aspect of an inquest that differs from an ordinary court hearing is that witnesses are usually not asked to remain outside Court while other witnesses are giving evidence. While this is the general practice, s.74 does give the Coroner power to order any person (or all persons) to remain outside the Court. Sometimes, notwithstanding the usual practice, it may be appropriate for the Coroner to be asked to exercise this power during the evidence of a particular witness. Whether such an application is justified will depend on the circumstances, and whether the integrity of the inquest and the public interest require it.

57. The family of the deceased person has a right[15] to appear in the inquest: s.57(3). The family is always given a copy of the brief of evidence. Sometimes the family will be legally represented (often by a lawyer from the Coronial Advocacy Unit at Legal Aid). In cases where the family is not legally represented, they are often invited to inform Counsel Assisting of any questions or concerns, so that (where appropriate) those matters can be addressed in the evidence.

58. It is the practice in most inquests for the family to be invited to read (or to have read out) a statement of their feelings about the deceased and their death. Where this opportunity is taken up, such a statement usually is made at the completion of the evidence, sometimes before submissions commence. Such a statement should generally be restricted (as noted already) to "feelings about the deceased and their death", and should not be seen as an opportunity to traverse issues that should have been dealt with in evidence.

59. In complex inquests (especially those where manner and/or cause of death are in dispute, or where recommendations are being considered) it is common for the Coroner to "reserve" their decision and to publish Findings at a later date.

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[15] S.57(3) says that a Coroner must grant leave to a relative unless there are exceptional circumstances that justify refusing leave.

Appearing for a "person of sufficient interest"

60. As there are no "parties" in an inquest, a person wishing to take part in the inquest must make an application for leave to appear. Section 57(1) provides that the Coroner may grant leave if of the opinion that the person has a "sufficient interest" in the subject matter of the proceedings. As noted above, the Coroner must grant leave to a relative of the deceased (absent exceptional circumstances): s.57(3).

61. The Coroner (in consultation with Counsel Assisting) will identify, before the inquest hearing, the persons (or entities) who appear to have a sufficient interest in the subject matter of the proceedings. The main guiding principle is procedural fairness. If it is possible that the inquest (or participants in it) will criticize a person (or entity) or if it is possible that adverse findings might be made against them, then the Coroner will usually direct that a "sufficient interest letter" be sent to that person (or entity), informing them of the inquest: see s.54(1)(d). A "sufficient interest" letter might also be sent where, although a person or entity had no involvement with the deceased or the death, a recommendation is being considered which may affect their interests or area of operation (eg where consideration is being given to recommending an amendment of the Road Rules, or to introduce a new form of road signage, it might be appropriate to send a sufficient interest letter to Police and to the Roads & Maritime Service).

62. The sufficient interest letter informs the person or entity of the inquest, and of their ability to make an application for leave to appear, under s.57(1). Where leave to appear is to be sought, this can be facilitated by first contacting Counsel Assisting (or the instructing Solicitor if there is one, or the Coroner's Court) and by attending a call over or directions hearing, and requesting a copy of the brief of evidence. The sending of a "sufficient interest" letter to a person or entity does not mean, however, that the person/entity is obliged to make an application for leave to appear. As Coroners are bound by procedural fairness, a sufficient interest letter might sometimes have been sent out of abundant caution. Lawyers may sometimes be asked to provide advice on the question of whether to seek leave. This can be a difficult task if you have not seen the brief of evidence (which may not yet be complete). Making contact with Counsel Assisting is likely to assist in such cases, in providing a better idea of the likely issues to be considered in the inquest, and whether your client's interests require active participation, no participation, or perhaps attending the inquest on a "watching brief" basis.

63. As noted above (see par 26) sometimes a witness will be reluctant to provide a statement (or a comprehensive statement) to the OIC. While there is no obligation to give a statement, the witness might be advised that this makes it more likely that they will be called as a witness (and will spend longer in the witness box).

64. At the hearing, it is Counsel Assisting who has the primary task of examining all witnesses (including your client if they are to be called). Any questions asked by other Counsel must be relevant to the issues (including recommendations) that affect the interests of their client, and should not repeat questions already dealt with by Counsel Assisting.

65. The primary object in appearing for a person granted leave is traditionally described as a protective one. Your task is to protect your client from any unfairness, and to assist them (so far as you can) in responding to criticism, or to suggested recommendations. Many experienced advocates granted leave to appear in an inquest say very little and ask very few questions.

66. There are however, occasions where a more proactive approach is beneficial. At the end of an inquest, the Coroner will deliver "findings" in relation to (among other things) the manner and cause of death. These findings will sometimes be critical of the actions of individuals, organisations, policies and procedures etc. It is important therefore, for the client to give consideration, (long before the hearing if possible) to whether steps should be taken to amend systems, policies, procedures (etc) so as to improve safety, and reduce the possibility of a similar fatality occurring in the future. Taking this kind of action (and providing evidence of the action to the Coroner through Counsel Assisting before the hearing) may avoid, or ameliorate adverse findings that might otherwise be made about your client's actions.

67. Consideration might also be given (in a case where it is apparent that the death was caused or contributed to by some fault of the client) to making an "apology" to the family of the deceased. In NSW, an apology (even one that implies or admits fault) cannot be used as an admission in civil proceedings: see ss.68-69 Civil Liability Act 2002[16]. I have personally seen apologies made to (and appreciatively received by) families in open Court in more than one inquest. As was noted by Deputy State Coroner Hugh Dillon in a paper presented to the NSW Bar in 2010[17] *"There are different ways of protecting a client's interests…This provision recognises that conciliation is a healing process for all involved in a tragedy".*

68. There can be no single "best approach" to representing a client at inquest, as each case will turn upon its circumstances, and each case will involve a balancing of risks. As noted above, it is a good idea to make contact, and to maintain contact, with Counsel Assisting, as this will provide you a better opportunity to be informed of the live issues in the inquest as it develops.

69. One of the risks to be assessed when appearing in an inquest is how to advise the client before they give evidence (if they are to be called). Section 58(2) provides that (subject to other provisions in the Act) a witness cannot be

[16] An interesting question that might arise, however, is whether an apology made in NSW might be capable of being used as evidence in another state (or country). This might be a relevant question for a manufacturer which markets a product in various places.

[17] "The roles of counsel in the Coronial Jurisdiction – A paper for the NSW Bar 7 Sep 2010"

compelled to answer a question or produce a document that might tend to incriminate them, or render them liable to a civil penalty. This provision however, is subject to s.61, which empowers a Coroner to compel a witness to give evidence if the Coroner is satisfied that the interests of justice require it, and giving the evidence will not render the witness liable to a criminal offence or civil penalty under a law of a *foreign country*. This is colloquially known as "giving the witness a certificate". Section 61 might be regarded as the Coronial version (in a different form) of s.128 of the (NSW) Evidence Act 1995 (given that the Evidence Act does not apply in the Coroner's Court: Decker v State Coroner [1999] NSWSC 369; 46 NSWLR 415).

70. Advising a client on whether to object to giving evidence (and whether to seek a s.61 certificate) will depend on the circumstances, and will involve an assessment of risk to the client's interests.

71. It is always important however, to explain to the witness the process of giving evidence. Many (if not most) witnesses called to give evidence in an inquest will have no experience in giving evidence in court, and will usually be very nervous. As with any witness, it is wise to tell them to listen closely to the question, and to answer that question, as shortly and as directly as possible. Although the particular advice to be given to a witness will depend on the circumstances, there will be cases where the evidence makes it obvious that the witness has committed an error or oversight, has failed to comply with procedures, or has fallen below an acceptable standard in some other way. In these cases, it may be in the interests of the witness for some "frank" advice to be given, pointing out to them (if it is justified) that on the objective facts, their conduct is likely to be the subject of adverse comment. A witness who admits an obvious error is far more likely to receive an "easier" time in the witness box, and may avoid strong criticism in the Coroner's findings. Such a witness is more likely to impress as one who is prepared to acknowledge a mistake, and to learn from it. Of course, the witness might, in some cases, have grounds to seek a certificate under s.61.

72. Special circumstances might apply in the case of professional persons who are called to give evidence. Although they may be entitled to take the objection to giving evidence, this might not be a "good look" for them professionally. As Chester Porter QC observed in a 1993 paper[18] - *"…a doctor who refuses to describe how an operation was performed…*(might expect that this will) *…subject them to considerable criticism within their professional calling…"*

73. When appearing for a professional person (eg a medical practitioner) it is also important to consider whether there might be grounds for the Coroner to refer his or her findings to a disciplinary body (such as the Health Care Complaints Commission). If there may be grounds for such a referral, then this will be another factor to be taken into account when advising the client about giving evidence (and whether to take the objection under s.58 and seek

[18] "Appearing at a Coronial inquest: The Functions of an Advocate" – quoted in Waller at p.49.

a s.61 certificate). The approach to each case involves a "judgment call" by the client, after receiving advice of the available options. However there are likely to be cases where a witness will avoid an adverse finding (and a referral to the HCCC etc) by making frank admissions of a failure or shortcoming, and giving evidence which demonstrates that they are ordinarily a trustworthy and competent practitioner, who has learned from an unfortunate mistake (see also the comments above in relation to making an "apology").

74. Sometimes (despite the general protection of s.58(2)), a Coroner will compel a witness, under s.61(4), to give evidence. This power can be exercised where the Coroner is satisfied that it is in the interests of justice to do so. Such certificates are not readily given to "persons of interest" in homicide cases (see discussion below under this topic). However, different considerations apply where (for example) a police officer takes objection to giving evidence about a shooting death of a civilian (see Rich v Attorney-General of NSW [2013] NSWCA 419). In cases of that kind, the Coroner may take the view that there is a public interest in a police officer who is permitted to carry a firearm explaining his or her actions.

75. One area of contention is whether a witness is entitled to take a "global objection" to being compelled under s.61(4) to answer *any* questions that might tend to incriminate or render them liable to a civil penalty, or whether the objection needs to be taken and ruled upon question by question. In the Court of Appeal decision in Rich v Attorney-General (above) doubt was expressed (at [46]) as to whether a "global" objection was permitted by the terms of s.61(1), which refers to objection to "particular" evidence. The Court of Appeal however did not have to finally decide this question (see [47]). In Decker v State Coroner [1999] NSWSC 369; 46 NSWLR 415 - Adams J also (at [2]) observed[19] that "…*in general, the objection should be taken to each question as it is asked to enable the court to determine whether it be appropriately taken…"* (his Honour then went on to observe that the course of action taken by the Coroner in standing the witness down, after concluding that *any* question was likely to incriminate him was *"not inappropriate having regard to the nature of coronial inquiries…"*). The safer course therefore (for a witness who is required to give evidence under s.61) might be to take particular objection to each question, depending upon what it asks.

76. The media often takes great interest in inquests (no doubt because of their tragic and often sensational circumstances). Journalists will frequently be present in court, and cameras will often be seen outside and in the vicinity of the court (especially on the first day). It is wise to inform a client of this possibility and of the chances that they may be named, and possibly filmed or photographed. Although the general principle is that inquests are open to the public (s.47, s.74(2)(a)), consideration might be given to whether there is a

[19] In relation to s.33 of the (repealed) Coroners Act 1980, which contained the protection from self-incrimination (etc).

proper basis to seek a non-publication order under s.74 in relation to particular evidence or particular individuals.

77. Keep in mind that specialised grief counsellors and other support services are available through the Coroner's Court to assist family and other persons experiencing emotional trauma associated with a death. In an appropriate case, arrangements might even be made for a counsellor to accompany a person or witness in Court.

78. There can be no "one size fits all" approach to appearing for an interested person at inquest. However, Counsel who embraces the issues likely to be raised in an inquest, and who works to advise and assist the client to deal with them in a proactive and cooperative manner, (rather than sticking their head in the sand both before and during the inquest), is more likely to achieve a satisfactory outcome, both for the client, and for others.

Appearing for a "person of interest"

79. The term "person of interest" is to be contrasted with "person of *sufficient* interest" (already considered above). The term "person of interest" (or POI) is normally used to refer to a person whose actions / inactions (amounting to an indictable offence) caused, or may have caused, the death. The term is most commonly applied in homicide cases.

80. A Coroner, when making findings, is not permitted to indicate or in any way suggest that an offence has been committed by any person: s.81(3). This provision is aimed at protecting the rights of a person suspected or accused of committing an offence (given that Coronial findings are not subject to the rules of evidence, and do not involve proof beyond reasonable doubt). See also s.74(1)(c) which permits a non-publication order to be made with respect to any submissions concerning whether a "known person" may have committed an indictable offence.

81. In addition, s.78(1)(a) requires that a Coroner suspend an inquest where indictable charges concerning the death have been laid. The Coroner is however, permitted to commence the inquest and take evidence to establish the fact of death, and the identity, date and place of death: s.78(2)(a). Section 78(1)(b) applies if the Coroner forms the opinion that there is a reasonable prospect that a "known person" would be convicted of an indictable offence which raises the issue of whether that person caused the death. Where the Coroner forms that opinion (at any stage of the proceedings) the Coroner can continue the inquest and record findings under s.81(1), or suspend the inquest. In many cases however, it is common for the Coroner to suspend the inquest once "the opinion"[20] is formed. The Coroner is then required to forward to the DPP a copy of the depositions, and a statement specifying the

[20] It has been said that this refers to a "final" rather than a provisional opinion, although there may be cases where the formation of the opinion becomes almost inevitable at an early stage: Young J in Musumeci (above) at [102].

name of the "known person": s.78(4). The DPP will then consider whether or not to lay charges. Section 79 sets out the circumstances in which a suspended inquest (or an inquest which has not been commenced, because of the operation of s.78) can be resumed or commenced.

82. In inquests where there is a "POI" (or more than one) it is usual for that witness to be called (if they are to be called) as the last witness. As already noted, a witness called in an inquest is entitled to object to giving evidence which might incriminate, or render the witness liable to a civil penalty: s.58(2). An advocate appearing for a POI would no doubt wish to advise the client about this provision, so that an informed decision can be made.

83. As discussed above, it is possible in some circumstances for a witness to be "compelled" by the Coroner to give evidence (under the protection of a certificate): s.61(4). In practice however, it would be unusual for a POI in a suspected murder or manslaughter case to be granted a certificate by a Coroner, where objection is taken by the witness under s.58(2). That is because compelling the witness to give evidence under the protection of a certificate might prejudice any future prosecution: s.61(7)(b) provides that any evidence obtained, even as an *indirect* consequence of evidence given under a s.61 certificate cannot be used in a NSW Court. Therefore, if a witness is forced to give incriminating evidence, and is later charged with an offence, problems are likely to be faced by the Prosecution in seeking to disprove that the evidence was not obtained as a direct or *indirect* consequence of the person having given evidence under compulsion. In practice therefore, where a POI is placed on the list of witnesses to be called by Counsel Assisting, the questioning of that witness (if objection is taken under s.58(2)) is in most cases likely to be short. In Correll v Attorney-General (NSW) [2007] NSWSC 1385; 180 A Crim R 212, the Plaintiff, who was the prime suspect in an alleged murder, sought to challenge a Coroner's rulings in relation to self-incrimination. This case is useful because it provides an indication of the scope of evidence which might have a "tendency to incriminate". Bell J said (at [36]) that even the answer to the question "*Did you know* (the deceased)?" may have had a tendency to incriminate. At [45] her Honour also said – "*It is with respect difficult to see how answers by a person who is a prime suspect for the offence of murder concerning his movements in the period surrounding the death of the victim may not possess a tendency to incriminate".*

84. The granting of a s.61 certificate might however be more likely where a witness takes the objection in relation to some peripheral offence (not related to the death). Note the comments above as to taking a "global" objection, or objection to "particular" questions, and the Court of Appeal decision in Rich v Attorney-General.

Finally

85. Finally, but very importantly. Inquests always involve, by their very nature, traumatic and tragic (and sometimes violent and gruesome) events. For the family of the deceased, this is not just another court case. It is their

opportunity (although an emotional and difficult one) to address concerns and questions about a tragic death of a loved one. It is a time of re-visiting or visiting for the first time many (often private) aspects of the life of the deceased. In addition, in many inquests there will be others (friends, by-standers, doctors, nurses, police, child-care workers) who have suffered (or are suffering) emotional trauma as a result of the death, or the questions and issues flowing from it. This should not be forgotten.

86. When appearing in an inquest, we as lawyers should always act in a manner that pays respect to the special vulnerability of family members and others who may have been affected by the death. This applies not only to the manner of asking questions and making submissions (courteously and respectfully) but also to our conversations and actions while simply waiting in or around court.

87. Inquests can be quite cathartic for family members and others who have been traumatised by a death. The process of a public ventilation of issues, and answering (at least some) of the family's questions seems to have a healing effect in many cases. We as lawyers have a responsibility, when appearing in Coronial proceedings, not only to assist our clients, but also to act in a professional and compassionate manner which promotes the administration of justice - of which Coronial inquests are an extremely important part.

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[21] I acknowledge the assistance provided by the following articles and texts: (1) Waller's Coronial Law & Practice in NSW (4th Ed) Abernethy, Baker, Dillon & Roberts (Lexis Nexis 2010); (2) "The roles of counsel in the Coronial jurisdiction – A paper for the NSW Bar 7 Sep 2010" by Deputy State Coroner Hugh Dillon; (3) "Coronial Law and Practice in NSW – A Practical Guide for Legal Practitioners" – Deputy State Coroner Dorelle Pinch (Revised 19 August 2005)

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