PART 2

CORONIAL INQUIRIES

INTRODUCTION

The public seminar on Coronial Inquiries reported in this volume is one manifestation of the concern evident in New South Wales in recent times over the conduct of inquests. As a number of contributors to the seminar note, two Royal Commissions and a number of inquests which have attracted a large measure of public attention have highlighted the inadequacies which have been, and to some extent continue to be, apparent with the law and procedure relating to the conduct of inquests in New South Wales.

Concerns about the adequacy of inquiries into deaths which occur in state institutions, or which for other reasons are suspicious or unusual, are not confined to New South Wales. The group INQUEST has highlighted problems which exist within Great Britain in this regard.[1]

Whilst all deaths which are unexpected or suspicious require careful investigation and consideration, it is particularly important that deaths which occur in state custody are thoroughly investigated. Both the agencies of the state which are responsible for the management and operation of such institutions, and those who have responsibility for investigating the circumstances of deaths that occur in such locations must be fully accountable to the public if they are to maintain legitimacy.

As Russell Hogg has argued, it is clear that:[2]

> State agencies are charged with particular public responsibilities and equipped with considerable public resources, and what are often extensive powers, to manage and coerce the lives of others in their care or custody. The vesting of such powers and responsibilities must be coupled with appropriate mechanisms of public accountability.

This theme is explicitly addressed by several of the papers presented in this issue.

The Honourable J.H. Wootten points out in his paper that the death of an aboriginal person in custody must be seen within a social and historical context which recognises the vulnerability of aboriginal people in custody and is sensitive to the real concern and suspicion which may attach to such deaths. Full, open and impartial investigations are vital if such suspicion is to be allayed and if meaningful policies are to be developed to prevent further aboriginal deaths in custody.

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1 See several of the chapters in Hogan, M., Hogg, R., and Brown, D., *Death in the Hands of the State* (1988).

2 Id at 6.

The particular difficulties which attach to investigating deaths which occur within the health system are addressed by Michael Sexton's paper which draws upon the evidence presented before the Chelmsford Royal Commission. Questions about the investigative resources available to coroners are also raised by other speakers and it is evident that to date those resources have been entirely inadequate.

Michael Hogan's detailed presentation incorporates a thorough critique of the current New South Wales coronial system, together with a very detailed issues paper which goes to the heart of addressing questions about the objectives of the coronial system. His paper acknowledges the important recent changes in legislation and practice which have been adopted in New South Wales such as those discussed by the Attorney General, and by Acting State Coroner Hand in their contributions to the seminar.

Whilst some reforms have been implemented, much remains to be done in New South Wales to remedy the deficiencies which have been highlighted by the Royal Commission into Aboriginal Deaths in Custody, the Royal Commission into Chelmsford, the Public Interest Advocacy Centre and other informed critics. As evident from Michael Hogan's paper, the current New South Wales system of coronial inquiries does not compare well with that in Victoria, nor with that in a range of other countries such as Scotland and Canada.

Since I am writing this brief introduction whilst in Ontario, Canada, it seems appropriate to build upon the references to the Ontario coronial system which were made in the seminar, and to briefly outline some aspects of that system.

Coronial inquiries in Ontario are normally held before a Coroner who is a qualified medical practitioner and who has investigative powers which include the seizure of anything "material to the purposes of the investigation".

In deciding whether to hold an inquest, the coroner is required to consider, inter alia, the desirability of the public being fully informed of the circumstances of the death, and to the likelihood that the jury on an inquest might make useful recommendations directed to the avoidance of death in similar circumstances. The inquest is held before a jury of five people. Inquests are required to be held in cases where people die whilst in custody.

A Chief Coroner controls, supervises and directs all coroners in the performance of their duties, and part of the function of that office is to bring the recommendations of coroners' juries before the appropriate authority. The legislation allows for the appointment of regional coroners. A Coroners Council, composed of a judge of the Ontario Court and not more than four other people, one of whom must be medical practitioner, hears receives and investigates complaints against coroners, and may recommend the termination of the appointment of a coroner.[3]

3 Coroners Act, Revised Statutes of Ontario, 1980, c93, as amended in: 1984, c11 and c55; 1986, c64; and 1989, c56.

Proponents of the Ontario model argue that the system works well — in 1988, 30,041 were investigated and 181 inquests were held. However, the Ontario coronial system is not without its critics. In particular, concerns have been voiced about the heavy reliance upon police to carry out much of the investigative legwork.[4] Debate is also apparent as to value of appointing medically, rather than legally, qualified coroners (although some coroners possess both qualifications).

The Ontario model of coronial inquiry represents one of a range of alternatives worthy of consideration in any reform of the New South Wales coronial system.

The Attorney General, Mr Dowd's assurance that the coronial system is very much on the reform agenda is a welcome one. It is hoped that through providing a forum for the public discussion of the New South Wales coronial system, the Institute of Criminology has contributed to the process of law reform. However, as the Honourable J.H. Wootten has noted in his paper, such reform needs to be accompanied by careful evaluation and monitoring in order to ensure that institutional change translates into an actual change in practice.

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4 "Ontario's system of inquests called tool of the establishment", *Globe Mail*, 14 April 1990, pA10.

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