RECENT APPELLATE CORONIAL LAW DECISIONS IN AUSTRALIA

Introduction

There have been a number of appellate decisions in coronial law in the past twelve months. Although none of these decisions changes the law in any way that is likely to be of significance for the way in which coronial proceedings are conducted, the authorities do contain helpful statements of relevant principles and useful examples of the application of those principles.

The cases are grouped into the following topics:

1. Cases concerning the decision to hold an inquest;
2. Findings and procedural fairness;
3. Referral of information to prosecuting authorities;
4. Non-publication orders; and
5. Decisions concerning autopsies.

Finally, this paper also considers the recent decision of the High Court in Burns v The Queen [2012] HCA 35, which concerns the question of whether a supplier of drugs may be guilty of manslaughter in circumstances where the purchaser of the drugs dies of a drug overdose in the supplier's presence.

Although this decision does not concern coroners or coronial proceedings, it is important to coroners in jurisdictions where the coroner is obliged to forward information to prosecuting authorities where the coroner is of the view that a person has committed an indictable offence.

Cases concerning the decision to hold an inquest

There have been three recent appellate decisions concerning the decision to hold an inquest: Conway NSW State Coroner [2011] NSWCA 319 (28 September 2011); Irfani v State Coroner [2011] WASC 270 (3 October 2011); and Taing and Nuoin v The Territory Coroner [2011] NTSC 58 (9 August 2011).

Conway concerned a decision of the State Coroner refusing to hold an inquest into the death of M, a 15 year old young person who died in a motor vehicle accident in Sydney in 2003. At the time M was homeless. The vehicle in question was stolen and was driven by a young man who was providing M with accommodation at the time. M's death had been thoroughly investigated by NSW police. However, M's mother had ongoing concerns about the manner of her death, and sought that an inquest be held, to investigate, inter alia, whether the Department of Community Services ("DOCs") could have done more to assist M find accommodation.

The State Coroner refused to hold an inquest, indicating that the manner and cause of M's death was sufficiently disclosed, and that an inquiry into M's relationship with DOCs was too remote. Justice Barr agreed with this decision: Conway v Jerram [2010] NSWSC 371. M's mother sought leave to appeal from the decision of Barr J. Leave was refused by the Court of Appeal on 28 September 2001.
In refusing leave to appeal Young JA commented that a coroner has a “wide, but not unlimited, mandate to hold or not hold an inquest concerning the death of a person” (at [47]). At para [49], his Honour observed that “in the usual cases of death, a line must be drawn at some point beyond which, even if relevant, factors which come to light will be considered too remote from the death.”

**Taing and Nuong** concerned a decision of the NT Supreme Court relating to a decision of the NT Deputy Coroner refusing to hold an inquest into the deaths of two fishermen who died in a fire at their campsite. As with the death in the *Conway* case, there had been an extensive police investigation into the deaths.

In the Supreme Court, Blokland J accepted that it would be “desirable” to hold an inquest if there were some “practical benefit to the next of kin in terms of better understanding … what occurred to the deceased, or that there be a benefit to the general public, a section of it, or to the overall administration of justice” (at [54]). Justice Blokland emphasised, however, that “[a]n inquest should not be held where it would clearly be a futile exercise.” (at [54] and [56])

Justice Blokland accepted that a “comprehensive” investigation had been conducted by police (at [65]). In these circumstances, his Honour stated that “[w]ithout pointing to any further evidence or how an inquest would reveal such evidence it has not been demonstrated that an inquest into the deaths of the deceased would serve any useful purpose.” For these reasons, Blokland J declined to order that an inquest be held.

**Irfani** concerned a decision of the WA State Coroner refusing to hold an inquest into the death of Fatima Irfani. Ms Irfani died in a Western Australian hospital in 2003. She had arrived at Christmas Island as a refugee in 2002. She suffered from hypertension and hepatitis C. In January 2003, whilst in detention, she complained of severe headaches over a number of days. Around noon on 15 January 2003, Ms Irfani collapsed. She was initially taken to the Christmas Island hospital, but was later that day flown to Perth in a critical condition. A head CT scan showed that she had an intra-cranial haemorrhage. Surgery was performed. However, her condition deteriorated, and she died on 19 January 2003.

Ms Irfani’s family sought that an inquest be held into her death. The issues to be raised in the inquest concerned the care and treatment provided to Ms Irfani in detention at Christmas Island and the timing of her transfer to Perth. No issues were raised as to the care and treatment provided to Ms Irfani after the transfer to the Perth Hospital.

A coroner in Western Australia declined to hold an inquest. Ms Irfani’s family sought an order from the Supreme Court requiring an inquest to be held.

As Ms Irfani was not “in care” at the time of her death, an inquest was not mandatory. However, Ms Irfani’s family argued that because Ms Irfani was in immigration detention, the death was analogous to a death in custody.

Justice McKechnie in the Supreme Court in Western Australia accepted that there is a public interest in holding a public inquiry into deaths occurring in immigration detention (at [37]). However, his Honour also observed that “the ultimate purpose of the Coroner is to inquire into a particular death.” (at [37]). His Honour expressed the view that the circumstances of the particular death, “being well documented” would not lead to the “wider inquiry sought by the plaintiffs.” (at [37]). Justice McKechnie
emphasised that “the focus of an inquest is into the death and the immediate circumstances giving rise to the death. It is not a general inquisition into the detention system.” (at [43]) In this regard, his Honour observed that two independent experts briefed by the Coroner had concluded that the standard of the medical response on Christmas Island was reasonable, subject to one exception. That one exception was the administration of a drug, however, there was no evidence that that drug was in fact administered or that it had anything to do with Ms Irfani’s death.

Justice McKechnie also observed that there had been a lengthy delay from the date of the death to the date that the Supreme Court was asked to order that an inquest be held (at [40]). Whilst such a delay is not a barrier to an inquest being held, it is “one of the relevant facts to be taken into account.” (at [40]).

His Honour observed that the Coroner had undertaken an investigation and would make findings. His Honour stated that he was “unpersuaded that a formal inquest as part of this investigation [would] sufficiently advance the Coroner’s knowledge in this case in the interests of justice.” (at [47])

Comment: It may be observed that there are a number of themes that recur in the above three decisions. First, the decisions confirm the width of the coroner’s discretion as to whether or not to hold an inquest. The decisions (particularly Conway and Irfani) also confirm that the starting point when determining whether or not to hold an inquest is the coroner’s statutory duty to determine the date, place, cause and circumstances (or manner) of death. Finally, the decisions confirm the importance of a thorough police investigation as part of the coronial process. It may not be necessary to hold a public hearing where there has been a thorough investigation, and it appears from that investigation that a public inquest will not shed any further light on the date, place, cause and circumstances of the death.

Findings and procedural fairness

Onuma v Coroner’s Court of South Australia [2011] SASC 218 (9 December 2011) is an interesting decision of the Supreme Court of South Australia, which provides guidance to coroners on questions of procedural fairness.

Onuma concerned an inquest into the deaths of two elderly women who each died following surgery for a vaginal prolapse. The same surgeon performed the procedure in each case. Both women suffered from a perforated bowel that was caused at some stage during their respective surgical procedures.

At the conclusion of the inquest, the Deputy Coroner made findings. In those findings, the Deputy Coroner was critical of the competence of the surgeon who performed the surgeries in question. The Deputy Coroner also made recommendations to the Royal Australian and New Zealand College of Obstetricians and Gynaecologists concerning the competence of surgeons performing vaginal prolapse surgery.

The surgeon in question appealed the Deputy Coroner’s findings.

The grounds of appeal in the Supreme Court included complaints about the findings made by the Deputy Coroner, the comments made by the Deputy Coroner, the
recommendations made by the Coroner and a complaint about a denial of procedural fairness.

The complaint about the formal findings related only to one of the deceased – Mrs Hillman. The Deputy Coroner found Mrs Hillman’s cause of death to be “hypoxic ischaemic brain injury due to an intracerebral and subdural haemorrhage as a consequence of anticoagulation given to treat a left subclavian vein thrombosis and pulmonary thromboemboli, and peritonitis following perforation of the small bowel during surgery for vaginal prolapse.” (at para [25])

In considering this ground, Kelly J emphasised the distinction between findings as to the “cause” and “circumstances” of a death, and observed that the coroner has an “obligation to inquire into all of the facts which may have operated to cause the death of the deceased and as well to inquire into the wider circumstances surrounding the death of the deceased”. Justice Kelly concluded that the Deputy Coroner was required to set out the case and circumstances of Mrs Hillman’s death, “which necessarily included the unfortunate and catastrophic series of post-operative complications described in the reports...” (at para [40])

Justice Kelly acknowledged that these matters were traversed in the “Findings of Inquest”. However, her Honour found that these matters should have been included in the express finding which the Deputy Coroner made about the cause of death (at para [42]).

The appellant also complained about particular comments made by the Deputy Coroner concerning the appellant’s lack of competence. Justice Kelly held that the comments were not supported by the evidence, observing that it was difficult to say that “something has been done incorrectly or wrongly on the basis of one-off, or two-off, events.” (para [58])

However, although her Honour found that the Deputy Coroner should not have commented that the surgeon lacked competence, the Court declined to make a finding that the Deputy Coroner should have found that the appellant was appropriately qualified and did possess the necessary skill and competence. In the Court’s view there was insufficient evidence before the Coroner to justify a finding on this topic one way or another.

As to the complaints about the recommendations, Kelly J disagreed with the appellant’s submission that the recommendations were based solely on the impugned comments, observing that the expert evidence did provide a proper basis for the recommendations. However, her Honour also held that the Supreme Court did not have jurisdiction to set aside recommendations. In her Honour’s view, recommendations were not part of the statutory “findings” which are subject to an appeal under s. 27(1) of the Coroners Act 2003 (SA). In this regard, her Honour disagreed with the decision of Debelle J in Saraf v Johns (2008) 101 SASR 87.

The final complaint related to an allegation that the appellant had been denied procedural fairness because the Deputy Coroner made comments concerning his competence without first advising him of the Coroner’s intent to make such comments. In rejecting this ground, Kelly J commented that there was “no doubt” that a Coroner is subject to rules of natural justice and fairness, and that those rules “require that any party likely to be affected, either directly or indirectly, by a decision
is to be given the opportunity to be heard and to make submissions before any decision is made”. (at [95])

However, her Honour observed that Counsel Assisting had asked (over objection) a number of questions of the appellant and relevant experts relating to the appellant’s competence. Moreover, Counsel Assisting had specifically raised the topic of the appellant’s competence in closing submissions, and counsel for the appellant had had a right to reply to these submissions. In view of these matters, Kelly J concluded that the Deputy Coroner had complied with his duty of procedural fairness.

In Danne v the Coroner [2012] VSC 454, a surgeon who was a party to an inquest sought access to a postmortem CT scan and tissue samples. The Coroner granted access conditional on the surgeon providing the Coroner with copies of any expert reports subsequently prepared concerning this evidence.

The Supreme Court of Victoria set aside the Coroner’s order. The Court held that the Coroner had erroneously sourced the power to make the condition as being an aspect of the coronial jurisdiction over the body of the deceased. The Court held that once removed, tissue samples are no longer part of the body. The Court also held that the condition breached the coroner’s duty to afford natural justice, and that the condition was inconsistent with legal professional privilege.

Referral of information to prosecuting authorities

In Nona and Ahmat v Barnes [2012] QSC 35 (29 February 2012), the appellants sought review of a decision of the Queensland State Coroner refusing to refer information to the Director of Public Prosecutions (“DPP”) pursuant to s. 48(2) of the Coroners Act 2003 (Qld). In particular, the appellants sought an order that the State Coroner provide a “statement of reasons” pursuant to the Judicial Review Act 1991 (Qld).

The Supreme Court of Queensland dismissed the application, finding that the decision of the State Coroner refusing to refer the information was not a “reviewable decision” under the Judicial Review Act because it did not “confer, alter or affect legal rights or obligations”.

Non-publication orders

Bissett v Deputy State Coroner [2011] NSWSC 1182 (7 October 2011) concerned an inquest held in New South Wales involving a police shooting of a mentally ill man (Adam Salter). A critical incident investigation was held, and in the course of that investigation, a “walk through” interview was conducted between investigating officers and Sergeant Bissett, the police officer who had shot and killed Mr Salter. The walk-through interview was recorded on DVD.

A critical issue in the inquest was whether Sergeant Bissett shot the deceased in self defence or in defence of other police officers. Some of Sergeant Bissett’s answers in the DVD were exculpatory, and some of her answers were incriminatory.
The DVD was admitted into evidence (over objection) and the ABC made an application for access to it. The Deputy State Coroner granted access, but imposed a short non-publication order to enable Sergeant Bissett to approach the Supreme Court to seek an injunction prohibiting the Coroner from providing the DVD to the media.

Justice Hulme held that it was appropriate for the transcripts of the DVD to be published, but that, until further order, there should be no publication of the DVD walk through itself. Justice Hulme took into account that there was a real possibility that the Deputy State Coroner would refer the matter to the DPP and that Sergeant Bissett may be charged with a serious criminal offence. His Honour also took into account the fact that there was a substantial possibility that the DVD walkthrough would not be admitted in any trial. In these circumstances, publication of the DVD could jeopardise any future trial.

Justice Hulme distinguished the DVD from the publication of other evidence before the coroner, including the transcript of the DVD, stating “in its inherent nature, it will be appreciated not simply by one sense, but by two – hearing and sight.” (at [25]) Because of this, his Honour considered that the DVD was more likely to be remembered than a mere publication of the transcript.

In these circumstances, His Honour accordingly concluded that the publication of the contents of the DVD was liable to prejudice the proper administration of justice and that publication should thus be restrained: at [27]. However, his Honour also held that permanent prohibition of publication of the DVD was not required, and that publication should only be delayed until it became apparent that no trial of the Sergeant Bissett was likely in the foreseeable future, or that any such trial had been held.

Note: In Bissett, the Court erroneously applied the Courts Suppression and Non-Publication Orders Act 2010 (NSW), which has no application to coronial proceedings. The appropriate legislation was s. 74 of the Coroners Act 2004. However, the principles which Hulme J applied would appear to be of general application.

It may also be of interest to note that the Bissett inquest led to a Police Integrity Commission Inquiry which was held this year into the conduct of the critical incident investigators. The decision of the Inquiry is pending.

Decisions concerning autopsies

There are two recent decisions of the Northern Territory Supreme Court concerning autopsies: Evans v Northern Territory Coroner [2011] NTSC 100 (6 December 2011) and Raymond-Hewitt v Northern Territory Coroner [2011] NTSC 94 (22 November 2011).

Evans and Raymond-Hewitt each concerned the question of whether an autopsy should be ordered in circumstances where the deceased were indigenous persons, and where the family of the deceased strongly objected to the autopsy on spiritual grounds.
Evans concerned a young baby who had died in his sleep. The likely cause of death was SIDS. Raymond-Hewitt concerned an indigenous man who had died in a road accident when his four wheel drive collided with a Mack Truck on the Arnhem Highway.

In both cases, the Supreme Court directed that no autopsy be held. In reaching these determinations, the Supreme Court in both cases emphasised that there was no suggestion of foul play. The Court observed in both cases that there was a public interest in making an accurate finding as to the cause of death, but also observed in both cases that it was relatively unlikely that an autopsy would shed any further light on the cause of death.

Comment: The above cases illustrate that genuinely held spiritual beliefs of the family of the deceased will typically override the public interest in accurately determining the cause of death, particularly where there is little likelihood of an autopsy shedding any further light on the cause of death unless there is any suspicion of foul play, in which event, spiritual concerns will take second place to the public interest in investigating those suspicions.

Criminal decision: Manslaughter for death resulting from a drug supply

Burns v The Queen concerns the liability of an accused for manslaughter arising out a drug supply. The facts, briefly stated, were as follows: the appellant and her husband jointly supplied the deceased with methadone. The deceased injected the methadone within the appellant’s apartment, but it was not clear whether the appellant assisted the deceased with the administration of the drug.

The deceased remained in the apartment for a period of time after injecting the methadone. The appellant told the deceased that had to leave. The appellant’s husband assisted the deceased to leave the apartment. The following day, the deceased’s body was found in a toilet block in the yard of the appellant’s apartment. A forensic pathologist gave evidence that the deceased died from a combination of the methadone and a prescribed drug which the deceased had taken earlier.

The appellant and her husband were each charged and were each convicted of manslaughter. The appellant’s husband died in custody without any appeal to his conviction. The appellant appealed her conviction, first the NSW Court of Criminal Appeal and then to the High Court.

In the High Court, the prosecution relied on two alternate bases for sustaining the conviction of manslaughter: namely manslaughter by unlawful and dangerous act and manslaughter by criminal negligence. By a majority, the High Court held that the conviction for manslaughter could not be sustained on either basis. In dissent, Heydon J expressed the view that a conviction for manslaughter by unlawful and dangerous act was available.

Manslaughter by unlawful and dangerous act: In the High Court, the Crown conceded that the act of supply could not, of itself, sustain a conviction for manslaughter by unlawful and dangerous act. Every member of the High Court accepted that this was a proper concession.
All members of the High Court accepted that the supply of an illicit drug is unlawful, however, they held that the supply of a drug is not dangerous. The Court explained that supplying an illicit drug is not dangerous because illicit drugs are not dangerous in and of themselves. Rather, illicit drugs are only dangerous if they are consumed. In this regard, the Court stated that the voluntary act of the deceased in consuming the methadone broke the chain of causation, so that it could not be said that the appellant had, in supplying the methadone, “caused” the deceased’s death.

Although the Crown had conceded that the act of supply was not sufficient of itself to sustain a conviction for manslaughter by unlawful and dangerous act, the Crown sought to maintain the conviction on the basis that the appellant, acting in concert with her husband, had assisted in the administration of the drug to the deceased.

The majority did not decide whether assisting in the administration of an illicit drug could sustain a conviction for manslaughter by unlawful and dangerous act. Rather, the majority found that there was insufficient evidence for the Crown to establish that the appellant had in fact assisted in the administration of the drug. Justice Heydon dissented on this point – his Honour would have ordered a retrial on the basis that there was sufficient evidence for a jury to find that the appellant had assisted in the administration of the drug.

**Manslaughter by criminal negligence:** In order to sustain a charge of manslaughter by criminal negligence, the Crown must first establish that there was a duty between the accused and the deceased which requires the accused to act.

All members of the Court denied that the relationship between a supplier of drugs and the purchaser of drugs did not give rise to any relevant duty. In making this finding, the Court emphasised again that the appellants’ actions in supplying drugs to the deceased did not “imperil” his life – rather “the imperilment of the deceased was the result of his act in taking the methadone.” (at [105])

In the circumstances of this case, the Court determined that there was no relationship between the appellant and the deceased which would have required the appellant to obtain medical assistance for him.

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20 November 2012