Recent Decisions concerning the Scope of the Coroner's Jurisdiction at Inquest

Helen Roberts

Deputy Coroner

Northern Territory

Australasian Coroner's Conference 2006

Port Moresby

In *Harmsworth v State Coroner*[1], the Victorian Supreme Court made findings which circumscribed the powers of a Coroner to admit evidence, and limited the matters considered relevant to a Coroner's jurisdiction at inquest. That case was decided in 1989 and is generally cited in any argument with respect to the scope of a Coroner's powers at inquest. In this paper I discuss three recent Supreme Court decisions concerning the scope of the jurisdiction at inquest and the powers of the Coroner to admit and consider evidence around the circumstances of a death (or fire). In each Australian State and Territory, the legislative provisions establishing the Coroner's jurisdiction at inquest are slightly different, but the statements of principle have general application.

In ***Harmsworth v State Coroner*** the Director-General of the Office of Corrections sought declarations that the State Coroner (Victoria) had exceeded his jurisdiction with respect to particular matters he sought to examine in the course of an inquest into five deaths in a prison fire. The facts were that a prisoner within a high security detention unit in the Prison set fire to a barricade that he and four other prisoners had constructed within their building. The prisoner had that day been informed that his application for reclassification had been rejected and it was assumed this was a reaction to that news. The way in which the barricade was constructed along with other features of the building meant that it took an hour or so to extinguish the fire, by which time the five prisoners were dead.

A number of different matters were raised by the plaintiff in the proceedings, but his complaint was essentially that the Coroner wished to examine matters which were not within his jurisdiction. Those matters included evidence about the physical and management structure of the prison, and in particular the high security unit; attitudes and theories with respect to maximum security detention within the prison system; evidence

[1] *Harmsworth v State Coroner* (1989) VR 989

of complaints to the Ombudsman from prisoners housed within the high security unit; evidence of all fires occurring at the complex within the past ten years.

For procedural reasons which are not relevant here, Nathan J did not make the declarations sought but he did made findings that the above matters would be, for the most part, outside the coroner's jurisdiction. His Honour's reasoning was based upon an argument about causation and remoteness. At 995-996 he held:

The coroner's source of power of investigation arises from the particular death or fire. A coroner does not have general powers of enquiry or detection. The enquiry must be relevant, in the legal sense to the death or fire, this brings into focus the concept of "remoteness". Of course the prisoners would not have died, if they had not been in prison. The sociological factors which related to the causes of their imprisonment could not be remotely relevant. This can be tested by considering how wide, prolix and indeterminate the inquest might be if each of the many facets of the individual personalities, of all those involved were to be considered. A coroner would be confronted with a need to enquire into the personal peculiarities of all the prisoners who barricaded themselves in. Both those who relented and those who did not. Whether for example, one group or person suborned others, and if so why and how ...Such an inquest could certainly provide material for much comment. Such discursive investigations are not envisaged nor empowered by the Act. They are not within jurisdictional power.

Nathan J went on to hold that the power to comment "on any matter connected with the death" is not a power which stand separately from the power to investigate the death but arises as a consequence of that primary function of the coroner. On the basis of those statements of principle, Nathan J held that the challenged issues were *ultra vires*. As to the physical and management structure of the prison and the high security unit, he allowed only that questions about the availability of fire fighting equipment and forces would have been relevant and nothing wider. After discussing the limits of the powers, however, his Honour went on to make the following comments (at 999):

Salient lines of enquiry yet to be pursued by the coroner appear to be the reason why the deceased and his cohorts refused to abandon their barricade during the 25 minute period of negotiation and what were the immediate precipitating factors causing him to ignite the barricade. Supplementary lines of enquiry relating to the deaths of the cohorts, would be to examine their individual participation in the barricade building, their part in the negotiations and whether they were dissuaded from abandoning their positions by pressure from other prisoners.

The decision in *Harmsworth* was a finding clearly limiting the extent of a Coroner's jurisdiction at inquest to admit evidence touching on matters which might prompt comments or recommendations rather than going directly to the Coroner's findings as to *how death occurred.*

(i) Atkinson v Morrow

The Queensland State Coroner was holding an inquest into the death of a man from an apparently self-administered overdose of methylamphetamine. His remains had been found three weeks after he was last seen alive, in a field in a rural-type area of Queensland. The background to his death was that early one morning in March 2003 the deceased had told a service station attendant that there were two men in the nearby bushes preparing to shoot him. While the police were on their way, he started discharging petrol from the bowser onto the ground around him. When the police arrived, he told them he knew no one was chasing him but he wanted a lift out of town to a truckstop about 12km away. The police took him and left him there. In preparation for the inquest the coroner directed that a statement be prepared by a senior police officer to "give evidence about the police service guidelines for dealing with similar situations". The situations contemplated were those in which police had to deal with persons with possible mental illness and/or, police transporting members of the public in police vehicles. Although such a statement was prepared by a Chief Superintendent, the Commissioner

for police later submitted at the inquest, and on appeal, that the statement was inadmissible.[2]

Section 34 of the *Coroners Act* 1958[3] provided that a Coroner may admit evidence that in his opinion was "necessary for the purpose of establishing or assisting to establish any of the matters within the scope" of the inquest. Therefore the questions before the Queensland Court of Appeal[4] required consideration of the scope of an inquest held in accordance with the provisions of the *Coroners Act* 1958. Specifically, whether the statement relating to police procedures, and (one assumes) the attendant questions as to whether the police in this case had adhered to them, fell within that scope. Section 24 provides that an inquest is held for the purposes of establishing, inter alia, *when, where and* ***how*** *the death occurred*. Section 43 provides that at an inquest the coroner shall find, inter alia, *when where and* ***how the deceased came by his or her death***.

In argument, the Police Commissioner relied upon the English Court of Appeal decision in *R v North Humberside Coroner; ex p Jamieson* [1995] QB 1, a decision which clearly narrowed the scope of an inquest under the UK legislation. The Queensland Court of Appeal, however, held that the English approach was influenced by the English legislative history. Their Honours noted that the provisions referred to above, sat within a context which established a wide jurisdiction for a coroner to inquire into the cause and circumstances of a person's death. The Court held (at [14]):

the coroner was correct in concluding here that it was part of his function in conducting the inquest into the death of [the deceased] to inquire into all the circumstances attending that death or which might have caused it.

The Court went on to hold that the Chief Superintendent's statement, annexing the Operational Procedures Manual and other related documents, was admissible. The Court

[2] *Atkinson v Morrow* [2005] QSC 353.
[3] Note that deaths occurring before 1 December 2003 in Qld are dealt with under the Coroners Act 1958, now replaced by the Coroners Act 2003.

of Appeal made it clear that the powers of a coroner to admit evidence at an inquest are very wide. In terms of confirming that general proposition, this decision is a clear precedent. However, the facts in this case did not provide a significant challenge to established principles about the purpose and scope of an inquest.

The Canberra bushfires Case[5]

Large bushfires spread from bushland into residential areas of Canberra in January 2003, causing widespread damage and four deaths. An inquiry into the fires was opened in June 2003 and was heard over the following 16 months, with about 85 hearing days complete by the time of this application. The decision of the Full Court of the Supreme Court of the ACT concerned an application for an order that the Coroner be prohibited from further conducting the inquiry on the basis of "apprehended bias". An application to the Coroner that she disqualify herself on that basis was made before her and dismissed by her in October 2004. The application was made while the inquiry was still at the stage of taking evidence.

The grounds of the 'bias application' were varied. The contention overall was that there were a series of acts and decisions which indicated that the conduct of the Coroner and her counsel-assisting, was directed to "finding people responsible for failing to extinguish the bushfires or warning the community of them, rather than determining their cause and origin". Those "acts and decisions" included the manner in which expert witnesses were engaged; the decision to attend a "view" in company of certain experts; the availability of notes taken during that "view"; the approach taken to the case by counsel-assisting; and the manner of dealing with certain witnesses. The Court of Appeal examined each of the asserted acts and decisions, and dismissed each individually and collectively, as establishing grounds upon which a reasonable lay observer might reasonably apprehend bias. It is important to note that the Court did this in a particular context, that being one in

[4] Note the application was initially heard by a single Justice and dismissed - see [2005] QSC 92. The applicant Commissioner then appealed to the Court of Appeal.
[5] *R v Coroner Doogan; ex parte PeterLucas-Smith & Ors* [2005] ACTSC 74

which, essentially, the Court stated that the applications were premature.[6] The Court held at [188]:

Some of the grounds relied upon plainly provide no basis for any reasonable apprehension of bias, which other provide some possible ground for concern but only if adverse findings as to certain issues are contemplated. Any findings as to these issues would clearly be beyond the scope of the jurisdiction conferred by the Coroners Act and the likelihood of adverse findings on others is presently a matter of speculation. In these circumstances we cannot be satisfied that even the cumulative weight of the matters raised by the prosecutors have established grounds upon which a reasonable lay observer might reasonably apprehend that the first respondent might not bring an impartial mind to the resolution of some question that she is required, entitled, or likely to decide.

Of interest in this decision is what the Court of Appeal had to say about the "scope of the jurisdiction" and the extent of the questions that the Coroner might be "required" or "entitled" to decide. The court discussed the scope of jurisdiction on the basis that the apprehension of bias question must be judged by reference to the questions that the judicial officer is required to decide in particular proceedings. The Court held that the scope of the inquiry must be determined by reference to the terms of the legislation:[7]

[The Coroners Act] does not provide a general mechanism for an open ended inquiry into the merits of government policy, the performance of government agencies or private institutions, or the conduct of individuals, even if apparently related in some way to the circumstances in which the death or fire occurred.[8]

And further[9],

[6] The Court acknowledged the dilemma that the timing of such an application caused the prosecutors.
[7] In the ACT a coroner is empowered by s18 to hold an inquiry into "the cause and origin of the fire".
[8] At para [15]
[9] At para [28]

[the power conferred by the Act] does not authorise the coroner to conduct a wide-ranging inquiry akin to that of a Royal Commission, with a view to exploring any suggestion of a causal link, however tenuous, between some act, omission or circumstance and the cause or non-mitigation of the fire. As Nathan J said in Harmsworth v The State Coroner[10], such discursive investigations might never end and hence never arrive at the findings actually required by the Act. It would also be difficult to contain such inquiries within reasonable bounds whilst at the same time ensuring due fairness ...a coroner might be constantly torn between the need to contain the scope of the inquiry and the need to ensure that all interested parties were treated fairly. More fundamentally, the section does not confer jurisdiction to conduct inquires of that scope.

The Court went on to illustrate this proposition with a series of examples.[11] Those examples, when analysed, suggest that the Court had in mind quite a narrow scope for the jurisdiction of the Coroner at inquest. Some examples of matters too remote to be regarded as causative of the fire, were: was there a failure on the part of government to embark on adequate fuel reduction measures and if so was this failure due to money or a misguided policy approach; should fire crews have been deployed differently; did some householders contribute to the destruction by failing to prepare their homes for fire. As to these matters and other, the Court held (at [27]):

Whilst none of these suggested issues could be said to be irrelevant, they are somewhat remote from the concept of the cause and origin of the fire, and any adequate investigation of them would involve not only substantial time and expense, but also delving into areas of public policy that are properly the prerogative of an elected government rather than a coroner or indeed, any other judicial officer.

[10] (1989) VR 989

[11] The Court made reference at paragraph [13] to an "issues list" that counsel-assisting had disseminated to the parties, commenting on two occasions, that many matters on it were outside the scope of jurisdiction conferred by the Act. However, the Court did not identify any of these issues, preferring instead to use non-specific examples.

In addition to this important statement, the Court also held, relying upon *Harmsworth*, that the conferral of the power to make comments does not enlarge the scope of the Coroner's jurisdiction to conduct an inquiry.[12]

However, after a number of statements generally consistent with the approach taken in *Harmsworth*, the Court ultimately declined to make any rulings as to whether specific matters which were potentially to be canvassed in the inquest were or were not *sufficiently proximate to fall within the concept of "cause and origin" of the fires*. The Court allowed that a liberal approach was acceptable in the early stages of an inquiry, when a coroner is still seeking to identify what issues are likely to arise.

Doomadgee v Clements: Palm Island[13]

The deceased died in a watchhouse cell at the Palm Island police station. He died as a result of a lacerated liver. Essentially, the coroner had to determine how that injury occurred. On the facts presented to the inquest, it occurred either (i) accidentally, when the prisoner and Sergeant Hurley fell onto a concrete floor in the course of his attempts to get the prisoner through the back door of the police station; or (ii) through the application of deliberate force inflicted by Sergeant Hurley to the prisoner when he was in his cell. At the inquest, the question arose as to whether the coroner would admit and consider evidence from two other Aboriginal men who alleged that on separate occasions in 2004, Sergeant Hurley assaulted them while they were his custody. (There was also a third allegation by a woman that Sgt Hurley had run over her foot when driving a police vehicle in the course of arresting her brother, which had previously been the subject of a complaint to police).

The coroner ruled that she would not admit what became known as "the tendency evidence" for the purposes of her duty to make findings under s 45 of the *Coroners Act* 2003. That section provides that she must find, inter alia, "what caused the person to die". She ruled that she had sufficient evidence surrounding the events, including witnesses

[12] At para [41]

and video evidence, to make factual findings. She held that it would be impermissible for her to rely upon evidence of another alleged assault for the purposes of drawing an inference about what occurred on the occasion in question. However, she held that she would admit the evidence for the broader purpose of making appropriate comments pursuant to s 46 relating to public health or safety, administration of justice, or prevention of future similar deaths. Her decision not to admit the evidence for the purpose of making factual findings was challenged by the family and community; her decision to admit the evidence as potentially relevant to her comment power was challenged by Sergeant Hurley and the Police Commissioner. Both matters were considered together by the Supreme Court.

The Court confirmed, at [28], that the Coroner's enquiry into how, when, where and by what cause the person died is 'extensive' and not confined to the specific matters listed. The power to comment is 'ancillary' to the power to make findings. The Court went on to cast a much wider net than the ACT Court of Appeal was prepared to cast in the *bushfires* case. It held (at [31]) that the coroner is empowered to address matters of public health and safety or the administration of justice:

with a view to exposing some failing, deficiency or wrong and/or suggesting measure which may be implemented for the public benefit. Section 46(1), being remedial in nature, should be construed liberally.

Further (at [33]):

Something connected with a death may be as diverse as the breakdown of a video surveillance system, the reporting of the death, a police investigation into the circumstances surrounding the death, and practices at the police station or watch house concerned.

[13] *Doomadgee & Anor v Clements & Ors [2005]QSC 357*

The Court went on to say that due to the "scope and indefinite boundaries" of a coroner's role, it would normally be inappropriate to interfere with the gathering of evidence by a coroner. Indeed, the Court ultimately held, that it was an error for the Coroner to exclude evidence on the basis that it would be inadmissible was she to apply the ordinary rules of evidence in the circumstances. Although the Court did not specifically discuss *Harmsworth*, other than to refer to the submissions of the police in reliance upon it, it appears the substance of the approach taken in *Doomadgee* does not follow *Harmsworth*.

The cases above each deal with different legislative formulations, but essentially the same question; what is the scope of the Coroner's jurisdiction at inquest? The two Queensland cases affirmed the broad jurisdiction at inquest, including a broad power to comment. When the factual situations and examples given by the courts are analysed, it appears that the decision in *Doomadgee* does not follow *Harmsworth*. The ACT Supreme Court, on the other hand, took an approach closely aligned with that taken in *Harmsworth*. It is to be regretted that the Court chose to illustrate the general principles espoused with hypothetical examples rather than the available "issues list" that was mentioned during the judgment. Applying the general propositions as held by that Court, to a particular factual situation, remains a challenge. One of the issues still at large is the extent of the power to comment on matters connected with the death. An assertion that the power to comment does not allow for the admission of evidence otherwise not relevant to the primary power (to make findings) is not consistent with well-accepted practise at inquests.