Crown Solicitor's Office

NSW GOVERNMENT

Hypothetical inquest into the death of Jo Jackson

www.cso.nsw.gov.au

Inquiries & Community Law Client Seminar
25 October 2017

The facts

The facts set out below are largely drawn from the decision of *Harmsworth v The State Coroner* [1989] VR 989. The names of agencies or persons are otherwise fictitious.

Jo Jackson was a 24-year-old held in custody in high security detention (Block K) in a correctional centre administered by the Department of Corrections and Parole ("the Department"). JJ was serving the third year of a five-year sentence for a sexual assault.

On 1 October 2016, JJ was advised that his application for reclassification had been rejected. That afternoon, JJ, together with other prisoners, constructed a barricade within Block K and set fire to it.

Due to the nature of the cladding in the cell building – comprised of aluminium composite material, a combustible product implicated in numerous fires globally over the last decade – there was quickly a conflagration.

JJ and two other prisoners were killed. An autopsy report confirms that the cause of JJ's death was first degree burns and smoke inhalation from the fire.

The nature of the inquest

Mandatory inquests

The inquest is "required to be held" pursuant to s. 27 of the *Coroners Act 2009* because jurisdiction to hold the inquest arises under s. 23. That jurisdiction arises where, among other things, it appears to the coroner that the person died "in other lawful custody".

23 Jurisdiction concerning deaths in custody or as a result of police operations

(1) A senior coroner has jurisdiction to hold an inquest concerning the death or suspected death of a person if it appears to the coroner that the person has died (or that there is reasonable cause to suspect that the person has died):

(a) while in the custody of a police officer or in other lawful custody, or

(b) [...]

27 General circumstances in which inquest required to be held

(1) An inquest concerning the death or suspected death of a person is required to be held in any of the following circumstances:

(a) [...]

(b) if the jurisdiction to hold the inquest arises under section 23,

(c) [...]

(d) if it appears to the coroner concerned that the manner and cause of the person's death have not been sufficiently disclosed (unless the case is one in which an inquest has been suspended or continued under section 78).

57 Representation in coronial proceedings

(1) The coroner in coronial proceedings may grant leave to any person, who in the opinion of the coroner has a sufficient interest in the subject-matter of the proceedings, to appear in person in the proceedings or to be represented by an Australian legal practitioner.

(2) Any person granted such leave may examine and cross-examine any witnesses on matters relevant to the proceedings.

(3) A coroner holding an inquest concerning the death or suspected death of a person must grant leave under subsection (1) to any person who is a relative of the deceased person (or suspected deceased person) unless the coroner is satisfied that there are exceptional circumstances that justify the coroner refusing leave.

(4) ...

Fire inquiries

30 Inquiries concerning fires and explosions

(1) A coroner has jurisdiction to hold an inquiry concerning the cause and origin of a fire or explosion if the coroner is satisfied that the fire or explosion has destroyed or damaged any property within the State.

(2) A coroner has jurisdiction to hold a general inquiry concerning a fire or explosion that has destroyed or damaged any property within the State, but only if the State Coroner gives a direction under this Part that such a general inquiry be held.

(3) The jurisdiction of a coroner to hold a general inquiry concerning a fire or explosion extends to the examination of all of the circumstances concerning the fire or explosion (including, but not limited to, an examination of its cause and origin).

An inquiry may be required to be held where the fire destroyed or damaged property in the State, and where either a direction is given by the State Coroner to hold an inquiry or where one has been requested by an authorised public official (Commissioner of NSW Fire Brigades, Commissioner of NSW Rural Fire Service, or Attorney General (s. 32)).

Issue 1 – scope of the inquest

The scope of the inquest is under consideration by the Coroner and counsel assisting. JJ's family have written to the Coroner raising a number of issues.

The letter from JJ's family

> Please your Honour, answer our questions about JJ's death:
>
> 1. What **caused** the fire? Why was JJ allowed to have matches? Why couldn't they evacuate JJ?
>
> 2. Why did the **mental health system** fail JJ? We tried to get him help before he went to gaol but they said they couldn't keep in him hospital and he discharged himself.
>
> 3. We need you to look at **all fires in gaols in the last ten years**. There was a big one in another gaol 6 years ago where the sprinklers didn't work. There was also that false alarm in K Block last year where the officers took ages to open the cells up.
>
> 4. JJ's lawyer was hopeless. He told JJ his sentence was too lenient and not to appeal. JJ could have been out before he died – or even found NOT GUILTY!!!!!!!!!!!!!!!!!!!!!!

Findings required

81 Findings of coroner or jury verdict to be recorded

(1) The coroner holding an inquest concerning the death or suspected death of a person must, at its conclusion or on its suspension, record in writing the coroner's findings or, if there is a jury, the jury's verdict, as to whether the person died and, if so:

(a) the person's identity, and

(b) the date and place of the person's death, and

(c) in the case of an inquest that is being concluded—the manner and cause of the person's death.

(2) The coroner holding an inquiry concerning a fire or explosion must, at its conclusion or on its suspension, record in writing the coroner's findings or, if there is a jury, the jury's verdict:

(a) as to the date and place of the fire or explosion, and

(b) in the case of an inquiry that is being concluded—as to the circumstances of the fire or explosion.

(3) Any record made under subsection (1) or (2) must not indicate or in any way suggest that an offence has been committed by any person.

Other considerations relevant to scope

Harmsworth v The State Coroner [1989] VR 989 per Nathan J (at 996)

> "A coroner does not have general powers of enquiry or detection [...]
>
> Of course, the prisoners would not have died if they had not been in prison. The sociological factors which related to the causes of their imprisonment could not be remotely relevant. This can be tested by considering how wide, prolix and indeterminate the inquest might be if each of the many facets of the individual personalities, of all those involved were to be considered."

Re Doogan; Ex parte Lucas-Smith [2005] ACTSC 74; (2005) 158 ACTR 1; (2005) 193 FLR 239 per Higgins CJ, Crispin and Bennett JJ

> "[28] Section 18(1) does not authorise the coroner to conduct a wide-ranging inquiry akin to that of a Royal Commission, with a view to exploring any suggestion of a causal link, however tenuous, between some act, omission or circumstance and the cause or non-mitigation of the fire. As Nathan J said in *Harmsworth v The State Coroner*, such discursive investigations might never end and hence never arrive at the findings actually required by the Act."

Conway v Jerram, Magistrate and NSW State Coroner [2011] NSWCA 319 per Young JA

> "[47] ... It is clear that a coroner has a wide, but not unlimited, mandate to hold or not hold an inquest concerning the death of a person. When an inquest is held, the scope depends on all the circumstances. The inquest may be held to determine who is the deceased, when and how he or she died and this is the primary purpose of the inquest."
>
> "[50] ... it is a matter for the exercise of discretion and common-sense by the coroner."

See also:

- *Maksimovic v Walsh* [1983] 2 NSWLR 656 at 662 per Clarke J
- *X v Deputy State Coroner for New South Wales* [2001] NSWSC 46; (2001) 51 NSWLR 312 per O'Keefe J
- *Atkinson v Morrow & Anor* [2005] QSC 92 per Mullins J
- *Doomadgee v Deputy State Coroner Clements* [2005] QSC 357; [2006] 2 Qd R 352 per Muir J

Draft list of issues

Inquest into the death of Joe "JJ" Jackson and fire inquiry into 'Block K'

1. Determination of the statutory findings required by s. 81 of the *Coroners Act 2009*, including in particular the manner (or circumstances) of death and whether the prison had adequate systems (including training of staff) for evacuating prisoners;
2. The cause and origin of the fire (including the extent to which the combustible cladding may have contributed to the fire);
3. Whether it is necessary or desirable to make any recommendations in relation to any matter connected with the death or fire.

Note: Issues list subject to change

Tips

- Scope is not unlimited – an inquest is not a "roving" Royal Commission
- Limits are defined by relevance and remoteness, with reference to primary purposes of an inquest or inquiry
- Raise issues early and set out the basis for doing so

Issue 2 – application for non-publication orders

At the commencement of the inquest, an application is made by the Department seeking non-publication orders over:

- *the names of all correctional staff who are to be called as witnesses*
- *certain internal policies*
- *a map of the correctional facility*

pursuant to s. 74 of the Coroners Act 2009.

73 Meaning of "published"

For the purposes of this Part, matter is published only if it is:

(a) inserted in any newspaper or any other periodical publication, or

(b) publicly exhibited, or

(c) broadcast by radio or by television, or

(d) published by means of the Internet.

74 Powers of coroner to clear court and prevent publication of evidence or submissions

(1) A coroner in coronial proceedings may, if of the opinion that it would be in the public interest to do so, order:

(a) any or all persons (including witnesses in the proceedings) to go and remain outside the room or building in which the proceedings are being heard, or

(b) that any evidence given in the proceedings not be published, or

(c) that any submissions made in the proceedings concerning whether a known person may have committed an indictable offence not be published.

(2) For the purposes of subsection (1), the coroner may, in forming an opinion as to the public interest, have regard (without limitation) to the following matters:

(a) the principle that coronial proceedings should generally be open to the public,

(b) in the case of an order that is proposed to be made in relation to a witness in the proceedings—the likelihood that the evidence of the witness might be influenced by other evidence given in the proceedings if the witness is present when that other evidence is given,

(c) national security,

(d) the personal security of the public or any person.

A person must not contravene an order made under this section.

Maximum penalty: 10 penalty units or imprisonment for 6 months (in the case of an individual) or 50 penalty units (in any other case).

Victoria v Brazel [2008] VSCA 37; (2008) 19 VR 553; (2008) 181 A Crim R 562 per Maxwell P, Buchanan JA, Vincent JA

B was attacked by other prisoners while held in high-security prison. He sought compensation from the State for failing to prevent the assault. The State resisted disclosure of certain documents on the basis of public interest immunity. The Judge ordered the State to disclose a schematic diagram of the prison unit and a security review report. The decision was upheld on appeal.

> "[47] As to the damage which may result from disclosure, it is necessary to consider whether the content of the document is 'current and controversial'. Obviously, if the information is out-of-date, the risk of injury to the public interest is likely to be much reduced, if not non-existent. The need for secrecy may be short-lived or long-lasting. Everything depends on the subject-matter and content of the information in question."
>
> "[68] Contrary to the assumption on which the State appears to have acted in this interlocutory litigation, it is never enough merely to assert – as if it were self-evident – that disclosure of the information in question will harm some particular aspect of the public interest. The claim for immunity must be articulated with rigour and precision, and supported by evidence demonstrating the currency and sensitivity of the information, so as to constitute a compelling case for secrecy. Anything less will be unlikely to suffice.
>
> "[69] We wish to say something finally about the deletion of names from the parts of the documents [...]. Concealment of a person's identity could only be justified, in our view, if a clear case was made that the identification of that person as having made a particular comment, or provided particular information, in the course of the review or investigation of the incident would expose that person to danger."

See also:

- *Bilbao v Farquhar* [1974] 1 NSWLR 377 per Hardie, Hutley and Bowen JJA
- *Attorney-General (NSW) v Mirror Newspapers Ltd* [1980] 1 NSWLR 374 per Moffitt P, Hope JA, Samuels JA
- *ICAC v Chaffey* (1993) 30 NSWLR 21 per Gleeson CJ, Kirby P, Mahoney JA
- *Bissett v Deputy State Coroner* [2011] NSWSC 1182, (2011) 83 NSWLR 144 per Hulme J

Tips

- Onus is upon the party seeking to prohibit publication (although Coroner can make order of own motion)
- Each case must be considered on its own merits
- Advance notice of applications is highly desirable
- Applications should clearly identify the material the subject of the proposed non-publication order and be supported by evidence (including as to currency and sensitivity of the information) and submissions which clearly articulate the "public interest" contended to weigh in favour of the order being made
- Confidentiality undertakings can establish an additional measure of protection

Issue 3 – privilege against self-incrimination

During the inquest, Mr Shoddy, of Construction Co, gives evidence (not contained in his statement) to the effect that at a safety meeting two weeks before the fire, he advised the Manager of Block K, Officer Barker, about the flammability of the cladding, having described the cells as a "death trap".

58 Rules of procedure and evidence

(1) [...]

(2) Except as otherwise provided by this Act, a witness in coronial proceedings who is a natural person cannot be compelled to answer any question or produce any document that might tend:

(a) to incriminate the witness for an offence against or arising under an Australian law or a law of a foreign country, or

(b) to make the witness liable to a civil penalty.

61 Privilege in respect of self-incrimination

(1) This section applies if a witness in coronial proceedings objects to giving particular evidence, or evidence on a particular matter, on the ground that the evidence may tend to prove that the witness:

(a) has committed an offence against or arising under an Australian law or a law of a foreign country, or

(b) is liable to a civil penalty.

(2) The coroner in the coronial proceedings must determine whether or not there are reasonable grounds for the objection.

(3) If the coroner determines that there are reasonable grounds for the objection, the coroner is to inform the witness:

(a) that the witness need not give the evidence unless required by the coroner to do so under subsection (4), and

(b) that the coroner will give a certificate under this section if:

i. the witness willingly gives the evidence without being required to do so under subsection (4), or

ii. the witness gives the evidence after being required to do so under subsection (4), and

(c) of the effect of such a certificate.

(4) The coroner may require the witness to give the evidence if the coroner is satisfied that:

(a) the evidence does not tend to prove that the witness has committed an offence against or arising under, or is liable to a civil penalty under, a law of a foreign country, and

(b) the interests of justice require that the witness give the evidence.

(5) If the witness either willingly gives the evidence without being required to do so under subsection (4), or gives it after being required to do so under that subsection, the coroner must cause the witness to be given a certificate under this section in respect of the evidence.

(6) [...]

(7) In any proceeding in a NSW court within the meaning of the *Evidence Act 1995* or before any person or body authorised by a law of the State, or by consent of parties, to hear, receive and examine evidence:

(a) evidence given by a person in respect of which a certificate under this section has been given, and

(b) evidence of any information, document or thing obtained as a direct or indirect consequence of the person having given evidence,

cannot be used against the person. However, this does not apply to a criminal proceeding in respect of the falsity of the evidence.

76 Publication of certain questions, warnings, objections, submissions and comments

A person must not publish any of the following matters without the express permission of the coroner in the coronial proceedings concerned:

(a) any question asked of a witness that the coroner has forbidden or disallowed,

(b) any warning that a coroner has given to a witness that he or she is not compelled to answer a question,

(c) any objection made by a witness to giving evidence on the ground that the evidence may tend to prove that the witness has committed an offence,

(d) any submissions made by or on behalf of a person appearing or being represented in the proceedings or by a person assisting the coroner, or any comment made by the coroner, concerning whether an inquest or inquiry should be suspended under section 78.

Maximum penalty: 10 penalty units or imprisonment for 6 months (in the case of an individual) or 50 penalty units (in any other case).

Atkins v Attorney General of New South Wales [2016] NSWSC 1412 per McCallum J

Application arising from the inquest into the death of Matthew Leveson. In the course of the inquest, the Coroner determined that Mr Atkins was required to give evidence. Mr Atkins appealed the Coroner's ruling.

> "[147] The right to silence is of course important. But so is the coroner's jurisdiction. The existence of the coroner's power to grant a certificate under s. 61 of the *Coroners Act* acknowledges the prospect that there will be cases in which a higher value will be placed on determining the manner and cause of a person's death than on the prosecution of any criminal offence".

Borland v NSW Deputy State Coroner [2006] NSWSC 982 per Grove J (upheld in *Attorney General of NSW v Borland* [2007] NSWCA 201 per Ipp and McColl JJA and Handley AJA)

The deceased died when his motorcycle was involved in a collision, in circumstances where he had been followed by police. The Coroner determined that the interests of justice required that a police officer should give evidence. In that decision, it was noted:

> "[26] … there was a balance to be taken between the importance of evidence sought to be compelled and the magnitude of the risks to which the witness would be potentially exposed if the claim to privilege was denied.
>
> "[27] An assessment of the risk and the level of possible penalty was a material consideration."

See also:

- *Rich v Attorney General of New South Wales* [2013] NSWSC 877 per Barr AJ; *Rich v Attorney General of New South Wales* [2013] NSWCA 419 per Bathurst CJ, Beazley P, Leeming JA

Tips

- Clearly identify the jeopardy your client faces if giving evidence without a certificate – whether an offence, civil penalty or disciplinary consequences
- Find out in advance whether your client will give evidence willingly if a certificate is issued
- Give counsel assisting early notice of objections to giving evidence
- Prepare a typed list of topics to be covered by the certificate sought, which can be annexed to the certificate if granted

Issue 4 – apologies in the coronial jurisdiction

The NSW Ombudsman provides extensive guidance on apologies for organisations: *Apologies - a Practical Guide (2009)*:

https://www.ombo.nsw.gov.au/__data/assets/pdf_file/0013/1426/Apologies-Guidelines-2nd-edition-March-2009_.pdf

Amongst other matters, key messages set out in that guide include that:

- An appropriate apology can be beneficial in numerous respects, including in terms of moral, emotional, personal, financial and systemic benefits.
- An effective apology must usually include an express acceptance of responsibility or fault for the actions or inaction that caused the harm.
- Where a problem has caused harm, a 'full' apology will consist of a 'package' of actions including admissions of responsibility, explanations of cause, actions to put things right (where possible) and expressions of sorrow and remorse.
- A partial or otherwise inappropriate apology can do more harm than good.

The Department's apology

> *The Department of Corrections and Parole extends its deepest condolences to the family and friends of JJ. His death was a tragedy. His loved ones and supporters may, however, take some comfort in the knowledge that since JJ's death the Department, in conjunction with a number of external consultants, has undertaken a thorough review of its systems and as a consequence of that review has implemented a number of improvements to its policies and procedures for correctional centres throughout NSW.*
>
> *The Department continually seeks to improve its systems, policies and procedures to safeguard those persons under its care and will give due consideration to implementing any recommendations made by the Coroner arising from JJ's tragic death.*

Tips

- In NSW there is statutory protection from liability for apologies: s. 69, *Civil Liability Act* 2002 (subject to certain exceptions – see s. 3B)
- Real value in an apology (particularly at an early point)
- Where appropriate, it is consistent with Model Litigant Principles to apologise
- Important to consider the form, timing and content of apology
- *Ombudsman NSW – Apologies a Practical Guide (2009)* provides assistance for agencies to craft and deliver an appropriate apology

Issue 5 – Family statements/testimonials

At the end of the formal evidence, but prior to closing submissions, coroners frequently invite a member of the deceased person's family to give a statement about him or her.

Dillon and Hadley note: "It goes without saying that such testimonials and personal statements ought not be used as opportunities to make submissions concerning findings the coroner should make or to insult or criticise witnesses".[1]

> *Our family has been torn apart after losing JJ. He was a loving son and brother to us even, though he had his issues.*
>
> *We have to live with the fact that he was MURDERED by the prison system. We hope those responsible for his death have to live with that too.*
>
> *Just two days before JJ died, Officer K rang me and said "He's not getting into minimum yet. But don't worry, no one will be in K block for long because it's going to need to be shut down and renovated.*

Tips

- A family statement should not be inflammatory
- It is good practice for the statement to be circulated to counsel assisting and the legal representatives for the parties before being read onto the record
- It is not formal evidence in the inquest, nor should it be in the form of submissions

[1] 'The Australasian Coroners Manual' (2015), Hugh Dillon and Marie Hadley, p. 95.

Issue 6 – recommendations

In the 6 months following the fire, the Department engaged external consultants to undertake a complete audit of all correctional facilities and removed the combustible cladding from all buildings. Extensive fire drill training programs and fire safety equipment upgrades have been undertaken. This material is not yet before the Coroner.

3 Objects of Act

The objects of this Act are as follows:

[...]

(e) to enable coroners to make recommendations in relation to matters in connection with an inquest or inquiry (including recommendations concerning public health and safety and the investigation or review of matters by persons or bodies),

[...]

82 Coroner or jury may make recommendations

(1) A coroner (whether or not there is a jury) or a jury may make such recommendations as the coroner or jury considers necessary or desirable to make in relation to any matter connected with the death, suspected death, fire or explosion with which an inquest or inquiry is concerned.

(2) Without limiting subsection (1), the following are matters that can be the subject of a recommendation:

(a) public health and safety,

(b) that a matter be investigated or reviewed by a specified person or body.

[...]

Doomadgee v Clements [2005] QSC 357; [2006] 2 Qd R 352 at [31] per Muir J

A case regarding the cognate section of *Coroners Act 2003* (QLD) re recommendations confirms that the recommendatory power ought to be construed liberally, given it is beneficial in nature.

His Honour stated:

"[33] Any matter on which comment is made, as well as having the requisite relationship, must be connected with the death under investigation. But, as counsel for the Attorney-General pointed out in the course of their submissions, there is no warrant for reading "connected with" as meaning only "directly connected with". Something connected with a death may be as diverse as the breakdown of a video surveillance system, the reporting of the death, a police investigation into the circumstances surrounding the death, and practices at the police station or watch house concerned."

Harmsworth v The State Coroner [1989] VR 989 per Nathan J

Recommendations must have a rational relationship with the findings:

> "The powers to comment and also to make recommendations pursuant to s 21 (2) are inextricably connected with, but not independent of the power to enquire into a death or fire for the purposes of making findings. They are not separate or distinct sources of power enabling a coroner to enquire for the sole or dominant reason of making comment or recommendation. It arises as a consequence of the exercise of a coroner's prime function, that is to make "findings".

The Commonwealth Ombudsman has published a list of principles to guide agencies responding to recommendations:

http://www.ombudsman.gov.au/__data/assets/pdf_file/0015/36213/09115-CO_FS_Principles-of-Good-Practice_01.pdf

The principles encourage agencies to, among other things:

- participate in the coronial process;
- be responsive and transparent;
- use recommendations to identify and drive improvement in agency work
- be timely; and
- inform the coroner and the public of actions taken.

Tips

- Engage with counsel assisting early as to formulation of the issues and commence early preparation of any "remedial" statement
- Early "remedial" work may not only reduce the scope of the inquest (or obviate the need for an inquest at all), but also result in no recommendations
- Be proactive in the formulation of draft recommendations – engage with counsel assisting to ensure relevant data/information has been provided and raise any resourcing or practical issues as to implementation early
- Note *Premier's Memorandum M2009 – Responding to coronial recommendations* – sets out the process for responding to coronial recommendations directed at Ministers and government agencies, with objective of increased accountability and transparency