THE CORONER'S EXERCISE OF DISCRETION: ARE GUIDELINES NEEDED?

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I Introduction

This article discusses an inquest into the tragic death of a 78 year old Indigenous man, who died in August 2006 after he was left at an airstrip at Kalkarindji in the Northern Territory. The man – who, in accordance with family wishes not to name him, will be referred to as the Elder – had been instrumental in the Wave Hill walk-off, the famous 1966 strike involving Gurindji stockmen, house servants and their families who 'walked off' Wave Hill cattle station demanding the return of their land and protesting against the work and living conditions on the station. In about May 2007, pursuant to the provisions of the *Coroners Act* (NT), the Coroner decided to hold an inquest into the death of the Elder, with the inquest taking place on 13 to 16 November 2007 and 15 to 16 April 2008. The family of the Elder appeared at the inquest.[1]

Not surprisingly, the family found the experience of the inquest traumatic. The Coroner, in several instances, exercised her discretion contrary to the family's wishes, without giving any reasons as to why she had not exercised her discretion in their favour. This distressed the family and also affected the way the family perceived the inquest process and its adequacy.[2] Under s 41(d) of the *Coroners Act* (NT), coroners are afforded a very broad discretionary power to make directions and do anything that they think fit for the purpose of an inquest. While there were a number of instances in the inquest into the Elder's death where the Coroner's exercise of discretion distressed the family, this article will discuss only two in detail: the first concerned the location of the inquest and the second related to the interpreter at the inquest. I have chosen these two instances to discuss in greater detail because the decisions made in those instances were the ones that most greatly affected the family.

In the first part of this article, I give some details about the Elder's life and summarise the circumstances surrounding his death. I then go on to discuss in the second part of the article how the ways in which the Coroner exercised her discretion impacted upon the family (and the broader community in some respects), and indicate how I consider the Coroner should have exercised her discretion in the circumstances of the case. In the third part of the article I argue that there is a clear need for guidelines to be implemented in relation to the manner in which coroners exercise their discretion in respect of matters such as the location of an inquest and the use of interpreters during an inquest, especially where there has been a specific request from the family that the discretion be exercised in a particular way. I also outline some matters I consider should be included in those guidelines. The final part of the article outlines the submissions of the family in relation to the relevant circumstances concerning the death of the Elder and the recommendations that the family requested the Coroner make to the Attorney-General. I compare those submissions and recommendations to the Coroner's findings and recommendations.

II Background

On 11 August 2006, the Elder, who lived in the remote community of Daguragu, approximately 550 kilometres south west of Darwin in the Northern Territory, became ill with pneumonia. As already noted, the Elder had been

involved in the Wave Hill walk-off – he was the eldest of only three surviving men who participated in the walk-off. He was partially deaf and blind and did not speak very much English. He was also, in the words of his nieces:

> an important law, ceremony and medicine man in the business of our people, known in communities from Yuendumu to Yaralin. He was a wise man, a knowledge man and a teacher. He was known for his cleverness, his great sense of humour, his cheeky reactions. The government authorities stole his sister, our mother, from his family when she was 6 years old but he was there to tell her that her family had never forgotten her when she found them more than 50 years later. In his working life he had been an accomplished horseman. His limp was the result of a broken hip and ankle not properly corrected. He had been a slave to a master and he had struggled against that system for the rights of his people. He had been one of those who had fought to be paid the same wage as white stockmen for the same work.[3]

According to another member of the Elder's community, he:

> meant a lot to [the Daguragu and Kalkarindji communities]. He was a respected person. He was an important figure for men's business. He was one of the people with all of the stories and all of the culture. When he passed on, he took with him our tribal ceremony song, and all that goes with it.[4]

After the Elder became ill, his family took him to the local medical clinic in the nearby community of Kalkarindji. The doctor on duty examined the Elder and decided that he needed to be evacuated to Katherine Hospital as his condition was too serious to be treated at the clinic. The Elder's daughter had her bag packed ready to accompany the Elder to Katherine. The evacuation was not completed before that doctor went off duty at about 4:30 pm.

At 7:00 pm that night, another doctor, Dr Buchanan, commenced her shift as the District Medical Officer for the clinic. She was on call from her home in Perth. The nurse on duty at the clinic told Dr Buchanan that the Elder needed an escort because he was frail and elderly, and that his family had someone ready to go with him. Despite having had no direct contact with the Elder, the doctor ignored the nurse's advice and decided that the Elder did not need an escort to accompany him to Katherine. No one explained to the Elder's family why he was not allowed to have an escort.

The Elder was flown to Katherine in the early hours of 12 August 2006. The Elder had only been to Katherine two other times in his life. One of those times was a previous hospital visit, when he had been accompanied by his wife. On arrival at Katherine Hospital[5] the Elder was assessed and admitted. An interpreter was not used. The Elder remained at the hospital receiving treatment until 18 August 2006. Not once during his stay was an interpreter brought to the hospital to explain to the Elder what was happening to him. None of his treating doctors assessed whether he needed an escort to stay with him while he was in hospital.

On 18 August 2006 a doctor decided that the Elder was well enough to go back to his community. That day was Freedom Day, the 40th anniversary of the Wave Hill walk-off. A nurse contacted the hospital's Patient Assistance Travel Scheme ('PATS')[6] department and asked a patient travel clerk to arrange the Elder's travel back home.

There were no flights available for the Elder to travel back to his community on 18 August 2006, so the patient travel clerk arranged a flight for 21 August 2006. The patient travel clerk said that she acted in accordance with PATS procedure and sent a fax to the Kalkarindji clinic stating that the Elder was going to return to the community on 21 August 2006. No one at the clinic ever saw the fax and it has never been found.

In the afternoon of 21 August, the Elder was taken to Tindal airport, just outside of Katherine, and boarded an Aboriginal Air Services plane with several other passengers. The pilot flew to Yarralin (a community on the way to Kalkarindji) first, and then to Kalkarindji. When they reached Kalkarindji, the pilot helped the Elder off the plane and escorted him to a shelter just outside the gate to the airstrip. The pilot then went back to his plane and flew off, leaving the Elder at the shelter. No one went to collect the Elder.

Four days later, on 24 August, the police were notified that the Elder was missing. With the assistance of some community members, the police searched the area in the vicinity of the airstrip by foot, motorbike and helicopter for four days. The Elder was not found. On 28 August the police called off the search.

Three members of the community decided to search for the Elder themselves. Later that same day they found the body of the Elder. He was only 800 metres from the airstrip.

III The Coroner's Exercise of Discretion

While a more detailed discussion of two specific exercises of discretion by the Coroner is given below, there were a number of other instances where the Coroner exercised her discretion in a way that, although open to her and not improper, distressed the Elder's family. This was because it was not clear to them whether the Coroner had taken into account their concerns, or for what reasons the Coroner decided not to exercise her discretion in their favour, as reasons were not provided to the family. These included:

- the Coroner's refusal or failure to provide the Elder's family with various documents referred to both in the inquest brief and by witnesses during the giving of their evidence, despite the family's repeated requests;[7]
- the Coroner's acceptance into evidence of, without inviting submissions from the family as to the relevance of and weight to be attributed to, a report into the Elder's death that had been commissioned by the Katherine West Health Board and the Northern Territory Department of Health, notwithstanding the family raising concerns with the Coroner about the report's relevance and independence;[8]
- the Coroner's rejection of the family's requests[9] for further investigations into relevant matters that had not been fully explored or explored at all (eg, the existence of guidelines for District Medical Officers, records of plane arrivals at the Kalkarindji community);
- the Coroner's failure to call as witnesses the police who conducted the search for the Elder, despite the Coroner initially accepting the family's request that these witnesses be called in order to ascertain the adequacy of the search;[10] and
- the Coroner's refusal, without giving reasons, of some of the family's requests[11] for additional witnesses to be called.

I now turn to the two exercises of discretion by the Coroner that had the most distressing and substantial impact on the family.

A Location of the Inquest Hearing

1 How the Coroner Exercised Her Discretion

The issue of what was the appropriate location for the inquest first arose in May 2007. At that time, the Coroner[12] advised the family[13] that the inquest would be held between 13 and 16 November 2007 in Katherine. The family of the Elder wanted the inquest to be held in Kalkarindji because they considered that:

- it would be respectful to the Elder and to his family, and would serve as a recognition of the status and importance of the Elder in the community;
- Kalkarindji was the place where he had passed away;
- it would enable the family and the rest of the community to attend the hearing and, where relevant, give evidence;
- it would give the family and the rest of the community a chance to say their personal goodbyes to the Elder and gain closure;
- it would be in the interests of justice and good public policy.

The family therefore formally requested that, at the very least, two days of the inquest be held in Kalkarindji.[14] The family indicated that they were very keen for this to occur.

In June 2007 the Coroner advised the family that only the first day of the inquest would be held in Kalkarindji and gave no reasons why it was not possible for at least two days of the inquest to be held in Kalkarindji.[15] On 25 October 2007 I telephoned the Coroner's office and also sent an email to the Coroner's office, requesting a return telephone call. I did not receive a return telephone call. The following day I telephoned Counsel Assisting the Coroner to discuss the logistics of the inquest. I indicated that the family and the community preferred the inquest to be held in Kalkarindji and that it was more respectful for the community for the inquest to be held in Kalkarindji. I was informed that the matter required further consideration. The family then again requested that the Coroner hold a minimum of two days of the inquest in Kalkarindji, while still indicating that the preference was for the whole of the inquest be held in Kalkarindji.[16] The Coroner did not respond to the family's request.

Approximately a month later, on 30 November 2007, I telephoned Counsel Assisting the Coroner, again to discuss the logistics of the inquest, and advised him that it was not going to be possible for the family to travel overnight from Kalkarindji to Katherine. The family then sent a further letter to the Coroner stating:

> We note that 75 per cent of the inquest is to be held in Katherine. We find this disappointing, particularly given that the old man died in Kalkarindji, his family lives in Kalkarindji and that the broader community in Kalkarindji has an interest in the outcome of the inquest. We consider that in terms of providing access to justice and for public policy reasons it would be more appropriate for at least half of the inquest to be held in Kalkarindji.[17]

The Coroner did not respond to this letter. In the end, only the first day of the inquest (13 November 2007) was held in Kalkarindji. The remainder of the inquest was held in Katherine.[18]

2 Impact on the Family

The Coroner's decision not to hold the entire inquest in Kalkarindji had a significant impact on the family. As the family wanted to attend the whole of the inquest, they were forced to travel from their home and the place where they felt most comfortable to Katherine. The logistics of transporting the family and community members, along with their legal representatives and an interpreter, from Kalkarindji to Katherine by road overnight (bearing in mind that the journey by road takes in excess of five hours) posed no mean feat. The family had no means of road transport and could not afford to charter a plane to Katherine. In addition, the family did not have any accommodation in Katherine. As things transpired, the North Australian Aboriginal Justice Agency ('NAAJA') chartered a bus, found a bus driver and arranged accommodation. NAAJA is a legal aid organisation with limited funding, and it is subject also to restrictions with regard to its funding arrangements. NAAJA was required to bear the costs of the travel, accommodation and all incidentals, such as food, which added up to a substantial amount.

The family could not understand the Coroner's decision not to hold the inquest in Kalkarindji and, further, could not understand why she had not even provided them with responses to their requests or explained to them why the inquest could not be held in Kalkarindji. They pointed out to me that they had travelled over six hours on a bus, without air-conditioning, in high temperatures, just to be present at the inquest, while the Coroner had flown on a plane and had no idea what the journey to Katherine had been like for them.

The family was also unhappy that the people from the Daguragu and Kalkarindji communities were not able to watch the 'Coroner's business'. They also felt that some members of the community were not given sufficient opportunity to present their views on what had happened to the Elder to the Coroner because they were not in the community on the first day of the inquest and were not able to travel to Katherine to be present for the remainder.[19]

3 Comments

I consider that, in the circumstances of this case, the Coroner should have held the inquest into the Elder's death in Kalkarindji.[20] There may have been good reasons behind the Coroner's decision not to do so, and the Coroner probably took various considerations, such as availability of accommodation and the location of the other witnesses, into account in making her decision. However, those reasons and considerations were never communicated to the family. Consequently, the family was left wondering whether the Coroner had even considered their request and, if their request was considered, what factors the Coroner had regard to in making her decision and what weight she gave to those factors. The family was offended by what they thought was a failure by the Coroner to communicate adequately with them.

B Interpreter in the Inquest

1 How the Coroner Exercised Her Discretion

Shortly prior to the inquest, the family contacted the Coroner to ascertain the identity of the interpreter the Coroner had organised to be present at the inquest, and to confirm that the interpreter spoke the correct language. Two family members were going to be giving evidence, and the family had presumed that the Coroner would organise an interpreter for them[21] so that they could give their evidence in their native language, Gurindji. The family also thought that the interpreter would then be present in the room in order to translate the proceedings for them. However, the family was informed that no interpreter had been arranged and, in fact, no thought had been given to the need for an interpreter.

In a letter to the Coroner, the family stated:

> As a courtesy to the Coroner, we confirm that we will organise for an interpreter fluent in the Gurindji language (the language spoken in the Kalkarindji area) to be present

> at the inquest. However, we consider it the responsibility of the Coroner's office to pay for and transport the interpreter ... [We request that you] provide us with confirmation that the Coroner's office will pay for the interpreter and arrange his or her transportation.[22]

Following this letter, the Coroner advised the family that an interpreter had been organised for the inquest. However, the Coroner later advised the family that funding for an interpreter would only be supplied for the first day of the inquest, as the Coroner considered that that was the only day an interpreter would be required.

It came to the family's attention, after several inquiries with the Katherine Language Centre, that the Coroner had not confirmed with the Centre that an interpreter was needed for the inquest. An email to the Coroner sent on 9 November 2007 stated:

> Can you please confirm you actually have an interpreter booked for Tuesday who speaks the Gurindji language and who that person is? We were told yesterday by the Language Centre that an interpreter has not yet been found.[23]

The Coroner did not respond.

On the first day of the inquest an interpreter was present. Counsel Assisting advised the Coroner that: 'It seems that four of our witnesses ... from what I could detect they're more comfortable in Gurindji and ... we do have an interpreter here and she can interpret as and when necessary.'[24] The first witness called to give evidence was the Elder's son. Counsel for the family requested that the interpreter assist the Elder's son to give his evidence. As the interpreter began translating the questions, it became clear that the interpreter was not speaking in Gurindji.[25] Counsel for the family confirmed this with the interpreter. The interpreter that the Coroner had organised was a Kriol speaker,[26] whereas the witnesses the interpreter was translating for were Gurindji speakers.

2 Impact on the Family

The family was disappointed by the Coroner's decision to fund an interpreter for only the first day of the inquest. Given that the family's main language is Gurindji and the proceedings were conducted in English, there was the potential for the family to not fully understand what was happening. The family felt, rightly or wrongly, that the Coroner was in a better position to bear the cost of an interpreter than they were. Ultimately, the family did arrange its own interpreter for the inquest.[27]

The family's feelings were compounded when it transpired that the Coroner had arranged a Kriol interpreter rather than a Gurindji interpreter. Although the Elder's son, who understands some Kriol, was able to give his evidence with the assistance of the Kriol translator, that process was not an easy one. The Elder's son had to try to translate the questions from Kriol into Gurindji in order to understand them, and he would then have to translate his answers from Gurindji to Kriol. The family felt that having an interpreter in the wrong language meant that there was the potential for the evidence being given to be distorted. In addition, they felt that it showed a lack of understanding of the need to ensure that the correct interpreter for the particular circumstances is chosen.

3 Comments

I respectfully submit that, in the circumstances of this case, the Coroner should have funded an interpreter for the family for the duration of the inquest in order to ensure that they understood the proceedings. In addition, the Coroner should have ensured that the interpreter that was ultimately chosen was able to speak the correct language. Again, there may have been good reasons behind the Coroner's decision not to make an order that the Court fund an interpreter for the family and to provide a Kriol interpreter, and the Coroner probably took various considerations, such as the cost and availability of the interpreters, into account in making her decisions. However, those reasons and considerations were never communicated to the family.

IV Guidelines

A The Need for Guidelines

I respectfully submit that the family's experience of the inquest could have been less traumatic had the Coroner exercised her discretionary powers in the manner requested by them or, alternatively, provided the family with a formal response outlining the reasons why she was not prepared to exercise her discretion as requested by them. I therefore consider that, in order to avoid similar situations arising in the future, there is a need for guidelines to be implemented in relation to how the coroner should exercise his or her discretion in relation

to particular aspects of the coronial inquest procedure. These include, but are not limited to, the location of an inquest and the use of interpreters during an inquest.

Guidelines would also be beneficial for other reasons. First of all, they would improve consistency in coroners' exercise of their discretionary powers, which in turn would lead to greater transparency. Additionally, they would give family members of the deceased in coronial inquests a greater idea about how the inquest will run and how their requests will be determined.

B Content of Guidelines

In my respectful opinion, guidelines for coroners in relation to the exercise of their discretion should contain a general guideline to the effect that, where the family requests that the coroner exercise his or her discretion in a particular manner, it is the coroner's responsibility to give serious consideration to the request and, where possible, grant the request, provided that the request is reasonable and made with good reason. Furthermore, the guideline should stipulate that, in the event that the coroner determines not to grant the request, the family must be given clear reasons why their request will not be granted.

For Indigenous Australians, the land and community where they live is particularly important, as it represents the core of their spirituality and is fundamental to their wellbeing. I therefore consider that, in relation to the location of the inquest into the death of an Indigenous person, the following matters should be contained within the guidelines:

(a) preference should be given to holding the whole of an inquest in the community of the person who has passed away.

(b) if, in the exercise of his or her discretion, the coroner determines that it is not possible for the whole of an inquest to be held in the community of the person who has passed away, the coroner must consider and weigh up the following factors:

- the location of the other witnesses and the availability of telephone and video conference facilities;
- availability of accommodation;
- what travel arrangements the family will need to arrange in order to be present at the inquest;
- the broader community interest in the inquest; and
- the interests of justice and any relevant matters of public policy.

(c) if it is not possible for the whole of the inquest to be held in the community of the person who has passed away, then some of the inquest should be held at that place, and the coroner should explain to the family, either in writing before the commencement of the inquest, or orally at the beginning of the inquest, why the coroner determined that it was not possible for the whole of the inquest to be held at that place.

I consider that the above guidelines strike an acceptable balance between ensuring that the needs and wishes of the family and broader community are met and the practical considerations.

In my opinion, it is in the interests of justice to allow all witnesses at a coronial inquest to speak with the aid of an interpreter if English is not their first language. The coroner should therefore exercise his or her discretion to allow an interpreter for all such witnesses. A rudimentary understanding of the English language may not be sufficient to allow a witness to fully comprehend the questions he or she is asked and form the necessary response. There is a wealth of evidence available in support of this submission[28] that makes it, in my respectful opinion, entirely unacceptable for a coroner to refuse an interpreter for a witness whose first language is not English.

I therefore consider that it would be appropriate to include the statements to the following effect in guidelines for coroners as to the exercise of their discretion:

- when requested to do so, the coroner must, unless it is impractical or impossible to do so, provide an interpreter for a witness in the language requested by that witness;
- when requested to do so, the coroner must, unless it is impractical or impossible to do so, provide an interpreter for the family of the person whose death is being investigated, in the language requested by the family; and
- if the coroner determines that it is impractical or impossible to provide an interpreter in either of the circumstances mentioned above, the coroner must

> explain to the witness or family, in writing before the commencement of the inquest, why the coroner determined that it was impractical or impossible to provide an interpreter.

While I do not outline a complete set of guidelines in this article, in my opinion a complete set of guidelines would need to make provision for other matters that coroners are required to exercise their discretion in relation to. These matters include the entitlement of families and other interested parties to receive copies of relevant documents, and requests by families and other interested parties that certain documents be produced to the coroner for his or her consideration.

V Submissions, Recommendations and Findings

A Relevant Circumstances Concerning the Death

The family submitted to the Coroner that each of the following circumstances directly related and contributed to the death of the Elder.

1 Failure to Provide an Escort

The Elder satisfied the PATS guidelines for receipt of an escort and was therefore entitled to receive an escort on three separate occasions: when he was flown from Kalkarindji to Katherine Hospital; when he was in Katherine Hospital receiving treatment; and when he was discharged from Katherine Hospital and flown to the Kalkarindji community.[29] Despite the Elder's entitlement to receive an escort in those three situations, none was provided. Dr Buchanan overrode the nurse's recommendation and advocacy in favour of an escort for the Elder.[30] Despite his entitlement to receive an escort on three separate occasions, the Elder was not properly assessed in relation to his need for an escort at any time.[31]

In relation to the provision of an escort, the Coroner found that the Elder, by virtue of his age, frailty, deafness and language difficulties, undoubtedly qualified under the PATS guidelines for an escort. There was, however, confusion as to the guidelines' operation, the Coroner noted. She stated:

> [The Elder] should have been accompanied by an escort for his safe transport and hospitalisation. That need should have been met on transfer out of his community but could also have been identified and met either during hospitalisation or on discharge. ... It would have been appropriate for the Clinic at Kalkaringi to follow up to the escort situation the following day and it would be, in my view, good practice for the Clinic to have in place a system for escort review when patient transfers have occurred out of hours to ensure that if an escort was warranted and for some reason did not eventuate, that further steps then be taken to advocate for an escort for hospitalisation and/or repatriation.[32]

The Coroner noted that the Elder's stepdaughter would have been a suitable escort, and that she was 'deeply distressed that she had been unable to fulfil her role of caring for her stepfather during his illness and treatment and assist his safe return'.[33]

2 Failure by Pilot to Make Contact

In his evidence, the pilot conceded that he could have used his CDMA telephone to contact the PATS department at Katherine Hospital, the Kalkarindji clinic or the Daguragu Community Council to advise that the Indigenous Elder had arrived back in the community.[34] In relation to the pilot, the Coroner found the following:

> [The pilot] knew the distance from the airstrip to Kalkaringi. He had a phone and the telephone number of the Clinic. It was still early afternoon when staff would have been present. There could not have been any anxiety about the need to take off because of failing light. It may not have been part of his contractual obligations to ensure that passengers were picked up and it may have been that he had been directed by his employer to do nothing other than his flight duties. It may be that he assumed that as there had never been a problem in the past, someone would eventually arrive to pick up [the Elder]. However his actions in simply depositing an elderly frail man returned from a hospitalisation at the most basic of facilities at the airstrip when he might just as easily make a quick call to the Clinic or to the Patient Travel Office in Katherine, lacked the most basic element of human compassion. [The Elder] was not a parcel to be deposited for someone to collect. Respect for his age and situation, would it may be hoped have caused most people to make that call to assist him. That telephone call to the Clinic would almost certainly have altered the outcome for [the Elder]. It was not an omission that caused his death, but it might well have prevented it.[35]

3 Police Search and Date of Death

The Elder's body was found on Monday 28 August 2006. Between 24 August and 27 August helicopter searches passed directly over the place where the Elder's body was found, and foot searches passed close to, and apparently within eyesight of, the place where the Elder's body was found. The country where he was found was relatively open and the Elder's clothing was visible.[36] There was no evidence before the Coroner challenging the integrity of the police search. Counsel Assisting the Coroner called no evidence to suggest that those people involved in the search could have, but failed to, see the Elder at the place where his body was found. Therefore, the only conclusion is that, during the police search, the Elder was still alive and mobile, and was not in the location where he was ultimately found. There is evidence in support of the proposition that the Elder walked between five and 10 kilometres before he passed away and that he had died not more than three days before being found.[37] In line with this evidence, and the evidence of the police search, it was contended by the family that the Elder passed away either on 27 August or on a date unknown between 24 and 27 August. The family argued that any forensic evidence to the contrary, inconsistent with evidence of the police search, should be rejected. However, in her findings, the Coroner rejected this submission, stating:

> There is no support on the evidence for the proposition advanced by Counsel for the Family and I find that [the Elder] passed away no later than Wednesday evening 23 August 2006, which may be noted was prior to the search commencing.[38]

4 Patient Travel Facsimile Transmission to Kalkarindji

The family argued that there was insufficient evidence to establish that the Katherine Hospital PATS department notified the Kalkarindji clinic by facsimile transmission on Friday 19 August 2006 or at all about the planned return of the Elder to Kalkarindji. Furthermore, they argued that there was no evidence that anyone at the Kalkarindji clinic did any act, or omitted to do any act, that in any way contributed to the death of the Elder.

In relation to this matter, the Coroner found the following:

> The weight of the evidence supports the view that the fax was sent to Kalkaringi on 18 August 2006, advising of [the Elder's] travel on the Monday. Ms Sheals and the other staff at Patient Travel [at Katherine Hospital] had a very set routine as to how they arranged and advised of the travel. There is no reason why she would depart from these long established procedures on this occasion. Her evidence of sending the fax is supported by the records for those phone lines. No fault with the fax machine at Kalkaringi has been identified.
>
> The Clinic had a system for dealing with faxes that advised of return Patient Travel which may, at the least, be described as haphazard. ...
>
> The system for return Patient Travel was defective from the Hospital end as well. ... [T]he system of sending faxes to advise of travel relied on an assumption that one having been sent to a Clinic, that it would be received and acted upon. ...
>
> There was no system check to ensure that such communications had been received by Clinics. ... That the system had worked without fatal incident led to an assumption and complacency that the system worked well and efficiently but in truth, it was almost inevitable that what occurred with [the Elder] would happen at some point in time.[39]

5 Comments

In conclusion, the Coroner found that the Elder's death was a 'preventable death and a tragedy'.[40] I agree with this statement. The Coroner's findings generally support the proposition that the systems in place failed the Elder and led to his untimely death.

6 Recommendations

The family of the Elder requested that the Coroner make the following recommendations to the Attorney-General.

Recommendation 1: Increase Local Primary Health Care

In the family's view, the death of the Elder evidenced a need for an increase in health funding in the Kalkarindji and Daguragu communities. The family requested the Coroner recommend that the resources available for primary health care in the communities of Kalkarindji and Daguragu be increased.

The Coroner declined to make this recommendation on the basis that there was nothing before her to suggest that current funding levels were inadequate or that increased resources would have resulted in a different outcome in this matter.[41]

Recommendation 2: Trauma Counselling

Given the significant trauma the family and members of the Kalkarindji and Daguragu communities suffered as a result of the Elder's passing, the family requested that professional trauma counselling and mental health service delivery be made available to them as soon as possible, to assist them to cope.[42]

The Coroner did not make this recommendation and gave no reasons why not.

Recommendation 3: Implementation of Senate Recommendations

In September 2007, the Commonwealth Senate Standing Committee on Community Affairs released a report entitled *Highway to Health: Better Access for Rural, Regional and Remote Patients*, [43] which made 16 recommendations for improving access to health in rural, regional and remote communities. The family requested that the Coroner recommend the adoption and implementation of these recommendations as a matter of urgency, with the highest priority given to recommendation 16. Recommendation 16 is specifically concerned with the improvement of Indigenous patients' access to health services and recommends the identification and adoption of best practice standards in the area.[44]

The Coroner declined to recommend the adoption of the Senate recommendations, though she did express support for recommendation 1, which deals with the need for the next Australian Health Care Agreement to recognise the fundamental importance of patient assisted travel schemes.[45]

Recommendation 4: Local Decision-Making

It was requested by the family that the Coroner recommend that the decision-making authority for escorts be housed in a local or regional setting with people who have direct access to the patient, potentially with broader use of the Katherine West Health Board and the staff of the Kalkarindji clinic.

The Coroner declined to make this recommendation, stating that the primary consideration in making a decision as to qualification for an escort will now be met by to the Patient Risk Profiling Tool, which provides criteria against which a patient's need for an escort is to be assessed.[46]

Recommendation 5: Advising Family

It was submitted by the family of the Elder that the family of a patient who is sent from the community to receive health care should be directly informed of their relative's travel arrangements at each step in the journey, and also when their family member is expected to return to the community.

The Coroner agreed with this submission and recommended that the implementation of an advice scheme be considered.[47]

Recommendation 6: Treating Doctors

The family submitted that the Northern Territory Department of Health should institute a system whereby doctors treating patients from remote communities are required to specifically consider the patient's need for an escort for their journey home to their community. Should a treating doctor refuse an escort, they should record their reasons for doing so.

While the Coroner did not make this exact recommendation, she did recommend that, where a decision is made remotely by a District Medical Officer to refuse an escort, the reasons for the refusal should be recorded and a copy should be provided to the clinic requesting the escort. The Coroner also recommended that the need for an escort for persons from remote communities be emphasised in staff training as a primary consideration when determining patients' overall health needs and care.[48]

Recommendation 7: Local Transport

The family requested a recommendation from the Coroner that local community members be hired by Katherine West Health Board to assist the staff at Kalkarindji clinic transport patients to and from the Kalkarindji airstrip when necessary.

The Coroner did not make this recommendation and gave no reasons why not.

Recommendation 8: Council Notification

The family submitted that PATS offices should be required to notify the Daguragu Council of all PATS flights inbound to the Kalkarindji airstrip at least 24 hours prior to the arrival of the aircraft, and that a recommendation to this effect be made. This was to safeguard against the potential for failures in communication between the Katherine Hospital and the Kalkarindji clinic to occur in the future.

The Coroner declined to make this recommendation, stating that the suggestion was not practical and that, in any event, it was not clear how it would provide any assistance.[49]

Recommendation 9: Use of Interpreters at Katherine Hospital

The family requested the making of a recommendation that the Katherine West Health Board be required to seek assistance from an interpreter sourced from the Aboriginal Interpreter Service for a patient whose first language is an Aboriginal language. Where an interpreter is available, they should provide assistance to the patient at the time of admission and during treatment.

The Coroner agreed that, subject to interpreter availability, there should be greater use of interpreters at admission and during treatment for persons identified as requiring that assistance.[50]

Recommendation 10: Use of Interpreters During the Investigation

The family considered that, when the Northern Territory Police are conducting interviews with potential witnesses who do not speak English as a first language in order to prepare witness statements for inclusion in an inquest brief, an interpreter from the Aboriginal Interpreter Service should be present. It was submitted by the family that a recommendation be made to this effect by the Coroner.

The Coroner did not make this recommendation and gave no reasons why not.

Comments

It is disappointing that the Coroner did not see fit to make more of the recommendations requested by the family. Given the obvious distress shown by some members of the family and community during the inquest, it is particularly surprising that the Coroner did not address the family's request for the provision of trauma counselling in her decision.

VI Conclusion

It is evident from the inquest into the tragic death of the Elder that the exercise by coroners of their broad discretionary power as to the conduct of inquests can negatively impact on the experience of an inquest for the families of the deceased. Especially distressing to the Elder's family in this case was the Coroner's exercise of discretion in relation to the location of the inquest and the interpreter that was used. In order that similar distress to families might be avoided in future coronial inquests, there is a need for the implementation of guidelines giving guidance to coroners as to how they should exercise their discretion. As the inquest into the Elder's death indicated, this need for guidelines is particularly acute in relation to the location of an inquest and the use of interpreters during inquests.

Ultimately, what I hope the reader takes away from this article is that it is important for coroners, in making decisions about how an inquest is to be conducted, to give greater consideration to the feelings of the family. Coroners must recognise that, in the end, it is important to ensure that the family of the deceased comes away from an inquest feeling that they have had the best possible opportunity to put forward their point of view and that, in their eyes, justice has been done.

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* Shannon Chapman is a lawyer with Blake Dawson, Perth. Many thanks to Emily Keys for her assistance. Blake Dawson seconds solicitors (two a year) to the North Australian Aboriginal Justice Agency ('NAAJA') to fill the position of Civil Lawyer at NAAJA's Katherine office. From June 2007 to July 2008 I filled that position. At that time, NAAJA's funding guidelines prevented NAAJA from representing a family at a coronial inquest where the death did not occur in custody. I was not subject to that restriction, which has since been lifted. After a barrister who consented to act in the matter on a pro bono basis withdrew from the case, Northern Territory Legal Aid consented to fund a barrister to represent the family at the inquest. The views expressed in this article are

those of the author, and do not necessarily represent those of Blake Dawson or NAAJA, and Blake Dawson and NAAJA take no responsibility for the views expressed in this article.

1 The Elder's family was represented by barrister Patrick McIntyre. I was the briefing solicitor.

2 Nothing in this article is intended to, or should be taken to, suggest that the Coroner was not entitled to exercise her discretion in the manner she did, that the Coroner exercised her discretion improperly, unreasonably or without taking the family's wishes into account, or that there was any sort of wrongdoing on the part of the Coroner or Counsel Assisting the Coroner.

3 This is an extract from a statement that was written by the Elder's nieces and read to the Coroner at the inquest.

4 This statement was contained in a statutory declaration made by Michael Paddy, one of the elders of Daguragu community and President of the Daguragu Community Government Council, which was submitted to the inquest.

5 The Northern Territory Department of Health and Community Services is responsible for the administration of Katherine Hospital.

6 The Northern Territory Department of Health and Community Services is responsible for the administration of the PATS scheme.

7 Letter from the author to Counsel Assisting the Coroner, 31 October 2007; email from the author to Counsel Assisting the Coroner, 5 November 2007; email from the author to Counsel Assisting the Coroner, 9 November 2007; letter from the author to Counsel Assisting the Coroner, 7 February 2008; letter from the author to Counsel Assisting the Coroner, 14 March 2008.

8 The family did not consider that it was proper for this report to be included in the brief to the Coroner because it: 'pursues certain lines of enquiry and makes conclusions that are rightly for the Coroner herself to investigate and determine, therefore purporting to perform the Coroner's role. We are also concerned about the actual and perceived independence of the report ...' Letter from the author to Counsel Assisting the Coroner, dated 26 October 2007. Note that Counsel Assisting the Coroner did state to the Coroner that the conclusions made in the report should be treated with some caution: Transcript of Proceedings, *Inquest into the Death of* [the Elder] (Northern Territory Coroner's Court, Ms Sue Oliver SM, 13 November 2007) 218.

9 Email from the author to Counsel Assisting the Coroner, 5 November 2007; email from the author to Counsel Assisting the Coroner, 6 November 2007; email from the author to Counsel Assisting the Coroner, 7 November 2007.

10 Email from Counsel Assisting the Coroner to the author, 7 November 2007.

11 Letter from the author to Counsel Assisting the Coroner, 31 October 2007; email from the author to Counsel Assisting the Coroner, 6 November 2007; email from the author to Counsel Assisting the Coroner, 9 November 2007.

12 Where in this article I refer to the Coroner advising of a particular matter, that advice was communicated to me by either one of the staff at the Coroner's office, or by Counsel Assisting the Coroner.

13 Where in this article I refer to the family being advised of a particular matter, that advice was communicated through me, as their legal representative, by either one of the staff at the Coroner's office or by Counsel Assisting the Coroner.

14 Email from James Ogilvy (previous Blake Dawson secondee to NAAJA) to the Deputy Coroner, 2 June 2007.

15 Letter from the Coroner's office to the author, 29 June 2007.

16 Letter from the author to Counsel Assisting the Coroner, 26 October 2007.

17 Letter from the author to Counsel Assisting the Coroner, 31 October 2007.

18 The Coroner did grant a request by the family that the inquest reconvene on the second day at 2:00 pm, to allow sufficient time for the family to travel to Katherine.

19 The Coroner was notified of the identity of these community members and that they were prepared to give evidence at the inquest.

20 There are cases where the whole of an inquest into a person's death has been held in the place where that person passed away. For some examples, see Northern Territory Department of Justice, *Coroner's Office: Inquests for 2001–2008* <http://www.nt.gov.au/justice/courtsupp/coroner/inquestlist.shtml> at 21 November 2008.

21 Note that there were other witnesses who also required an interpreter to give their evidence.

22 Letter from the author to Counsel Assisting the Coroner, 31 October 2007.

23 Email from the author to the Coroner, 9 November 2007.

24 Transcript of Proceedings, *Inquest into the Death of* [the Elder] (Northern Territory Coroner's Court, Coroner Oliver, 13 November 2007) 5.

25 The family's interpreter indicated to me that the interpreter was speaking in Kriol, not Gurindji.

26 Although the interpreter did speak some Gurindji, the interpreter mixed Gurindji and Kriol words together, rather than speaking straight Gurindji and was in the main translating the questions into Kriol.

27 A community member consented to travel to Katherine with the family and interpret for them during the proceedings.

28 See, eg, Queensland Criminal Justice Commission, *Aboriginal Witnesses in Queensland's Criminal Courts* (1996) ch 5, extracted in (1996) 1(4) *Australian Indigenous Law Reporter* 76.

29 Transcript of Proceedings, *Inquest into the Death of* [the Elder] (Northern Territory Coroner's Court, Coroner Oliver, 13 November 2007) 85, 150–2; Notes made by the author of the testimony of P Campos in the *Inquest into the Death of* [the Elder] (Coroner's Court, Ms Sue Oliver SM, 13 November 2007).

30 Transcript of Proceedings, *Inquest into the Death of* [the Elder] (Northern Territory Coroner's Court, Coroner Oliver, 13 November 2007) 156 (testimony of B McNamara and Dr Buchanan).

31 Transcript of Proceedings, *Inquest into the Death of* [the Elder] (Northern Territory Coroner's Court, Coroner Oliver, 13 November 2007) pages 150–2, 161.

32 *Inquest into the Death of* [the Elder] [2008] NTMC 057 (Unreported, Northern Territory Coroner's Court, Coroner Oliver, 1 September 2008) [56]–[58] <http://www.nt.gov.au/justice/courtsupp/coroner/> at 21 November 2008.

33 Ibid [56].

34 Notes made by the author of the testimony of A Cartress in the *Inquest into the Death of* [the Elder] (Coroner's Court, Ms Sue Oliver SM, 21 November 2007).

35 *Inquest into the Death of* [the Elder] [2008] NTMC 057 (Unreported, Northern Territory Coroner's Court, Coroner Oliver, 1 September 2008) [71] <http://www.nt.gov.au/justice/courtsupp/coroner/> at 21 November 2008.

36 Internal Memorandum from Senior Constable Meng to Officer in Charge, Katherine Investigation Unit, 20 March 2007.

37 Transcript of Proceedings, *Inquest into the Death of* [the Elder] (Northern Territory Coroner's Court, Coroner Oliver, 21 November 2007) 23–4.

38 *Inquest into the Death of* [the Elder] [2008] NTMC 057 (Unreported, Northern Territory Coroner's Court, Coroner Oliver, 1 September 2008) [20] <http://www.nt.gov.au/justice/courtsupp/coroner/> at 21 November 2008.

39 Ibid [33], [35]–[37].

40 Ibid [88].

41 Ibid [82].

42 Transcript of Proceedings, *Inquest into the Death of* [the Elder] (Northern Territory Coroner's Court, Coroner Oliver, 13 November 2007) 16, 52, 56; Counsel Assisting the Family, *Statement to the Inquest into the Death of* [the Elder], as annexed to the closing submissions.

43 Senate Standing Committee on Community Affairs, Parliament of Australia, *Highway to Health: Better Access for Rural, Regional and Remote Patients* (2007) <http://www.aph.gov.au/Senate/committee/clac_ctte/completed_inquiries/2004-07/pats/report/index.htm> at 14 November 2008.

44 Ibid xii.

45 *Inquest into the Death of* [the Elder] [2008] NTMC 057 (Unreported, Northern Territory Coroner's Court, Coroner Oliver, 1 September 2008) [80] <http://www.nt.gov.au/justice/courtsupp/coroner/> at 21 November 2008. See also Senate Standing Committee on Community Affairs, Parliament of Australia, above n 43, ix.

46 *Inquest into the Death of* [the Elder] [2008] NTMC 057 (Unreported, Northern Territory Coroner's Court, Coroner Oliver, 1 September 2008) [86] <http://www.nt.gov.au/justice/courtsupp/coroner/> at 21 November 2008.

47 Ibid [84].

48 Ibid [86].

49 Ibid [83].

50 Ibid [81].