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Mining the inquest lode

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Histories of Australia always mention the gold rushes. The lure of gold brings together for a year or two thousands who toil with pans in the hope of reward, a service industry which provides transport, food and drink, a criminal element which intends to get rich quick, and finally - when the dust settles on the last person to leave - a quiet backwater of 'a once upon a time' village and piles of tailings.

But those histories usually don't mention the gold left behind in those tailings. They don't mention the later industry which is sustained by much more efficient methods of gold extraction. A few people with expertise but no limelight do very nicely. In short the histories don't reveal how another's trash contains buried treasure.

The public and lawyer perception of inquests is so very like the historical coverage of gold in Australia. There is intense, though short lived interest in the big events. Public and political emotions run riot when a public spectacle demolition of a hospital goes wrong, when a landslide brings death to a ski village, and when a deranged shooter picks the picturesque ruins of a convict hell for a

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Thredbo Landslide

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Coronial & other Inquiries

Mining the inquest lode

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shooting gallery. Those are examples in which it is the place and the manner of death which is highlighted. The names of the dead are not long remembered, save by their nearest and dearest. The names, however, may sometimes constitute the 'big event': football star dies when car rolls; senior police officer murdered in his driveway; fashion leader dead in apartment; rock star found in bizarre situation in hotel room. You could put a name to each of these, couldn't you?

Whether it is the place, the manner of death, or the name of the deceased which catch the public eye, the traditional tasks for the inquest are still the same: who died, when, in what manner and by what cause. These are the same tasks that the inquest performs for the thousands upon thousands of coronial cases that are never mentioned in the news.

Traditional too, but less recognised and often overlooked, has been the task of the Coroner to offer recommendations about how to prevent a repetition of the tragedy. Centuries old records contain recommendations that the cliff edge be fenced so that casual walkers would not perish, that wells be sealed, that loads be weighed, and so on.

Those recommendations, adopted or not, would be quickly forgotten - the inevitable consequence of not being a part of any formal set of precedents - bringing the other inevitability that the mistake was certain to be made again and again in other places, with other actors and victims, at times near and far.

The IT revolution has changed all that. The National Coronial Data Base means that coroners, government, industry, lawyers and the media can all - at the touch of cursor to an icon - rediscover what was found, and what was recommended at previous inquests. A coroner sitting in Perth can find that his inquest into a lift shaft death on a building site has parallels with inquests about the same sort of death in Sydney and Melbourne. Did those earlier inquests lead to recommendations? If so, have they been implemented? If not, why not?

Lawyers acting for the deceased's relatives should quickly develop a keen interest in what's inside that database. Ease of access creates its own precedent setting values. Once it is widely understood that knowledge is readily available about the extent of actual and potential harm from some process or activity then the failure to access that knowledge is negligent.

It will be negligent if manufacturers, engineers, construction firms, prison authorities, hospitals, physicians, occupational health and safety authorities, transport bodies, to name just a few, fail to act on the clear findings and recommendations flowing from inquests. The veil has been lifted - ignorance of danger will be self-inflicted and it will entail culpability.

While some plaintiff lawyers are very alive to the civil claims to be made in the aftermath of a disaster inquiry I have yet to see any signs that plaintiff lawyers know how to mine the tailings for a steady flow of smaller rewards. Just as tailings extractions depends upon better and more efficient methods of identifying and extracting the gold, so the unmined opportunity in Australian coronial practice is presented by the IT revolution. The National Coronial Data Base is the key to identifying and pursuing a rich lode of actionable negligence.

'Civil Action' has been such a successful book about a plaintiff lawyer right out of his depth that a film has been made. Plaintiff lawyers should read the book, see the film, and weep. It is a case history in how to mismanage plaintiff litigation. Defence lawyers should pray that not too many plaintiff lawyers learn the lessons that the author Hart has embedded in the story. Too many children living close to an American industrial town develop leukaemia. The probable cause is water contamination, the result of poor industrial waste discharge practice. The hapless victims don't all acquire their disease at the same time. It is not like the disaster that on one night befell the first born of the Egyptians who refused to let Moses and his people go. The process afflicts a succession of late twentieth century children in their gentle neighbourhood over years. This is an example of a 'diffuse disaster'. The results of living with asbestos are a better known example. Apart from the miners and their families the victims have included workers thousands of miles from the nearest mines, but working with lagged pipes and other industrial applications.

Serendipity often explains our past success in identifying diffuse disasters, whether it is cancer from the poisons in the drinking water, the occasional, but widely separated side effects from a wonder drug, or a series of warehouse tragedies because a fork lift has a design defect. Someone wondered if there was another case and chanced upon first one, then another, and another. Interest in the instant case caused a successful search for a pattern. The fact that the search was so difficult, so contingent on good luck, has meant that until now it often never began, or it was soon abandoned. No more. Keywords and free text searching combine in seconds to produce leads that help to prepare for the forthcoming inquest and to assess the prospects for any later civil action.

A short reflection on changing trends in our civil and criminal practice, and the part played by our magistrates, produces some irony. Criminal committals and inquests share a 'non-judicial' label. Both have developed out of a jury process. The committal is a ministerial function. The inquest is an inquiry. The results of both bind no one. Yet, so significant is the information that might be revealed and the findings that might be made, that issues about their scope, their process, their findings and their public reporting emerge in the appeal courts all the way to the High Court.

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Canberra Hospital Implosion

Unexpectedly it is committals that are waning and inquests that have taken on a new lease of life. Just as the criminal defendant is losing the open ended opportunity to look for fissures in the prosecution wall the civil plaintiff is gaining an ever more powerful tool to open up potential civil claims and to gain significant evidence to support those claims.

However, it is a tool that demands a deal of preparation, both before and at the hearing.

It is foolish to stand on the sidelines as those responsible for assisting the coroner go about their preparation. While their objectives and those of plaintiff lawyers have some common elements there are differences. This is most easily understood by a glance at the range of findings open to coroners: unlawful homicide, lawful homicide, suicide, misadventure, accident, natural causes, death from industrial disease, lack of care, and open. What the coroner needs to make one of these findings is rather different to what a plaintiff lawyer would like to speed up a settlement or enhance the verdict. The lawyer is looking for duty, foreseeability, breach and damage. The coroner, however, need not assess 'blame' or 'contributory negligence' when finding that there was an accident or misadventure, or even a suicide (that might have been prevented; eg Aboriginal Deaths in Custody Inquiry). Even the notion of 'contribution' which is found in some coronial legislation is not a statement equivalent to civil liability. Nevertheless the pre-hearing inquiries for both coroner and potential plaintiff are sifting the same material.

The quality of that sifting (by which I mean knowing what to look for, what tests to apply, who to employ to conduct and interpret the tests) is heavily dependent upon the skills of the coronial support staff, the workload and the enthusiasm of the coroner. Be prepared to make up for any shortfall. Search for possible witnesses, identify areas of expertise that may help explain what happened and how it could, and should have been avoided, and then persuade the coroner's office to take up your leads.

Parallel inquiries are possible but run the risk of both irritating potential witnesses and muddying the assessment of their evidence. They are also expensive, so who is going to pay? It is better to persuade the coronial office to engage the services, for example, of an independent and highly regarded expert to provide a report which all interested parties can access well before the hearing. Traffic accident causation and unexpected death during or immediately after surgery are two areas where this approach is useful.

An incidental benefit of this approach is that a potential plaintiff can gauge the attitude of the likely defendant (and its insurer) by their response to the report of the independent expert. If that future defendant engages their own counter expert and brings in senior counsel to 'do over' the independent expert then the lines are clearly drawn.

Another important benefit of early, active participation in the preparation for the public hearing is identifying which interests coalesce with yours and which are antagonistic. The reasons are the same as direct how you order the defendants in your initiating civil process: who or what is be locked in, what is the most powerful order for cross examination, who or what is most likely to raise a settlement flag first. Remember too that the obverse of your desire to open up every possibility is the equally hard-pressed desire by defendant lawyers to keep the lid on, to shorten the inquiry, to limit its purview.

If the independent expert and his or her opinion is likely to be under attack then be ready to respond. Good strategy demands that those who want that opinion and the expert to survive should both jointly invest in preparing that expert for cross examination and fund supporting opinion from other highly regarded experts. The risk from poor preparation ▶

is that your experts will be successfully impeached at a later civil hearing as shortcomings in their inquest reports and spoken evidence are elicited before a trial judge and possibly a civil jury.

Of course, you might choose to jettison a poor inquest witness and come up with someone new for trial. Then again, consider the impact of the *Jones v Dunkel* submission from the defendant, "You will remember how in my cross examination I referred repeatedly to the views of Dr Expert. You will remember how those views - which were expressed at a public hearing - supported the claims of the plaintiff. You will remember how one after another each of the plaintiff's experts in this trial felt unable to give full support to the views of Dr Expert. The experts called by this side were brief, brutal and persuasive in their dismissal of Dr Expert's views. Surely then, you like me, given the significance of the views of Dr Expert, expected to see him in that witness box. He never came. We've never seen him. Why?"

Ensuring a good, persuasive explanation from your experts and lay witnesses is just one part of what needs to go well at the inquest hearing. Assuming proper involvement in the preparation then there should be no problems with the Coroner allowing your appearance at the inquest and permitting you full scope to lead evidence, to cross examine, and to make submissions.

Think very carefully about your position along the bar table. I wonder about the expertise of any advocate who appears for a party likely to shoulder the ultimate blame and sits close to counsel-assisting the coroner. That may indicate that the advocate has been assiduous in helping counsel-assisting to understand events in a way that exonerates his client. But it is much more likely that the advocate never got so close as even to consult counsel-assisting before the formal hearings began. Then every other party who wishes to sheet the blame home to his client gets the opportunity to see his line of presentation and his attack upon other witnesses. Then they identify the openings and one after the other sheet responsibility home to his client.

Consider this example: an infant has died in a hospital after being transferred, too late, from another hospital. The grieving parents want to know who to blame. They have been contrasting the attention and service received by their child at the second hospital with the inattention, apparent lack of concern (until things were critical), and mixed messages that they received from the nursing and medical staff at the first hospital. By the time of the public hearings they have seen a number of written statements. They understand, and so does everyone else, that the on-call specialist at the first hospital seems to carry the blame. He told the parents not to worry; he told the nurses that the parents were unduly agitated; he chose not to come back after some hours and review the child's condition. He came only when the registrar panicked.

Now take the bar table, seen from the back of the court, from left to right. Counsel-assisting the coroner is at the far-left end. Each witness called by counsel-assisting is usually then cross examined in the same order as the parties sit along the table from left to right. Counsel for the specialist needs to hear how the other parties - the parents, the nurses, the two hospitals - deal with those witnesses. If he cross-examines first then any damage that he does may be repaired by a cross-examination from another party which seems rather more like a constructive re-examination than a demolition. It follows that one would expect to see competent counsel for the specialist along the line and well to the right.

Quite apart from good witness preparation, and a tactical sense of where to appear in the pecking order of the bar table, the astute plaintiff lawyer will also weigh up the content of any final submission. A number of advocacy texts call for a draft of the closing submission to be ready before the opening address is made. I find that something of an overstatement, but it is a worthwhile reminder of the necessity to have a game plan with fall back positions that can be brought into play as conditions change.

Plaintiff lawyers are looking for clear lines of causation, whatever language is used in the formal findings. There is always debate about whether it is better to speak first or speak last. No doubt the debate will continue until we have some empirical evidence to resolve the issue. Meanwhile the usual rules apply: be correct about the facts, have a crisp and engaging theme to which you can repeatedly refer, have an explanation which can explain those facts in the most plausible, probable way. If it is possible to interest the local media in a way which evokes sympathy for your client and opprobrium for another party then pursue it.

If your preparatory research has shown that the equipment has failed and killed before, that the manufacturer has appeared at other inquests in other places and asserted 'it's a one off', that there have been no recalls or service changes, then it's pay up time. This is the civil equivalent of the criminal defendant who shows no remorse and therefore deserves heavy punishment.

In this issue of *Plaintiff* there are companion articles about some 'big name' inquests and inquiries, the cases that attract big firms, big publicity and big fees. But the coroner, year after year, examines the seemingly routine. All is not what it seems - there are many opportunities to be revealed by the National Coronial Data Base. Like the tailings at gold sites I expect efficient plaintiff lawyers to do very nicely from reworking old cases and finding links to today's inquests and tomorrow's civil actions.

Further Reading

'The Inquest Handbook', and, 'The Aftermath of Death' are two books which collect contributions about inquest law, practice and opportunities. Both are edited by Hugh Selby and published by Federation Press. For orders and information phone Federation Press on 02 9552 2200 or email: info@fedpress.aust.com.

For help in identifying and understanding expert issues see Freckelton and Selby, 'Expert Evidence', LBC Information Services. For information and orders phone LBC on 1800 650 522 or email: lbccustomer@lbc.com.au.

For information about the database and access to it contact the office of the State Coroner. ■