THE CORONERS COURT, INQUESTS AND INQUIRIES, AND NOTABLE CASES

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THE NSW CORONERS COURT

History of the Coroners Court

The office of the Coroner dates back to as early as 1194 in England. In the early years of the Coroner's office, the Coroner's duties were largely administrative - they collected taxes and kept the King's records. In 1787, the Coroners Court was part of the legal system established in NSW by Governor Phillip and had expanded to include investigating deaths. From 1861, the Coroners Court could also hold inquests into fires/explosions.

Legislation

The act that regulates the activities of the Coroners Court is the ***Coroners Act 2009*** **(NSW)** ('the Act'). The legislation provides that the role of the court is to:

- investigate certain deaths to determine the identity of the deceased and the date, place, circumstances and medical cause of death
- to investigate the cause and origin of fires and explosions.

Reportable Deaths and Fires

The NSW Coroners Court has **jurisdiction** to investigate the circumstances of a death if the deceased person has a connection with the state of NSW. As specified in the Act, individuals must:

- Ordinarily be a resident of NSW; or
- In NSW; or
- Travelling to or from a place in NSW.

In relation to a fire or explosion, it must have occurred in NSW for the NSW Coroners Court to have jurisdiction.

FACT
Coroners in NSW investigate about 6000 reportable deaths annually

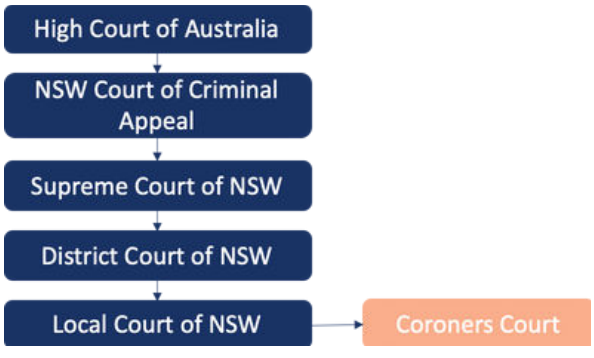
Role of the Coroners Court

Australian court systems are **adversarial**. This means that there are two opposing sides presenting arguments to the court.

However, the role of the Coroners Court is not to make a determination of guilt, but rather to discover what caused an event to occur, with the intention of reducing the number of preventable deaths and fires/explosions. This means that the Coroners Court has an **inquisitorial role** in which:

- There are no sides. All parties collaborate in the search for the truth; and
- State Coroners, Deputy State Coroners and Coroners do not rely on the accuser to put forward information and evidence; they investigate actively and discover information for themselves.

The Coroners Court is a division of the Local Court in NSW and sits in the NSW court hierarchy as follows:



Who's Who in the Coroners Court

There are a number of other people you would find in a Coroners Court:

State Coroner, Deputy State Coroner or Coroner

As specified in section 7 of the Act, the State Coroner and Deputy State Coroner(s) are Magistrates of the Local Court and have the duty of presiding over proceedings. Section 12 also enables the Attorney General to nominate to the Governor any other persons qualified as an Australian Lawyer to be appointed as Coroners. All magistrates are able to act as a Coroner.

CORONERS ACT 2009

s 7(2)
A person is qualified to be appointed as the State Coroner or a Deputy State Coroner only if the person is a Magistrate.

s 12(2)
A person is qualified to be appointed as a coroner only if the person is an Australian Lawyer.

Throughout a coronial inquest into a death, the Coroner will attempt to answer the following questions:

- Who died?
- When and where did the person die?
- How did the person die?
- What happened and why?

See example of Theo Hayez on page 7.

In a coronial inquires into fires and explosions, the Coroner will attempt to discover the cause and origin of the fire or explosion. The secondary aim to all inquiries and inquests, whether related to death or fires and explosions, is to ascertain if there is anything that can be done in future to prevent similar deaths or damage caused.

For more information, see:
https://www.coroners.nsw.gov.au/coroners-court/how-the-coroners-court-work/jurisdiction.html

Counsel Assisting the Coroner

Generally a police prosecutor who helps the Coroner run and organise the inquest.

Lawyers

Their role is to represent the interests of various parties.

Court Officer

They ensure the hearing runs smoothly and administers the oath to the witness.

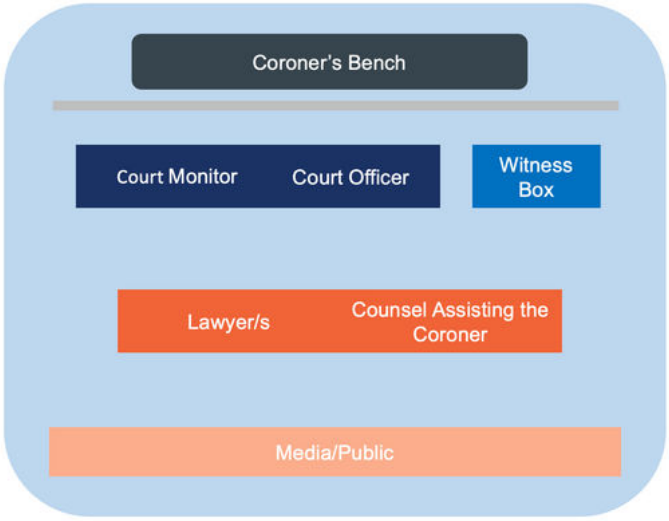
Court Monitor

They record the inquest and document particular things that are being said.

Witness

From the witness box, witnesses evidence about what they know.

The Media and Public

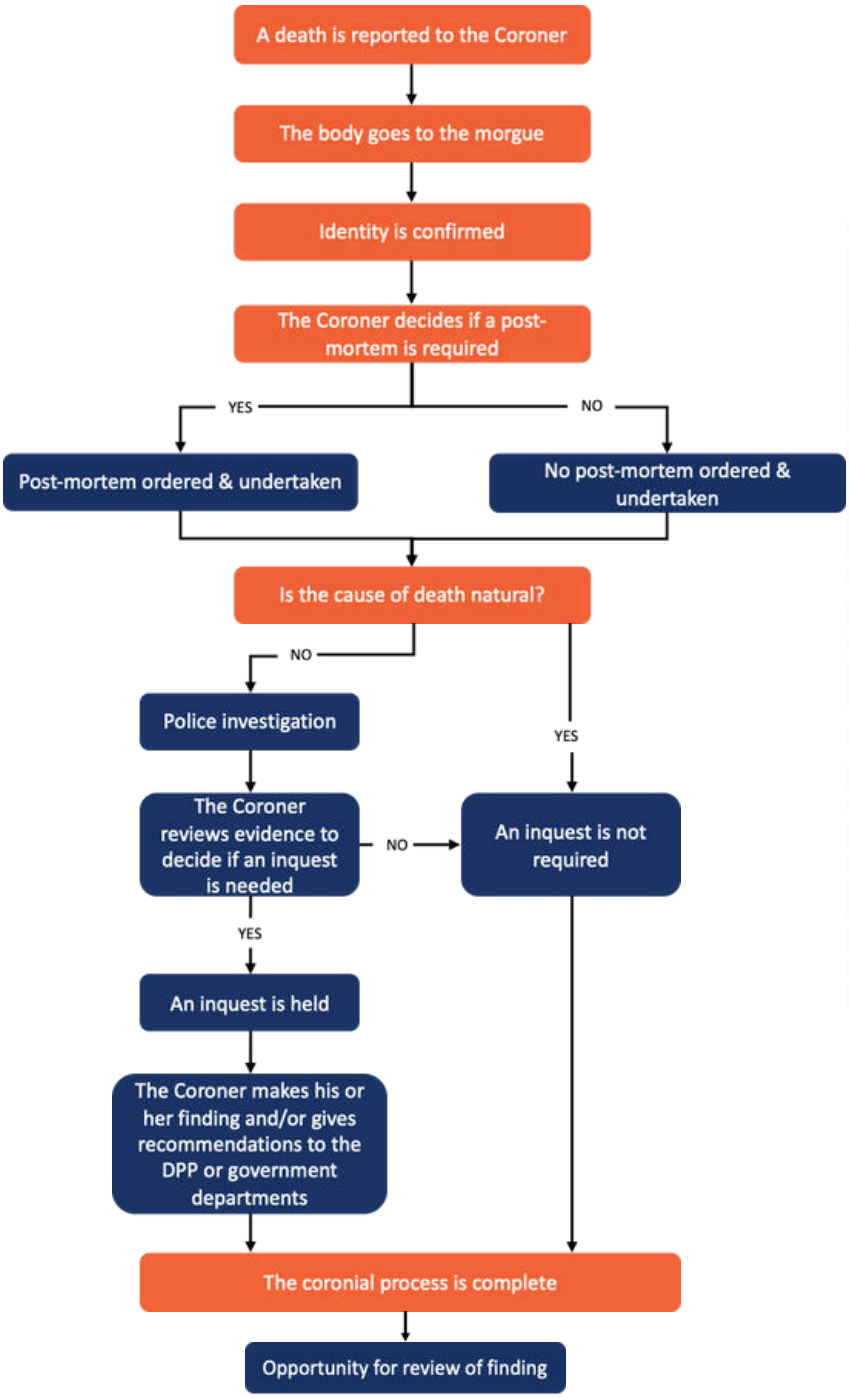


INQUESTS AND INQUIRIES

What are Inquests?

An **inquest** is a court hearing where the Coroner considers evidence to determine the identity of the deceased and the date, place, circumstances, and medical cause of death. An inquest can investigate a single death or multiple deaths. At the end of an inquest, a Coroner will make a finding.

The diagram below shows the process of a Coronial inquest in NSW:



What are Inquiries?

An **inquiry** is a court hearing where the Coroner investigates a fire or explosion which caused damage to property, but did not cause death to anyone. The Coroner's role is to determine the cause and origin of the fire or explosion.

FACT
The average length of an inquest or inquiry in NSW is 12 months.

What happens During Inquests and Inquiries

During an inquest or an inquiry, the following steps generally occur:

OUTCOMES OF INQUESTS AND INQUIRIES

At the conclusion of the proceeding, the Coroner may make a finding in relation to a death or fire:

- A finding of fact is a conclusion arrived at by the Coroner.
- An open finding is a decision saying that a crime has been committed but not naming a criminal, or saying that there has been a death but not naming the cause of the death.

Once a finding has been made, the Coroner can:

Make recommendations to Government ministers/departments

The Coroner may make recommendations to government agencies with the intention of improving public health and safety. See Dunukul Mokmool on page 8.

Refer to the DPP if a known person may have committed an indictable offence

The Coroner does not have the power to find someone guilty of a crime. Yet, the Coroner may refer the matter to the DPP if, at some time throughout the proceeding, the Coroner forms the opinion that a known person has committed an indictable offence in connection with the death. In such cases, the Coroner must suspend the inquest. It is then a matter for the DPP to decide whether charges will be brought against the person. See Parwinder Singh on page 8.

Review of Coronial Decisions

The opportunity for Coronial decisions to be reviewed aligns with the appeals process in other courts in NSW. The scope for review of Coronial decisions also upholds important rule of law principles, such as an **open, impartial, and independent judiciary.** It similarly operates as an important **check and balance** on the processes and powers of the Coroners Court.

If you are a person with a sufficient interest in a death or a fire/ explosion being investigated, you can write to the NSW State Coroners at the Coroners Court who will review the matter. If a hearing has been dispensed with, you can also ask the Coroner for written reasons for the decision. This is an example of open justice.

A Coroner may decide to reopen an investigation if the discovery of new or fresh evidence deems it necessary or in the interests of justice to hold an investigation. This is what happened in the inquest into the death of Azaria Chamberlain, which is outlined on page 9.

In NSW, the Supreme Court has the power to direct that an inquest or inquiry be held, where the Coroner has dispensed with one. Additionally, the Supreme Court can direct that a fresh hearing be held if it is in the interests of justice.

THE CORONERS COURT, INQUESTS AND INQUIRIES, AND THE RULE OF LAW

How do the hearings of the Coroners Courts uphold rule of law principles?

Equality Before the Law

The Coroners Court upholds one of the most important rule of law principles: the law is applied equally and fairly to all citizens. This can be seen by the way the Coroners Court will investigate any death which is sudden, unexpected, or unexplained, regardless of an individual's status.

Accessibility, and Open, Independent, and Impartial Judiciary

The Coroners Court provides **access to justice.** The court enables all citizens to report an unexplained death or fire/explosion to the Coroner, which may then be investigated if it is deemed necessary. Citizens can therefore use the Coroners Court to seek solutions to their problems and receive just outcomes.

Further, any member of the public or media can attend an inquest or inquiry in the Coroners Court. Like many other courts in Australia, enabling the general public to view a hearing allows the law to be **known and accessible.** Additionally, allowing the public and media to witness a hearing **opens the law up to criticism** and upholds principles of **open justice.** This also encourages citizens to be **engaged and active** in our legal system, which is fundamental to the strength of the rule of law.

Presumption of Innocence?

Although the Coroners Court does not determine the guilt of any individual, the inquests and inquiries held in the Coroners Court may have important implications for the **presumption of innocence.** If a matter is referred to the DPP, and a case is committed to trial by the DPP, publicity of the hearing or the Coroner's findings could impinge on an accused's presumption of innocence. This is because the widely publicised outcomes of the coronial hearing could prejudicially influence the perception of a jury tasked with determining an accused's guilt or innocence at trial.

It is also important to note that the same stringency in admitting evidence is not always applied in coronial proceedings.

Therefore, publicity of the coronial hearing and findings (determined by the Coroner using evidence that is not bound by the usual rules of evidence in other courts) may be prejudicial to an accused's right to the presumption of innocence.

Fair and Prompt Outcomes?

The length of an inquiry or inquest in NSW varies. However, on average, a hearing before the Coroners Court takes 12 months. The considerable length of such proceedings impacts upon fair and prompt outcomes for parties involved in the inquest/inquiry. In addition, should a trial follow, it could take many years for a full resolution to be reached.

CURRENT INQUESTS AND INQUIRIES BEFORE A CORONERS COURT IN NSW

Fire Inquiry: NSW Bushfires Coronial Inquiry

The NSW Bushfires Coronial Inquiry commenced in August 2021 and is still currently before the NSW Coroners Court. This inquiry is an investigation into the property damage and destruction arising from the 2019-2020 NSW bushfire season. The inquiry has also opened a number of inquests into the deaths arising from the fires during this time. The State Coroner is focussing on events particular to each death, rather than a widespread investigation into the bushfires which has already been conducted by the NSW Independent Bushfire Inquiry.

To give you an idea of this particular inquiry, we have canvassed the events of two different hearing days:

May 11 2021

- The inquiry opened inquests into the deaths of Andrew O'Dwyer and Geoffrey Keaton, both volunteer firefighters, who died when a tree collapsed on their firetruck near Buxton on December 19 2019, causing their truck to veer off the road and down an embankment.
- Witnesses, who were also in the fire truck at the time, were called to give evidence.
- Dash cam footage recovered from the fire truck was also admitted to the Coroners Court. It showed the tree crashing directly onto the fire truck.
- There was no evidence that could establish that Geoffrey Keaton, the driver, had braked after the tree fell down.
- It is likely that Geoffrey Keaton had no control of the fire truck once the tree hit the top of the truck.

March 21 2022

- The inquiry opened an investigation into the Bills Crossing Crowdy Bay Fire which started on 26 October 2019.
- The fire burned for 9 weeks and covered 13,000 hectares.
- 84% of the Crowdy Bay National Park was impacted by the fire.
- 6 properties were damaged or destroyed by the fire.
- The fire caused 1 fatality.
- Mark Fullgar, from the RFS fire investigation and arson intelligence who was tasked with investigating the fire, was called to give evidence at the Coroners Court. He gave evidence that lightning could be the only cause of the fire, due to the inability of anyone to physically get in to the site due to its remote location.

As mentioned before, the NSW Independent Bushfire Inquiry was conducted in January 2020 (before the NSW Bushfires Coronial Inquiry) and was an independent expert inquiry into the 2019-20 bushfire season. The aim of this Independent inquiry was to provide recommendations to NSW ahead of the next bushfire season. It outlined 76 recommendations, which can be read here in the final report (https://www.dpc.nsw.gov.au/assets/dpc-nsw-gov-au/publications/NSW-Bushfire-Inquiry-1630/Final-Report-of-the-NSW-Bushfire-Inquiry.pdf).
The recommendations are aimed at improving bushfire preparedness and response.

Disappearance Inquest: Inquest into the Disappearance of Theo Hayez

An inquest into the disappearance of Belgian backpacker, Theo Hayez, began in November 2021 and continued through to December 2021 at the Byron Bay Coroner's Court. 18 year old Theo was last seen at about 11pm on 31 May 2019 walking away from a nightclub in Byron Bay. His body has never been found.

The inquest heard that Theo's mobile data, uncovered by his family, shows he searched on Google Maps for directions back to his hostel, but then walked towards the Cape Byron Lighthouse in the opposite direction. Analysis of Theo's phone data suggests that he tried to scale the steep headland below the Lighthouse that night. This data also indicates that Theo never reached the Lighthouse.

The Officer in charge of the case gave evidence at the inquest that Theo's bank and social media accounts have not been used since the day of his disappearance, and he therefore believes Theo is deceased.

The only piece of evidence found was Theo's grey cap he had been wearing on the night of his disappearance on July 7 2019. State Coroner Teresa O'Sullivan ordered another search of the northern end of Tallows beach in October 2021, but no new evidence was uncovered.

The inquest has heard that there is no evidence of foul play in Theo's disappearance. A number of theories have emerged:

- Theo was disoriented due to intoxication.
- Theo was trying to find a beach party on the beach below the Lighthouse with an unidentified person.
- Theo was seeking to visit the famous Lighthouse.

The current police theory is that Theo scaled the cliffs near the Lighthouse, then fell and was swept out to sea.

The findings of the inquest are set to be handed down on 21 October 2022.

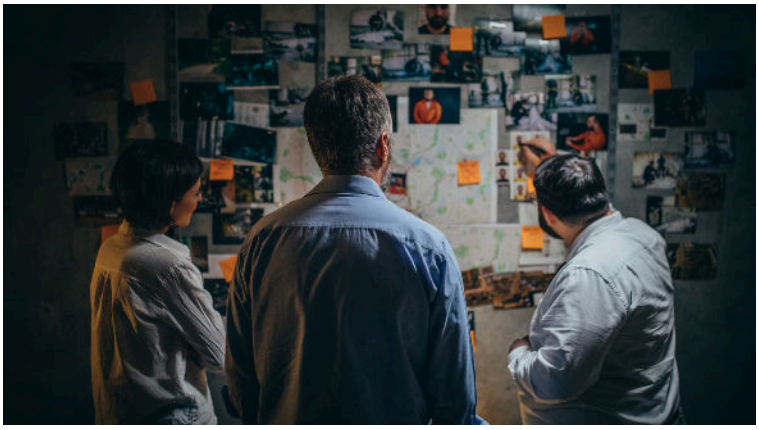
Death Inquest and Referral to the DPP: Inquest into the Death of Parwinder Kaur

On December 2013, Parwinder Kaur died as a result of receiving burns to almost 90% of her body. She was seen by neighbours running down the driveway of her Sydney home engulfed in flames. A police investigation took place following the December 13 incident, but it was left at a loose end. Following widespread media attention, the case was referred to the Coroner.

The Coronial inquest into Parwinder's death began on 28 September 2015 at the NSW Coroners Court. About a month later, on 27 November 2015, the NSW Coroners Court formed the opinion that:

"the evidence was capable of satisfying a jury beyond reasonable doubt that a known person [had] committed an indictable offence, that there was a reasonable prospect that a jury would convict the known person of the indictable offence, and that the indictable offence would raise the issue of whether the known person caused the death with which the inquest or inquiry [was] concerned."

On 1 November 2017, Parwinder's husband, Kulwinder Singh, was charged with his wife's murder. Kulwinder's first trial began on 18 October 2019 resulted in a hung jury. Following the second trial on 29 March 2021, the jury found Kulwinder innocent.



Death Inquest and Recommendations: Inquest into the Death of Danukul Mokmool

An inquest into the death of Danukul Mokmool began in May 2019 and concluded in June 2019. On 26 July 2017, a number of triple 0 calls were received claiming that a man, later identified as Mokmool, was wielding scissors and threatening a shopkeeper. Four police officers ran to the scene where one officer attempted to used pepper spray on Mokmool, but it had no effect. Mokmool ran at Senior Constable Tse wielding the scissors. Senior Constable Tse and Senior Constable Jakob Harrison opened fire and shot four times. Mokmool died as a result of a gunshot wound to the head.

The findings, handed down on 5 August 2019, by Deputy State Coroner Elaine Truscott were that:

"Danukul Mokmool died on 26 July 2017, at Central Railway Station, Eddy Avenue, Sydney, of a gunshot wound to the head, as a result of a police operation. He was experiencing a psychotic episode and was shot by police officers in circumstances where he ran at police with scissors in his hands..."

She then made the following **recommendations** to the Commission of Police NSW in order to improve outcomes in the future:

"...That consideration be given to amending the applicable Standard Operating Procedures so that uniformed officers performing frontline duties are required to carry a Taser absent good reason not to."

PAST INQUESTS AND INQUIRIES IN AUSTRALIA

Death Inquest: Inquests into the Death of Azaria Chamberlain

Note: These inquests occurred in the NT Coroners Court operating with similar jurisdiction inside the bounds of the NT.

One of Australia's most high profile cases, the death of Azaria Chamberlain on 17 August 1980 at Uluru in Australia's Northern Territory, also known as the 'dingo's got my baby' case, led to four separate coronial inquests.

Inquest 1: 16 December 1980

It was put forward in evidence that the damage caused to Azaria's clothing was inconsistent with what could be caused by a dingo. The Coroner, Barritt J, concluded that neither of Azaria's parents were "in any degree whatsoever responsible for her death." However, Barritt J made an **open finding,** stating "the body of Azaria was taken from the possession of the dingo and disposed of by an unknown method, or by a person or persons name unknown."

Inquest 2: 14 December 1981

The second inquest into Azaria's death came about when the Attorney General of the NT, Chief Minister Everingham, filed a motion to quash the findings of the first inquest based on newly discovered evidence: quantities of blood in the Chamberlain's car. It was put forward at the inquest that Lindy Chamberlain, Azaria's mother, took Azaria from the campsite and murdered her in the family's car with a sharp instrument.

Biologist Joy Kuhl gave evidence at the inquest that she found fetal blood beneath the passenger seat of the car. Dingo expert James Cameron was also called to give evidence. He found that the tear in Azaria's clothing could not have come from a dingo, stating it was "more consistent with scissors."

During the inquest, the Coroner formed the belief that Lindy and Michael (Azaria's father) Chamberlain had committed the murder of their daughter. The matter was therefore **referred to the DPP** and the second inquest was never been completed. At the subsequent trial, Lindy was charged with the murder of Azaria and Michael was charged as an accessory after the fact.

Inquest 3: December 1995

The discovery of Azaria's matinee jacket in an area with several dingo lairs in 1986 led to Lindy's release from prison, after the NT Court of Criminal Appeals unanimously overturned Lindy's and Michael's convictions. In December 1995, a third inquest into Azaria's death resulted in an **open finding.** The Coroner, John Lowndes SM, found that the evidence adduced did not enable him to determine the cause and manner of Azaria's death.

Inquest 4: 12 June 2012

The fourth inquest into Azaria's death was held in June 2012 before Coroner Elizabeth Morris SM. The purpose of this inquest was to determine whether there was sufficient evidence to adduce a cause of death of Azaria. The Coroner found "the cause of [Azaria's] death was as the result of being attacked by a dingo."