Enhancing the role of coroner as inquisitor: Practical tips for expert witnesses in coronial proceedings

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A coroner's inquest

Juror- "The man's alive sir for he has open'd one eye."

Coroner- "Sir, the doctor declar'd him dead since & he must remain dead sir, so I shall proceed with the inquest."

Source: Wellcome Library, British Museum. Thos. McLean, 1826, London (26 Haymarket).

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Outline

- Understand key features of Australian coronial jurisdictions
- How these features impact on expert opinion evidence
- Practical tips for expert witnesses in coronial proceedings

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Adversarialism

'[T]*he parties, and not the judge have the primary responsibility for defining the issues in dispute and for investigating and advancing the case.'*

- Australian Law Reform Commission, *Managing Justice: A review of the Federal Civil Justice System* (2000), Sydney, ALRC, para 1.117

'Paradoxically, conflict is used to resolve conflict. It's focus on proof rather than truth..'

- Freiberg, A. (2011). Post-adversarial and post-inquisitorial justice: transcending traditional penological paradigms. *European Journal of Criminology* (2011) 8(1), 82 – 101 at 84

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Inquisitorialism [or perhaps non-adversarialism]

'The aim is truth-finding, rather than dispute determination, and it adopts a multidisciplinary, rather than a legally focused approach.'

'Co-operation rather than conflict.'

- Freiberg, A. (2011). Post-adversarial and post-inquisitorial justice: transcending traditional penological paradigms. *European Journal of Criminology* (2011) 8(1), 82 – 101 at 84

- Coroners do not determine issues of guilt or liability and are not bound by the rules of evidence: *Harmsworth v The State Coroner [1989] VR 989; Clancy v West (Unreported 17/08/ 1994, Supreme Court of Victoria, Harper J).Keown v ; Kahn* [1999] 1 VR 69

The coroner is the inquisitor: a fact finder

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The standard of proof: balance of probabilities

'The seriousness of an allegation made, the inherent unlikelihood of an occurrence of a given description, or the gravity of the consequences flowing from a particular finding, are considerations which much affect the answer to the question whether the issues had been proved to the reasonable satisfaction of the tribunal. ***In such matters, "reasonable satisfaction" should not be produced by inexact proofs, indefinite testimony, or indirect inferences…'***

- *Briginshaw v Briginshaw* (1938) 60 CLR 336 per Dixon J, HCA

Graver consequences require you to be more certain and robust in your probabilities assessment

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Practical tips for expert witnesses in coronial proceedings

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Read and abide by any applicable codes of conduct, practice notes and rules. Understand your role and obligations.

Common principles:

- Overarching duty to the court
- Independence
- The need for specialised knowledge based on the person's training, study or experience
- The opinion must be 'wholly or substantially based on that knowledge'

Be aware of potential biases:

- Adversarial bias: expert tailors evidence to support client
- Unconscious partisanship: expert does not intentionally mislead court, but is influenced to give evidence in a way that supports client
- 'Selection bias' – experts chosen for known views that support case

NSW Law Reform Commission, Report 109, *'Expert Witnesses'*, NSWLRC, Sydney

- Also, hindsight bias of experts

Understand client legal privilege, it's limitations and waiver

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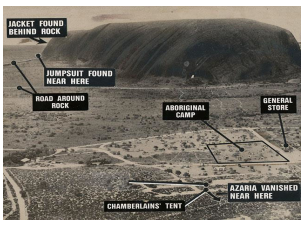
The death of Azaria Chamberlain

- Four Coronial Inquests
- Murder trial and conviction
- Appeals, inc. to the High Court
- A Royal Commission



Source: National Museum of Australia, Chamberlain Collection

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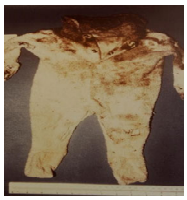
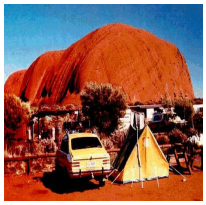
Jumpsuit



Matinee jacket

Chamberlain's car and tent at camp site



Source: Northern Territory Police Force

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A more recent example

Investigation into the death of Robert LOVE, COR 2015 0833 (Vic)

''Professor P did not assist me to make any definitive findings about the cause of Robert's death, nor how he sustained his injuries described by Dr L. Fundamentally, I was unconvinced that his qualifications in biomechanics were sufficiently relevant to the issues I must determine, and in consequence, I was not persuaded to prefer Professor P's opinion over Dr L's findings and conclusions about Robert's medical cause of death.

Dr L is a forensic pathologist who has engaged in this specialist area since 1993 and has performed over 1,500 autopsy examinations during this time. Professor P formulated many inferences from "facts" he had imagined, and he could not adequately explain how his expertise in the movement of the musculoskeletal system enabled him to conclude that the likely cause of death was a head injury, based on his calculations about the force required to cause injury. In addition, his theory on force required to avulse hair from the human head, whether self-attained versus inflicted by a third-party, lacked peer and/or academic/scientific endorsement.'

- Coroner Jamieson, para 5-6, 6 November 2020

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Don't be defensive. Be open, transparent, frank and forthright

Where appropriate, make concessions early

'Medical experts have agreed the death of 29-day-old baby Levi Shane Vanin was not preventable just as a coronial inquest into the boy's death more than four years ago was due to begin'

- Jordanna Schriever, The Advertiser, 16 February 2021

Media [mis]reporting: 'Inquest into the death of baby Levi Shane Vanin called off after experts agree it wasn't preventable'

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Divide between experts appears great on the papers, but evaporate or diminish during a hearing or hot tub.

Investigation into the death of Damon AMIET, COR 2013 1584 (Vic)

Investigation into the death of Travis FERNANDEZ, COR 2014 5936 (Vic)

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Pro-actively assist the coroner: Scope, instructions missing pieces in the puzzle. Could they have been framed more appropriately? Have they misconceived or miss something?

Make no assumptions about the coroner's medical knowledge. They are not medical practitioners

Use medical terminology only where necessary. Explain basis for views in simple terms

Pro-actively offer explanations, check in with the Coroner on her understanding

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Express opinion in terms of the standard of proof: on balance of probabilities. Other alternatives? Comparatively assess probabilities of each option

Be mindful of the *Briginshaw* sliding scale. How certain are you of your probabilities assessment? How certain ought you be?

Admit when you are not sure, can't be definitive, or don't have an answer. Explain why

Investigation into the death of Maxwell CAMPBELL, COR 2014 5828 (Vic)

Disclose limitations. Explain 'real-life' factors if relevant to the clinical context

Inquest into the death of Hamid KHAZAEI, 2014/3292 (Qld)

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Don't ignore the family. Acknowledge their loss

Section 70, *Coroners Act 2008* (Vic):

Apology or reduction or waiver of fees
(1) In this section, ***apology*** means an expression of sorrow, regret or sympathy but does not include a clear acknowledgement of fault.
(2) In an investigation of a death or fire—
(a) an apology; or
(b) a reduction or waiver of fees payable for a service provided to the person who died—
does not constitute an admission as to any matter, for the purposes of findings that are made under section 67 or 68.

Would you have done anything differently?

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Impact of coronial proceedings on participants: family members

Significant, complex and variable. A finding of death particularly traumatic in missing persons cases.

See for example Glassock, G. *'Australian families of Missing People: Narrating their Lived Experience'* (2011) Unpublished doctoral dissertation, University of New England; and Wayland, S. *'I still hope,' but what I hope for has changed'* (2015) Unpublished doctoral dissertation, University of New England.

Families expect some measure of closure from an inquest, and that distress results when definitive answers and closure are delayed or fail to eventuate.

See for example: Hands, T 'Under the microscope: reforming Western Australia's coronial system' (2012) *Brief* 39 12-15

Families benefit from the opportunity to be heard, compassionate treatment, appropriate education about the coronial process and available support services.

- Dartnell S. et al, 'An opportunity to be heard: family experiences of coronial investigations into missing people and views on best practice'(2019) Front. Psychol. 10: 2322.

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Section 8, *Coroners Act 2008* (Vic):

'When exercising a function under this Act, **a person** should have regard, **as far as possible in the circumstances,** to the following—

(a) that the death of a family member, friend or community member is distressing and distressed persons may require referral for professional support or other support;

(b) that unnecessarily lengthy or protracted coronial investigations may exacerbate the distress of family, friends and others affected by the death…'

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Respectful disagreement if justified, not 'blaming'

Impact of coronial proceedings on participants: non-family members

Employees felt aggravated by perceived professional and personal attacks, 'pointing fingers' during cross examination; pressure from the presence of family members; stress increased depending on level of personal involvement with deceased; emotional impacts; anxiety leading up to an inquest.

- Sweeney Research, 'A qualitative research report for the Coronial Council of Victoria' (2011), extracts reproduced in Freckleton, I, 'Minimising the counter-therapeutic effects of coronial investigations: in search of balance' (2016) *QUT Law Review* Vol. 16, Issue 3, pp. 4-29

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Towards a more trauma-informed approach?

'[T]here is a need in the coronial context to service the needs of **all participants** to investigations by coroners in a **humane and empathic way**, which provides information, and endeavours to arrive at understanding about what has been responsible (factually and medically) for the occurrence of deaths'

- Freckleton, I, 'Minimising the counter-therapeutic effects of coronial investigations: in search of balance' (2016) *QUT Law Review* Vol. 16, Issue 3, pp. 4-29

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Thank you

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