Introduction

The Coroner's work is generally misunderstood as being limited to dealing with death and the bodies of deceased people. An accurate observation is that the work of the Coronial Service in Victoria not only involves death and some fire but is also directed to public learning, understanding and prevention.

The required qualification for a Coroner in Victoria is a law degree and not a qualification in a scientific, medical or other specialty. However, in any Coroner's investigation there is obligation to harness the results of scientific, medical and all other specialist disciplines for broad use and advantage of the general community.

The Coroner in Victoria is not a source of medical, scientific or other specialist knowledge but rather is a catalyst by which the specialist knowledge of others is converted to public knowledge for the purpose of public learning and prevention.

Investigation and the Adversary Court Process

Our adversary court system of English background is often compared with an inquisitorial court process of European background. As will be illustrated, the method of a Coroner's work is somewhat similar to that of a European investigating magistrate. In performing this work a Coroner's process relies on and uses the best of specialist knowledge in medicine, science and all other specialties.

It has been observed that - "There have been many developments in the fields of medicine and science with which the law has not kept pace."

Does a Coroner's investigation fit within the phrase "the law" and, if so, where does it fit?

Prior to 1986 the functions of Coroners in Victoria were substantially those of Coroners in England. The functional strength of pre-1986 Coroners was the conduct of a public hearing (inquest) in which public issues could be considered in a public forum.
The functional weaknesses affecting the former Coroner's process were that:

- his function was court-based to the exclusion of broad involvement in investigation prior to inquest;

- he was limited to considering one case at a time without the added dimension of many similar cases in one investigation;

- he was concerned with the legal rules of evidence and legal standards of proof as used in the ordinary courts rather than being able to consider all reasonable materials;

- his conclusions involved death characterisation by terms such as "misadventure" and "accidental" rather than ordinary language;

- there were a number of autonomous Coroner's regions throughout Victoria raising issues of procedures, jurisdiction, resources and artificially restricting broad-based statewide case knowledge;

- there was a lack of medical specialty in forensic pathology relied on by a Coroner as opposed to clinical or anatomical pathology directed more to disease than to death; and

- there existed in coronial toxicology (chemical analysis of autopsy tissue) a defective statutory accountability to Coroner who remained publicly responsible but powerless to avoid case delays when awaiting toxicology results.

In view of the significant issues affecting the traditional English Coroner in Victoria the direction of change was to retain only the strengths of the English system and to introduce the strengths of the American Medical Examiner system.

A Medical Examiner in the United States of America is a forensic pathologist who investigates in order to determine medical cause of death. His strength lies in his involvement in the investigation process. His weakness is a lack of public hearing process and lack of public consideration of public issues arising in death.

With the commencement in June 1986 of the Victorian Coroners Act 1985 the Victorian coroner became a statutory hybrid of the English Coroner and the American Medical Examiner. Characteristics of the hybrid are that the Coroner:

- is an investigator with responsibility and involvement in his investigation process (ss. 15, 31)

- works in partnership and shares the Coronial Services Centre with the Victorian Institute of Forensic Pathology which is
established by the *Coroners Act* 1985 and which provides the forensic medico-scientific process akin to that of the Medical Examiner (s. 66);

- retains a public hearing (inquest) process in which public considerations are placed in the public domain (ss. 17, 34);

- is not bound by the rules of evidence and can be informed in any manner reasonable (s. 44);

- is not limited to single case investigations but can investigate many cases as a class to enable broader understanding (s. 43);

- has shifted from performing a predominantly English traditional legal function to a codified statutory function involving public education, understanding and prevention; and

- administers one coronial service for the state of Victoria with its full-time administration and investigation functions at State Coroner's Office in South Melbourne.

**Structure**

The Victorian Coronial Service is a tiny organisation in which the full-time, 24 hours per day State Coroner's Office in South Melbourne comprises some 25 people, being State Coroner and Deputy, Coroner's Clerks, police and typing and clerical staff. Around the State of Victoria there are Coroners and Coroner's Clerks constituted by Magistrates and clerks of the Magistrates' Court and totalling some 70 people. The whole of the Victorian Coronial Service actually engaged in Coroner's work at any particular moment is estimated to be approximately 50 people.

As broadly as death and fire affect all areas of community existence the Coroner's work is also wide-ranging, varied and reliant on the specialist knowledge of others.

Both by the small size of the Coronial Service and by the need for specialist knowledge outside the Coronial Service the Coroner's work relies on every individual, organisation, institution and specialist relevant to any investigation. In general terms the Coroner relies on the community he serves.

The Coronial Service in Victoria succeeds or fails according to its ability:

- to harness many disparate forces of specialty knowledge;

- to cause a process of public interaction between the harnessed forces and the community's affairs; and
- with a view to public learning, understanding and prevention.

Functions

The Victorian Coroner performs five functions as follows:

1. to enable registration of death and the lawful disposal of the body of a deceased person in every case in which a doctor does not write a certificate of the cause of death under the Registration of Births, Deaths and Marriages Act 1959 (Vic) or its ex-Victorian equivalent. There are approximately 30,000 deaths in Victoria per year of which approximately 4,500 (or 15 per cent) are Coroners' cases. The 85 per cent group of non-Coroners' cases are natural causes deaths in which a treating doctor writes a certificate of the cause of death. One part of that certificate is forwarded to the Registrar of Births, Deaths and Marriages to enable registration of death and another part of the certificate accompanies the body to enable burial or cremation. In all cases where a doctor's certificate is not written the only other method of having the death registered and the body lawfully disposed of is by Coroner's papers (ss. 3, 13, 15, 19(1)(d), 22 Coroners Act 1985);

2. to investigate every aspect of reportable death to conclude the deceased's identity, all the circumstances of the death, the medical cause of death, the particulars to register the death and the identity of any person who contributed to the cause of death (ss. 15, 19(1)). In this investigation the Coroner relies on not only his own administration and understanding of the event but also on specialist investigators - police, scientists, forensic pathologists, aviation investigators, dangerous goods and industrial investigators and any and every other specialist who can assist. All investigators are bound to provide to the Coroner and the Coroner is entitled to receive all relevant information as a matter of law (ss. 13(4), 14(1)(2), 27(1), 46, 60, 66(1), 73);

3. to investigate every aspect of those fires which raise public and community issues - to conclude the source and origin of the fire, all the circumstances surrounding the fire and the identity of any person who contributed to the cause of fire (ss. 31(1), 36(1)). In this investigation also, the Coroner relies on not only his own administration and understanding of event but also on specialist investigators - police, arson chemist, fire service investigators, explosives experts and any and every other specialist who can assist. Again, all investigators are bound to provide to the Coroner and the Coroner is entitled to receive all relevant information as a matter of law (ss. 32(3), 39, 60);
4. to draw together the investigation materials to see what can be learned and understood and to see what could be done to avoid repetition of adverse events (ss. 19(1)(2), 36(1)(2)); and

5. to inform the community and those who organise the community's affairs of what has been analysed, learned and understood and of what could be done to avoid repetition. This public information is provided by the public inquest, the Coroner's public documents and findings and by formal report and recommendation by Coroner to the Attorney-General (ss. 17, 20(1), 21(1)(2)(3) 34 37(1) 38(1)(2)(3) 57(1)).

Classification

The Coroners Act 1985 prohibits a Coroner from making findings or comments that a person has or might have committed a criminal offence (ss. 19(3), 36(3)). Further, neither the Coroner's findings or the transcript of inquest is admissible in any court of any fact contained in them (ss. 20(2), 37(2)). Finally, the Coroner and any person acting under an authority given under the Coroners Act is prohibited from giving evidence in any court or judicial proceedings about anything coming to their knowledge in carrying out their powers, duties or functions under the Coroners Act (s. 62).

These provisions mean that the Coronial Service is not part of either the criminal justice system or the civil justice system and is not involved with civil or criminal liability.

Rather, the Coroner is a civilian investigator obtaining fact and causation for the purpose of public learning and prevention. The Coroner is a public messenger with task completed on delivery of the message. It is then for the community to decide how or indeed whether it will act on the information provided. The Coroner's work is that of a catalyst in which specialty knowledge is converted into public knowledge with a view to community change for the purpose of prevention.

Reportable Death

Section 3 Coroners Act 1985 is a definition section in which one of the definitions is that of "Reportable Death", being that kind of death which is reportable to a Coroner.

In the context of the Victorian Coronial Service functioning in matters connected with Victoria reportable death requires Victoria to be the place of the deceased's body, or the place of death, or the place of cause of death or the place of the deceased's residence (s. 3 "Reportable Death" (a) – (d)). Reportable deaths are those which are:

- unexpected;
- unnatural;
- resulting from violence, accident or injury;
- during or resulting from anaesthetic;
- while in police or prison custody;
- while in state care such as psychiatric services, intellectual disability services and wardship of children;
- of unknown people; and
- without a treating doctor's certificate of natural causes death of his patient pursuant to the *Registration of Births Deaths and Marriages Act 1959* (Vic.) or its ex-Victorian equivalent (s. 3, "Reportable Death", (e) - (l)).

**Report to State Coroner**

Section 13 Coroners Act 1985 provides so far as relevant

"(1) A person who has reasonable grounds to believe that a reportable death has not been reported must report it as soon as possible to a Coroner or the Officer in Charge of a police station."

"(2) The Coroner or the officer must inform the State Coroner of the reported death as soon as possible."

"(3) A doctor who is present at or after the death of a person must report the death as soon as possible to a Coroner if (a) the death is a reportable death; or (b) the doctor does not view the body; or (c) the doctor is unable to determine the cause of death;...."

"(4) the death of a person who was held in care (custody or state care) immediately before death must be reported as soon as possible to a Coroner by the person under whose care the deceased was held."

The effect of these provisions is to require all reportable deaths to be reported to the State Coroner's Office in South Melbourne as soon as possible 24 hours per day and 7 days per week.

In the context of the statewide Coronial Service the 24 hour per day resources of the State Coroner's Office and the Victorian Institute of Forensic Pathology there is good sense in the statewide requirement that all reportable death be informed to State Coroner's Office as soon as possible at any time of day or night 365 days per year.

**Coroner's Investigation - Death and Fire**

Section 15 Coroners Act 1985 describes a Coroner's task as being to investigate a death. This is a different statutory function to that seen in previous Coroners Acts which described a Coroner's task as that of conducting an inquest
over a body within one of a number of local territorial regions within Victoria.

Section 31 Coroners Act 1985 describes a Coroner's task as being to investigate fire. This is a different statutory function to that seen in previous Coroners Acts which described a Coroner's task as that of conducting an inquest into a fire. As a matter of practicality the Coronial Service is involved only in those fires which raise public issues and concerns and with a view to public learning, understanding and prevention. There is little point in the Coronial Service simply duplicating the processes of other investigators or of the civil and criminal law in those cases involving arson and fire insurance dispute.

A Coroner's investigation under the present Act, like any investigation, commences at the scene of event being investigated and may or may not involve an inquest. As in any investigation, the scene of death or fire requires thorough investigation while the scene remains. Once the scene has been cleared there may be no recovery of whatever may have been lost or overlooked.

All present Coroners in Victoria are Magistrates and, while every Victorian Coroner is an investigator, there is a difference between a full-time Coroner working exclusively in the Coronial Service at the State Coroner's Office and a Coroner whose coronial work forms part of general Magistrates' court work. The differences are substantially that:

- a full-time Coroner at State Coroner's office is part of a 24 hour per day office and is available and equipped to work 24 hours per day 7 days per week;

- magistrates in country Magistrates' Courts and at Melbourne Magistrates' Court are generally part of the Magistrates' court system and are generally not available and equipped to work in the Coronial Service 24 hours a day, 7 days per week;

- a full-time Coroner is not involved with the criminal law judicial process or the civil law judicial process and is not constrained by those processes from being involved in the Coroner's investigation and administration from its beginning at the scene of event;

- a Coroner whose substantial work is as Magistrate in the Magistrates' Court, being a judicial officer in an adversary system of criminal law and civil judicial process, has a consideration of not compromising his judicial position by close and physical involvement in the investigation process; and
the work of the state Coroner's Office involves a broad, statewide information base, a broad statewide perspective of reportable death and a working relationship with ability to obtain assistance from most specialist fields.

**Routine Cases**

The Coroner's investigation in every case commences at the scene of death or fire. With some 5,500 reportable deaths and some fires investigated by Coroner per year in Victoria it is not possible for a Coroner to attend every scene of death or fire. Approximately 5,000 of the 5,500 annual Coroners cases are routine for the Coronial Service and in those cases police at the scene of event, (as coordinating authority under the Emergency Management Act 1986 and with particular responsibilities under the Coroners Act) are relied on as Coroner's agent.

**Non-Routine Cases**

In cases of death and/or fire which are significant and non-routine the state Coroner's Office needs to be informed of the event at the earliest possible time, within minutes of occurrence and while the scene remains. In such non-routine cases of significance there is police communication to the state Coroner's Office as an incident report. The state Coroner's Office responds administratively by telephone or actively by people proceeding to the scene depending on the circumstances of the case.

The following are events which could be described as non-routine and significant.

**Reportable Death**

1. All incidents involving three or more deaths (including motor vehicle fatality).

2. All incidents involving one or more deaths if incident involves-
   
   (a) aviation (aircraft, parachute, hang-glider or any other aviation matter);
   
   (b) significant industrial fatality;
   
   (c) public department, instrumentality or agency:-
   
   - including police (police car, deaths of or by police, death in police custody);
   
   - including prisons (cell death);
   
   (d) public health or safety;
(e) community concern;
(f) homicide;
(g) a requirement for a forensic pathologist at the scene of death.

**Fire**

Any fire, including explosion, if given significance by the following types of considerations.

(1) **Where no Death**

(a) Serious injury where death is a real possibility.
(b) Significant property damage.
(c) Community concern.
(d) Public health or safety.

(2) **Where Death**

Same considerations as set out above for Reportable Death

**Coroner at Scene of Death or Fire**

In the context of attending a scene of death or fire the Coroner's statutory right is set out in ss. 26(1) and 41(1) Coroners Act 1985.

- "A Coroner who has jurisdiction to investigate a death (s. 26) or a fire (s. 41) may, with any help thought fit

(a) enter and inspect any place and anything in it; and

(b) take a copy of any document relevant to the investigation; and

(c) take possession of any thing which the Coroner reasonably believes is relevant to the investigation and keep it until the investigation is finished."

It has been seen as a matter of practice and reality that the Coroner relies on those who are experts at a scene of event to carry out the field investigation as a matter of specialty. In the context of administration and co-ordination of the scene the Coroner fits into co-ordination by the Victoria Police pursuant to the Emergency Management Act 1986 (Vic). However, the Coroner attends, enters and inspects a scene of death and fire as a matter of statutory right (ss. 26(1)(a), 41(1)(a)).
There are generally three reasons why a Coroner attends a scene of death or fire involving investigation, administration and public responsibility.

**Investigation**

(i) The Coroners Act places on a state Coroner a responsibility in every Coroner's investigation as well as in the broad direction of the Coronial Service investigation process. In cases of significance it is a matter of fulfilling that obligation for a state Coroner to attend the scene, obtain first-hand information of the specific facts of that event and of the investigators present.

(ii) In significant cases there is further responsibility that state Coroner consider at the commencement of the investigation process and commencing at the scene whatever may be the event's broader circumstances and context on a statewide basis. Further consideration relates to the investigation of these broader circumstances and by whom. *(Coroners Act 1985, ss. 6, 7, 13, 16, 24, 33, 66, 67(2); Emergency Management Act 1986, s. 10. Victoria State Disaster Response Plan (Displan), Part 6, Appendix B, Paragraph 3(ii)).*

(iii) To commence a Coroner's objective analytical process one step removed from the primary investigation process.

**Administration**

(iv) To commence the process of drawing together the various specialty investigators for issues relevant to a Coroner and to engage the services of a forensic pathologist with forensic pathology investigation commencing at the scene *(s. 27, 73 Coroners Act)*.

(v) To exercise responsibility for the bodies of deceased people, their administration at the scene, removal, destination on removal, organising autopsy *(s. 24 Coroners Act. s. 10 Emergency Management Act. Part 6, Appendix B, Paragraph 3(i) Displan)*.

**Public Responsibility**

(vi) The Coroner's investigation is different from and proceeds in a totally different direction to a crime investigation. A crime investigation commences at the scene with given facts and is concerned with charging, conviction and sentence of an offending individual. A Coroner's investigation commences at the same scene with the same given facts, adds facts of broader circumstances and then analyses and learns for the ultimate purpose of public prevention. In death and fire events of significance there is public responsibility that the Coroner commences the Coroner's job at the place where the job commences – at the scene.
Autopsy

A fundamental process of any death investigation involves obtaining primary source facts by autopsy. An autopsy is an investigation of the body of a deceased person for the purpose of ascertaining the medical cause of death and surrounding circumstances such as pre-existing medical condition, injury, drugs and disease.

Section 27(1) Coroners Act provides

"If a Coroner reasonably believes that it is necessary for an investigation of a death, the Coroner may direct the Institute, a pathologist or a doctor under the direct supervision of a pathologist to perform an autopsy on the body."

An autopsy is not mandatory but is performed - "If a Coroner reasonably believes that it is necessary for an investigation of a death....". (s. 27 Coroners Act). A Coroner's autopsy can only be performed by direction of a Coroner or a Coroner's Clerk on behalf of a Coroner (s. 27).

The Coroner's discretion is generally exercised by directing that there be an autopsy in cases where the medical cause of death cannot be reasonably ascertained from other sources such as hospital records and in cases where the death involves crime and the criminal law process. An autopsy is generally not required when the medical cause of death is reasonably ascertainable from the deceased's medical history and the death does not involve the criminal law process. In all cases there is communication with a forensic pathologist.

Power of Entry, Search and Seizure

Reference has been made to sections 26(1) and 41(1) Coroners Act 1985 which enable a Coroner, with any help thought fit, to enter and inspect any place and anything in it and to take relevant documents and things. In totality the provisions provide an ability to enter, search and seize. The same power to enter, search and seize can be exercised by a policeman named in a Coroner's Warrant.

Sections 26(3) and 41(3) Coroners Act 1985 provide as follows with respect to death and fire investigations respectively.

"A Coroner may, if the Coroner reasonably believes it is necessary for the investigation in writing authorise a member of the police force to do any one or more of the following at or between specified times during a specified period (not exceeding one month after the authority is given):

(a) To enter a specified place;
(b) To inspect a specified place and any thing in it;

c) To take a copy of specified documents or classes of documents;

d) To take possession of specified things or classes of things."

A copy of the warrant must be given to the owner or occupier of premises entered and to the person in possession of documents and things inspected, copied or taken (s. 26(4)).

The basis of a Coroner or a policeman authorised by him entering, searching and seizing pursuant to sections 26 and 41 is a Coroner's reasonable belief that such a procedure is necessary for the investigation. The basis of such a reasonable belief is not restricted to an Information on Oath as is required by the Commonwealth and State Crimes Acts, and in that context is one of the broadest powers of its type in Australia. It is also observed that the common law requirements concerning the execution of search warrants do not apply in that there need be no limitation imposed on a Coroners Act Warrant by the time of day or night at which the warrant is executed.

A balance to the broad power exercised by a Coroner or policeman authorised by him under sections 26 or 41 is seen in section 62(1) of the Coroners Act.

"A Coroner or a person acting under an authority given under this Act must not be called to give evidence in any court or judicial proceedings about anything coming to their knowledge in carrying out their powers, duties or functions under this Act."

This provision would appear to cover not only criminal law proceedings but also civil claims and reflects the situation that the Coroner's powers are limited to his own functions which do not involve criminal or civil liability.

In other words, if criminal investigation is involved then the requirements of the criminal law have to be met. The Coroner has broader and fuller powers but limited to his own investigation and its purposes.

**Inquests**

Apart from cases in which the holding of an inquest is mandatory an inquest is one of a number of tools available to a Coroner for the purpose of investigation, public information and warning but which may or may not be used according to the type of case.
In death investigations an inquest is mandatory in cases:
- of homicide (murder, manslaughter and culpable driving);
- of deceased persons who were in police or prison custody;
- wards of State and intellectually disabled people under the control or care of the Community Welfare Services Department;
- a patient in an alcohol or drugs treatment centre;
- a non-voluntary psychiatric patient under the Mental Health Act 1986;
- where Attorney-General or state Coroner direct (s. 17(1)).

In every other death case where an inquest is not mandatory the Coroner has a discretion as to whether or not an inquest is held (s. 17(2)).

In fire investigations an inquest is mandatory if the Attorney-General or the state Coroner direct (s. 34(1)(2)). In every other fire investigation a Coroner has a discretion as to whether or not an inquest is held (s. 34(3)).

Approximately 80 per cent of all Coroners' cases are disposed of without inquest with due decision as to whether or not an inquest is required being based on the purpose of an inquest or public hearing. An inquest is a public hearing using court procedure:
- admitting reasonable materials and not being bound by the rules of evidence (s. 44);
- as an inquiry process of the Coroner and not an adversary process in which opposing parties are responsible for adducing their own materials.
- the purposes of an inquest are to inquire to obtain facts; and
- to provide a public forum for considering public issues of death and fire.

If sufficient uncontested facts are contained in witness' statements and if there are no public issues to consider then there is no point in conducting a public hearing. This type of case is disposed of without inquest.

**Completion Without Inquest**

In cases where it appears on early information from police report, autopsy and other sources that the facts are
ascertained and that there are no public issues then the case is a candidate for disposal without inquest.

Coroner's staff then communicate with the investigating policeman and request from him a statement to bring up-to-date the Coroner's information. Also requested are photocopies of whatever statements have been obtained in whatever form they then exist. If, on receipt of that information, there is still no reason for inquest then Coroner's staff advise the investigating policeman and all interested parties of intent to complete the case without inquest. That advice also requests response if anyone has any doubts about the facts or desires an inquest to be held (s. 18 (death) and s. 35 (fire) give anyone the right to request an inquest). If there is no response indicating that an inquest is required the Coroner's findings are made on the basis of the documents and without inquest and copies are forwarded to the investigating policeman and all interested parties.

**Cases With Inquest**

In cases where an inquest is required the Coroner's staff asks the investigating policeman to prepare an Inquest Brief.

On receipt of the Brief all the witness' statements and materials are read and decision is made by the Coroner's Office as to which witnesses to call to give evidence. Sometimes further witness' statements are obtained and sometimes the Brief is sent to specialists for expert opinion. An Inquest hearing date is set, witness' summonses are prepared and sent to local police stations for service. An inquest then commences on the date fixed for hearing and pursuant to s. 46 Coroners Act which sets out the statutory administration relating to witnesses, evidence and orders.

**Mandatory Inquests/Committal Proceedings**

Although most death cases involving homicide (including culpable driving) substantially involve issues for the criminal law rather than civilian public issues for a Coroner an inquest is mandatory pursuant to s. 17(1)(a) Coroners Act 1985. Those criminal cases are prepared and heard as committal proceedings in the Magistrates' Court. At the end of the committal proceeding the Magistrate, then sitting as a Coroner, makes Inquest findings on the same materials already provided him in the committal proceeding.

In those few criminal law death cases which also involve broader public issues requiring a Coroner's consideration outside the criminal law process the committal proceeding is heard and completed without Inquest findings. There is then a separate inquest adopting the materials already adduced in the committal proceedings and calling additional evidence relating to the broader public issues to be considered by the Coroner.
Finding and Comments

Section 19 Coroners Act 1985 provides for the Coroner's findings and comments at the end of an investigation into death and whether or not an inquest is held.

"19(1) A Coroner investigating a death must find if possible
(a) the identity of the deceased; and
(b) how death occurred; and
(c) the cause of death; and
(d) the particulars needed to register the death under the Registration of Births, Deaths and Marriages Act 1959; and
(e) the identity of any person who contributed to the cause of death.

(2) A Coroner may comment on any matter connected with the death including public health or safety or the administration of justice.

(3) A Coroner must not include in a finding or comment any statement that a person is or may be guilty of an offence"

The finding involving the identity of the deceased is obtained either by visual identification of the body by a person who knew the deceased in life or by comparison of postmortem findings relating to fingerprints, tattoos, scars, teeth, surgery and any aspect of body identification with records obtained of the deceased during life.

The finding concerning how the death occurred involves all the surrounding circumstances of the death and the cause of death relates to the medical cause of death. The particulars needed to register the death relate to the function of the Coronal Service of providing to the Registrar of Births, Deaths and Marriages the particulars required to enable death registration.

Section 36 Coroners Act provides for the Coroner's findings and comments at the end of a fire investigation and whether or not an inquest is held.

"36(1) A Coroner investigating a fire must find if possible
(a) the cause and origin of the fire; and
(b) the circumstances in which the fire occurred; and
Section 36(2) is identical to s. 19(2) concerning comments and
s. 36(3) is identical to s. 19(3) being prohibition against a
Coroner's involvement in the criminal law process.

The Coroner's finding of the identity of any person who
contributed to the cause of death (s. 19(3)) or fire (s.
36(3)) is a finding of fact and causation and is not a
classification of that fact and causation as either criminal
or civil liability. This is confirmed by the prohibition
against a Coroner concluding as to criminal offence (ss.
19(3), 36(3)) and by ss. 20(2), 36(2) and 57(3) which provide
that both the Coroner's findings and the transcript of inquest
are not evidence in any court of any fact asserted in them.

Sections 19(2) and 36(2) enable a Coroner to make comments in
his findings on any matter connected with the death or fire
including public health or safety or the administration of
justice. This is the statutory base of the Coroner informing
the community of matters found, lessons learned and
recommendations to prevent repetition. Not only is such
material stated publicly in inquest but its written form in
the findings, transcript of inquest and Coroner's file become
public documents available to anyone.

Report and Recommendations

Section 21 Coroners Act 1985 with respect to death and s. 38
with respect to fire set out the statutory basis on which the
Coroner informs government of relevant matters learned in an
investigation. These sections provide for a Coroner to report
to the Attorney-General of his conclusions and recommendations
with a view to avoiding repetition. These sections also deal
with reporting to the Director of Public Prosecutions
indictable offences not already being dealt with by the
criminal law process.

Individual Cases/Many Cases/Public Issues

In the past, Coroners have not really come to grips with
classes of cases and broad issues which may arise from them.
One reason has been the limitation imposed by considering only
one case at a time independently of all other cases.
Consideration in isolation of one set of facts narrows the
view of the matter being considered and often results in
conclusions for one case alone.

A second reason for Coroners having failed to meet classes of
fatality in the context of community considerations has been
consideration of the rules of evidence and a legalistic
approach to Coroners' cases to the exclusion of being able to
take a broader view of public and social issues.
Recognition of these matters has resulted in specific changes in the Coroners Act 1985 (Vic). Section 43 provides

"The State Coroner may direct that more than one death or more than one fire or both a death or deaths and a fire or fires be investigated at one inquest."

This section enables the investigation and consideration of many similar cases in one investigation with ability to obtain the broadest understanding from the perspective of many similar cases. The provision is enhanced by the Coronial Service no longer comprising a number of autonomous coronial regions throughout the state but rather being a statewide service administered from the full-time state Coroner's Office. This statewide structure enables the recognition, collection and collation of cases on a statewide basis.

Another relevant change is contained in s. 44 Coroners Act 1985.

"A Coroner holding an inquest is not bound by the rules of evidence and may be informed and conduct an inquest in any manner the Coroner reasonably thinks fit."

This section enables a Coroner to obtain and consider all reasonable materials whether or not admissible in the ordinary courts. In conjunction with the broad changes already discussed this section enables a Coroner to consider class fatality in the context of its public issues and with reference to a social function of public learning, understanding and prevention.

The Application of Scientific, Forensic Pathology and Other Specialty Disciplines

The Coroner's process is only as good as the information, expertise and knowledge provided it. The Coroner's process is justifiable only if it can do something worthwhile with the provided information, expertise and knowledge. It is necessary to consider both the process and the justification. To this end, some representative areas of the Victorian Coroner's work are discussed.

Forensic Pathology and its Scientific Support

In the past a problem which had faced the Victorian Coronal Service was the absence of medical specialty in forensic pathology as opposed to anatomical or clinical pathology. At a time when this problem threatened the disintegration of the full-time Coroner's Office in Melbourne the ethic and perceived public duty of several eminent anatomical pathologists in public hospitals resulted in those
pathologists performing coronial autopsies on a part-time basis.

Ensuing years saw this initial pathologist's response to crisis develop into a routine practice in which the Coronial Service functioned on part-time, rostered once-a-week pathology work by active or retired Directors of Hospital Pathology Departments.

Difficulties experienced by the Coronial Service in this situation involved:

- a full-time Coronial Service having to administer coronial pathology in circumstances where a part-time pathologist on a once-a-week roster was present for two hours once a week on one day between approximately 7 am and 9 am; and

- the non-existence of a viable specialty of forensic pathology in Victoria and the consequent non-existence of a full-time forensic pathology service dedicated to serve a full-time Coronial Service.

The Coroners Act 1985 has swept away this historical problem by establishing the Victorian Institute of Forensic Pathology. The establishment of the Institute has resolved the Coronial Service problem in two stages.

The first stage of resolving the historical forensic pathology problem for the Coronial Service was achieved by the establishment of the Institute with statutory objectives to provide, develop and enhance forensic pathology and related services in Victoria (s. 64(2) Coroners Act 1985). The Institute is also the Department of Forensic Medicine at Monash University with its Director being the Professor of Forensic Medicine. The result of the Institute's establishment is the establishment of forensic pathology as a viable medical specialty in Victoria.

The second stage of resolving the historical forensic pathology problem for the Coronial Service is the Institute's statutory function and obligation to serve the Coronial Service. This statutory function and obligation is provided for by the Coroners Act 1985 as follows:

- a Coroner may direct the Institute to perform an autopsy and to retain and preserve autopsy material (s. 27);

- the Institute is under statutory obligation to ensure the performance of an autopsy, to report the results to the Coroner and to keep a record of the autopsy (s. 73);

- the functions of the Institute in general terms are to provide to the Coronial Service forensic pathology and related scientific services (s. 66(1));
- the Institute's functions are "Subject to the directions of the State Coroner" (s.66(1)); and

- the State Coroner is a member of the Victorian Institute of Forensic Pathology Council (ss. 67, 69).

The substance of these provisions is that the Institute is the full-time provider of forensic pathology and related scientific services with functions specifically and by statute dedicated to serving the Victorian Coronial Service.

Suicide

The investigation of suicide relies on a variety of expertise which may be involved in one or other of many cases. That expertise may involve specialty investigation and knowledge in crime scene, ballistics, forensic pathology with its clinical sciences and toxicology, odontology, handwriting, fingerprints, fire investigation, psychiatry and social sciences.

Despite the broad and significant range of specialty skill applied to suicide investigation, Coroners have not really come to grips with suicide. One significant reason is the limitation imposed by a Coroner considering only one case at a time independently of all other cases. A consideration in isolation of one set of facts has tended to result in Coroners concluding substantially the factual mechanism of death, whether or not it is suspicious, whether or not the deceased's conduct resulted in his own death and whether or not the deceased intended to take his own life. This constitutes a legalistic approach to one case and provides legal conclusions for one case, but does little else.

Another significant reason for the failure of Coroners in dealing with suicide is a preoccupation with legal admissibility of evidence and standard of proof. In some jurisdictions a Coroner's concern in suicide is whether or not the deceased's intent to take his own life has been proved beyond reasonable doubt according to the rules of evidence. In other words, there is consideration of the criminal law standard of proof.

In the face of the compelling public issues of suicide the function of Coroners in a manner just described is accepted as being a legal function of some value. However, in the context of social function and in considering community learning, understanding and prevention the Coroner's traditional legalistic role does not adequately serve a modern community, does not deal with important community issues and has failed.
Although every suicide is a Coroner's case, public death investigation is generally deficient in assisting the community to deal with the issue.

In considering suicide Coronership has generally failed socially because of traditional legalistic process of being limited to one case at a time and, in that case, being restricted to narrow considerations of mechanism of death, the deceased's conduct and the deceased's intent.

Coronership in Victoria has taken a fresh approach. A modern Coroners Act has produced in Coroner's process a civilian investigation relying on whoever may have expertise and for the purpose of public information and public learning with a view to preventing avoidable recurrence. A modern basis of Coroner's process is the ability to conduct a class investigation of many cases with common features.

Suicide is eminently suited to class investigation and is worthy of the best application possible of modern Coronership.

To this end, approximately two years ago a working party was established by the state Coroner's Office and the Royal College of Psychiatrists with a view to better investigating and considering completed suicide. Psychiatrists did not have facts while Coroner's investigation did not have expertise to seek meaningful facts or to interpret those facts.

The working party's first project involves suicide in Victoria by people under 25 years of age, of which there are some 100 cases per year. There are a number of aspects to the project.

1. The completed development of an interview schedule to obtain meaningful facts from relevant sources.

2. The successful use of the interview schedule by members of the Victoria Police as agent of the Coroner in suicide cases.

3. Expertise to interpret the facts obtained.

4. The matching of completed suicide cases by age, gender and place of residence with an equal number of hospitalised suicide attempts as well as with a further equal number of non-hospitalised suicide attempts. This matching aspect of the project is being run by psychiatric registrars in a number of public hospitals.

5. The use of expertise in psychiatry, police, demography, computer data, research assistants and Coroner's administration.

6. Any results of public value being placed into class inquest by Coroner's process.
7. Any results of psychiatric value being placed into a research paper for publication.

8. The field project is to cover a period of twelve months.

9. A grant of $30,000 from the Australian Rotary Health Research Fund has enabled the project to commence.

The Victorian State Coroner's Office is also involved in the Youth Suicide Working Party of the Victorian Health Promotions Foundation and the Suicide Working Party of the National Health and Medical Research Council.

The Coroner's Office was involved in a completed suicide research project by the Department of School Education (Vic).

Accepting that suicide is a complex issue without easy answers, the Victorian Coronial Service can but enable the broadest dissemination of its factual information and seek the best advice on those facts as can be obtained.

An ultimate benefit which may be derived from effective use of Coroner's process is the converting of specialist knowledge and understanding to public learning, understanding and prevention where possible.

Motor Vehicle Fatality

Motor vehicle fatality constitutes one of our community's largest single classes of untimely and unnatural death. Consideration of Coroner's function leads to a conclusion that Coroner's investigation must follow the path already described. Coroner's process relies on the best of specialty knowledge and application - whether in field investigation, forensic pathology and its scientific support, vehicle and roadway mechanical and design engineering, expertise in the physics of movement, weight and speed in conjunction with surfaces, gradients and surrounding objects.

Once provided with the best of specialty investigation and knowledge the Coronial Service has a duty to have the specialty knowledge placed into the public arena and disseminated in a form which is generally understandable. A Coroner's investigation of motor vehicle fatality should ultimately be directed to public education.

Custody Death

All deaths in custody are Coroners' cases, all require investigation and with public hearing (inquest) made mandatory. In recent years much has been said of custody death and its investigation.
This paper sets out a method of Coroners' investigation which is capable of meeting modern expectations of custody death investigation. Specialist investigation of custody death involves:

- an experienced general field investigator;

- specialist investigators in crime scene, ballistics, photography and the range of specialty available to a homicide investigation; and a forensic pathologist and his support in forensic technical services, toxicology, histopathology microbiology and haematology.

The substance of this paper deals not only with the functions of a viable Coronial Service but also with its dependence on the skill, training, expertise and specialty knowledge of others. It is clear that the recommended quality and results of Coroner's inquiries into custody death are dependent upon the quality and results of specialist investigation of the primary facts and the specialist interpretation of those facts.

Fire

It has been said in this paper that there is little point in the Coronial Service simply duplicating the process of other investigations or of civil and criminal law judicial process. Arson and fire insurance disputes are primarily the province of the courts and not of the Coroner.

Fires involving the Coronial Service are those:

- resulting in death;

- involving public and community issues and concerns; and

- with sufficient repetition and public concern to warrant Coroner's investigation of many fires together as a class of case.

As with every area of Coroners' investigation the Coronial Service relies on the knowledge, training and skill of specialists. Such specialists include police CIB and Arson Squad; Fire Brigade Fire Investigation Unit, Arson Chemists, Photographers, Scientists with knowledge of explosives and metallurgy, Industrial Chemists, general and specialist investigators engaged by insurers and private interests and the range of specialty death investigation in fatal fires.

All Specialty Cases

The same principles apply to all Coroner's investigations involving specialty knowledge and application. The Coroner's process is as good as specialist knowledge enables it to be.
The Essence of Coronership

The essence of Coronership in both death and fire investigation is reliance on others and the use of others' expertise.

One of the basics of death investigation is ascertaining the identity of a deceased person. In cases of non-visual identification a Coroner's investigation relies on dentistry, medicine, radiology, fingerprinting, scene investigators, photography and in some cases molecular haematology providing DNA identification.

A Coroner's investigation seeking circumstances in which death occurred is required to ascertain and interpret those circumstances across the range of human affairs. In whatever area of life reportable death occurs the surrounding circumstances involve specialty knowledge in every conceivable aspect of modern life.

Similarly, in fire investigation a Coroner's investigation relies on the range of chemical, engineering, electrical, building design and all other specialty involved in understanding and interpreting fire.

Conclusion

The work of an investigating Coroner is very different from what is generally understood as the work of the courts in an adversary court process. An investigating Coroner can but rely on the expertise of others in all aspects of life and in all specialties. In relying on all other specialties an investigating Coroner will be informed of and use whatever may be the latest of current knowledge, skill and development known to those with expertise who are being relied on.

Whatever may be an answer to whether or not "the law" has kept pace with many developments in medicine and science, it may be that a Coroner's investigation does keep pace by reason of being a product of the specialties on which it relies.

The ultimate benefit which the community may derive from a Coronial Service is the public statement of investigated and concluded facts for the purpose of public learning, understanding and prevention. Without assistance by the range of scientific, medical and all other specialty disciplines a Coronial Service could not function. With specialist support the task of the Coronial service is to convert specialist knowledge into a form which is also understandable by the non-specialist. In this way the Coroner is a catalyst assisting in public education with a view to prevention by change.