ASIA PACIFIC CORONERS SOCIETY

CONFERENCE 2018

TUESDAY 13 NOVEMBER 2018

It is a pleasure to join you this evening in the newly opened impressive new courts precinct. May I join in welcoming delegates from other Australian jurisdictions and from overseas, at what is undoubtedly the finest time of the year to come to Canberra. The rule in Canberra is to keep the heater on until after Armistice Day. Then for a glorious three to four weeks the blossoms are out, the weather is balmy and life is blissful until the heat of the Canberra summer hits. You have not only been discerning enough to come to Canberra during this pleasing, if small, window, but the program that Chief Coroner Walker and her team have put together is excellent. It is a privilege to have Sir Angus Houston to speak on the work done under his leadership on the identification of victims from the MH17 tragedy. And equally it is a privilege to have Professor McGorry as the keynote speaker. Few Australians of the Year have turned their term of office, if that is the right way of describing it, to such good use; Professor McGorry single-handedly has put youth mental health and suicide clusters on the map for all of us. Coroners, I suspect, have an acute understanding of the value of his work.

One focus of the Conference is on therapeutic aspects of the coronial process. The recognition, including the legislative recognition, of the need to maintain communication with families

throughout the coronial process, to include families in decisions as confronting as the decision to hold an autopsy, to have their voice heard about the impact of the death at the inquiry, these are the most notable changes in coronial practice that I have witnessed over the course of my professional life.

The change is mirrored, albeit to a lesser extent, in the way in which criminal courts dealing with homicide offences have come to acknowledge the effect of the proceeding on the family of the victim. Victim impact statements are now routinely received and allow the family to confront the offender with the extent of their loss. They have come to play an important and, one hopes, a cathartic role in the criminal proceeding. Judges have come to learn, as Michael King says he learned when he was the Geraldton Coroner, of the importance of referring to the deceased by his or her name and not as "the deceased"[1].

There remains a limit to the extent to which the judge or the coroner can offer meaningful support to the bereaved family given the formality and restraint that the discharge of judicial duties requires. Recognition of this limitation highlights the other notable innovation that has taken place during the course of my time in practice: the development of forensic counselling services. I note

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[1] King SM, "Applying Therapeutic Jurisprudence in Regional Areas: The Western Australian Experience" (2003) 10(2) *eLaw Murdoch University Electronic Journal of Law* at [49].

that in some jurisdictions this service is delivered through the Coroner's Court itself, as in Western Australia and South Australia, which sounds to be an ideal model. In whichever way the service is delivered, its importance lies not only in general grief counselling, but in explaining the coronial process so that families have an understanding of the coroner's function and realistic expectations about the likely outcome of any inquiry.

The "Sample of Coroner's Introductory Remarks at Inquest" in the appendix to Hugh Dillon's and Marie Hadley's *Australasian Coroner's Manual* impresses me as clear and appropriately sensitive. Reading it makes me conscious again of how far we have come from the approach to the conduct of inquests a generation ago. Hugh Dillon always speaks of his experience as Deputy State Coroner (NSW) as the most stimulating and interesting of his judicial work. This is a sentiment that I can readily understand, although I do not underestimate the emotional demands of the work.

I have always felt that the importance of the work of the coroner has never been better expressed than it was by Hutley JA in *Bilbao v Farquhar*[2]. I was a law student at the time of the decision. It concerned a case which at the time was a cause célèbre. Maria Bilbao, the sister of Jose Bilbao, brought proceedings in the Supreme Court of New South Wales, seeking an order in the nature of

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[2] [1974] 1 NSWLR 377 at 385.

mandamus directed to Murray Farquhar, Stipendiary Magistrate, compelling him to resume the hearing of a coronial inquiry. Jose Bilbao died in custody as the result of injuries which it appeared he had sustained in the Central Police Station cells. The inquest had been terminated when charges were laid against two police officers in connection with the death. Farquhar SM discharged both officers at the committal hearing and subsequently declined to resume the inquest.

The Court of Appeal held that Farquhar SM's reasons for that refusal were attended by legal errors, which included his Worship's concern that publicity might reflect badly on the discharged police officers. Hutley JA observed that this consideration was irrelevant to the determination of whether the Inquest should be resumed. His Honour went onto say this[3]:

> "It must, however, be remembered that here, under suspicious and tragic circumstances, a person died, and the fact that he was a lonely migrant without relatives in this country does not in any way diminish the serious importance of canvassing all avenues to determine the manner and cause of his death, even if this inquiry may embarrass the authorities. This is particularly so because he appears to have died in consequence of an injury which he suffered while in the custody of the State. Such an inquiry may assist those in control of the police in avoiding any repetition."

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[3] *Bilbao v Farquhar* [1974] 1 NSWLR 377 at 385.

The importance, in an appropriate case, of holding a public inquiry into the manner and cause of a death is self-evident. So, too, is the importance of the coroner's role in making recommendations to the appropriate authority arising out of the evidence adduced at the inquiry. The *Coroners Act 1997* (ACT) has as one of its main objects the making of recommendations about the prevention of deaths, the promotion of general public health and safety and the administration of justice[4]. The discharge of this important function requires that procedural fairness is accorded to any person or body who might be affected adversely by any recommendation. It is important that those persons or bodies see that any adverse finding is one reached on the evidence by an impartial judicial officer. Balancing the need for sensitivity towards the grieving family and the appearance, and reality, of judicial detachment is a particular skill required of judicial officers in this unique jurisdiction.

I have unpardonably slipped into seriousness at a welcome reception. All I can say is I hope that the screening of *Joe Cinque's Consolation* tomorrow night is more entertaining and that your deliberations during the next three days are fruitful.

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[4] *Coroners Act 1977* (ACT), s 3BA(1)(d)(i), (ii) & (iii).