A three-cavity autopsy of the NSW coronial system: what's going on inside?

The review of the Coroners Act – a new court? A new system?

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In 2010, a 'new' Coroners Act came into force. I use the ironical quotation marks because there was little really new about the Act. As is standard procedure, the Act included provision for a review after it had been operating for five years. The Justice Department began that review in 2014, expecting to make a few cosmetic changes. The then State Coroner, Michael Barnes, who had overseen the implementation of a new Coroners Act in Queensland in 2003, saw many deficiencies in the NSW Act and suggested a serious rewrite. He did not, however, expect that, by March 2019, the statutory review would remain incomplete and that whatever is to become of the coronial system would not be resolved until after the State election in that month.

Why has the delay been so extensive? The answer is probably that there is an internal competition of ideas between those who support the current structure, at the apex of which is the Chief Magistrate of

the Local Court, and those who are arguing for comprehensive reform. How that contest will be decided will be discovered after the election. The Local Court seeks to maintain the status quo in which the coronial system is located within and controlled by the magistracy. The reformers argue for a new organisation.

The foundations of the current structure of the coronial system were laid down in 1901 when the NSW magistracy was given control of it. In that year, steam engines – operating at 8% efficiency – were high tech. As the 20th century dawned, it made administrative sense to take the system out of the hands of amateur coroners and idiosyncratic juries and give it to educated, middle-class legal professionals familiar with police investigations and legal procedure. In the long term, however, it was a wrong turn. It folded the coronial system into the criminal justice system where it has remained to the present day. The investigation of suspicious death was its focus. While surreptitious homicide is self-evidently important, it is rare and, when suspected, is investigated thoroughly by police. Far more effective use can be made of this system.

In 1913, a medically trained English barrister and coroner, William Brend, lamented that the coronial system in his country was collecting vast amounts of medical and other data that was not being applied to improving public health. In a paper entitled 'The Futility of the Coroner's Inquest', published in *The Lancet*, he contended that 'the inquest verdict has no legal weight and does not settle legal questions; it has frequently little scientific value and does not provide accurate medical statistics.' He argued that, because the coronial system operated without a clear public policy strategy and because individual coroners, operating singly without guidance, made idiosyncratic decisions, the potential for deriving public health benefits from the coronial system was being wasted.[1] He argued that coronial data should be used for epidemiological research to guide the development of public health policy.

The criminal justice orientation of the Local Court limits the effectiveness of the coronial system. The cultural habits of mind and practice of magistrates are oriented towards managing and processing large volumes of relatively uncomplicated criminal matters as efficiently a and quickly as possible. Single cases are dealt with seriatim. Magistrates have no jurisdiction or capacity to treat them epidemiologically. Decisiveness and speed are the qualities most admired in magistrates by those who run the Local Court. High clearance rates are the KPI that keeps the Chief Magistrate's Office happiest. Some senior magistrates refer to the coronial jurisdiction of the court as a 'tick-a-box' jurisdiction – their view is that coronial cases can be disposed of almost effortlessly in most instances before they return to the real work of punishing drink-drivers, hotel heroes and other miscreants.

The shock, confusion, messiness and sadness of the broken human lives the coronial files document – and the potential for protecting lives from future tragedies – is not registered by such a 'tick-a-box' mindset. Not all magistrates bring such lack of empathy or narrowness of vision to their coronial responsibilities. In fact most are thoroughly decent human beings. But without a reorientation towards a philosophy of respect for human life and the desirability of finding ways of protecting it *through the coronial system*, coronership is wasted on the Local Court. The success or quality of coronial services are not and never should be measured merely by 'clearance rates' – too much is at stake for bereaved families, others involved in sudden and unexpected deaths, and society at large.

The untested assumption, based on historical practice and institutional inertia, that experience in criminal justice is the primary qualification for excellent coronership, remains at the heart of the Local Court's claim to control of the system. During his evidence at the Budget Estimates hearings before the NSW Parliament's Legal Affairs Committee, the attorney general, the Hon. Mark Speakman SC, was asked questions about the NSW coronial system and the argument reformers are making for a specialist court. On that question, the attorney stated:

> I know there is one school of thought that we should have a separate coronial jurisdiction. There is another school of thought that it is best dealt with in the Local Court and that you get more well-rounded decision-makers if they have spent a bit of time in general matters in the Local Court—mostly crime—and go into the coronial jurisdiction and come out again. So there are different schools of thought which are probably impossible to reconcile, but ultimately the statutory review will deal with both those schools of thought and make recommendations.[2]

The argument that 'you get more well-rounded decision-makers' if they have spent time sitting in criminal courts as magistrates is that of the local court hierarchy. It is noteworthy that the Attorney did not commit himself to the chief magistrate's position and that he recognised the impossibility of reconciling the two ideas in contest. One will have to give.

While the current team of full-time coroners based at Lidcombe is an excellent group – possibly the best team NSW has ever had – our system as a whole is not designed for purpose and is distorted by the criminal justice orientation of the Local Court. About 80% of the workload of the NSW Local Court consists in criminal proceedings of various kinds. Few magistrates ever have to grapple with complex medical evidence, public policy questions or the myriad issues that call for decisions from coroners.

On the other hand, under the Coroners Act, coroners are required to supervise medical investigations – every one of the 6500 deaths reported to coroners requires forensic medical review. How are coroners, without experience and training in medicine or science, to deal with such questions? The answer is that they either delegate the decisions to the forensic pathologists or court registrars, or they struggle to learn the ropes. My own experience was that it took about two years before I felt competent in discussing and making medical decisions and five years before I felt I was reasonably expert in this field. It is an impossible task for country magistrates, who do not have the opportunity to work shoulder-to-shoulder with forensic pathologists, cannot develop sufficient volume of experience to become competent, and who are not given the training and professional development in this field, to build either the professional rapport with the doctors or the medical knowledge to make well-informed decisions of this kind.

Judges and magistrates rarely develop expertise in the inquisitorial method that coroners apply. The separation of powers and principles of due process and fair trial separate the judiciary from the executive in the criminal and civil justice systems, and from the parties to litigation. Yet coroners are inquisitors – *they* are responsible for directing and overseeing investigations of sudden and unexpected deaths. This, again, requires a very different mindset from the conventional judicial approach in which the opposed parties frame the issues. Early in my coronial career, my counsel assisting asked me what I wanted her to do about some issue. My first thought was, 'What are you asking me for? I'm the judicial officer.' For me, the discussion that followed was a seminal moment for me in discovering the realities and responsibilities of coroners as leaders of investigations. The criminal (and civil) justice system require judicial distance from the parties and their dispute; coronership requires full engagement at an elemental level in identifying and framing the issues, establishing the scope and direction of the investigation, and a doggedness in following the evidence wherever it leads to relevant answers to questions about the causes or circumstances of a death. It is a misconception that 'well-rounded' criminal magistrates are equipped for ready translation to the inquisitorial method, at least at a sophisticated level.

In the criminal jurisdiction of the Local Court it is rare for a magistrate to deal with more than a few issues in a case, much less write a detailed judgment or decision. Yet in the coronial jurisdiction, many inquests, especially medical cases or those implicating state agencies, raise complex issues of fact and causation can be as complex as those dealt with in the Supreme Court. Acquiring and developing the competence to manage such inquests is not achieved overnight. Managing a high-volume court list is not adequate preparation for it.

The most fundamental problem with the Local Court's claim to control over the system, however, is that it lacks a coherent philosophical, theoretical or policy basis. What is, or what are, the purposes of the coronial system? Why is the Local Court the most appropriate anchorage for it? Nothing in the Act or the Local Court's literature about the coronial system provides a clear answer to these questions. From 1901 until now, the questions simply haven't been asked.

Brend's criticism of the English coronial system of the early 20th century can be echoed in this state. Brend thought that his system should be oriented towards, and designed to promote, public health and safety. That made sense in 1913, and it makes even more sense in NSW in 2019. More than 6500 thousand cases are reported to coroners annually in NSW. About half are due to natural causes. The remainder are due to suicides, accidents and other causes. Only a tiny fraction of the whole are homicides or suspicious deaths. The potential for saving lives lies in more thoroughly investigating many of the non-natural deaths, especially those in which systems failures are implicated, and in following up some natural deaths with family members who may be vulnerable to similar morbidities.

All of this suggests that a grounding in criminal law and procedure, while valuable experience, goes nowhere near qualifying magistrates as competent coroners.

It follows, then, that the NSW Government should first decide the purpose of the coronial system and design the organisation around that theory or policy, rather than the reverse. The principles for a theory of or policy for an excellent coronial system are, I believe, the following:

- Respect for and protection of the basal human right – the right to life;
- An orientation towards public health and safety rather than suspicious deaths;
- A priority to be given to healing and therapeutic approaches to the bereaved relatives and others affected by sudden and unexpected deaths;
- Accountability of the state – the social contract between the State and the members of the community to protect us from harm is implied in all coronial practice.

If these are the elementary principles, investigation of death by coroners would prioritise the prevention of future deaths and serious injury, and, where the state is implicated in a death, bringing it to account. Grieving relatives' most earnest desires include finding answers to their burning questions (how and why did this happen?) and, if possible, preventing others from suffering the same fates. In my view, there is no such thing as 'closure' – but it is possible to lift some of the burden of grief, bewilderment, confusion and despair. As a coroner, it was remarkable to me how so many people responded positively to demonstrations of respect they received from state officials, such as coroners, doctors, police officers, court counsellors and public servants who treated them compassionately.

Although some of the work of coroners relates to unsolved homicides and suspicious deaths, recent thinking about coroners emphasises their roles in enhancing public health and safety. In the 21st century, to conceptualise the coronial system as a unique state institution that combines public health and safety principles with therapeutic justice and human rights protection, rather than as a team of detectives or criminal court magistrates, is the way of the future.[3]

Instead of being a thin stratum of a pyramidal Local Court system in which the chief magistrate sits at the apex, specialist coroners should be the hub around which the moving parts of the coronial system operate – families and family support staff; medical and scientific investigators; police investigators; lawyers; ad hoc experts; epidemiological and policy researchers; and administrators – with state coroner having primary responsibility for co-ordinating and harmonising the efforts of all participants in the system. This organisation should be removed from the Local Court's administration and supervised by the state coroner and overseen by a strategically focussed multi-disciplinary board or council comprised of representatives of NSW Health, the Attorney-General, NSW Police and organisations such the Law Society, the NSW Bar and expert community representatives, especially those who can articulate the concerns of bereaved families.

The review of the coronial system in NSW remains on foot. There are many ways in which the system could be improved but the critical issue is how we conceive of the system as a whole and what we want it to do. How our next government approaches this task will set the system in concrete for the foreseeable future – will they reform or will the system still be steam-driven in a generation's time?

Coronial discretion: towards better decision-making?

William Brend noted that 'One of the first things [about the English coronial system of 1913] that arrest[s] attention… is the great diversity of principle among coroners in the selection of case upon which to hold inquests and of procedure in the conduct of inquest'.[4] The same could be said of NSW coroners in 2019 because of the hybrid organization of the system, its institutional ossification in the Local Court structure, and its lack of a coherent principles and philosophy or theory of practice.

Discretion is exercised by coroners in many ways – among them decisions concerning autopsies and medical investigations; decisions about the form, depth and direction of police investigations; decisions about scientific or other expert investigations or reviews; decisions about holding or not holding inquests; decisions about the scope of inquests; decisions about the management of inquests; and decisions about whether to make recommendations following inquests, how recommendations are framed and to whom they are delivered.

The decision with greatest impact on bereaved families and others involved in coronial case is that of holding or not holding an inquest. Coroners have virtually unfettered discretion in practice. While broad criteria are set out in the Local Court bench book to assist magistrates makes these decisions, there are few standard procedures. Coroners, therefore, like Brend's English coroners a century ago, operate very individualistically. This leads to great inconsistency in decision-making, resulting in unpredictability, confusion and complaints from agencies such as NSW Health. Developing guidelines for the exercise of the discretion would be a first step to improving the decision-making process. I suggest, though, that until the cottage industry system is replaced by a specialist coronial court in which these decisions are centralised and managed in a methodical way, the current inefficiency will continue to characterise the process of selecting inquests.

Although there are sometimes high profile public interest cases that demand full public inquests, the most effective way of using inquests would be to concentrate on two key areas: (a) preventable deaths, especially those contributed to by systems failure and (b) holding to account government agencies with a particular duty of care (police, corrective services, child welfare agencies, disabled care organisations, psychiatric hospital are obvious examples) for deaths occurring in their domains.

One important guiding principle should be that, insofar as is reasonably possible, a public health or epidemiological approach is taken to decision-making about inquests: cases should

be clustered so that lessons learned can be generalised. One-off cases (and recommendations) are far less likely to achieve death preventive impact than cases with a broad evidence base.

Centralising the decision-making process so that specialist coroners, working according to consistent standards, exercise the discretion would be a superior arrangement to the amateurish chaos that prevails at present. Guidelines could be developed in consultation with interested parties, such as NSW Police, NSW Health, Corrective Services, the Crown Solicitor's Office, the Human Rights Commission and non-government organisations such as the Public Interest Advocacy Centre, the Law Society, the NSW Bar, the Medico-Legal Society, and Suicide Prevention Australia.

Again, to achieve such efficiencies requires thinking about the first principles of the coronial system and how they can best be implemented in practice.

Inquests: can we do better?

According to the 2018 Report on Government Services, in 2017 NSW had a coronial clearance rate of 94.5%. It ranked 6th out of 8 Australian jurisdictions in that respect.[5] The number of inquests conducted in NSW also dropped alarmingly over the period 2016 and 2017:[6]

No. of inquests conducted in NSW:

Year	Inquest
2005	187
2006	212
2007	209
2008	243
2009	165
2010	196
2011	290
2012	148
2013	142
2014	140
2015	150
2016	120 (a 20% drop on 2015)
2017	84 (a 30% drop on 2016)

This is bad news for bereaved families and the community more generally. While it is largely a resourcing issue the Local Court's policy of rotating experienced specialist coroners out of the system back to the Local Court (or retirement if they choose not to return to the general bench of the Local Court) after a certain number of years is a contributory factor. 'Fresh blood' is inexperienced and therefore less efficient generally than old hands. Reported deaths also continue to increase as the population increases. Since 2010, the first year of operation of the 2009 Coroners Act, reported deaths have increased approximately 21% yet the number of full-time coroners has remained the same.[7]

The effect is that a backlog of cases is building up to the detriment of bereaved families and others. It can be cleared by doing 'quick and dirty' inquests, by refusing to conduct inquests or discretionary inquests until the backlog is dealt with, or – as it should be – it can be managed properly by resourcing the jurisdiction with more coroners, support staff, research resources and by providing the support, training and professional development coroners need.

The backlog of cases imposes undue pressure on coroners to dispense with discretionary inquests. Yet inquests are the primary way by which coroners exercise their death preventative function. Only when inquests are conducted do coroners in NSW have power to make recommendations.[8] More subtly, holding inquests prompts action on the part of organisations such as NSW Health, Corrective Services and other agencies to take action to remedy systems failures. Many agencies are very keen to demonstrate publicly that there is no need for a coronial recommendation because they have addressed such issues.

And as I have suggested above, those inquests that are conducted could be more effective in mitigating risk of future deaths if epidemiological techniques were applied. Some NSW coroners understand this well: in recent years, such approaches have been taken, among others, to drug deaths of 'doctor-shopping' patients; deaths of rock fishers; deaths in high-speed police pursuits; and deaths due to quad-bike rollovers. Recently, an inquest has been announced into deaths at music festivals. Yet these tend to be the exception rather than the rule, especially in relation to deaths reported to country magistrates.

Most people directly involved in the coronial system know that one of the few small measures of comfort for bereaved families is the potential that an inquest may discover life-saving lessons. Holding sophisticated, efficient inquests concentrating on preventable deaths is one way our society can demonstrate respect for the dead, provide comfort to the bereaved and advance the welfare of our community.

Conclusion

This paper is being written shortly before a state election that will have momentous consequences for the coronial system in NSW. I am hopeful that, in a spirit of bi-partisanship, both sides of politics will join in long-overdue root-and-branch reform of the system. Reform would, I suggest, be an inherent good for bereaved families and our society more generally. But there is a hard economic incentive to build a more effective system as well. The Australian government has estimated that the economic value of a human life in this country is approximately $4.5 million.

If the death preventive potential of the NSW coronial system could be lifted even marginally to save a few extra lives, it would be worth its own cost many times over. My hope is that the next NSW government will embrace the opportunity this state has to develop the best coronial system in the world. It would not be very costly in overall terms (say, $6-7million extra per annum out of a health and justice budget in its billions) and the human benefits would be immeasurable. It is within reach if the vision is there.

ENDNOTES

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1 William A. Brend, 'The futility of the coroner's inquest', *The Lancet*, 17 May 1913, 1404-1408.

2 The Hon. Mark Speakman SC, Evidence, NSW Parliament, Legal Affairs Committee Budget Estimates hearing, 4 September 2018 transcript pp13-14. https://www.parliament.nsw.gov.au/lcdocs/transcripts/2117/Transcript%20-%204%20September%202018%20-%20CORRECTED%20-%20PC4%20-%20Attorney%20General.pdf accessed 27 February 2019.

3 See Jennifer Moore, *Coroners' Recommendations and the Promise of Saved Lives*, (Cheltenham: Edward Elgar, 2016). Moore, a lawyer and epidemiologist, argues for a public health orientation to coronial services. See also Ian Freckelton & David Ranson, *Death Investigation and the Coroner's Inquest*, (Melbourne: Oxford University Press, 2006).

4 Brend (1913), 1404.

5 Productivity Commission. 8 *Report on Government Services 2018*. Table 7.8 http://www.pc.gov.au/research/ongoing/report-on-government-services/2018/justice/courts/rogs-2018-partc-chapter7.pdf

6 At the time of writing, the figures for 2018 were not available. Anecdotal evidence suggests that the number of inquests conducted has risen from 2017 levels. The clearance rate may also have risen.

7 The 2011 Local Court Annual Review reports that in 2010 5448 deaths were reported to coroners. The 2017 Annual Review reports that this had risen to 6602 deaths in 2017.

8 *Coroners Act 2009*, s 82.