THE ROLE OF THE CORONER[1]

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As most of you would be aware, the current Government is committed to a programme of legal reform which is partially implemented, and which will result in further, major legislative changes being introduced in the current session of Parliament. The coronial system is very much on that reform agenda. Very important changes were made in 1989, shortly after the government assumed office and further changes are being planned.

The importance of the coronial system is being increasingly recognised, as the interest in this seminar indicates. Aspects of the system have come under scrutiny recently in a variety of forums and the identification of problems has led to the extensive changes of the last couple of years. The process of review is continuing.

The State Coroner has just completed a review of the *Coroners Act* and his report is being circulated to a number of organisations for comment. It is hoped that recommendations arising from that report will be introduced into Parliament in the very near future.

One consequence of all this activity has been an intense examination of the role of coroners. Before you can judge whether an institution is working properly, it is necessary to define its role.

Many people have expressed differing views on the role of coroners. Those views sometimes reveal more about the particular interests or concerns of the speaker than they do about effectiveness and efficiency of the coronial system. At the risk of doing the same thing, I will try and describe the role of coroners. To do that, I think it would be helpful to look firstly at what coroners are supposed to do.

The *Coroners Act* does not contain an exhaustive definition, though it is a useful starting point. Section 22 talks about those things which coroners should include in any findings. In respect of deaths, these include the identity of the deceased, the date and place of death and "the manner and cause of his death". In respect of fires, the things to be established are the date and place of the fire and "the circumstances of the fire".

The phrases "the manner and cause of his death" and "the circumstances of the fire" lie at the very centre of the role of coroners. It is the investigation of those matters which will usually take most of the time in the conduct of the coronial inquiry.

Why is it considered necessary to have coroners inquiring into these matters? What purpose is served?

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1 Paper delivered at a public seminar entitled "Coronial Inquiries", convened by the Institute of Criminology at Sydney University Law School, 10 October 1990.

I think the basic function of coronial inquiries is to reassure the public that murders and arsons are not going undetected. It is also to reassure the public that people in positions of control over others, such as doctors in hospitals or police holding people in custody, are not abusing their positions by neglecting people in their care or actively causing them harm.

Coroners can reassure the parents of Sudden Infant Death Syndrome victims that they are not to blame for the death of their child. Coroners can reassure the families of prisoners or patients in mental hospital that, if their relative should die while in the particular institution, their death will not go unexamined. Coroners can reassure the users of motor vehicles that any inherent dangers in those machines or their use which result in death will be brought to the attention of authorities who can take action to remedy the situation. Coroners can reassure the owners of and workers in industrial facilities that any unsafe design or work practice which results in a death or a fire will be thoroughly investigated.

Reassuring the public is a basic function of coronial inquiries but it is not the only responsibility of coroners. Perhaps it is inevitable because of the emotional overtones of much of the workload of the coronial system, but it is clear many people have unrealistic expectations of what the system can or should do, and they fail to understand the constraints which surround a coroner.

It is often difficult in a particular case to establish and define the coroner's responsibility and, on occasion, it is necessary to conduct quite an extensive investigation into collateral issues. In this regard, coroners need to be concerned with more than the strict legal requirements of their role. They need to be sensitive to any particular features of the matter before them which may demand special attention. For example, where a young child has died, the coroner needs to be aware of the needs of the parents, both to come to terms with what has happened and to feel that everything possible has been done in respect of the child's death.

However, there are real and necessary limits on coronial inquiries. Coroners are guardians of the public interest within the confines of their statutory responsibility. That public interest places demands on coroners but it also imposes limitations on what coroners should or should not do.

Coroners do not conduct criminal trials. If the coroner forms the opinion that the evidence establishes a *prima facie* case, it is not up to the coroner to deal with that person for that offence. Many people expect the coronial system to punish people who might be thought, reasonably or unreasonably, to be responsible for the death of someone they knew. This expectation is often based on a combination of emotion and a misunderstanding of the coroner's role. Coroners cannot convict people or commit them for trial.

Coroners do not punish people for what the evidence at an inquest indicates they may have done. Responsibility for that falls to other bodies. It is important to remember that while the coroner is an administrative office rather than a judicial one, being inquisitorial rather than adversarial, it has many of the responsibilities of judicial office.

That imposes certain duties on coroners. They must perform their functions in an equitable manner, ensuring that the proceedings are conducted with appropriate fairness, dignity and care and that the processes of the court are not being abused.

Coroners are confronted by human tragedy every day. They are forced constantly to examine what human beings do to each other or what happens to human beings, whether by design, by accident, or by simple neglect. However, they must distance themselves from the emotional aspects of what they are dealing with. It is quite proper for a coroner to feel sympathy for the family of the deceased. I would, in fact, be quite concerned if coroners were not moved by some of the cases which come before them. However, the coroner should not allow the parties a free hand to use the inquiry to make accusations or advance theories which do not relate to the circumstances of the death and which are not supported by available information.

Equally, coroners should not preside over fishing expeditions. Parties should not be permitted to take advantage of coronial proceedings merely to obtain information which might otherwise be denied to them by the operation of the law or rules of court.

Coroners are required to act in the public interest, difficult though it may often be to determine what the public interest requires. They are not the mouthpieces for particular pressure groups or lobbyists, nor should coronial inquiries be used as a means of conveying a partisan message to the public via the publicity often given to coronial hearings.

While coroners are entitled to make statements or recommendations as part of their findings, those statements and recommendations should be made as a consequence of evidence that has been presented in the course of the inquiry. Considerable pressure is often exerted on coroners to make recommendations or to offer criticisms which are not really justified by the available evidence. The fact that coroners resist those pressures, where they feel it is not appropriate to comment beyond their formal finding, often causes disappointment as well as the occasional view that the system has in some way failed. However, the system has not failed, it has simply not met the perhaps unrealistic expectations placed on it.

Finally, I would like to reiterate this Government's commitment to revision of the coronial system. I believe that we are well-served by the coroners in this State but I think that no one would argue that some changes were necessary in the past and further changes may also be required.

One of the major changes made in recent times has been the creation of the State Coroner's Office. The State Coroner has a number of important roles, including the monitoring of all deaths reported to coroners throughout the State, and the giving of directions to particular coroners or to all coroners regarding the holding of inquests.

Attached to the State Coroner's Office is the Coronial Investigation Unit, which investigates matters at the direction of the State Coroner. The Unit is responsible to the

State Coroner and investigative expertise is available where the local police lack the necessary expertise or where their involvement would be inappropriate.

The coronial system in New South Wales disposes of thousands of inquests into deaths and inquiries into fires every year. In 1989, 5806 deaths and 3495 fires were reported to New South Wales coroners. In a vast majority of cases, the holding of an inquiry was dispensed with. In some cases, an inquest was only held because it was required by the *Coroners Act.*

In other words, the majority of coronial cases are routine and are dealt with appropriately. Of course, all coroners should be conscious of the fact that no death is routine to the family of the person who has died. As I mentioned before, coroners need to be sensitive to any special features of the matters that come before them which need to be considered in dealing with the matters.

Coroners deal with hundreds of straightforward "routine" matters every year. Their role is prudential and largely administrative. These deaths are subjected to scrutiny and detailed medical examination to ensure nothing improper has occurred. Once that has been established, the coroner can terminate his or her involvement by dispensing with the holding of an inquest. In exceptional cases, the State Coroner is in a position to become personally involved where the case has particular complexity or sensitivity.

Before finishing, I would like to mention briefly that discussions are taking place between the Attorney General's Department, the Police Department and the Department of Health concerning a revamp of forensic science services. It is hoped to establish a new co-ordinating body to organise the provision of forensic services throughout the State. This is a much needed reform and I anticipate that a public announcement about important initiatives in the area of forensic services will be made soon. Once these changes have been introduced and fully implemented, I believe that the coronial system in this State will be as effective and efficient as we all expect it to be.