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Death Investigation and the Evolving Role of the Coroner

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Grief is a journey, often perilous and without clear direction, that must be taken. The experience of grieving cannot be ordered or categorized, hurried or controlled, pushed aside or ignored indefinitely. It is inevitable as breathing, as change, as love. It may be postponed, but it will not be denied.[1]

Death is a subject which has long inspired extraordinary art, music and literature. Currently, in one form or another, it dominates our television screens and our cinematic experiences. It continues to preoccupy, fascinate, confront, repel and terrify us. Contemporary necrographers, sociologists of death and scholars on palliative care have highlighted the extent to which in the aftermath of the two World Wars and in the era of institutionalisation and medicalisation of death we have a different, more removed relationship with our ancient foe – western communities are alienated from death like no previous civilisation.[2] But that does not detract from the reality of grieving, bereavement and the need to try to learn how in future to prevent preventable deaths.

These responses to the phenomenon of death and its appurtenances play an important role in the dynamics that generate our perceived needs for investigation of deaths which are sudden, unexplained or otherwise not readily accountable. We need to understand the causes of such deaths; to set the public record straight about them; to take criminal and civil action against malefactors, where appropriate; to learn the lessons that are to be learned from tragedies; and to avoid avoidable deaths.[3] Traditionally, our principal means to these various ends has been the institution of the coroner. This address scrutinises the roles of the coroner in the context of the 1 July 2007 commencement of the Coroners Act 2006 (NZ), the latest in an extensive series of reforms of the contemporary role of the coroner. It argues that the most recent reforms are an important consolidation of the evolving role of the coroner but that further consideration

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1 Furnia, M, *Safe Passage: Words to Help the Grieving*, 2003.

2 See eg Kellehear, A (ed), *Death and Dying in Australia*, (Oxford University Press, Melbourne, 2000); Howarth, G, "The Rebirth of Death: Continuing Relationships with the Dead" in Mitchell, M (ed), *Remember Me: Constructing Immortality, Beliefs on Immortality, Life and Death*, (Routledge, New York, 2007); Jalland, P, *Changing Ways of Death in Twentieth Century Australia*, (UNSW Press, Sydney, 2006); cp Edwards, C, *Death in Ancient Rome*, (Yale University Press, New Haven, 2007).

3 See *R v Coroner for North Humberside; ex parte Jamieson* [1995] QB 1; *Morris v Dublin Coroner* [2000] 3 IR 603; United Kingdom, *Report of the Committee on Death Certification and Coroners*, Cmnd 4810 (1971) (the Brodrick Report);); Norris, JG, *The Coroner's Act 1958: A General Review* (Law Department, Melbourne, 1981).

needs to be given to the changing relationship between coronership and public health and safety.

The Changing Institution of the Coroner

The institution of coronership arguably can be traced back to the ninth century.[4] There is evidence of a coroner at least in name as early as the reign of King Alfred (871–910).[5] It seems most accurate, though, to date the true origins of the institution of coronership as we know it to the Council of Eyre in 1194.[6] From that

4 See eg Vickers, RH, *The Powers and Duties of Police Officers and Coroners*, (TH Flood, Chicago, 1889), pp 166–167; Waldo, FJ, "The Ancient Office of Coroner" (1910) 8 *Transactions of the Medico-Legal Society* 101.

5 See Knapman, P and Powers, MJ, *The Law and Practice of Coroners* (Barry Rose Publishers Ltd, Chichester, 1985), p 1; Knight, B, "The Development of Medico-Legal Systems" in Mant, K (ed), *Taylor's Principles and Practice of Medical Jurisprudence* (Churchill Livingstone, London, 1984), p 1.

6 See eg Freckelton, I and Ranson, D, *Death Investigation and the Coroner's Inquest* (Oxford University Press, Melbourne, 2006); Dorries, C, *Coroner's Courts: A Guide to Law and Practice* (2nd ed, Oxford University Press, Oxford, 2004); Matthews, P, *Jervis on the Office and Duties of Coroners* (12th ed, Sweet & Maxwell, London, 2002); Thomas, L, Friedman, D and Christian, L, *Inquests: A Practitioner's Guide* (Legal Action Group, London, 2002); Farrell B, *Coroners: Practice and Procedure* (Round Hall, Sweet & Maxwell, Dublin, 2000); Levine, M and Pyke, J, *Levine on Coroners' Courts* (Sweet & Maxwell, London, 1999; Hunnisett, RF, *Sussex Coroners' Inquests 1603–1688* (Public Record Office, Sussex, 1998); Leckey, JL and Greer, D, *Coroners' Law and Practice in Northern Ireland* (SLS Legal Publications, Belfast, 1998); Waller, K, *Coronial Law and Practice in New South Wales* (3rd ed, Butterworths, Sydney, 1994); Knight, B, "Crowner: The Origins of the Officer of Coroner": http://www.britannia.com/history/coroner1.html, viewed 10 September 2007; Sim, SJ and Ward, T, "The Magistrate of the Poor? Coroners and Deaths in Custody in Nineteenth Century England" in Clark, M and Crawford, C, *Legal Medicine in History* (Cambridge University Press, Cambridge, 1994); Marshall, TD, *Canadian Law of Inquests* (2nd ed, Carswell, Ontario, 1991), p 10ff; Knapman, P and Powers, MJ, *Law and Practice on Coroners* (Barry Rose, Chichester, 1985); Granger, C, *Canadian Coroner Law: A Legal Study of Coroner and Medical Examiner Systems in Canada* (Carswell, Toronto, 1984); Holdsworth, W, *A History of English Law* (7th ed, Methuen & Co, London, 1956) Vol 1, p 82; Manson, A, "Standing in the Public Interest at Coroner's Inquests in Ontario" (1988) 20 *Ottawa Law Review* 637; Moskoff, FK and Young, J, "The Roles of Coroner and Counsel in Coroner's Court" (1987–88) 30 Crim LQ 190; McKeough, J, "Origins of the Coronial Jurisdiction" (1983) 6 UNSWLJ 191; Norris, JG, *The Coroner's Act 1958: A General Review* (Law Department, Melbourne, 1981), p 1 United Kingdom, *Report of the Committee on Death Certification and Coroners*, Cmnd 4810 (1971) (the Brodrick Report); Burns, P and O'Keefe, JAB, *The Functions and Powers of Justices of the Peace and Coroners* (Sweet & Maxwell (NZ), Wellington, 1968); Hunnisett, RF, *The Medieval Coroner* (Cambridge University Press, Cambridge, 1961); Hawkins, HS, *Manual for Coroners and Magistrates in New South Wales* (Govt Printer, Sydney, 1914); Smith, WR, *A Manual for Coroners* (Hussey & Gilligham, Adelaide, 1904; Gross, C, *Selected Cases from the Coroner's Rolls*, AD 1265–1413 (Bernard Quaritch, London, 1896), Vol 9; MacNevin, TE, *Manual for Coroners and Magistrates in New South Wales* (Govt Printer, Sydney, 1895); Vickers, RH, *The Powers and Duties of Police Officers and Coroners* (TH Flood & Co, Chicago, 1889), p 165; Baker, W, *A Practical Compendium of the Recent Statutes, Cases and Decisions Affecting the Office of Coroner* (Butterworths, London, 1851).

time onwards the role of coroners has evolved remarkably. In the Middle Ages the principal duties of the coroner were as a tax gatherer, protecting the pecuniary interests of the Crown, in particular those arising from the administration of criminal law by ensuring the safekeeping of fines, deodands, recognisances and shipwrecks. Much of the early coroner's role was focused upon matters other than death investigation – for instance, one of the coroner's time-consuming responsibilities was ensuring that monies arising from treasure trove and royal fish reached the King. Another duty was in respect of felons who sought refuge in a church or other religious premises. A felon prepared to "abjure the realm" renounced his property, which through the coroner was forfeit to the Crown, and was safeguarded by the coroner out of the jurisdiction. If persons failed to attend at four successive county courts in response to public proclamations, they would be enrolled. The coroner had a formal participation in the process, enrolling proceedings and holding an inquest on the chattels of the outlaw which would be forfeit to the Crown, again through the coroner.

Anyone finding a dead body in unusual circumstances was under a duty to "raise the hue and cry" and to inform the four nearest neighbours of the discovery, who would notify the bailiff of the hundred who in turn would summon the coroner.[7] He had the power to "attach" any witnesses, which effectively compelled them to attend his court. He could also take sureties to "encourage" attendance. Before the rise of the local magistracy and local police forces, the coroner was the principal agent in the investigation of homicide. He could also fine the community for unexplained murders. When he found that a person had committed suicide, his verdict would be that the deceased was a "felo de se" and would order his property to be forfeit to the Crown. Until 1823, the coroner also had a role in arranging the funerals of suicides – who were often taken in a carriage after dusk to a crossroads where they were staked through the heart and buried by the official hangman.[8]

However, the passage of time and a flurry of amendments to coronial legislation late in the nineteenth century and again toward the end of the twentieth century have seen most aspects of the ancient jurisdiction of the coroner abolished or fundamentally reformed.[9] Even coroners' juries have little of a contemporary existence, lingering still for occasional inquests only in jurisdictions such as the United Kingdom and New South Wales. The ancient rider, attached to the formal decision of the coroner and coroner's jury, has been taken away from United Kingdom coroners[10] but still exists in recommendations and comments for which express provision is made in all Australian jurisdictions and in New Zealand.[11]

Since Victoria's Coroners Act 1985, continuing reform has characterised the legislation regulating the coroner's jurisdiction throughout Australia and New

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7 See Knapman and Powers, n 5, p 2; Freckelton and Ranson, n 6, p 8.

8 See Kadri, S, *The Trial: A History from Socrates to OJ Simpson* (Harper Collins, London, 2005), p 1178.

9 See Freckelton and Ranson, n 6, ch 1.

10 By contrast with the United Kingdom: see Coroners Rules 1953 (UK), rule 36; Coroners Rules 1984, rule 36.

11 See Freckelton and Ranson, n 6, ch 18.

Zealand. Major changes have been made to the role of the coroner by a series of amendments in New South Wales and new legislation in other jurisdictions:

- The Coroners Act 1997 (ACT)
- The Coroners Act 1993 (NT)
- The Coroners Act 2003 (Qld)
- The Coroners Act 2003 (SA)
- The Coroners Act 1995 (Tas)
- The Coroners Act 1996 (WA)

The New Zealand Law Commission published a report on *Coroners* in 2000,[12] the Law Reform Committee of the Victorian Parliament[13] published a report on the Coroners Act 1985 (Vic) in 2006 and in the United Kingdom the Department of Constitutional Affairs published for consultation a Coroners Bill 2006 (UK).[14] On 1 July 2007 the Coroners Act 2006 (NZ) came into force. In 2007 the Western Australia Law Reform Commission was given a reference to advise on improvements able to be made to the Coroners Act 1996 (WA).[15]

What can be identified consistently in relation to the institution of coroner is its extraordinary capacity to "shape-shift" and adapt to meet contemporary needs. A nineteenth century example of this phenomenon was the brief re-emergence of the deodand under Coroner Wakley to compensate bereaved families for losses arising from industrial deaths.[16] Perhaps the greatest challenge thus far for the institution of the coroner exists, though, in the contemporary era when there is a proliferation of investigators of death, many of which are expert, data-driven and preventative in orientation. The question for its future is whether the coroner's tried and tested assets of openness and public confidence will enable it to reconfigure itself as an entity able to investigate from a broader and more independent perspective than its rivals and thereby to maintain its relevance.

Early New Zealand Coronership

New Zealand was proclaimed a British colony in May 1840 but remained technically part of New South Wales until 22 December 1841. This did not inhibit the importation of the institution of coronership; Dr John Johnson was gazetted New Zealand's first Coroner and Colonial Surgeon on 3 May 1841. It was only a few years until the passage of New Zealand's first specifically coronial legislation: the Coroners Ordinance 1846 (NZ), which provided that "Every person acting as a Coroner ... shall have all such powers and privileges and be liable to all such duties and responsibilities as any Coroner in England." Thus, not surprisingly, early New Zealand coronial practice was very much derivative of that in place

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12 New Zealand Law Commission, *Coroners*, Report No 62, Govt Printer, Wellington, 2000: http://www.lawcom.govt.nz/UploadFiles/Publications/Publication_70_139_R62.pdf, viewed 17 September 2007.

13 http://www.parliament.vic.gov.au/lawreform/default.htm, viewed 17 September 2007.

14 http://www.dca.gov.uk/legist/coroners_draft.pdf, viewed 17 September 2007.

15 See http://www.lrc.justice.wa.gov.au/3_coronial_tor.html, viewed 23 November 2007.

16 See Freckelton and Ranson, n 6, p 16.

at the time in England. Since then it has taken an increasingly different route.

Distinctive local needs commenced to be recognised by the Coroners Act 1858 (NZ). An example was that coroners were given jurisdiction to hold inquests into fires, even where no death occurred.[17] New Zealand-specific coroners' legislation took on a more characteristic flavour with the passing of the Coroners Act 1867 (NZ) which, for instance, provided that coroners were empowered to act throughout the whole country, but not obliged to hold an inquest at a distance further than 20 miles from their residence.[18] A level of overlap existed between the responsibilities of coroners and justices but for the most part there seem to have been few demarcation disputes or tensions. Section 12 of the 1867 legislation provided that when an inquest should be held and no Coroner or Deputy was present within 24 hours any "Justice of the Peace may hold it and exercise all the powers and jurisdiction vested in coroners".[19]

Section 8 provided that the special subjects concerning which coroners had jurisdiction to inquire, and to which their jurisdiction was confined were:

> (1) The manner of the death of any person
> (a) who is slain or drowned; or
> (b) who dies suddenly, or
> (c) in prison, or
> (d) while detained in any lunatic asylum; and
> whose body shall be lying dead
> (2) The cause and origin of any fire whereby any building, ship, or merchandize, or any stack of corn, pulse, or hay, of any growing crop, shall be destroyed or damaged.

The wide responsibility to inquire into fires causing loss to property was indicative of the sensitivities attaching to any kind of conflagration that put the colony's scarce resources at risk.

In his advice for coroners, Johnston commented in 1868 that:

> the matters to be inquired into at the inquisition generally, as partly indicated by the Statute of Edward, are as follows: the identity of the dead person; the place of death; and if the body was brought to the place where it is lying, how, whence, and by whom it was brought; whether any person was present at death; who, if any, were culpable, 'either of the act or of the force'; and whether he fled for it; what wounds or marks there are, and the length, breadth, and deepness thereof, and in what part of the body they are, and how many wounds were given; and if any person be found culpable; then what goods he has, and what lands, and what is the value of them.[20]

He was in favour of utilising medical expertise wherever it was necessary for coroners' fact-finding, contending that where the cause of a death was not "very apparent", "it is most desirable that competent medical men (who from

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17 This occurred also in a number of Australian jurisdictions around the same time: see Freckelton and Ranson, n 6, p 651ff.

18 Coroners Act 1867 (NZ), s 11.

19 The degree of overlap was emphasized by the fact that by s 8 all coroners were stipulated to be Justices of the Peace.

20 Johnston, AJ, *A Handy Book for the Coroners of New Zealand*, (Govt Printer, Wellington, 1868), p 12.

reading and experience ought to know the most proper course to be adopted for ascertaining the facts and phenomena most likely to throw light upon the cause and circumstances of the death) should have the earliest opportunity of making a proper examination of the body, for the purpose of giving evidence at the inquest. In many cases it is desirable that a regular post mortem examination and dissection should be made. Coroners have power to summon medical witnesses, and to direct the making of a post mortem examination; and this they ought to do, as it would seem, in all cases where the cause of death is questionable".[21]

Because of the abolition of deodands in England, and the adoption of Statutes 9 and 10 Vic in New Zealand by the English Acts Act 1854 (NZ), deodands were never imported into New Zealand law. Nor were a number of the other ancient revenue-protecting and asset-protecting roles of the coroner. Nonetheless in 1978 Coroner Stewart in Nelson called for their return in the form of a power for coroners to order confiscation of motor vehicles which had caused people's deaths.[22] He was not successful.

However, many English procedures in relation to inquests were transported to New Zealand. For instance, under s 17 of the Coroners Act 1867 (NZ) every person holding a publican's licence was obliged to receive into his or her house any dead body brought to it for the purpose of an inquest. The "general rules of evidence" were stipulated to apply to proceedings in the Coroner's Court "as well as in other tribunals".[23]

Whenever a coroner's jury returned a verdict of murder or manslaughter against any person, it was the duty of the coroner to issue a warrant for the apprehension of the accused and to commit him or her to prison.[24] A finding of murder or manslaughter against anyone by a coroner's jury had the effect of an indictment. The creation of a modern police force made this function unnecessary, and the defects of inquest procedure made it unjust. The Criminal Code Act 1893 (NZ) provided that no one should be tried on a coroner's inquisition.[25]

Initially New Zealand coroners sat with a jury – originally of at least 12, but reduced to six in 1885 with provision for a majority verdict of four. Coroners' juries became optional in 1908, except where a Justice of the Peace acted as coroner, which was rarely. Juries in inquests were only abolished in 1951.

Fortunately, in the 1970s the medical historian Dr Laurie Gluckman chanced upon four leather bound volumes which were copies of the first 384 inquests conducted in Auckland between 1841 and 1864. The edited edition of these verdicts, published in 2000, constitutes an invaluable opportunity to understand death and its investigation by coroners in the early years of New Zealand.[26] What follows constitutes a brief analysis of the causes of death found by jurors and the riders attached by jurors to inquisitions.

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21 Johnston, n 20, p 11, 20.

22 Stewart, GP, *The Rough and the Smooth*, (The Heritage Press, Waikanae, 1994), p 252.

23 Johnston, n 20, p 20.

24 Johnston, n 20, p 39.

25 See too Coroners Act 1908 (NZ), s 6.

26 Gluckman, L, *Touching on Deaths: A Medical History of Early Auckland Based on the First 384 Inquests*, (Doppelganger, Auckland, 2000).

Alcohol usage was a major issue in the new colony with considerable levels of consumption and widespread debates about the evils of intoxication and the establishment of temperance societies. It was identified by coroners' juries as a feature in 91 of the 384 inquests (23.69%) in the first 23 years of Auckland's coroner system. Twenty-two of the alcohol-related deaths were classified as "accidental" and alcohol was considered a factor in eight suicides, 20 sea or river drownings, three deaths from burns, one fall from a horse, eight cases of lunacy and 23 cases of apoplexy. A history of drinking was remarked upon in 36 cases and 56 people were considered intoxicated at their time of death. Eight were said to have had delirium tremens and two were described as suffering from the "horrors", which was probably the same phenomenon.

Apoplexy was identified as the cause of death in 44 of the inquests (11.46%). It was a diagnosis made when a patient suddenly collapsed with loss of sensation and movement. The diagnosis was made after autopsy in 30 instances but alcohol was considered a factor in many of the same deaths. In 19 of the inquests (4.94%) death was considered as of cardiovascular origin – in all but one instance the deceased persons were male. Only one death was attributed to cholera. John Drinkwater was said by surgeon Walter Lee to have died in January 1854 from "English cholera". However, the jury was clearly anxious that this could have been the start of an epidemic of the kind that afflicted England the previous year and led to the Harbour and Quarantine Regulations 1854 (Eng). The jurors requested the coroner "to call the attention of the authorities to the fact that the neighbourhood in which this man died impregnated with foul air and that, from the medical evidence, it is likely to predispose to diseases of this nature."[27]

Drownings were very prominent as a cause of death (33.84%), 111 of the 384 deaths being found to have taken place in the sea, 18 in wells and one in a tannery pit. A number of inquests dealt with more than one such death. Part of the epidemic of drownings was attributable to a low rate of swimming skills, even amongst sailors, but also to alcohol abuse[28] and unsatisfactory protection against perils.[29] An example was New Zealand's first recorded inquest – into the death of Arthur Turtley who sailed in July 1841 from Waiheke to Auckland on 8 July. His boat was found upturned the following day. His body was not discovered for some two to three weeks but, upon discovery, was summarily buried on a beach above high water mark, about a week before the inquest, to protect against mutilation by dogs. The body was exhumed and the identity of the deceased was ascertained from his clothing. No autopsy was conducted and the jury's verdict was "death by suffocation and drowning as result of accident".[30]

Deaths were ascribed to fires in 11 cases. Few inquests in fact took place into

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27 Gluckman, n 26, p 184.

28 For instance the inquest into the death of Anne Belcher on 22 July 1844 concluded that, "While in a state of intoxication did fall into a bucket, being in state of insensibility – died by accident": Gluckman, n 26, p 129.

29 For instance, on 2 July 1862 at an inquest into the death of Thomas Wood, a labourer, on 2 July 1862 a jury recommended that the attention of the Authorities be called to the need to erect a fence along the margins of a "dangerous pool" into which the deceased has fallen and drowned in unclear circumstances.

30 Gluckman, n 26, p 117.

fires that caused only property damage. A number of inquests took place into the deaths of prisoners. It is apparent that some who were committed to gaol for offences such as vagrancy were significantly psychiatrically unwell. An example was Charles Chambers who was sentenced to seven days imprisonment on 11 July 1842. He was described by the officer in charge of the gaol as "of unsound mind ... He became, for a time, outrageous, talking all night, and destroying his blanket ... He received his full entitlement of rations allowed to prisoners ... He had every care that the place could afford". By contrast, a prisoner who had nursed him conceded that Chambers' habits were of "filthy disorganisation" but asserted "had deceased got tea and sugar and port wine he would have survived for a time". Evidence from the acting Colonial Surgeon contradicted the view of the prisoner and the jury's verdict was "Died from natural causes and not violence or neglect and by the Act of God."[31]

Verdicts of lunacy were made in 20 inquests (5.2%), and in part functioned to reduce the level of stigma associated with many suicide deaths. Thus Dudley Sinclair was found by a coroner's jury on 7 December 1844 to have "killed himself in a paroxysm of insanity"[32] and the finding in respect of Thomas, a hairdresser, on 20 August 1845 was that he "did hang and suffocate himself, being a lunatic and of insane mind".[33] Verdicts of "visitation of God" or non-specific natural causes were delivered in 54 cases (14.06%).

Riders are to be found within the collection of 384 inquests but they were relatively unusual. In all there were 21, meaning that the incidence of riders was in 5.5% of inquests. It is apparent that the juries of certain coroners generated more riders than those of other coroners. To this extent there is evidence of the unpredictable and somewhat erratic nature of nineteenth century riders. A number of riders (9 of 21: 42.86%) related to the risks of persons falling into wells or ponds, over cliffs or into the harbour. Occasionally juries expressed their distress or repugnance at what they perceived as cruel or unfeeling conduct. Risks for children, the intoxicated, the psychiatrically unwell and those confined in prisons were the subject of recommendations.

Certain of the riders are worthy of particular remark. John Davis (Inquest No 94) was found very tipsy and taken to the lock-up after midnight on 6 December 1850. The following day he pronounced that he was going to die. He was given water and a doctor was summoned. Shortly afterwards, after a blood vessel had given way in his left lung, he died. The jury expressed the opinion that "although no imputation rests against the police or lock-up keeper, in this case the erection of a proper sleeping place or quarters in the lock-up would diminish the risk of injury to prisoners in a state of intoxication".[34]

Catherine McKee (Inquest No 143) was admitted to the Auckland Lunatic Asylum in December 1854 after having burned all her husband's books except his Bible. She then went outside and broke the windows of their house with an axe. A constable was called and he tied her to the bed. She did not sleep but

31 Gluckman, n 26, p 128.
32 Gluckman, n 26, p 131.
33 Gluckman, n 26, p 133.
34 Gluckman, n 26, p 162.

on being untied cut the cat's throat and attempted to do the same to her child, whereupon she was conveyed to the asylum. There for the most part she was quiet but after six days cut her throat with window glass and a little later died. The jury's verdict was that "She cut her throat with a piece of window glass which she procured by thrusting her arm through the window bars of the Lunatic Asylum and breaking a pane of glass." The jury requested the coroner to write to the Asylum Superintendent "condemning the present protection offered the inmates of the Lunatic Asylum".[35]

Auckland's first recommendation about workplace safety took place in the context of the death of William Wishart on 3 August 1860 (Inquest No 288). He was an apprentice aged about 15 who was recorded as having been instructed to take down a triangle in a dangerous condition at an engineering works. It collapsed and a spar struck him, causing his death. The jury's verdict was that he died "accidentally, casually and by misfortune, died of crush injuries" and the jurors recommended that "the Coroner call the attention of the Authorities to a more strict supervision of works which, from the manner in which they are conducted, or otherwise, are likely to be attended with danger to the public".[36]

Evolution in the Role of the New Zealand Coroner

It was not until 1951 that codified legislation was introduced with the intention of combining and consolidating New Zealand's coronial law.[37] The Coroners Act 1951 (NZ) abolished coroners' juries,[38] made it unnecessary for coroners themselves to view bodies of the deceased, and removed the previous jurisdiction into fires.[39] An understanding of the accepted role of coroners in New Zealand can be seen in the *Final Report of the Working Party on Delays in the Release of Bodies for Burial*,[40] which stated:

> The interest of the state is to minimise the possibility of secret homicide, to establish causation in relation to deaths due to accidents and to establish the cause of death in those cases where a certificate from a doctor cannot be obtained.[41]

The report also went on to observe: "The whole purpose of the coroner's involvement is concerned with the public interest in identifying a deceased person, inquiring into the cause of death and, where necessary, drawing attention to matters which if rectified might prevent similar deaths occurring in the future."[42] This statement exemplifies the increasing focus during the 1980s, in New Zealand and elsewhere, on the coroner's potential role in death prevention. Coroner McElrea has commented:

> New Zealand Coroners no longer sit with a jury, they do not investigate causes of fire, nor can they indict for murder or manslaughter. There is now a plethora of investigative agencies, with power to investigate the circumstances of a death or

35 Gluckman, n 26, p 190.
36 Gluckman, n 26, p 266.
37 New Zealand Parliamentary Debates, Vol 3, 1951.
38 Coroners Act 1951 (NZ), s 13.
39 See Fire Services Act 1949 (NZ).
40 Department of Justice, Wellington, 1984.
41 Ibid, p 6.
42 Ibid.

> series of deaths. In 2005 there is much greater emphasis for Coroners on prevention of death in like circumstances. Early New Zealand coroners also performed this function.[43]

An insight into the real-world functioning of coroners in New Zealand outside the main cities is to be found in the autobiography of the Nelson coroner, Gerald Stewart. He occupied the role of coroner from 1963 until 1977, having assumed the appointment after retirement from the Indian Civil Service, the New Zealand Public Service and a period working as a rural solicitor. He described having "very little idea what the position entailed" on appointment, having only ever attended the coroner's court on one occasion as a watching brief for the widow of a deceased man.[44] He observed that in his fourteen and half year tenure he made two suggestions which were ignored until years later "and then someone else claimed credit for them."[45]

The Coroners Act 1988 (NZ) spelled out the functions of the coroner more specifically. Patterson J in *TMW Orchard v Osborne*[46] noted that although the coroner did not have a role in apportioning guilt subsequent to the 1988 legislation the coroner "must obviously be able to go beyond the mere cause of death if he is to serve a useful social function."[47]

However, until 2007 the New Zealand coronial system was regionalised (like that in the United Kingdom) with in the order of 72 coroners serving in 65 designated districts.[48] There were only three full-time coroners. This led Coroner Evans to comment: "Although communication by horse and four has now been overtaken by the internet, New Zealand continues to have a coroner in nearly every town. The coronial bench has at all times lacked a leader, with the result that there is considerable variation in coronial practices and standards and in the approach taken by coroners towards their work. Coroners are poorly remunerated for the work they carry out; legal firms in which most coroners are senior partners effectively subsidise the State; and the great bulk of coronial work is carried out by coroners in the main metropolitan centres."[49]

Comprehensive reforms were proposed by the New Zealand Law Commission in 2000 and then implemented by the Coroners Act 2006 (NZ), amongst other things, to:

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43 McElrea, 2005, at p 1.

44 Stewart, GP, *The Rough and the Smooth*, (The Heritage Press, Waikanae, 1994), p 251.

45 Ibid, p 252.

46 Unreported, High Court, Auckland, 19 July 1996.

47 See also *Matthews v Hunter* [1993] 2 NZLR 683; *Lauw v McLean*, unreported, High Court, Christchurch, 12 January 1988.

48 See Evans, G, *The New Zealand Commission Report on Coroners 2000*, paper presented to the Australasian Coroners' Society Conference, Brisbane, 2000. By contrast, as of late 2007 the coroner's jurisdiction in England and Wales remains fragmented, with approximately 127 coroner jurisdictions supported by 430 coroners' officers. There are only 23 full-time coroners, the rest being part-time: United Kingdom, *Death Certification and Investigation in England, Wales and Northern Ireland: The Report of a Fundamental Review*, Cmnd 5831 (2003) Ch 7 (the Luce Report); United Kingdom, *Reforming the Coroner and Death Certification: A Position Paper*, Cmnd 6159, 2004.

49 Evans, n 48, p 2.

- require that coroners be legally qualified;
- provide for ongoing coroners' training;
- regionalise coronial districts and move toward a system of full-time coroners;
- create a Chief Coroner of New Zealand;
- create rights of objection to post-mortem examinations.[50]

In arguing for modernisation of the coroner's jurisdiction in New Zealand, the Commission observed that:

> The inquiries of the Coroner should not be limited to matters of mere formality, but should be of social and statistical significance in a modern community.
>
> Recent research into the investigation and analysis of accidents and death has revealed the crucial importance of not focusing exclusively on what seems to be the immediate cause of a fatality: the primary causes can and frequently do lie much deeper. In this context it has progressively become evident that the fundamental causes of fatalities, and therefore the measures needed to avoid recurrence, can require a much broader perspective than the one currently adopted by Coroners.
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> With certain notable exceptions ... deaths tend to be considered in isolation. There is no system for appraisal of the background factors contributing to the death to determine whether it is an isolated episode or an example of a deeper seated problem. The Commission considers it imperative that an investigation into the possibility of fundamental causes be a regular exercise of the Coroner's functions. A true appraisal of apparently insignificant incidents can reveal, and then remove or reduce, the risk of disaster. This is made difficult at present, however, because there is no system for the collation and appraisal of one Coroner's findings in relation to others." [51]

Justice Baragwanath in an orientation to new coroners in June 2007 emphasised the need not to be distracted from what he described as "the bitter facts" that until the new legislation coroners "were under-resourced, lacked both leadership and proper systems, and were insufficiently valued within the community".[52]

The Coroners Act 2006 (NZ) has sought to address these deficits by modernising the institution of coronership in New Zealand, creating a centralised system including a Chief Coroner and a number of full-time coroners similar to that existing in jurisdictions in Canada and Australia. Until the system in force until 1 July 2007 New Zealand coroners mainly worked part-time, often in isolation,

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50 See Henare, D and Foster, M, "Coroners" (2000) NZLJ 274; Fogarty, J, "A Chief Coroner" (2000) NZLJ 316.

51 Law Commission of New Zealand, *Coroners*, Report No 62, Govt Printer, 2000, at para 8–10: http://www.lawcom.govt.nz/UploadFiles/Publications/Publication_70_139_R62.pdf, visited 6 September 2005.

52 Baragwanath, D, "How We Got Here: Law Commission Report 62 and the Coroners Act 2006" Coroners Orientation Programme 18 June 2007, Wellington: http://www.courtsofnz.govt.nz/from/documents/CoronersspeechJune07.pdf, viewed 17 September 2007.

and with limited formal administrative support and training.[53] There was a perception in many quarters that the coronial system did not take enough account of cultural beliefs and values, especially those of Māori. There were also reports that coroners' decision-making was at times patchy in quality and inconsistent in approach. Some contended that coronial practices had been insensitive to the needs of families, in relation to the treatment of the deceased, and the removal and retention of body parts.

The Coroners Act 2006 (NZ) is intended to address these concerns by:

- establishing the office of the Chief Coroner to provide leadership and co-ordination (s 7);
- moving to a smaller number of mostly full-time legally qualified coroners (s 103);
- ensuring families are notified of significant steps in the coronial process (s 22, 23);
- introducing a specific regime for retention and release of body parts and body samples (47, 48); and
- enhancing inquiry and inquest processes (s 57–91).

The overt wish of the legislature is that families derive a benefit from the reforms. The new Act broadens the definition of "family" to take into account modern family arrangements and cultural relationships (s 9), and allows families to appoint a representative to liaise with a coroner (s 22). The Act also requires coroners to perform their duties without delay (s 5), mandates the coroner to notify families at significant stages of the coronial process (s 22, s 23), allows families to review and touch the body of a deceased person with a coroner's authorisation (s 25), and gives families the right to object to a post-mortem examination if the death does not appear to be suspicious (s 33).

The Coroners Act 2006 (NZ) introduces a new regime in relation to retention of body parts and tissues (s 48). It attempts to ensure that body parts and body samples can be taken only for the purposes of medico-legal autopsy, that families are notified of the proposed retention (s 50), and that their representatives can request the return of the parts and samples (s 50). It also restricts how retained parts and samples can be used (s 56). The new provisions balance the value of retaining tissues for later examination against family members' desire to have tissues returned for cultural, spiritual, and other reasons.

The Modern Role of Coroners

As of the early part of the twenty-first century coroners investigate a wide variety of deaths in the public interest. These include:

- iatrogenic and nosocomial deaths, particularly in hospitals and day-care centres;
- workplace deaths potentially arising from breaches of occupational health and safety strictures;

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53 Save for gatherings of the Australasian Coroners Society and of the Asia-Pacific Coroners Society.

- deaths in institutions, such as prisons, places of juvenile detention, nursing homes and psychiatric hospitals;
- plane and boating deaths;
- deaths from natural phenomena, including bushfires and floods;
- accidental, potentially avoidable deaths, such as landslides and implosions; and
- suspicious and unexplained deaths that may have occurred in the context of criminality.

Coroners are unique figures in the Anglo-Australasian-American legal landscape and, as outlined above, coronership has been subject to continual and substantial change for over a century.[54] Coroners make findings and advance recommendations where they deem such a course appropriate,[55] but unlike judicial officers in criminal, civil, family and children's courts they have no powers of enforcement in respect of their findings and recommendations. They can no longer award compensation by way of deodands. Save in New South Wales, in Australia they no longer commit for trial nor do they sit with juries. Increasingly, their role is confined to investigating deaths, rather than an array of other functions which they previously possessed, although coroners in different parts of Australia retain a jurisdiction over fires, explosions, accidents and disasters.[56] While coroners are judicial officers with an increasingly prominent public profile,[57] nowhere in Australia, England or New Zealand until 2007 have they been of other than magisterial status.[58]

In recent years coroners and coronership have ceased to be immune from public and scholarly critiques. In part this constitutes a maturation of the institution and an emergence from scholarly anonymity for coronership. However, it also poses challenges. The new critical scholarship in relation to coronial practices and decision-making has gone so far as to call into question the ongoing relevance and utility of the institution. The following is a non-exhaustive summary of issues raised by critiques:[59]

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54 See Freckelton, I and Ranson, D, n 6.

55 See eg Norris, JG, *The Coroner's Act 1958: A General Review* (Law Department, Melbourne, 1981) p 134: "[I]t is well understood that in establishing the cause of death the coroner (or his jury) may in particular cases serve further purposes ... The major purpose to be served is safety."

56 See Coroners Act 1997 (ACT), s 52(2)(a)–(b); Coroners Act 1980 (NSW), s 22(2); Coroners Act 1993 (NT), s 34(1)(b); Coroners Act 2003 (SA), s 25(1); Coroners Act 1995 (Tas), s 45(1); Coroners Act 1985 (Vic), s 36.

57 See Waterford, J, "The Media and Inquests" in Selby, H (ed), *The Inquest Handbook*, (Federation Press, Sydney, 1998). See also Hand, D and Fife-Yeomans, J, *The Coroner: Investigating Sudden Death* (ABC Books, Sydney, 2004); Waller, K, *Suddenly Dead* (Ironbark Press, Sydney, 1994).

58 However, New Zealand's Chief Coroner is Neil MacLean DCJ: http://www.justice.govt.nz/coroners/coronial-process/chief-coroner.asp, viewed 17 September 2007. Similarly, in Victoria on 29 November 2007 Judge Jennifer Coate of the County Court was appointed State Coroner.

59 See further Freckelton, I and Ranson, D, n 6; Freckelton, I and Ranson, D, "The Evolving Institution of Coroner" in Freckelton, I and Petersen, K (ed), *Disputes and Dilemmas in Health Law*, (Federation Press, Sydney, 2006); United Kingdom, *Death*

- the unclear modern status of the coroner;
- inconsistency in decision-making by coroners;
- inflexibility in coroners' procedures;
- poor utilisation of data and expertise by coroners;
- the limited capacity of coroners to deal with complex cases;
- the questionable effectiveness of coroners in relation to hospital deaths and indigenous deaths;
- the substantial overlap of coroners with other investigators in relation to workplace deaths, eg occupational health and safety investigators;
- the lack of rigour in some coroners' decisions;
- the uninformedness of some coroners' recommendations;
- inconsistency among coroners' recommendations;
- the weakness in coroners' recommendations involving government;
- the limited implementation of coroners' recommendations;
- the limited accountability of coroners;
- the minimal training of coroners;
- the limited legal guidance available for coroners;
- inadequate resourcing of coroners' offices;
- dependence on reporting to coroners by police and medical practitioners;
- coroners' focus on deaths;
- delays in investigation and decision-making;
- difficulties experienced by coroners in procuring necessary evidence;
- limited funding for families to appear at inquests; and
- dissatisfaction by family members with coronial procedures.

It is apparent, then, that key elements of the jurisdiction of the coroner are now subject to re-evaluation and critique. This is not without warrant. The traumas caused by the conduct of Harold Shipman[60] in England, Jayant Patel[61]

Certification and Investigation in England, Wales and Northern Ireland: The Report of a Fundamental Review, Cmnd 5831 (2003), ch 7 (the Luce Report); Ranson, D, "How Effective? How Efficient? The Coroner's Role in Medical Treatment Related Deaths" (1998) 23 Alt LJ 284; Dame Janet Smith, *Third Report: Death Certification and the Investigation of Death by Coroners*, Cmnd 5834 (2004) at [7.74]; United Kingdom, *Report of the Committee on Death Certification and Coroners*, Cmnd 4810 (1971) (the Brodrick Report); Hogan, T, Brown, D and Hogg, R (eds), *Death in the Hands of the State* (Redfern Legal Centre Publishing, Sydney, 1988), pp 121–122; Bugeja, L and Ranson, D, "Coroners' Recommendations: A Lost Opportunity" (2005) 13 JLM 173; Pounder, D, "Coroner's Inquests: Do They Deliver Justice", Report of a Joint Law Society and Inquest Seminar (Inquest, London, 2001); New Zealand Law Commission, *Coroners*, Report No 62 (New Zealand Govt Printer, Wellington, 2000); Victorian Parliament, Law Reform Committee.

60 Dame Janet Smith, *Third Report: Death Certification and the Investigation of Death by Coroners*, Cmnd 5834, 2003; Kinnell, H, "Serial Homicide by Doctors: Shipman in Perspective" (2000) 321 *British Medical Journal* 1594.

61 See Davies, G, *Queensland Public Hospitals Inquiry* Report, Govt Printer, Brisbane, 2005: http://www.qphci.qld.gov.au/final_report/Final_Report.pdf, viewed 17 September 2007; Thomas, H, *Sick to Death*, (Allen & Unwin, Sydney, 2006); Kennedy,

in Australia, and Michael Swango[62] in the United States have left a legacy of anxiety about the potential for homicidal and grossly negligent medical practitioners to circumvent the jurisdiction of the coroner for an unacceptable period of time. It is clear that the routes by which deaths are reported to the coroner require re-evaluation in order to address community concern about the capacity of both medical practitioners and police to reduce the effectiveness of coroners' investigations.

In addition, the role of the coroner as an investigator of death is no longer unique; the coroner functions alongside workplace inspectors, police, the Health and Disability Commissioner, internal hospital directors of clinical governance and others within the public health sector, to name but some. Increasingly, the question being posed is whether coroners add enough that is worthwhile and distinctive to the institutions that otherwise exist to maintain law and order, to conduct criminal investigations, to undertake occupational health and safety investigations and that do reassessments of clinical interventions.

It is questionable too whether we are asking more than is plausibly deliverable when we seek of coroners that they function as high quality managers of complex, multidisciplinary investigations; judicial managers of often multi-party proceedings; authors of substantial findings documents; and designers of comprehensive proposals for reform of processes that carry unacceptable risks of death and serious injury. It may be that some of the components of the coroner's office will need to be disaggregated and redistributed so as to maximise the potential to capitalise on the skills most likely to be possessed by appointees from a principally legal practice background.[63]

Another issue for coronership of the twenty-first century is its relationship with its instruments of investigation – police, doctors, dentists, anthropologists, statisticians, public health specialists and other experts. A concern particularly ventilated in the aftermath of the Shipman and Patel scandals has been the identification of a need for doctors' death certificates at least to be the subject of some kind of auditing process to identify aberrant patterns and sinister trends. This has led to proposals from Dame Janet Smith,[64] the "Luce Committee"[65] and the Home Office[66] in the United Kingdom for an ongoing review by persons associated with an institute of forensic pathology, or similar, to review all, or at least a proportion of, death certificates. Comparable proposals were advanced by the Law Reform Committee of the Victorian Parliament in 2006.[67]

V and Walker, D, *Dancing with Dr Death*, (New Holland, Sydney, 2007).

62 See Stewart, JB, *Blind Eye: The Terrifying Story of a Doctor Who Got Away with Murder*, (Touchstone/Simon and Schuster, New York, 2000).

63 Notably a number of appointees under the Coroners Act 2006 (NZ) have diverse backgrounds in addition to their legal qualifications.

64 Dame Janet Smith, *Third Report: Death Certification and the Investigation of Death by Coroners*, Cmnd 5834, 2003.

65 United Kingdom, *Death Certification and Investigation in England, Wales and Northern Ireland: The Report of a Fundamental Review*, Cmnd 5831, 2003 ("The Luce Report").

66 United Kingdom, *Reforming the Coroner and Death Certification: A Position Paper*, Cmnd 6159, 2004.

67 http://www.parliament.vic.gov.au/lawreform/default.htm, viewed 18 September

Such an approach has not made its way into the Coroners Act 2006 (NZ). However, the post-Shipman and Patel concerns have identified not just the importance of a constructive ongoing relationship between the coroner's office and providers of pathology and other forensic medicine services but the capacity of [illegible] services to have the facility to review with an epidemiological focus phenomena identifiable from death certificates and reporting of deaths. Part of the answer in New Zealand may be the creation of a national institute of forensic medicine. But more will be required in terms of drawing upon specialist knowledge. If coronership is to fulfil a constructive function within the public health penumbra, it will need to utilise data from death certification and reporting of deaths more effectively. The potential of the National Coroners Information System[68] to facilitate this is substantial. It would be most advantageous for New Zealand to lock into the system and contribute to it.

Approaches such as therapeutic jurisprudence are providing a fillip to fundamental reconsideration of aspects of the legal system which have previously been taken for granted and which have exhibited a potential to function counter-therapeutically to the interests of those involved, such as family members. An important aspect of this consciousness is apposite in the context of coroners' inquiries and inquests.[69] The Coroners Act 2006 (NZ) has implemented a variety of reforms designed to alleviate distress caused to families by what have been perceived by some in the past as high-handed and insensitive processes and decision-making by coroners.[70] Under the new legislation, procedures are established to:

- accelerate coroners' inquiries by imposing upon coroners a duty of expedition (s 5);
- impose responsibilities of communication in relation to significant matters (s 22);
- permit family members access to post-mortem reports (s 27);

2007.

68 http://www.vifp.monash.edu.au/ncis/index.htm, viewed 17 September 2007. The Victorian Attorney-General at the launch of the NCIS in August 2000 proclaimed:

> The NCIS represents a world first in providing an Internet accessible database of coronial information across Australia. Coronial data is a rich source of information about the causes of preventable deaths in this country. (The NCIS) will provide a means of accessing data in a timely way and will increase the potential for coronial information to contribute to a reduction in preventable death and injury in Australia and in doing so, it will reduce both the emotional and financial burden of lost life in our community. The NCIS will revolutionise the way we investigate and respond to preventable deaths in Australia.

http://www.vifp.monash.edu.au/ncis/web_pages/testimonals.htm, viewed 17 September 2007.

69 See for instance Freckelton, I, "Death Investigation, The Coroner and Therapeutic Jurisprudence" (2007) 15 *Journal of Law and Medicine* 247; Johnstone, G and Took G, "Therapeutic Jurisprudence in the State Coroner's Office", unpublished paper, Office of the Victorian State Coroner, 2007.

70 New Zealand Law Commission, n 12.

- provide rights to family members to seek an inquiry (s 63);
- creating formal rights for family members to object to an autopsy (s 33);
- institute a process for family members to seek return of retained body parts and samples (s 50).

In addition, attempts are made to promote coroners' sensitivity to cultural and religious beliefs. Thus, under s 32(e) and (f) the coroner is obliged, amongst other things, to give consideration to the desirability of minimising the causing of distress to people who, by reason of their ethnic origins, social attitudes or customs, or spiritual beliefs, customarily require bodies to be available to family members as soon as possible after death; and the desirability of minimising the causing of offence to people who, by reason of their ethnic origins, social attitudes or customs, or spiritual beliefs, find post-mortems of bodies offensive.

The traditional legal framework is characterised by judicial officers making their decisions and then being *functus officio* – their role is concluded. However, the experience of problem-solving courts and modern processes of court management have recognised the advantages of ongoing judicial involvement in some circumstances. Such involvement, though, makes its own demands. As Wexler and Winick have put it, judicial officers "functioning in these ways need to develop enhanced interpersonal skills, to understand the psychology of procedural justice, to learn how to serve as effective risk managers, and to learn about the other approaches that therapeutic jurisprudence has to offer".[71]

Already in the coroner's jurisdiction, a number of courts provide grief and loss services to bereaved relatives.[72] This is an example of the ancillary role embraced by modern coroners' courts to reduce the adverse impact of the investigation and curial processes and to facilitate the acquisition of a measure of closure for relatives of the deceased person.

A cognate and important issue in respect of coroners' cases is what ensues in the aftermath of the making of recommendations by coroners. At present, by and large, there is no obligation on the part of anyone to respond in any way to the recommendations of coroners. This leaves as the only "weapon"/power possessed by coroners the potential criticisms generated of relevant bodies by the media. This is manifestly unsatisfactory. Yet mandating persons or entities affected by coroners' decisions to take consequential action is a significant and revolutionary step, transforming coroners from traditional examples of judicial officers into risk managers working in part within a complex public health regulatory context.

Law reform recommendations in this regard have been made in New Zealand

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71 Winick, B and Wexler, B (eds), *Judging in a Therapeutic Key*, (Carolina Academic Press, North Carolina, 2003), p 8.

72 See eg the Counselling and Support Service attached to the Victorian Coroner's Office: http://www.vifm.org/in_counselling.html, viewed 17 September 2007; J, Abernethy, "Current Issues in Coroner's Courts", paper presented to AIJA Magistrates' Conference, 13–14 September 2002: http://www.aija.org.au/Mag02/John%20Abernethy.pdf, viewed 17 September 2007.

in 2000[73] and in Victoria in 2006.[74] Legislated changes are commencing but they are not uniform. They do not find expression in the Coroners Act 2006 (NZ).

A Northern Territory coroner who holds an inquest into a death in custody is obliged to make such recommendations with respect to the prevention of future deaths in similar circumstances as the coroner considers to be relevant. The coroner must forward such recommendations to the Attorney-General who in turn must relay them to the relevant government agency or police force. The response of the agency and Commissioner of the police force in question must include a statement of the action that they are taking, have taken or will take with respect to the coroner's report or recommendation.[75] On receiving the response, the Attorney-General must, without delay, report on the coroner's report or recommendation and the response to the coroner's report or recommendation and may give a copy of her or his report to the coroner.[76] The Attorney-General must lay a copy of her or his report before the Legislative Assembly within three sitting days after completing the report.[77] This provides a very significant legislated follow-up to this category of sensitive cases.

Similarly, in the Australian Capital Territory, at the conclusion of an inquest, a coroner holding an inquest into a death in custody must include in a record of the proceedings of the inquest findings as to the quality of care, treatment and supervision of the deceased which, in the opinion of the coroner, contributed to the cause of death. The coroner is obliged to report such findings to the Attorney-General of the Australian Capital Territory, the custodial agency in whose custody the death occurred and to the Minister responsible for the agency, the Australian Institute of Criminology, if the deceased was an Aboriginal person or a Torres Strait Islander, to an appropriate local aboriginal legal service, and to any other person whom the coroner considers appropriate.[78] The custodial agency to which a report is given also has obligations under the Coroners Act 1997 (ACT). It must give to the Minister responsible for the custodial agency a written response to the findings obtained in the report.[79] In addition, there is prescription about the kind of response mandated from the custodial agency. It must include a statement of the action, if any, which has been, or is being, taken with respect to any of the findings contained in the report.[80] Further, the Minister is obliged under s 76(3) of the Coroners Act 1997 (ACT) to provide a copy of the response to the coroner in respect of whose findings the report relates.[81] The coroner is obliged to give a copy of the response to each person or agency to whom a copy of her or his report was given.[82]

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73 New Zealand Law Commission, n 12, p 208.

74 Victorian Parliament, Law Reform Committee, n 13, p 420.

75 Coroners Act 1993 (NT), s 46B(2).

76 Coroners Act 1993 (NT), s 46B(3)(a)–(b).

77 Coroners Act 1993 (NT), s 46B(3)(c).

78 Coroners Act 1997 (ACT), s 75(1)(a)–(e). See Freckelton I, "A Glimpse of the Future: The Coroners Act 1997 (ACT)" (1998) 6(1) JLM 26.

79 Coroners Act 1997 (ACT), s 76(1).

80 Coroners Act 1997 (ACT), s 76(2).

81 Coroners Act 1997 (ACT), s 76(3).

82 Coroners Act 1997 (ACT), s 76(4).

In Queensland the Coroners Act 2003 (Qld) provides that a coroner must give a written copy of the findings and comments made in relation to the investigation of a death in care or death in custody to the Attorney-General, the "appropriate chief executive" and "the appropriate Minister".[83] There are no provisions mandating follow-up to the findings and comments.

It may be that the death in care model in the Australian Capital Territory and the Northern Territory in due course will form a model for mandated responses from government and non-government agencies in circumstances other than deaths in custody and care.[84] It is disappointing that there is no such provision in the Coroners Act 2006 (NZ). There is much to be said for bodies the subject of coroners' recommendations being compelled to respond to coroners' recommendations made as a result of a death with which they have been found to be associated and to indicate whether they propose to change their practices or conduct. Such an obligation does not compel compliance with recommendations but does mandate responsiveness in the public interest and on the public record. If the New Zealand community expends considerable sums of money on public inquests, this would seem to be a modest and proportionate provision for monitoring and assessment of considered proposals arising from deaths that may have been avoidable.

Such a procedure would have important collateral advantages. It would act as a reality check and a quality control mechanism for coroners' recommendations. It would also enable data-based evaluation of the extent to which coroners' recommendations are implemented. Further, it would consolidate both the potential for enhanced public health and safety and the therapeutic potential for family members to be able to draw comfort that some positive outcome in terms of ongoing community safety may be able to be derived from their loved one's death.

Future Reform of Coronership

It is likely that in New Zealand, as elsewhere, law reform in relation to the institution of the coroner will continue apace as coronership continues to search for its place in contemporary legal and public health systems. The course of the coroner as a quasi-public health official appears set, especially in New Zealand where inquests can be convened for explicitly preventative reasons – "to reduce the chances of the occurrence of other deaths in circumstances similar to those in which the death occurred".[85] It is inevitable that coroners will be given some

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83 Coroners Act 2003 (Qld), s 47(1)–(2).

84 Recommendation 82 of the Victorian Parliament, Law Reform Committee, n 13 (p 409), proposed that coroners be able to refer findings and / or recommendations to any individual or agency and require them to provide within six calendar months a written response including a report as to whether any action has been taken or is proposed to be taken in response to the recommendation. Recommendation 85 (pp 409–410) proposed that the State Coroner be required to include in the coroner's annual report to Parliament a summary of all coronial investigations in which recommendations had been made and a summary of responses to the recommendations made in the previous year, including a list of those recommendations which are still awaiting implementation or responses.

85 Coroners Act 2006 (NZ), s 57(3).

powers to mandate responses to their recommendations.

However, other fundamental questions arise in relation to the role of coroners on the edge of the adversarial and investigative legal systems. Coroners are sometimes termed an oasis on the adversarial landscape by reason of their inquisitorial functions, an object of which is the clarification of the public record in relation to the circumstances and aetiology of deaths. However, for as long as coroners' courts remain under-resourced, the poor cousins of Magistrates' courts, ill-serviced by legal aid funding for family members,[86] and lacking in teeth, the question will remain whether the coronial system is the most cost-effective way in which we can investigate deaths that are without known cause or are unnatural or violent.

The great asset of the coroner's system is that it provides a public and sophisticated means of investigation into deaths that concern and distress the community. What distinguishes it from death investigation systems on the Continent[87] is that its focus transcends the criminal and broadly embraces the prophylactic. It is arguable that the coroner's court has been the first of the problem-solving courts of the modern era with its focus extending beyond making the findings mandated by legislation to answering issues raised by families, formulating preventative strategies and, in a number of jurisdictions, offering grief reduction services to the bereaved. The changes initiated by the Coroners Act 2006 (NZ) consolidate the provision of informational and culturally sensitive services to families of deceased persons.

However, ultimately, the viability of the institution of the coroner will depend upon the calibre of its incumbents, the esteem in which stakeholders and the general community hold them, and the preparedness of governments to support the institution by more than rhetoric. The recent reforms in New Zealand augur well in each of these regards but ongoing data-based and fundamental reflection about the role of the coroner and the inquest process will continue to be necessary if the relevance of modern coronership is to be consolidated.

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86 See Gibson, F, "Legal Aid for Coroners' Inquests" (2008) 15 JLM (in press).

87 See Freckelton and Ranson, n 6, ch 2.