

LESSONS LEARNED; ACCOUNTABILITY AND CLOSURE: IS THE CORONIAL PROCESS PROVIDING WHAT IS NEEDED TO INDIGENOUS COMMUNITIES?

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On Friday the 14 October 2005, the Department of Immigration and Multicultural and Indigenous Affairs ('DIMIA') owned monitoring vessel, the *Malu Sara*, sunk while travelling from Sabai Island to Badu Island in the Torres Strait. All five of the people on board, including two Indigenous Departmental officers and three passengers drowned. The findings of the coronial inquest into the loss of the vessel confirms that the tragedy was entirely preventable and highlights the appalling and parlous state of services provided to Indigenous and Torres Strait Islander persons living in remote communities. From the commissioning of vessels, to the building and inspection process, to the training of Movement Monitoring Officers, to the response to the calls for assistance, through to the initial investigation into the loss of the vessel, the tragedy is riddled with incompetence, apathy, racially motivated and inappropriate assumptions and a lack of accountability.

For the Indigenous communities involved who are seeking answers including how the tragedy was allowed to occur, how such occurrences in their communities will be prevented in the future, and whether parties involved will be held to account for their conduct; questions remain as to whether the coronial process in Queensland are able to adequately address such concerns. Using the *Malu Sara* inquest as a case study, this paper will look at how provisions under the *Coroners Act 2003* (Qld) have recently been interpreted and applied, with particular emphasis on the intersection between the role of the Coroner and the criminal process.

I INTRODUCTION

On Friday the 14 October 2005, the DIMIA owned monitoring vessel, the *Malu Sara*, sank while travelling from Sabai Island to Badu Island in the Torres Strait.¹ All five of the people on board, including two Indigenous Departmental officers and three passengers drowned. The findings of the coronial inquest into the loss of the vessel confirms that the tragedy was entirely preventable and highlights the appalling and parlous state of services provided to Indigenous and Torres Strait Islander persons living in remote communities.²

From the commissioning of vessels, to the building and inspection process, to the training of the Movement Monitoring Officers ('MMOs'),³ to the response to the calls for assistance, through to the initial investigation into the loss of the vessel, the tragedy is riddled with incompetence, apathy, racially motivated and inappropriate assumptions and a lack of accountability. Unfortunately this tragedy is not an isolated incident in remote Indigenous communities. High

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1 From the time of the loss of the *Malu Sara* to the date of the inquest the name of the Department of Immigration and Multicultural and Indigenous Affairs changed to Department of Immigration and Citizenship. In this paper, as in the inquest, the Department will be referred to as either 'DIMIA' or the 'Department'. Currently Indigenous affairs are administered under the Department of Families, Housing, Community Services and Indigenous Affairs.

2 *Inquest into the Loss of the Malu Sara* (Unreported, Queensland Coroner's Court, State Coroner Michael Barnes, 12 February 2009).

3 Movement Monitoring Officers ('MMOs') were employees of the Department, recruited from local Torres Strait Islander residents, to record arrivals and departures from the Islands and to manage the flow of people between Papua New Guinea and the Torres Strait Islands.

profile coronial inquests into the deaths of Mulrunji Doomadgee in Queensland⁴ and Mr Ward in Western Australia⁵ continue to remind us that the police and correctional services have failed to learn the lessons from the Royal Commission into Aboriginal Deaths in Custody.⁶ While others, including the inquest into the loss of the *Malu Sara*, remind us that for people living in remote communities, substandard services and disregard for human life continue to have devastating, yet avoidable consequences.

As the forum where unexpected deaths are explored, the coronial inquest has the potential to explain the causes and circumstances of a death and to make recommendations with a view to preventing similar deaths in the future.⁷ In this sense the coronial process has often been identified as having the ability to ‘speak for the Dead to protect the living’.⁸ Yet for remote Indigenous communities who continue to experience preventable deaths, these ideals are far from realised.

This paper considers how the modern coronial process operates to provide answers and accountability for Indigenous communities. By way of case example the paper will begin with a brief overview of the facts and findings of the inquest into the *Malu Sara*. The paper will then outline the preventative role of the modern Coroner’s court, with particular reference to the court in Queensland and consider its effectiveness. The fourth part focuses on the relationship between the Coroner’s court and the criminal process and examines the removal, in most jurisdictions, of the ability of the Coroner to attribute guilt. In conclusion it will argue that in order to provide greater accountability and answers for Indigenous communities there is a need to further refine and clarify the role of the Coroner.

II. FACTS AND FINDINGS OF THE INQUEST INTO THE LOSS OF THE MALU SARA

In 2005, the DIMIA, through its regional manager, sought tenders for the design, manufacture, supply and maintenance of six vessels for inshore patrol operations in the Torres Strait. The vessels were to be operated by local Torres Strait Islander MMOs, employees of DIMIA whose job involved patrolling the waters of the Torres Strait. The tender process was found to be severely lacking:

- (i) it was conducted by a regional manager who had limited experience in the procurement of marine vessels and who deliberately misrepresented that the waters in which the boats would be operating in were ‘smooth and partially smooth waters’ instead of ‘open waters’;⁹ and
- (ii) this deflected the need for an independent marine surveyor to inspect the vessels prior to being put into survey.¹⁰

4 There have been three inquests into the death of Mulrunji Doomadgee including *Inquest into the Death of Mulrunji* (Unreported, Queensland Coroner’s Court, Acting State Coroner Clements, 27 November 2006) and *Inquest into the Death of Mulrunji* (Unreported, Queensland Coroner’s Court, Acting Deputy Chief Magistrate Hine 14 May 2010).

5 *Inquest into the Death of Ian Ward*, (State Coroner of Western Australia, Alastair Hope, 12 June 2009).

6 Commonwealth, Royal Commission into Aboriginal Deaths in Custody (‘RCIADIC’), *National Report* (1991). As will be noted below, the coroner in the *Inquest into the Loss of the Malu Sara* raised concerns regarding the appropriateness of the police investigation into the loss of the vessel, similar to concerns raised regarding investigations in the RCIADIC.

7 See *Coroners Act 2003* (Qld) s 3, Objects of Act.

8 Thomas D’Arcy McGee (17th Century Irish-Canadian politician) referring to Law Reform Committee, Parliament of Victoria, *Coroners Act 1985 Final Report* (2006) 321 cited in Raymond Brazil, ‘Respecting the Dead, Protecting the Living’ (2008) 12 (SE2) *Australian Indigenous Law Review* 45, footnote 6.

9 The original draft of the Request for Tender referred to the boats as being required for ‘inshore and offshore patrol operations in smooth, partially smooth and open waters’, however without explanation the regional manager deleted the words ‘offshore’ and ‘open waters’. *Inquest into the loss of the Malu Sara* (Unreported, Queensland Coroner’s Court, State Coroner Michael Barnes, 12 February 2009) 16.

10 *Ibid* 17.

11 The contract was entered into with *Subsee* boat building company which was not an accredited boat builder or boat designer at the time of the tender, although the proprietor of the company ‘Mr Radke’ was accredited — *ibid* 22.

The tender was awarded to the boat builder¹¹ who provided the most cost effective quotation, and who (among other things) failed to build the boats with adequate flotation devices pursuant to requirements under the relevant safety codes. The boat builder deliberately employed shortcuts leading to unsatisfactory workmanship, unacceptable boat building and inadequate quality control¹² (the certification of the boat builder was found to be flawed and invalid).¹³ The regional manager and the tender evaluation panel failed to request certification from the boat builders and failed to identify deficiencies in the design of the vessel.¹⁴

A local marine repairer who inspected the prototype noted a number of deficiencies with the vessel and recommended its return to Cairns for modification. This was considered by the regional manager to be too expensive and instead some minor rectifications were made to the vessel onsite.¹⁵ Local MMOs also listed a number of concerns about the design and manufacture but these too were ignored by the regional manager as minor and ‘to be expected’.¹⁶ Of greatest concern was the lack of safety and navigation equipment aboard the vessels, the latter of which was requested by the MMOs. As was noted by the Coroner:

An explanation of Mr Chaston’s [the regional manager] failure to ensure the vessels were properly equipped might be found in the attitude he displayed when discussing the issue with two local marine equipment suppliers.... Mr Chaston said words to the effect; ‘the MMOs are two generations behind and would not be able to handle this type of equipment’.¹⁷

The Coroner found that the failure to fit the GPS ‘almost certainly contributed to the sinking of the *Malu Sara*’.¹⁸ The construction process was hampered by staff shortages, an unrealistic timeframe, incompetence and a lack of inspection and accountability.

Training for the MMOs who were to skipper the boats was minimal (particularly in relation to training regarding the use of new satellite phones which were the only source of communication).¹⁹ Shortly after use, problems associated with the vessel were noted however there was limited or no investigation into the problems undertaken.²⁰

Two days before the fatal voyage, the regional manager was advised that the boat sat too low in the water and that the void of the *Malu Sara* had taken water, but again, this was not adequately investigated.²¹ Despite requests made by the skipper on the day prior to the tragedy to delay the voyage due to weather conditions the regional manager gave permission for the vessel to take a passenger on a journey from Saibai to Badu Island. On the day of the tragedy, weather conditions had deteriorated further.

Mistakes were not limited to the construction and commission of the boats. On the day of the tragedy when the boat became lost in the fog in strong winds and seas, the skipper advised the Department base that the vessel was taking water, but no action was taken until nightfall (even then the regional manager failed to advise the Search and Rescue Mission Co-ordinator (Sergeant Flegg) that the boat had experienced a similar incident (with water entering a supposedly watertight bilge) two days earlier).²² Although communication over the satellite phone between the Department officer and the skipper was disjointed and interrupted, it was evident that selective and misrepresented information about the boat’s distress was passed onto the Australian Search and Rescue Service by both the regional manager and Sergeant Flegg.²³

12 Ibid 26.

13 Ibid 32.

14 Ibid.

15 Ibid 28.

16 Ibid 29.

17 Ibid 31.

18 Ibid.

19 Ibid 48.

20 Ibid 52.

21 Ibid 60.

22 Ibid 71, 72.

23 Ibid 86, 87.

The Coroner found that the response to the *Malu Sara's* calls reflected a cynical view within the police department that EPIRB's were used in the Torres Strait when people 'were inconvenienced rather than in peril'.²⁴ Such an attitude was evident from Sergeant Flegg's report to the AusSar officer that 'the report about the boat being out of oil was probably an exaggeration because the boat's occupants were "sick of being out there and want to get home"'.²⁵ It was noted by the Coroner that this comment was flippantly made at a time when the boat was most likely sinking and people on board were 'frantically trying to save themselves'.²⁶

The Coroner further found that Sergeant Flegg failed to take effective action, and inaccurately represented the seriousness of the *Malu Sara's* predicament in his log the following day.²⁷ Sergeant Flegg denied that he had been told by the Department officer who was in communication with the skipper of the *Malu Sara* that the vessel was sinking. He mistakenly believed the AusSAR helicopter was not operational (but did not check) and instead contacted the volunteer marine rescue organisation (VMR) to determine if a crew could attend and assist the *Malu Sara*. He did not advise that the vessel was sinking, instead stating that 'they're starting to take a bit of water in and they're bailing out'.²⁸

Reminiscent of police investigations into deaths in custody, Sergeant Flegg conducted the Queensland Police Service ('QPS') investigation into the incident, despite the fact that he was an integral part of the failed response. Although the Commissioner of Police accepted this was appropriate, the Coroner found that the investigation was flawed and should have been conducted by independent officers.²⁹

All five people aboard, including a young child passenger drowned after the boat sank.

III. THE CORONER'S RECOMMENDATIONS

A. *The Power To Make Comment*

Much has been written on the evolution of the coronial process in Australia over the last 25 years.³⁰ Of particular importance has been the move to a more preventative health role that provides Coroners with powers to make recommendations to prevent future avoidable deaths. While under the previous regime the Coroner had the power to make 'riders' on findings, these 'riders' were subsidiary to, and not part of, the determination of the cause of death and the possible commission of criminal offences.³¹ The elevation of the functionality of comments and recommendations, has provided the Coroner with the ability to consider both the wider systemic issues surrounding particular deaths as well as what may be done to prevent similar deaths in the future.

24 Ibid 69. There was evidence that authorities in the Torres Strait would often refer to activated EPIRB's as 'Empty Petrol I Require Boat'.

25 Ibid.

26 Ibid.

27 Ibid 68. The Coroner was unable to conclude whether this was deliberate to cover up the inadequacy of the response, or was due to misinformation by others.

28 Ibid 73.

29 Ibid 3. It should be noted that in June 2010, the Queensland Crime and Misconduct Commission criticised the Commissioner of Police for presiding over a culture of self protection, referring to the police handling of the investigation of the death of Mulrunji Doomadgee in police custody in December 2004 — Crime and Misconduct Commission, *CMC Review of the Queensland Police Service's Palm Island Review* (June 2010).

30 See, eg, Ian Freckleton, 'Death Investigation and the Evolving Role of the Coroner' (2008) 11 *Otago Law Review* 568; Ian Freckleton, 'Coronial Law Reform: the New Wave' (2006) 14 *Journal of Law and Medicine* 151; Roy Watterson, Penny Brown and John McKenzie, 'Coronial Recommendations and the Prevention of Indigenous Death' (2008) 12 (SE2) *Australian Indigenous Law Review* 4; Kate Allingham and Peter Collins, 'Coronial Reform in Western Australia' (2008) 12 (SE2) *Australian Indigenous Law Review* 90; Rebecca Scott Bray, 'Why This Law?: Vagaries of Jurisdiction in Coronial Reform and Indigenous Death Prevention' (2008) 12 (SE2) *Australian Indigenous Law Review* 27.

31 See, eg, the now repealed *Coroners Act 1958* (Qld) s 43 (5A), which provided that 'a rider shall not be or be deemed to be part of a coroner's findings but it may be recorded if the coroner sees fit'.

In Queensland the object of the *Coroners Act 2003* (Qld) includes to:

help to prevent deaths from similar causes happening in the future by allowing coroners at inquests to comment on matters connected with deaths, including matters related to —

- (i) public health or safety; or
- (ii) the administration of justice.³²

Included with these wider powers of inquisitorial investigation and fact finding, the Coroner is empowered to compel witnesses to give evidence, even where such evidence would incriminate the witness.³³

While this more expansive inquisitorial role has been embraced as having the potential to protect human rights³⁴ and promote therapeutic outcomes,³⁵ criticism has been levelled as to the limited ability of the coronial process to affect change and provide adequate redress for families of the deceased.³⁶ This criticism has been directed at the lack of sufficiently qualified judicial officers to determine complex health and safety issues, as well as the lack of resources to allow officers to investigate and address complex policy issues.³⁷

The greatest impediment affecting the effectiveness of coronial inquest is the lack of enforcement measures to ensure that recommendations receive adequate consideration and are implemented. Calls have been made to legislatively compel responses to coronial recommendations,³⁸ yet only in Victoria has this been comprehensively addressed.³⁹ In Queensland, where the comments relate to a government entity the Coroner must provide a written copy of the comments to the Attorney-General, the responsible Minister and the chief executive officer of the entity.⁴⁰ However, there is no requirement for any response to the recommendations or follow up on what, if any, action has been taken to consider or implement the recommendations.

In both the Australian Capital Territory ('ACT') and the Northern Territory ('NT') the Coroner's comments, at least in relation to deaths in custody, require a response. In the ACT this includes a written response to be provided by the custodial agency to the responsible Minister, who must then provide a copy to the Coroner, who in turn must forward the response to each person or agency to whom the comments were directed.⁴¹ In the NT the relevant agency must respond to the Attorney-General, who must then report to the Coroner and provide a copy of the report to the Legislative Assembly.⁴²

The most progressive reforms to date have occurred in Victoria. After extensive community consultation and recommendations from the Victorian Law Reform Commission that the *Coroners Act 1985* (Vic) be amended to empower the Coroner to require a written response from any individual or agency, the new *Coroners Act 2008* (Vic) requires a public authority or entity who has received recommendations from the Coroner to provide a written response within three months of the action that will or has been taken.⁴³ The response must then be provided by the Coroner to interested parties and published on the internet.⁴⁴

³² *Coroners Act 2003* (Qld) s 3.

³³ *Coroners Act 2003* (Qld) s 39.

³⁴ See, eg, Jonathon Hunyor, 'Human Rights in Coronial Inquests' (2008) 12 (SE2) *Australian Indigenous Law Review* 64.

³⁵ See, eg, Ian Freckleton, 'Death Investigation and the Evolving Role of the Coroner' (2008) 11 *Otago Law Review* 568.

³⁶ See, eg, Watterson, Brown and McKenzie, above n 30; Rory Downey, 'When Will People Read the Recommendations' (2008) 12 (SE2) *Australian Indigenous Law Review* 95.

³⁷ See, eg, Freckleton, 'Death Investigation and the Evolving Role of the Coroner', above n 30, 578, 579.

³⁸ See Watterson, Brown and McKenzie, above n 30, 19.

³⁹ The recently enacted *Coroners Act 2008* (Vic) is discussed further below.

⁴⁰ *Coroners Act 2003* (Qld) s 46(d).

⁴¹ *Coroners Act 1997* (ACT) s 75, 76.

⁴² *Coroners Act* (NT) s 46B.

⁴³ *Coroners Act 2008* (Vic) s 72.

⁴⁴ *Coroners Act 2008* (Vic) s 72.

The Victorian reforms should be considered as a first step (a minimum requirement) to perform a preventative function of the coronial process. In cases such as the *Malu Sara* where the recommendations, as outlined below, involve a number of government processes, agencies and statutory bodies, confidence can only be restored in these bodies where their response (and action) to coronial recommendations can be publically interrogated. The community, who generally at great emotional and personal cost relive the pain of the loss of a loved one through the coronial process have the right to know of the reasons where such a body fails to implement the coronial recommendations.⁴⁵

B. *The Coroner's Recommendations — Inquest into the Loss of the Malu Sara*

Apart from the comments referring to prosecution and disciplinary action which are discussed in the next part of this paper, the Coroner made ten recommendations in the inquest into the loss of the *Malu Sara*. The recommendations included:

- That the QPS review the performance of the Search and Rescue Mission Co-ordinator ('SARMC') and consider whether further training was required. In particular it was noted that 'senior members of the water police with search and rescue responsibilities have developed a cavalier attitude to marine incidents'.⁴⁶
- QPS policies be reviewed to determine the appropriateness of providing the SARMC with the power to task a rescue helicopter.
- Where a search and rescue operation has resulted in a death/s, these deaths should be investigated by independent police officers not involved in the search and rescue activities and who are appropriately qualified to undertake independent investigations.
- Department procurement policies and procedures should be reviewed to address the mistakes that were made in the procurement process for the *Malu Sara*.
- Maritime Safety Queensland should address weaknesses in its boat building and boat designer accreditation and /or take steps to rescind all existing accreditations and advise the public accordingly.
- That there be a review of Australian Maritime Safety Authority's paper based boat surveys, which at the time allowed boats to be brought into survey without proper independent inspection.
- The Department provide MMOs with appropriately equipped and seaworthy vessels, equipment and appropriate training.
- The Department should develop an appropriate emergency response plan and ensure that staff in the Torres Strait region receive appropriate training.
- That AusSAR officers receive further training.
- AusSAR and the QPS review the adequacy of search assets routinely available in the Torres Strait.⁴⁷

With no requirement for responses by government and QPS to the above recommendations, there is no guarantee for the people of the Torres Strait that such a tragedy would not occur again. The Australian government relies on the activities of the MMOs in the Torres Strait to patrol movement into Australia, and prevent the smuggling of prohibited goods and border incursions. Yet as the *Malu Sara* case demonstrates, the regard for the safety of these officers was lacking at all levels of government activity.

⁴⁵ See, eg, Watterson, Brown and McKenzie, above n 30, 4.

⁴⁶ *Inquest into the Loss of the Malu Sara* (Unreported, Queensland Coroner's Court, State Coroner Michael Barnes, 12 February 2009), 93.

⁴⁷ *Ibid* 93, 94.

IV. THE INTERFACE BETWEEN THE CORONIAL AND THE CRIMINAL PROCESSES

A. *Issues Arising from the Prohibition on Statements Attributing Guilt*

As discussed above, the removal of the power to commit for trial in Australian jurisdictions has allowed the coronial inquiry to assume a more inquisitorial function and to compel witnesses to give evidence, even where to do so would lead to self incrimination.⁴⁸ To protect witnesses from self-incrimination, the Coroners Act 2003 (Qld) provides that evidence is not admissible against the witness in any other proceeding (other than a proceeding for perjury).⁴⁹ Similar provisions apply in other Australian jurisdictions.⁵⁰ While few would doubt that this has significant benefits in providing for a more open inquiry, it is argued that the inability to attribute guilt has the potential to lead to further distress for families of the deceased.

For Indigenous communities it has been said that the ‘purpose of a traditional Aboriginal investigation into a death was to identify those responsible and was likely to be followed by a revenge expedition’.⁵¹ While the *Coroners Act 2003* (Qld) mandates referral to the appropriate prosecuting authority in situations where the Coroner reasonably suspects that an offence has been committed, this section has recently been read in conjunction with sections 45(5) and s 46(3) of the *Coroners Act 2003* (Qld) which precludes the Coroner from making any statement in their findings or comments, that a person is, or may be guilty of an offence or civilly liable. In the inquest into the loss of the *Malu Sara* the Coroner held that this prevented the Coroner from including in the findings any statement that a referral had been made to prosecuting authorities.⁵² To do otherwise, it was stated, would necessarily infer that a person may be guilty of an offence. No suggestion was made in the case by the Coroner that the families would be advised separately of any decision to refer the matter for prosecution. As will be discussed further below, the approach by the state Coroner in this regard (in relation to the intersection between the coronial and criminal processes) has been far from consistent.

While the section preventing statements that a person may be guilty of an offence may seem clear, a number of issues remain uncertain. How does it affect the Coroner’s power to make findings of fact, which may by their very nature infer potential guilt? And where such inferences can be drawn are parties advised of any decision to refer to prosecuting authorities? Does the section prevent submissions being made on behalf of interested parties that a person may be guilty of an offence and / or that a referral should be made to prosecuting authorities? Do the sections prevent a Coroner from making findings that a person is not criminally responsible? Each of these questions will be considered in turn.

B. *Findings of Fact*

It has been held that similar provisions in other jurisdictions must be construed in the context of the object of the coronial process, that is, to investigate the death and to make findings of how the person died and the cause of death. Care must be taken in the way findings are expressed however the Coroner is still compelled ‘to find the facts, from which others may, if necessary, draw legal conclusions’.⁵³

In referring to section 26(3) of the *Coroners Act 1975* (SA), her Honour Nyland J stated:

[Section] 26(3) refers not only to findings of criminal or civil liability, but also any ‘suggestion’ thereof. The addition of the word ‘suggestion’ is liable to cause confusion as it might be argued that the mere finding of certain facts can, in cases such as the present,

⁴⁸ *Coroners Act 2003* (Qld) s 37;

⁴⁹ *Coroners Act 2003* (Qld) s39. Similar provisions exist in other jurisdictions.

⁵⁰ *Coroners Act 2009* (NSW) s 61; *Coroners Act 2008* (Vic) s 57; *Coroners Act 2003* (SA) s 23; *Coroners Act 1995* (Tas) s 54; *Coroners Act 1996* (WA) s 47; *Coroners Act* (NT) s 38.

⁵¹ See Brazil, above n 8, 45.

⁵² *Inquest into the Loss of the Malu Sara* (Unreported, Queensland Coroner’s Court, State Coroner Michael Barnes, 12 February 2009), 95.

⁵³ *Keown v Khan* [1998] VICSC 83 (Unreported, 25 September 1998).

suggest or hint at criminal or civil liability and hence breach the section. This is due to the fact that certain acts, such as, in this case, sending a bomb, appear to have no possible legal justification. However, I do not think that s 26(3) should be read in such a way. The mere recital of relevant facts cannot truly be said, of itself, to hint at criminal or civil liability. Even though some acts may not seem to be legally justifiable, they may often turn out to be just that. For example a shooting or stabbing will, in some circumstances, be justified as lawful self-defence. As I have stated, criminal or civil liability can only be determined through the application of the relevant law to the facts, and it is only the legal conclusions as to liability flowing from this process which are prohibited by s 26(3). Thus, the word 'suggestion' in this section should properly be read as prohibiting the coroner from making statements such as 'upon the evidence before me X may be guilty of murder' or 'X may have an action in tort against Y' or statements such as 'it appears that X shot Y without legal justification'. In other words, the term 'suggestion' in s 26(3) prohibits speculation by the coroner as to criminal or civil liability...⁵⁴

Thus it is permissible for the Coroner to set out to how the death occurred and who may be responsible for the death (provided the Coroner refrains from 'using language that is applicable to decisions made by criminal and civil courts when they adjudicate upon the same issues').⁵⁵ Accordingly the sections should not adversely impact upon the ability of the Coroner to make frank and open findings of fact, even where such findings may by their nature infer potential guilt.

Where such frank and open findings of fact may be interpreted to infer a suspicion of guilt, there may be a genuine expectation from families and community members that those persons be brought to account before the full force of the law.⁵⁶ How this expectation is realised is far from clear. While natural justice requires that those suspected of committing criminal offences be afforded the opportunity to a fair hearing and a right to refrain from giving self-incriminating evidence, the *Coroners Act 2003* (Qld) empowers the Coroner to compel such evidence where it is in the public interest to do so.⁵⁷ Protection is provided to the witness, as the evidence, including derivative evidence is not admissible against the witness in any other proceeding (other than perjury).⁵⁸ Although it should be noted that protection is not absolute. Once the witness raises incriminating material, evidence relevant to the material may be sought and obtained through other avenues. It has further been held that natural justice requires that where referrals are made to prosecuting authorities, opportunity must be provided to the person to whom the referral relates to privately make submissions to the Coroner;⁵⁹ this is considered a separate and discrete matter from the Coroner's public findings.⁶⁰

However, the notification process must be devised in a manner where the defence is not compromised. It is submitted that to assist in obtaining closure and ensuring accountability, families of the deceased should be advised of any intended referral to prosecuting authorities.⁶¹ In the second *Inquest into the death of Mulrunji Domadgee*, the Acting State Coroner noted that she was required not to include in the findings, any information which would offend the prohibition contained in sections 45 and 46 of the *Coroners Act 2003* (Qld) (that is she could

54 *Perre v Chivell* [2000] SASC 279 (Unreported, 24 August 2000) [57]. Note that section 26(3) of the *Coroners Act 1975* (SA) provided that: 'A coroner holding an inquest must not in the inquest make any finding, or suggestion, of criminal or civil liability'.

55 Queensland Courts; *Queensland Coroners Guidelines* Version 0, December 2003, 8.14 [8.7.5]. <<http://www.courts.qld.gov.au/Factsheets/M-OSC-StateCoronersGuidelines.pdf>> at 23 November 2010.

56 It must be acknowledged that while the coronial inquest and findings may infer a suspicion of guilt, this is distinct from the criminal process, where facts must be established beyond reasonable doubt and issues regarding the Defendant's mental state and appropriate defences/excuses are tested.

57 *Coroners Act 2003* (Qld) ss 39(2) and 39(3).

58 *Coroners Act 2003* (Qld) ss 39(3) and 39(4).

59 *Annetts v McCann* (1990) 170 CLR 596.

60 See Glen Cranny, 'Coronial Inquests' (June, 2006) *Proctor* 26; *Annetts v McCann* (1990) 170 CLR 596.

61 As has been noted in this paper, the modern coronial process does not include a power to commit a person for trial. This is to ensure that the inquest can promote a more inquisitorial process with a view to prevention of future deaths rather than criminal investigation. There are no provisions in either the *Coroners Act 2003* (Qld) or the *Director of Public Prosecutions Act 1984* (Qld) requiring the Director of Public Prosecutions to disclose to families that an investigation or prosecution is being considered.

not make comment on the referral of the matter for potential prosecution). She noted however that:

[T]here is the competing interest of the family of the deceased who have a legitimate interest in knowing how the coroner has discharged this statutory obligation, if it arises. I simply indicate that I will consider my statutory obligation to inform prosecuting authorities, which would include informing the legal representatives of parties who may be affected and the family of the deceased. I emphasize that any decision to prosecute rests solely with other authorities.⁶²

It would appear that there is nothing to prevent a Coroner communicating privately with the families of deceased persons as to whether the Coroner has formed a reasonable suspicion that a person has committed an offence and that a referral to a prosecuting authority has been made. This is a critical aspect of the coronial process and for Indigenous communities (who require those responsible to be accountable for their actions), this should be a minimum requirement. There are no coronial guidelines addressing this issue, and no consistent approach by Coroners. In the inquest into the *Malu Sara* the Coroner did not make any public statement as to his view on whether such a communication could be made and did not indicate whether he would recommend that submissions made by counsel should be followed; rather families were left to ponder whether any further criminal action would be taken. This approach also appears inconsistent with the interpretation the Coroner has taken in other inquests where he was prepared to state in his findings that a referral had been made to the Director of Public Prosecutions ('DPP').⁶³

C. Counsel Submissions

Under the previous Queensland legislation, parties were not permitted to make submissions to the Coroner, except where the Coroner was considering committal for trial, and such submissions were restricted to issues of law.⁶⁴ No such prohibitions exist under the Coroners Act 2003 (Qld), although it has been suggested that the restriction imposed upon the Coroner of making statements attributing guilt will prevent submissions by counsel on such issues.⁶⁵ These arguments are drawn from authorities where similar provisions have been considered. In the Tasmanian Supreme Court case of *R v Tennent ex parte Jager*,⁶⁶ Cox J concluded that a similar provision in the Coroners Act 1995 (Tas) prevented parties from making submissions concerning legal responsibility and attribution of guilt. Cox J stated:

The focus of an inquest conducted under the Act being the ascertainment of facts without deducing from those facts any determination of blame, and the mischief sought to be avoided being the public naming of persons as suspected of criminal activity when they may never be charged, submissions to the coroner that he or she should form a belief that a named person has committed an indictable offence in connection with a death being investigated by the coroner would serve little purpose but to frustrate the intention of Parliament by attracting the very attention from the press and the public which the prohibition seeks to avoid.....In my view, the submissions of counsel in their addresses to the Coroner should be confined to the matters relevant to the factual findings which she is required to make and should not address the issue of any belief which she might form as to the commission of a crime committed in connection with a death which she has been investigating.⁶⁷

⁶² *The Inquest into the Death of Mulrunji* (Unreported, Queensland Coroner's Court, Acting State Coroner Clements, 27 November 2006), above n 4, 34.

⁶³ See, eg, *Inquest into the Death of Andrew John Bormen* (Unreported, Queensland Coroner's Court, State Coroner Michael Barnes, 16 July 2010).

⁶⁴ *Coroners Act 1958* (Qld) s 43(5A), provided that 'a rider shall not be or be deemed to be part of a coroner's findings but it may be recorded if the coroner sees fit'.

⁶⁵ See Cranny, above n 60.

⁶⁶ [2000] 9 Tas R 111.

⁶⁷ *Ibid*, 116.

In the inquest into the *Malu Sara*, counsel assisting the Coroner argued in written submissions that referral to the DPP should be made in respect of the boat builder's conduct in building the vessel.⁶⁸ Counsel for the boat builder submitted that:

the scheme of legislation in the Coroners Act (by reason of a reading of s 48 with sections 45(5) and 46(3) did not intend to give rise to and encourage public debate about the existence of reasonable suspicion' amongst the legal representatives and the Coroner.⁶⁹

He further noted that:

[a] consequence of the alternative view, namely a public debate about the existence of reasonable suspicion is permitted, is that a possible suspect is forced by reason of adverse publicity to join the debate and potentially disclose legal argument that would best be directed to the DPP in submissions.⁷⁰

In his findings and comments the Coroner made no reference or determination in relation to these issues, noting only that he was of the view that no statement could be made regarding a referral pursuant to section 48(2) of the *Coroners Act 2003* (Qld).⁷¹

D. Findings of No Reasonable Suspicion

In referring to the legislative intention in removing the Coroner's power to commit for trial in Victoria, Calloway JA in the case of *Keown v Khan* noted:

It follows that a person who kills necessarily contributes to the cause of death and that that is none the less true where the killing is in lawful self-defence. A coroner is not concerned with the latter question but will ordinarily set out the relevant facts in the course of finding how death occurred and the cause of death. The facts will then speak for themselves, leaving readers of the record of investigation to make up their own minds about lawful self-defence or any similar issue.⁷²

This view appears consistent with the Queensland Coroner's Guidelines, which at 8.7.5 state that while findings of fact can include conclusions regarding a person's or organisation's responsibility for the death, the Coroner 'must refrain from using language that is applicable to decisions made by criminal and civil courts when they adjudicate upon the same issues'.⁷³ While the state Coroner refrained from making any comments in the inquest into the *Malu Sara*, he has appeared willing to do so in other cases particularly where he has determined that no referral would be made.⁷⁴ In two recent inquests both involving police shooting, the Coroner has fully explained his application of the criminal law to the facts as found at the inquest.⁷⁵ In doing so he determined that the self-defence provisions under the *Criminal Code 1899* (Qld) afforded protection on the facts to the officers and therefore no 'reasonable suspicion' arose, which he noted was a prerequisite to referral to prosecuting authorities. Reasonable suspicion was interpreted to require consideration that the Crown could prove all the elements of the offence.⁷⁶

⁶⁸ *Outline of Counsel Assisting the Coroner* [520] – [522] presented to the *Inquest into the Loss of the Malu Sara*, above n 2. The submission was that the boat builder's conduct be referred to the DPP for consideration of a charge of manslaughter.

⁶⁹ *Outline of Counsel for the Boat Builder* [14] presented to the *Inquest into the Loss of the Malu Sara*, above n 2.

⁷⁰ *Ibid* [17].

⁷¹ *Inquest into the Loss of the Malu Sara*, above n 2, 95.

⁷² [1999] 1 VR 69, 72, 73.

⁷³ *Queensland Coroners Guidelines*, above n 55, 8.14 [8.7.5].

⁷⁴ *Inquest into the Death of Brett Thomas Johnstone* (Unreported, Queensland Coroner's Court, State Coroner Michael Barnes 10 March 2010); *Inquest into the Death of Alan Kent Dyer* (Unreported, Queensland Coroner's Court, State Coroner Michael Barnes 29 September 2010).

⁷⁵ *Ibid*.

⁷⁶ *Inquest into the Death of Brett Thomas Johnstone* (Unreported, Queensland Coroner's Court, State Coroner Michael Barnes 10 March 2010), 11. See, also *Inquest into the Death of Alan Kent Dyer* (Unreported, Queensland Coroner's Court, State Coroner Michael Barnes 29 September 2010), 13.