

**INQUEST INTO THE DEATH OF MULRUNJI ON PALM ISLAND
ON 19 NOVEMBER 2004**

MATTERS IDENTIFIED FOR ARGUMENT BY COUNSEL ASSISTING

**SUBMISSIONS ON BEHALF OF MS ERYKAH KYLE AS REPRESENTATIVE OF
PALM ISLAND ABORIGINAL COUNCIL**

1. These submissions address each of the eight matters identified in the document entitled “Matters for Argument”, prepared by T D Martin SC, Counsel assisting, dated 9 March 2005.

Matter 1: The Interpretation of ss 45, 46 and 36 of the Coroners Act and Consideration of Propensity Evidence

2. The first matter relates to the obligation imposed upon the Deputy Coroner pursuant to ss 45(5) and 46(3) of the *Coroners Act 2003* not to include in her findings or comments “any statement that a person is, or may be, (a) guilty of an offence; or (b) civilly liable for something”.

- (a) **To what extent does this obligation in ss 45(5) and 46(3) inhibit the Deputy Coroner in her findings and comments?**

For example, when dealing with cause of death, if the Deputy Coroner found as a fact that the Deceased died as a result of an application of force by Senior Sergeant Hurley, would the Deputy Coroner breach s.45(5) of the Act by going on to state in her findings, if she so found, that the application of force was deliberate, or, would she be in breach even by stating that the application of force was either deliberate or accidental?”

3. On one view, construed literally, ss 45(5) and 46(3) could be read to mean precisely what they say, namely that the Deputy Coroner is prohibited only from including in her findings or comments an express statement in relation to criminal guilt or civil liability, so as to avoid the possible coexistence of competing and conflicting conclusions of the Coroners Court and another court in which criminal or civil proceedings have been tried and determined.
4. Ms Kyle submits, however, that ss 45(5) and 46(3) should be understood purposively¹, as intended to preserve for a combination of criminal investigation and prosecution matters of possible criminal liability (and in the case of possible civil liability, civil litigation between parties). It follows that the Deputy Coroner is prohibited from including in her findings or comments a statement in relation to criminal guilt or civil liability, as well as any statement which plainly asserts every element of an offence (or of a cause of action). In her findings, therefore, the Deputy Coroner would avoid using words which suggest, in the legal sense, that every element of an offence has been

¹ *Acts Interpretation Act 1954* (Qld), s 14A.

committed (or that every element of a cause of action is made out). Necessarily, however, in ascertaining how the death of Mulrunji was caused, the Deputy Coroner must explore, extensively, facts bearing on criminal and civil liability.

5. A number of matters support a purposive approach to the construction of ss 45(5) and 46(3), and circumspection in the expression by the Deputy Coroner of any legal judgment in her findings.
6. The first of these is that pursuant to s 45, the investigating coroner is required to make judgement neutral findings of facts as to *inter alia* how a person died (s 45(2)(b)), and what caused the person to die (s 45(2)(e)). The emphasis is on fact-finding in relation to these matters, and not an expression of legal judgment. In *Keown v Khan* [1999] 1 VR 69 the Victorian Court of Appeal held that under the *Coroners Act 1985* (Vic), coroners are not concerned with questions of law but with findings of fact.² Ormiston JA said at [1] that findings of coroners ought to eschew use of language which connotes legal conclusions as opposed to factual findings. Callaway JA observed at [15] that he had consistently referred to "self-defence" rather than "lawful self-defence" or "justified" or "excusable" homicide. In the footnote to [15], in reference to the verdict of "unlawful killing" available in the United Kingdom, Callaway JA stated that a "verdict of "unlawful killing" would often inculcate a particular person by necessary implication, as would a discussion of evidence leading to a decision not to find that a person acted in lawful self-defence".
7. Another matter is that while the Coroners Court is bound to apply the rules of natural justice (*Annetts v McCann* (1990) 170 CLR 596; *Musumeci v Attorney General of NSW & Anor* [2003] NSWCA 77), the rules of evidence do not apply. Section 37(1) provides that the Coroners Court "is not bound by the rules of evidence, but may inform itself in any way it considers appropriate". There thus arise considerations of fairness. As Sir Thomas Bingham MR observed in *R v Coroner for North Humberside and Scunthorpe, Ex parte Jamieson* [1994] QB 1 at 24, the law accords a person accused of crime or a party alleged to have committed a civil wrong certain safeguards regarded as essential to the fairness of the proceedings, including a clear statement in writing of the alleged wrongdoing, a right to call any relevant and admissible evidence, and a right to address factual submissions to the tribunal of fact. Such safeguards are of particular significance in cases where possible criminal liability is indicated. The *Coroners Act* provides no statutory indication as to standard of proof to which a coroner needs to be satisfied. However, it appears settled that the civil standard of proof is applied, that is proof on the balance of probabilities as expounded in *Briginshaw v Briginshaw* (1938) 60 CLR 336: State Coroner's Guidelines at p 8.14; Ian Freckelton, "Conduct of Coronial Inquests" *Laws of Australia*, Vol 20.10, Chapter 6 at 133; also K Waller, *Coronial Law*

² In *Keown v Khan* [1999] 1 VR. 69 the Victorian Court of Appeal considered, *inter alia*, s 19 of the *Coroners Act 1985* (Vic) which provided (so far as relevant):

"(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 Births, Deaths and Marriages Registration Act 1996; 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."

It will be apparent that the provisions of s 19 are similar to those now contained in ss 45(1), 45(5) and 46(1)(a) & (b) the *Coroners Act 2003* (Qld).

and Practice in New South Wales 3rd Ed, at 71.³ In *X v Deputy State Coroner for New South Wales* (2001) 51 NSWLR 312 O’Keefe J said at [48] of ss 22(3) and 22A(3) of the *Coroner’s Act 1980* (NSW), which are analogous to ss 45(5) and 46(3) of the *Coroners Act 2003* (Qld):

“Both sub-sections [i.e. s 22(3) and 22A(3)] are in furtherance of a policy of protecting from prejudice a person who has been or may be charged with an indictable offence, as contemplated by s.19.”

8. Kevin Waller has opined that the purpose of s 22(3) is “to prevent coroners and juries from bringing down verdicts which indicate that people are or were guilty of crime, when coronial proceedings are not designed to that end. The issue as to whether a crime has been committed is not one for a coroner’s court”: op cit at 93. In *Musumeci v Attorney General of NSW & Anor* [2003] NSWCA 77 Young CJ In Eq said at [90] in relation to the NSW Act (in dissent but not on this point):

“The reason for the present structure of the Act ... has to do with the perceived unfairness in permitting a public declaration to be made by a coroner as to the guilt of a person who would later be put on trial, not on the material before the coroner which may well include a whole lot of inadmissible material, but rather on that evidence which was admissible in a court of law.”

9. It is also relevant to consider the inquisitorial nature of the coroner. As Freckleton has commented, the role of the coroner is “as close as we have in the Anglo-Australian legal system to that of an inquisitor in the European tradition” I Freckleton, “Expert Proof in the Coroner’s Jurisdiction” in H Selby (ed), *The Aftermath of Death: Colonials* Federation Press 1992, at 37. In *R v South London Coroner; Ex parte Thompson* (1982) 126 Sol J 625 (QB), Lord Lane CJ said at 628.

“It should not be forgotten that an inquest is a fact finding exercise and not a method of apportioning guilt. The procedure and rules of evidence which are suitable for one are unsuitable of the other. In an inquest it should never be forgotten that there are no parties, there is no indictment, there is no prosecution, there is no defence, there is no trial, simply an attempt to establish facts. It is an inquisitorial process, a process of investigation quite unlike a trial where the prosecutor accuses and the accused defends, the judge holding the balance or the ring, whichever metaphor one chooses to use.”⁴

10. Under the *Coroners Act 2003*, coroners have wide powers in relation to inquests. As the State Coroner’s Guidelines note at p 2.2, in an *inter partes* matter, it is the parties’ role to determine the scope of any pre-trial inquiries, what witnesses are called and what information is put before the judicial officer who remains aloof from that part of the proceedings and adjudicates upon the evidence put forward by the parties after having regard to their submissions. In an investigation and/or inquest commenced when a death is reported under the *Coroners Act 200*, there is no such separation of function. The Coroners Court has broad powers to hold pre-inquest conferences (s 34), to give orders and make directions it considers appropriate for the conduct of the inquest (s 35(1)), to require production of documents (s 37(2)), to order persons to attend to give evidence or to produce something (s 37(4)(a)), to order a person called as a witness to take an oath

³ Cf decisions in the United Kingdom where a finding of “unlawful killing” is available under the *Coroners Rules 1984* UK: eg in *R v Wolverhampton Coroner; ex parte McCurbin* [1990] 1 WLR 719; see Waller at 71; *Jervis on Coroners* Sweet & Maxwell Limited 2002 at 13-32.

⁴ This passage has been cited in a number of Australian authorities, for example in *Annetts v McCann* (1990) 170 CLR 596, per Toohey J at 616.

or to answer a question (s 37(4)(b)), and to comment on anything connected with a death, including matters relating to public health or safety; the administration of justice, or ways to prevent deaths from happening in similar circumstances in the future: s 46(1).

11. Finally, in Queensland (as in other Australian jurisdictions), the coroner no longer has power to transmogrify mid-way through proceedings to commit a person upon trial for murder, manslaughter, infanticide or arson.⁵ The *Coroners Act 2003* confers no function of a committing magistrate upon the Coroners Court, imposing instead clear statutory obligations in relation to the making of findings of fact, and recommendations in relation to the avoidance of deaths in similar circumstances. As Freckleton has commented, this “represents a shift way from determination of criminality and may be said to be laying the groundwork for establishing the coroner as a kind of watchdog into the circumstances of avoidable loss of life” op cit at 41.
12. Whilst ss 45(5) and 46(3) require circumspection in the expression of legal judgment in the Deputy Coroner’s findings, Ms Kyle submits that the provisions ought not be construed in any way to restrict or impede the Deputy Coroner in fully exploring all relevant factual matters surrounding Mulrunji’s death, and making findings of fact in relation to the matters enumerated in s 45(2)(a)-(e). As Sir Thomas Bingham MR said in *R v Coroner for North Humberside and Scunthorpe, Ex parte Jamieson* [1994] QB 1 26:

“It is the duty of the coroner as the public official responsible for the conduct of inquests... to ensure that the relevant facts are fully, fairly and fearlessly investigated. He is bound to recognise the acute public concern rightly aroused where deaths occur in custody. He must ensure that the relevant facts are exposed to public scrutiny, particularly if there is evidence of foul play, abuse or inhumanity. He fails in his duty if his investigation is superficial, slipshod or perfunctory.”

13. To like effect, the State Coroner’s Guidelines provide at p 7.5:

"Deaths in custody warrant particular attention because of the responsibility of the State to protect and care for people it incarcerates, the vulnerability of people deprived of the ability to care for themselves, the need to ensure the natural suspicion of the deceased's family is allayed and public confidence in State institutions is maintained. Further, a thorough and impartial investigation is also in the best interests of the custodial officers."

14. The *Coroners Act 2003* mandates that the inquest function is a fact-finding exercise “to seek out and record as many of the facts concerning death as the public interest requires” *R v South London Coroner; ex p Thompson*. In the case of a death in custody, the public interest requires the exposure to public scrutiny of all facts which in any way relate to the circumstances of death. As stated in the State Coroner’s Guidelines at [8.7.5]:

“There is no impediment to Coroners providing a full and complete narrative of the circumstances of death nor stating their conclusions as to the responsibility of individuals or organisations for the death provided they refrain from using language that is applicable to decisions made by criminal and civil courts when they adjudicate upon the same issues.”

⁵ See discussion by Nyland J in *Perre v Chivell* (2000) 77 SASR 282 at 288-290 of the history of the coroner’s criminal jurisdiction and the trend to prohibit findings of guilt and the committal of persons for trial.

15. In particular, pursuant to s 45(2)(e), the Coroner is obliged to endeavour to ascertain "what caused the person to die". The reality is that determinations of culpability are an inevitable corollary to the process in which findings of causation are required to be made. A finding that a person caused another person to die or that he or she contributed to a cause of death will almost inevitably precipitate civil action, disciplinary action, media ignominy and, potentially, criminal prosecution if these have not already occurred): Ian Freckelton, "Powers of Coroners" *Laws of Australia*, Vol 20.10, Chapter 5 at 105.
16. In *Keown v Khan* [1999] 1 VR. 69 Callaway JA said at [16]-[17] (footnotes deleted and emphasis added):

A coroner is not concerned with questions of law of that kind. Instead the coroner is to find the facts **from which others may, if necessary, draw legal conclusions**. As paragraph 153 of the *Norris Report* [Norris, *The Coroners Act 1958: A General Review* 1980] said:

"153. It is necessary to emphasise that if the coroner is no longer required to determine whether the cause of death was unlawful, and if so, who was guilty of the crime, the original purpose of the verdict, to indicate legal responsibility for the death, substantially disappears. If the coroner or jury is not to include any statement of legal responsibility or to express any conclusion of law on the matters he or the jury is required to determine as recommended in paragraph 125 above, this consequence is reinforced. The result is, as stated by the Brodrick Committee (para. 16.40):- 'In future the function of an inquest should be simply to seek out and record as many of the facts concerning the death as public interest requires, without deducing from those facts any determination of blame.' The findings of the coroner or jury should in terms be findings of fact only. To quote the Brodrick Committee again:- '**In many cases, perhaps the majority, the facts themselves will demonstrate quite clearly whether anyone bears any responsibility for the death**; there is a difference between a form of proceedings which affords to others the opportunity to judge an issue and one which appears to judge the issue itself.' (ibid)."

...

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.** (That was the point made by Sir John Norris in paragraph 153 of his report.) **It is of the first importance that, where a person's reputation is at stake, the relevant facts are clearly brought out.**

17. In ascertaining how the death of a deceased person was caused, the coroner must often necessarily explore facts bearing on criminal and civil liability: *R v Coroner for North Humberside and Scunthorpe, Ex parte Jamieson* [1994] QB 1 per Sir Thomas Bingham MR at 24; cited with approval by Nyland J in *Perre v Chivell* (2000) 77 SASR 282 at [53]. That a finding by a coroner might lead to a subsequent determination of civil or criminal liability does not preclude the coroner from making the particular finding of fact: Nyland J at [55]. Similarly, the coroner is required to provide a complete narrative of all relevant facts and make proper findings relating to the cause of death. That an ordinary member of the public might or would conclude, upon reading such narrative

that such facts establish or hint at a crime of, say, murder, does not render the recital of such facts prohibited pursuant to ss 45(5) and 46(3).

18. In the example given by Counsel assisting, Ms Kyle submits that the Deputy Coroner would exercise some circumspection in use of the word “*deliberate*” in a finding as to death resulting from the application of force by Senior Sergeant Hurley. This is because such a finding could be capable of being characterised as a finding as to criminal (and civil) liability, involving the application by the Deputy Coroner of the relevant law in relation to the facts, and a legal conclusion by the Deputy Coroner that the essential elements of a crime (as well as a civil obligation) have been made out. As Nyland J, observed in *Perre v Chivell* at [55]:

“There are ... a number of essential elements which the Crown is required to prove beyond reasonable doubt before a person can be found guilty of the crime of murder. These include proof of an intention to kill or cause grievous bodily harm.”

19. In *Perre v Chivell*, Nyland J regarded it as of significance that the coroner had not made a finding as to the existence of such intention: “He had simply recorded his findings as to the sequence of events which culminated in Sergeant Bowen's death.” Nyland J at [55].
20. In the circumstances of the present case, a finding entirely consistent with the restriction in ss 45(5) and 46(3), and the obligation to make the findings enumerated in s 45(2), might provide, for example, that:

“The Deceased died as a result of severe internal soft tissue injury caused in a scuffle in which a relatively large part of Senior Sergeant Hurley’s frame came into violent contact with the unprotected abdomen of the Deceased, resulting in [and then list injuries].”

Matter 1 (cont’d)

- (b) To what extent are parties permitted to make submissions, particularly in relation to the matters set out in s 45(2)?**

21. Counsel assisting has asked a related question to that addressed above:

“If the Deputy Coroner is constrained in her findings (and comments) such that, to continue the example above, she cannot state in the findings that any application of force to the Deceased was or may have been deliberate, does it necessarily follow that persons permitted to appear are prohibited from making submissions that any application of force was or may have been deliberate?”

To what extent are parties permitted to make submissions, particularly in relation to the matters set out in s 45(2)?”

22. Consistently with what is submitted above, Ms Kyle submits that the parties should be permitted to make submissions (and to cross-examine witnesses)⁶ in relation to all relevant factual matters surrounding Mulrunji’s death, as to the findings of fact which the Deputy Coroner should make in relation to each of the matters enumerated in s

⁶ As envisaged by s 36(1).

45(2)(a)-(e), and as to the comments the Deputy Coroner should make in relation to the matters enumerated in s 46(1). In making rulings in relation to the receipt of evidence and submissions, the Deputy Coroner would have regard to the acute concern of the Palm Island Aboriginal community, as well as the public generally, of seeking to ensure that the relevant facts are fully and fairly investigated and permitted to be the subject of submission by interested parties.

23. In relation to the matter enumerated in s 45(2)(e), “what caused the person to die”, submissions (and cross-examination) will necessarily explore facts bearing on criminal and civil liability. Just as the Deputy Coroner is not precluded from making findings of fact which might lead to a subsequent determination of civil or criminal liability, neither are the parties precluded in making submissions (and examining witnesses) in relation to facts bearing on liability. That members of the public might conclude that questions to witnesses and submissions can only be consistent with a crime of, say, murder, does not prohibit the putting of such question or the making of such submission.
24. Ms Kyle accepts that an objection could be taken by a party to evidence sought to be adduced, or a submission sought to be made, on the basis that such evidence or submission involves legal judgment, being a plain assertion of criminal guilt or civil liability, or of every element of an offence (or of a cause of action). As a practical matter, the latter are unlikely to be easy to detect.

Matter 1 (cont’d)

(c) The use to be made of propensity evidence and the admissibility of such evidence

25. Counsel assisting has asked any representatives who wish Counsel assisting to call propensity evidence to identify such evidence known to date and to state its purpose or purposes in the Inquest

[An order prohibiting this part of the submissions was made on 30 March 2005 by the Deputy State Coroner. This order was opposed by the Council – see argument below]

Matter 1 (cont’d)

(i) Should any such propensity evidence be called in the Inquest, should the evidence be called in closed Court (see s 35) and publication of the information be prohibited? (see s 41.)

26. Ms Kyle submits that evidence in relation to past complaints should be called in open Court. The integrity of the inquest requires that there be adherence to the fundamental rule that the administration of justice must take place in open court: *Raybos Australia Pty Limited v Jones* (1985) 2 NSWLR 47 at 50 (CA); *John Fairfax & Sons v Police Tribunal* (1986) 5 NSWLR 465 at 476G (CA). In *John Fairfax & Sons v Police Tribunal* McHugh JA said @ 476-477:

“The fundamental rule of the common law is that the administration of justice must take place in open court. A court can only depart from this rule where its observance would frustrate the administration of justice or some other public interest for whose protection Parliament has modified the open justice rule. The principle of open justice also requires that nothing should be done to discourage the making of fair and accurate reports of what occurs in the courtroom. Accordingly, an order of a court prohibiting the publication of evidence is only valid if it is really necessary to secure the proper administration of justice in proceedings before it.”

27. In *John Fairfax Pty Ltd v Attorney-General (NSW)* (2000) 181 ALR 694 Spigelman CJ said at [52]-[55]:

"52 There can be no doubt that the principle of open justice is one of the most fundamental aspects of the system of justice in Australia. It informs and vitalises numerous specific rules and practices. (See my address to the 31st Australian Legal Convention "*Seen to be Done: The Principle of Open Justice*" (2000) 74 ALJ 290 and 378).

53 The principle of open justice is so fundamental as to be of constitutional significance. As Lord Shaw described the principle in *Scott v Scott* [1913] AC 417 at 473, it is:

'...a sound and very sacred part of the constitution of the country and the administration of justice'.

54 In *Scott v Scott*, the House of Lords held that there was no inherent power of the Court to exclude the public. This principle was immediately applied by a unanimous High Court. (See *Dickason v Dickason* (1913) 17 CLR 50 at 54).

55 In *supra* at 51, the High Court unanimously recognised that:
Dickason

'...one of the normal attributes of a Court is publicity.'

56 In *Daubney v Cooper* (1829) 109 ER 438 at 440, proceeding in public was described as:

'...one of the essential qualities of a Court of Justice.'

28. A non-publication order should be made only in wholly exceptional circumstances, where the presence of the public or public knowledge of the proceedings is likely to defeat the paramount duty of the courts: *Attorney-General v Leveller Magazine* [1979] AC 440 at 450; 457; 469; *Mirror Newspapers Limited v Waller* (1985) 1 NSWLR 1 at 11-12; *David Syme & Co Limited v GMH Limited* [1984] 2 NSWLR 295 at 311; *R v Richards and Bijkerk* [1999] NSW CCA 114 at [39].
29. It has often been acknowledged that an unfortunate incident of the open administration of justice is that embarrassing, damaging and even dangerous facts occasionally come to light: *John Fairfax Group Pty Limited v Local Court of New South Wales* (1991) 26 NSWLR 131 per Kirby P at 142-143; cited with approval by Grove J in *SG v DPP & Ors* [2003] NSWSC 413 (16 May 2003). Such considerations have never been regarded as a reason for the closure of courts, or the issue of suppression orders in their various alternative forms: see, e.g. *David Syme & Co Ltd v General Motors-Holden's Ltd* (1984) 2 NSWLR 294; *Raybos Australia Pty Limited v Jones* 1985 2 NSWLR 47; *R v Chief Registrar of Friendly Societies; Ex Parte New Cross Building Society* [1984] QB

227; *R v Bromfield; Ex parte West Australian Newspapers Ltd* Court of Appeal, Supreme Court of Western Australia, 21 June 1991, unreported, per Malcolm CJ at 22; *Rockett v Smith* Court of Appeal, Queensland, unreported 21 March 1991 per Derrington J at 7.

30. A significant reason for adhering to a stringent principle, despite sympathy for those who suffer embarrassment, invasions of privacy or even damage by publicity of the proceedings is that such interests must be sacrificed to the greater public interest in adhering to an open system of justice: *John Fairfax Group Pty Limited v Local Court of New South Wales* (1991) 26 NSWLR 131 per Kirby P at 142-143.
31. Ms Kyle submits, as representative of the Palm Island Aboriginal Council, that the integrity of the inquest into the death of Mulrunji requires the exposure to full public scrutiny of all the relevant facts.

Matter 2: Access to Senior Sergeant Hurley's Disciplinary Records

32. This matter is dealt with in relation to matter 1(c) above.

Matter 3: Use in the Inquest of Evidence adduced on Palm Island on 28 February 2005

33. The circumstances which halted the inquest commenced by the State Coroner on 28 February 2005 are documented. They did not include any issue of jurisdictional error. Therefore and given that an inquest is merely one of the tools of a coronial inquiry - albeit in the circumstances of this case a mandatory one - there is no proper basis to exclude from consideration any matter of investigation up to the point of the State Coroner standing aside on 2 March 2005.
34. At the mention of the matter before the Deputy Coroner on 3 March 2005, the position communicated by Counsel assisting, viz., that "a new inquest" be convened correctly reflected the position of Ms Kyle as then held. However that position is no longer maintained. The opportunity afforded by the questions posed by Counsel assisting has led to a closer examination of what is the appropriate course to be taken from this point.
35. Sections 63(4) & (5) of the Act permit the "new coroner" to have full regard to all that has occurred in the entire inquiry (including that which was elicited at the inquest) and, with respect, the Deputy Coroner ought to do so.
36. This may still nevertheless mean that some further evidence will need to be elicited from people who were called to give *viva voce* evidence on 28 February 2005. Whether that is done in the form of public questioning at an inquest is a matter that the Deputy Coroner should decide after reviewing what has occurred to this point.

Matter 4: Venue

37. Section 66 of the Act permits the Coroners Court to convene "at any place". Ms Kyle's position is that the inquest should be held on Palm Island so that the participation of the

immediate and extended family and the rest of the very close-knit community on the Island is most likely, in all practical senses, to be achieved.

38. Firstly, the death has had and continues to have an immense impact upon the Palm Island community. It is a close-knit, relatively small community (approximately 3000 people). The community desire to see an impartial and transparent inquiry is understandably high.⁷ Many members of the deceased's family and extended family live on Palm Island and have expressed a desire to, and in fact attended the first two days of the previous inquest. Practical access to the inquest is an important step in the process of community understanding of what happened to a well-known and well-liked member of the community. Having a real and practical opportunity to acquire an accurate understanding of the evidence is pivotal to the ongoing process of mourning, healing and "moving on". The council, in its community consultations, has ascertained that many members of the community wish to attend and observe the conduct of the inquiry and inquest.
39. Secondly, the benefits to the coronial inquiry if the inquest was held on Palm Island – particularly to establish a proper understanding of both the practicalities, circumstances and social conditions of the location in which the arrest, detention and death occurred and the complexities involved in police interaction with members of the indigenous community – are obvious.
40. Thirdly, despite the less than perfect forensic conditions, it is not unusual for the circuit courts of the Magistrates and District Courts to attend isolated communities and the risks and difficulties for the Coroner in this regard do not seem much more than when that occurs. Indeed, since the destruction of the police station the Magistrates Court has routinely attended the island, often for two days at a time, and there have been no reported incidents of concern in this respect. An observation by Magistrate Glasgow at one of the bail hearings is apposite:

“I have been there (Palm Island) on the 14th and 15th (December 2004). I've sat in my Courts there. I've been welcomed on the island. Every defendant who should have appeared, appeared before me and no warrants were issued. We proceeded in the normal way. I was not at all under threat. Neither was my staff. We entered that island as guests and were treated with respect as is my my – as my means I always treat the defendants before me similarly.”⁸
41. Fourthly, the extra costs that will be incurred by individual community members (particularly the family) in either commuting to Townsville or finding affordable accommodation will be of a greater proportional burden than what might be experienced by the government and institutional agencies in attending the island. It is understood that there are about 20 members of the direct family and a further 40 or so close friends and extended family members who wish to attend the inquest. In addition to the financial burden there are also the logistical difficulties regarding the children of these people and other members of the community who will be attending school on Palm Island and/or for whom it will be difficult to arrange alternative supervision during the

⁷ For example the funeral was attended by almost every indigenous member of the island community.

⁸ Reference should also be made to the observations of the Queensland Court of Appeal in allowing one of the people in the community to return to the island after enduring bail conditions prohibiting him from doing so: *Clumpoint v DPP* [2005] QCA 43 at [20]-[22], [29].

inquest period if their parents are in Townsville. There are also some family members who, due to age or illness, would not be able to travel to Townsville.⁹

42. Fifthly, if most of the family members are not able to attend an inquest held in Townsville, then the inquiry will fail to meet a primary objective, namely, to assist the family to understand and come to terms with what occurred. It will also make it extremely difficult to get ongoing instructions for the conduct of the hearing if the family and other community members are not able to be present when the evidence is being adduced.
43. Such an approach pays due regard to the Royal Commission into Aboriginal Deaths in Custody's observations as to the family and the public's rights to participate¹⁰ and the comments frequently and more recently made by heads of jurisdiction including the Chief Justice as to the need to bring the justice system into these 'isolated' communities.¹¹
44. The State Coroner indicated a "preference" for the inquest to be held "either as close as possible to the scene of death and/or where those with the greatest interest in the inquiry reside" and a keenness to ensure "that the residents of Palm Island have ready access to the hearing".¹²
45. This position was reflected in the convening of a Pre-Inquest Conference on the island on 8 February 2005 and the orders made by the State Coroner that day.¹³ After hearing submissions, his Honour recorded the competing interests, in sum, as follows:¹⁴
 - (a) The attendance and participation of the family and other members of the community would be better facilitated on Palm Island;
 - (b) Having the hearing on Palm Island would assist the inquest participants, including the Coroner, to better understand the issues to be ventilated at the inquest, including how the death came about, community relations on the Island;
 - (c) Townsville is a more suitable forensic environment – acoustics, equipment and accommodation;
 - (d) Security – the potential for proceedings to 'inflamm' violence in the community; and

⁹ Ms Kyle understands that the costs for family members attending Townsville on 3 March 2004 was met from donations within the community and that the Justice Department has refused requests for assistance in this regard.

¹⁰ **Royal Commission V1 Chapter 4 The Adequacy of Previous Investigations. 4.6 The Rights of the Deceased's Family – Introduction:**

"4.6.2 ... In many instances there has been little recognition that the family and the public have the right to expect a full, open and impartial inquiry with the greatest possible access to all relevant information.

4.6.4 There is a need for openness, frankness and sensitivity to the feelings of the relatives and friends of the deceased from the point of notification of death throughout the various stages of investigation. It should include the family of the deceased's full involvement in the inquest, if this is what the family wishes."

¹¹ In the matter of the first sittings by the Chief Justice at Thursday Island, 30 September 2002: <http://www.courts.qld.gov.au/publications/articles/speeches/2002/dj291002.pdf>.

¹² By letter to Ms Kyle's lawyers dated 6 January 2005.

¹³ His Honour restated this prima facie position at R17 L5-14.

¹⁴ R31 L455 – R34 L22.

- (e) The ability for Senior Sergeant Hurley to provide appropriate instructions, given his own personal security fears keeping him from travelling to the Island.

46. Relevantly, his Honour held as follows:¹⁵

“Obviously, all those participating in the process need to do our best to discover what happened, what caused the death. We also, if possible, need to satisfy those most interested in the matter (that we) have used a valid, legitimate and transparent process to do that...

Security is certainly an issue... I don't think the fact that there has been one violent incident, albeit over an extended period of time, and albeit an extreme reaction, indicates that on all future occasions when witnesses have provocative or confrontational questions put to them, that they or other members of the community will necessarily react with violence. I'm not saying that all risk of that can be excluded, but I'd suggest that is never the case, that all risks of that kind can be excluded. I don't (sic) believe that the risk is sufficiently negligible that we are required to face that risk in view of the other benefits that would flow from convening at least part of the inquest on Palm Island.

... And although, it may sometimes be easier to have whispered conversations at the Bar table, that's obviously not the only way in which those instructions can be obtained ... instructions could be obtained by telephone ... And I would intend ... not releasing witnesses until Mr Zillman was satisfied that he had all the instructions necessary to cross-examine them ...

If all of those things were satisfied, I would consider it appropriate that family members and other eyewitnesses give evidence here (Palm Island); that any witness who made a reasonable submission that they were concerned that they would come under pressure that might divert them from giving accurate or free testimony, or that they felt their physical security was at risk, could make application and I would grant them permission to give evidence in Townsville.¹⁶ As I think I've already indicated, I think the professional expert medical witnesses should also give evidence in Townsville.”

- 47. Following these rulings, the inquest started on 28 February 2005 on Palm Island in the newly constructed hall occupied by the Police Citizens Youth Association. Proceedings over two days were conducted at this venue. At those proceedings a substantial number of community members attended and there were no security or safety issues of concern.
- 48. There are some additional measures that can be taken to improve the quality of the environment in this venue to take the evidence on oath given the prevailing conditions, viz:
 - (a) Improvement in the audio and visual equipment. This is a matter about which the Justice Department might be approached to provide more resources.
 - (b) A requirement that each speaker to a witness move to a position and microphone immediately adjacent to the witness when doing so.

¹⁵ R33 L15-35; R33 L52 – R34 L34.

¹⁶ His Honour was referring to his findings made earlier (at R32 L55 – R33 L11) with respect to Hurley and other police witnesses.

49. If any witness can properly establish that their attendance on Palm Island raises an unacceptable concern for safety, then the Coroner should entertain such an application on its merits - that is, for each individual witness - and the parties should be heard as to their views.

Matter 5: Submissions in relation to obviating or reducing problems relating to miscommunication with Witnesses.

50. This is a matter that has been raised with Ms Kyle by many members of the community following the taking of evidence on 28 February 2005. It is a factor which has affected the capacity of this inquest to discharge its primary function, namely to assist in the “inquiry” into the facts that surround this death.
51. It is submitted that either directions by the Coroner under s 35(1) of the Act or an order under either s 21 or s 21A of the *Evidence Act* are necessary to attempt to address or at least ameliorate these concerns.
52. A perusal of the transcript reveals that it was difficult and on occasions impossible for Counsel assisting the inquiry and some of the other counsel appearing for parties to communicate effectively with a number of the witnesses who have been called to give oral evidence in the inquest. This was evident in both examination and cross-examination. The witnesses were all Aboriginal and residents of Palm Island.
53. The following matters became apparent as the hearing progressed:
- (a) Contradictory answers were being given following repetition of questions or alternative leading questions.¹⁷
 - (b) Evidence of times, dates and distance (in metric terms) when asked of and given by witnesses were at odds with other objective evidence.¹⁸ When such evidence was given in the abstract, there was no enquiry of how such times/figures were ascertained.¹⁹ It seemed that whilst the question was understood, the answer was no more than a guess, especially if the question was framed in a leading manner. The use of qualitative/relational questions e.g. by providing a comparative estimate using the length of the hall etc as a guide and contextual questions e.g. “before the post office opened” “not long after dark” etc removed these difficulties for witnesses.
 - (c) Witnesses were asked to adopt written statements without any inquiry as to their reading ability and without any contextualising of what was being sought.²⁰ In one obvious example, Patrick Nugent/Bramwell was thought by most of the counsel at the bar table to be adopting his first statement when in fact he was adopting his

¹⁷ Evidence of Patrick Bramwell: R77 L4; R78 79; R80 L6, 20. Roy Bramwell: R129 L10 & R130 L10; R131-134, R138-140.

¹⁸ Tracy Twaddle: R58 L40 & R59 L8. Patrick Bramwell: R72 L53; R77 L40-55; R82 L45-56. Edna Coolburra: R88 L29-35; R89 L43 – R90 L18. Verna Snyder: R109 L25-28. Malcolm Kidner: R114 L18, 38-41. Gerald Kidner: R103 L49-56.

¹⁹ Tracy Twaddle: R59 L53. Victoria Doomadgee: R64 L24. Patrick Brawmwell: R66 L35, R81 L36, 55.

²⁰ Tracy Twaddle: R57 L35-45. Victoria Doomadgee: R64 L5-10. Reginald Barry: R66 L10-20. Gladys Nugent: R92 L12-18. Malcolm Kidner: R114 L10-15. Noby Clay: R117 L10-18. Roy Bramwell: R129 L43-55; R136 L2-50, R138 L50 – R139 L10.

second.²¹ In another, Roy Bramwell counted the pages of his statement when he was asked how many “statements” he had in his hand. He had 4 pages but only 2 statements.²² Patrick Bramwell,²³ Roy Bramwell²⁴ and Malcolm Kidner²⁵ each admitted that they could not read, after having been asked to and in some cases, having adopted written statements.

- (d) There was use of language with specific community meanings, which were not understood by counsel assisting and other counsel.²⁶ Some of the more obvious examples are:
 - i Patrick Bramwell used the word “shy” when explaining his reason for not having given a fuller account on the first occasion.²⁷
 - ii Edna Coolburra made a distinction between what was the “white fella’s” interpretation of the description “drunk” from what she had meant, as she had sensed that she was being misinterpreted. She was cross-examined about her use of the word “drunk” without any clarification of what she meant by that term.²⁸ She later clarified that when she used the word “drunk” she meant to describe a person that was “tipsy” and a “happy drunk” as distinct from being heavily intoxicated, which had been the literal meaning taken by the examiners.²⁹
- (e) There were some ‘legal’ words used, which caused confusion.³⁰
- (f) Long questions providing choices of response, involving double negatives or rolling several propositions into the one question, led to confusion.³¹
- (g) Witnesses were asked to hypothesise, which led to confusion.³²
- (h) Sarcasm was unnecessarily employed.³³
- (i) Verna Snyder became distressed and confused, clearly needed an interpreter and then became overwhelmed out of frustration at not being understood.³⁴ She effectively ‘shut down’ near the end of her examination by counsel assisting. It was then thought that it was too difficult to continue and a decision, in effect, was made by the coroner and counsel assisting to place less weight on her account because of these communication difficulties.³⁵

²¹ R68-71, 75-76.

²² R126 L18-28.

²³ R68 L25-30.

²⁴ R129 L34.

²⁵ R115 L15.

²⁶ Roy Bramwell and Gladys Nugent were taken to task about the term “knocked down” instead of earlier statements using the words “knocked out”: RB R126 L35-41. GN R101 L30-54.

²⁷ R74 L35-43.

²⁸ R89 L28-41.

²⁹ R90 L40 – R91 L19.

³⁰ Eg. “true and correct”: Gerald Kidner: R102 L25-28; Gladys Nugent: R94 L55 – R95 L3. “Addendum statement”: R62 L22.

³¹ Patrick Bramwell’s evidence: R79 L35 – R80 L1.

³² Edna Coolburra: R89 L15-26. Gladys Nugent: R95 L33-36. Gerald Kidner: R104 L50-54, R106 L25-35, 43.

³³ R141-142.

³⁴ R110 L45-55.

³⁵ R112 L18 – R113 L1.

54. Oral submissions about these miscommunications were made by lawyers for the Council and counsel for HREOC at various stages. A joint note formalising the concerns of several counsel was signed and handed to Counsel assisting on 2 March 2005.
55. It is maintained that much more care, and indeed significant changes need to be taken by the Deputy Coroner (and all those assisting) with Aboriginal witnesses whose “bi-cultural (in)competence” in this setting is obvious, particularly in the formal setting of giving evidence at an inquest.
56. It is not just the language differences and the mode of communication which is hindering the proper taking of evidence, it is of course the whole setting in which this process is being undertaken.
57. It is an understatement to observe that being questioned in a court is an intimidating prospect. The inquest is being held in a large hall, the witnesses are placed in front of a large audience including about 16 non-Aboriginal lawyers and assistants sitting at the bar table, with recording equipment amplifying voices throughout the hall. Scores of members in the community including the family of the man whose death is being inquired into and at times, more than a dozen media personnel are in attendance. The state of acoustics is such that shouting is sometimes resorted to.
58. Section 21A (1) of the *Evidence Act* relevantly provides that a:

“special witness means a person who, in the court’s opinion would, as a result of a relevant matter, be likely to be disadvantaged as a witness or would be likely to be so intimidated as to be disadvantaged as a witness if required to give evidence in accordance with the usual rules and practices of the court.”
59. Section 21A(2) provides

“Where a special witness is to give or is giving evidence in any proceeding, the court may, of its own motion or upon the application made by a party to the proceeding, make one or more of the following orders or directions –
(...)
(f) another order or direction the court considers appropriate about the giving of evidence by the special witness, including, for example, any of the following –
(i) A direction about rest breaks for the special witness;
(ii) A direction that questions for the special witness be kept simple;
(ii) A direction that questions for the special witness be limited by time;
(iii) A direction that the number of questions for a special witness on a particular issue be limited.”
60. Section 21 is also of relevance in this context. It provides:
 - (1) The court may disallow a question put to a witness in cross-examination or inform a witness a question need not be answered, if the court considers the question is an improper question.
 - (2) In deciding whether a question is an improper question, the court must take into account-
 - (b) any other matter about the witness the court considers relevant including, for example, (...) cultural background or relationship to any party to the proceeding.

“improper question” means a question that uses inappropriate language or is misleading, confusing, annoying, harassing, intimidating, offensive, oppressive or repetitive.”

61. The issue sought to be raised is not novel. It has been the subject of judicial consideration where miscarriages of justice have been found as a result of this miscommunication: e.g. *R v Kina* CA No 221 of 1993.³⁶ The Queensland Court of Appeal in *Kina*³⁷ relevantly observed:

“In this matter there were insufficiently recognised, a number of complex factors interacting which presented exceptional difficulties of communication between her legal representatives and the appellant because of: (1) her Aboriginality (2) the ‘battered woman syndrome’ and (3) shameful (to her) nature of the events which characterised her relationship with the deceased. These cultural, psychological and personal factors bore upon the adequacy of the advice and legal representation which the appellant received and effectively denied her satisfactory representation or the capacity to make informed decisions on the basis of proper advice.”

62. The issue has also been embraced by linguists, anthropologists and other professional non-Aboriginal people who have worked in Aboriginal communities. The work of experts in this area such as Dr Diana Eades have been embraced by the Courts, the Department of Justice and professional bodies such as the Queensland Law Society and the Legal Aid Commission.
63. Importantly, this breakdown does not necessarily involve an assessment of the legal skill, forensic ability or intention of the questioner or cross-examiner or indeed of the Court itself. However the present ill-appreciation of the difficulties being experienced by some witnesses is either not being sufficiently noticed, causing frustrations on the part of both the witness and the examiner or being ignored. The gathering of evidence in a coronial inquiry and the eliciting of evidence at an inquest should not be adversarial; rather the purpose of the proceedings is to make a careful inquiry into the truth.
64. The rights of any party who might face other civil or criminal proceedings will not be abridged in any respect if the nature of questioning of the Aboriginal witness is made the subject of some specific directions under either s 35(1) of the Act or s 21A(2)(f) of the *Evidence Act* such as:
- (a) Each witness’ reading and bi-cultural communication competency should be ascertained prior to the witness giving evidence.
 - (b) Evidence should be taken primarily in narrative form. Examination should be limited to that which is necessary for the coroner to ascertain the evidence of the witness. Counsel for the parties who have been granted leave should identify what aspect of the evidence is sought to be clarified before cross-examination is permitted.
 - (c) In this context, repeating a question that has already been asked should not occur unless there is a proper basis for doing so.

³⁶ Also see *R v Condren* [1991] 1 Qd R 574.

³⁷ Fitzgerald P and Davies and McPherson JJA.

- (d) The circumstances where leading questions are appropriate and utilised should be monitored.
 - (e) Simple language should be used e.g. “then what happened?” instead of “what occurred after that?” There should only be one proposition per question and double negatives should not be used.
 - (f) Witnesses should be given a clear and informed choice of accepting or rejecting a proposition.
 - (g) Recognition that nods, raised eyebrows and movement of head and eyes are significant modes of communication in this community, perhaps through the reading into the record of such gestures.
 - (h) Facetious or sarcastic comments or questioning should be disallowed.
 - (i) Reference to and clarification of temporal issues must be appropriate having proper regard to how time is viewed in a community where many, if not most people do not use watches. It would be unfair to use gradients of minutes and hours in questions when that is not how time is assessed in daily life. Phrases like “a short time”, “a long time” or “after lunch” etc should be used instead. Similarly, with dates and distances.
 - (j) Limits must be placed on the time under which witnesses have to endure cross-examination and frequent breaks must be given.
 - (k) Appropriate interpreters should be utilised. They should be asked to ensure that the witness understands the question, be given time to explain that question on the record to the witness and thereafter communicate the witness’ answers to the Court.
65. Specifically, in respect of the witness Roy Bramwell it is submitted that his examination be given special attention due to his obvious bi-cultural limitations and the importance of his evidence to this inquiry. There needs to be some consideration given to whether the process of obtaining of his evidence should start again. In addition to the matters suggested in the preceding paragraphs, the following approach should be taken:
- (a) He should be allowed to firstly give an uninterrupted narrative of what he saw, prompted with leading questions where necessary and appropriate. He should be told where he used different expressions about the same subject matter and asked to explain in his own words why this is so.
 - (b) He should also be told that in the written statement that bears his signature there are words used which are not the same as expressions which are attributed to his voice on the transcript of an interview he had had with the police earlier or in his evidence at the first inquest.
 - (c) If possible, the recording of any interview should be played, in lieu of a transcript being read, so that any prior statements being relied upon are put in an appropriate context and reflect any non-verbal communications made.

- (d) A careful identification of the process that was undertaken in the production of the statement he signed should be undertaken before it is sought to be used as an evidentiary basis to suggest inconsistency under s 101 of the *Evidence Act*.
 - (e) There must be a proper foundation laid for the proposition that his statement to police in fact reflects his actual account. He has stated that he cannot read very well. The words "This statement has been read to me" within the statement are not sufficient.
 - (f) The police officer who took the police statement should be called to establish this fact before relying on it as a possible forensic device under s 101 of the *Evidence Act*.
 - (g) There is presently no other evidence in the brief that satisfactorily suggests that this statement in fact accurately records the version of events that he gave on a prior occasion.
 - (h) It should be ascertained why he sought the assistance of the Aboriginal Legal Service to prepare a second statement.
 - (i) The lawyer from the ALS should be asked why and the circumstances under which he took that statement.
 - (j) Roy Bramwell should be asked to explain if he can, and with an interpreter/linguist assisting, what he meant in the words he used and whether he used words with different connotations than when used in ordinary English.
 - (k) He should not be put into a situation where he is embarrassed about his communication limitations or that of those who are asking questions.
66. The ideal situation would be to have counsel assisting the coroner undertake this task, sensitively and with appropriate assistance in a video-taped procedure which is less intimidating overall than the present, before he is required to give evidence in a court setting.
67. If Mr Bramwell's integrity or reliability - or indeed that of any other witness from the community - is to be impugned, it should only be done after a fair process that takes into proper account the miscommunication issues set out above. It would be quite improper for any counsel to suggest to the witness that he or she is "lying" or "not telling the truth". Such an approach should not be permitted. A witness must be placed in a position of understanding regarding earlier statements and given a proper opportunity to explain any inconsistencies in the manner set out above.
68. Otherwise, it is respectfully submitted, this coronial process will not get to the truth of what happened, rather, it will fall on the relative degree of communication or miscommunication that is tolerated and which can be forensically taken advantage of by the skilful advocates appearing for the parties with their competing interests.
69. It is re-iterated that taking a sensitive approach to this process - which might include curtailment of cross-examination of some of the parties - will not prejudice anyone who

might ultimately face criminal proceedings, particularly having regard to the fact that committal proceedings are in fact the proper forum to provide the framework for that function.

Matter 6: In the event that Senior Sergeant Hurley were to claim privilege, whether the Deputy Coroner ought require Senior Sergeant Hurley to give evidence

70. Ms Kyle notes that the Deputy Coroner's capacity to conduct a full investigation of the facts in relation to the death of Mulrunji and to make findings required to be made pursuant to s 45(2) could be significantly impeded if Senior Sergeant Hurley claims privilege. There may therefore be a significant public interest in the exercise of the Deputy Coroner's power under s 39(2) to compel Senior Sergeant Hurley to give evidence. In that event, the evidence would not be admissible against him in any other proceeding (other than for perjury), nor would derivative evidence (meaning any information, document or other evidence obtained as a direct or indirect result of the evidence given by him) be admissible against him in a criminal proceeding: ss 39(3), (4).
71. Ms Kyle will make further submissions once it is known whether, to what extent, and at what stage of the proceedings a claim of privilege is made, in light of an assessment of the totality of the evidence already received when any claim is made.
72. It would not be inappropriate for Mr Hurley's representatives to be asked whether they can presently identify the position that he is likely to take so that any other resultant legal questions can be canvassed and settled.

Matter 7: By what name the deceased ought be referred to in the Inquest

73. Submissions have been made on behalf of members of the family that reference to the deceased should, having proper regard for cultural sensitivities, be "Mulrunji."
74. This request is supported by Ms Kyle in her representative capacity.
75. RCADIC 4.5.9 relevantly provides:

"Respect for the traditional, cultural values of Aboriginal people should be shown regarding the publication of the name of a deceased Aboriginal person, irrespective of the cause of death. Advice sought from the family of the deceased or their legal representatives should provide guidance for the exercise of a coroner's discretion in considering this matter."
76. It would seem appropriate that all documentation produced for this inquiry (and inquest) use "Mulrunji" in any reference to the deceased.
77. Some of the advocates at the bar table have had difficulty in pronouncing the name requested by the family and some of the witnesses, including close associates of the deceased, have not been aware of the family's request, or the name that has been requested. The latter problem can easily be addressed by these witnesses being told in conference before they are called, of the family's request.

78. In all the circumstances, the parties and witnesses should be requested to respect the family's request. However, it is for those individuals to decide how to conduct themselves on this issue. It may be difficult for a coroner to require respect from parties and their representatives on an issue such as this, but some attempt should be made. It is unclear why this issue is back on the agenda for redetermination.
79. The family's request is genuine and reasonable. It should be respected and accommodated in this inquiry.

Matter 8: Whether anyone, including Counsel assisting, has a right to make submissions to the Deputy Coroner in relation to whether she reasonably suspects a person has committed an offence (s 48). What is the ambit of s 48(2)? Is the obligation to consider and refer confined to information about offences connected with the death under investigation?

80. Section 48(2) provides in the case of information obtained by a coroner while investigating a death, not including information obtained under s 39(2), that where, from the information, the coroner reasonably suspects a person has committed an offence, the coroner must give the information to-- (a) for an indictable offence--the director of public prosecutions; or (b) for any other offence--the chief executive of the department in which the legislation creating the offence is administered.
81. Ms Kyle submits that there is no inhibition upon any person, including Counsel assisting, making submissions to the Deputy Coroner in relation to whether she reasonably suspects a person has committed an offence (s 48). To avoid offending the prohibition in s 46(3), such submission should avoid descending into any degree of particularity in analysis of the legal elements of relevant offences and the relevant evinced. To avoid offending the prohibition in s 46(3), the Deputy Coroner would refrain from making any comment on a submission, properly formulated. Similarly, to avoid offending the prohibition in s 46(3), and to otherwise discharge the statutory functions imposed upon her, the Deputy Coroner would continue to conduct the inquest into the death of Mulrunji, notwithstanding the provision by her of information concerning an offence she reasonably suspects to have been committed.
82. Pursuant to s 49, if the Deputy Coroner reasonably suspects (not **finds**) a person has committed an offence, she must give the information to-- (a) for an indictable offence--the Director of Public Prosecutions; or (b) for any other offence--the chief executive of the department in which the legislation creating the offence is administered: s 48(2): *Keown v Khan* [1999] 1 VR. 69 per Callaway JA at [15], Fn 35.
83. **[An order prohibiting this part of the submissions was made on 30 March 2005 by the Deputy State Coroner.]**
84. **[An order prohibiting this part of the submissions was made on 30 March 2005 by the Deputy State Coroner. This order was opposed by the Council – see argument below]**
85. Finally, Ms Kyle submits that the scope of s 48(2) is not confined to information about offences connected with the death under investigation. The language of the sub-section is plain, and there is no basis, textual, contextual or purposive, for importing any

limitation into it. It would be a bizarre result, at odds with Parliament's purposes plainly evinced in the *Coroners Act 2003*, if a person holding the office of coroner who has information founding a reasonable suspicion that an offence has committed, were either permitted or required to keep that suspicion to him or herself.

Additional matter raised – Issues, evidence and witnesses at the Inquest relating to section 46(1) comments

86. On 28 January, 1, 4 and 24 February 2005, the inquest brief was served on Ms Kyle's representatives. On 3 February 2005, a "proposed issues list" was circulated by the State Coroner. This list, with respect, provides appropriate 'terms of reference' for this inquiry to meet its statutory obligations. Since that time, there have been several communications with Counsel assisting seeking to determine the scope of matters for determination within those terms of reference and the evidence required to be tendered in order for the Coroner to reach appropriate remedial findings pursuant to s 46(1).
87. The following matters *inter alia* have been sought by Ms Kyle, to be included as evidence in this inquest:
- (a) Evidence from an appropriately qualified delegate of the Police Commissioner as to relevant policing policies and the implementation of RCADIC recommendations in light of local Palm Island conditions.³⁸
 - (b) Materials relating to the design of the previous watch house facilities and the proposed watch house and court facilities.
 - (c) Documentation of Palm Island's history to provide a context to the interaction between the indigenous community and police.
 - (d) Government departmental records of relevant service delivery policies and implementation.³⁹
 - (e) Evidence from witnesses on the Island of the recent history of relevant service delivery policies and implementation, including community and police relations etc. Ms Kyle tendered a list of witnesses from the Island who are able to provide evidence on some of these matters (Exhibit B18).

³⁸ RCADIC 13.2.24-13.2.30; 13.4.4; 13.4.18; 13.4.20.

³⁹ RCADIC 3.1.6: 3.1.6: "I want to stress that the inquiries by each of the Commissioners were conducted in a very rigorous way. The Commissioners subpoenaed all records from the relevant custodial and police authorities, courts and hospitals having dealings with the deceased, the coroners' records, all departments having specific dealings with Aboriginal people, and where appropriate, from legal aid offices. Guidelines were issued by Commissioner Muirhead in the early stages of the Commission dealing with questions of the availability of documents so subpoenaed to parties, and with pre-hearing and hearing procedures. Those guidelines, broadly speaking, covered all documents held by the Commission relative to any death--whether documents were subpoenaed as above, statements taken by the officers of the Commission, notes or tapes of interviews, proposed exhibits or any other material on the Commission file. These documents were open to all parties given leave to appear. The guidelines also included provision for pre-trial conferences and discussion as to the issues and the need to call witnesses as opposed to tendering their statements. There was also recourse to the Commissioner in the event of disagreement between parties. These guidelines were reviewed based on the experience of the Commission, and on 19 July 1989 I issued new guidelines to come into operation on 19 August 1989. A month was allowed for familiarisation and an opportunity for seeking changes to these guidelines. There were, however, no suggested changes and those guidelines operated from then on in the hearings into individual deaths. These guidelines were designed to secure efficiency in hearings and the maximum access to all material by all parties."

88. Counsel assisting have advised that many of these evidentiary matters have been or are being sought or have been obtained. Also, oral evidence has been obtained from some members of the Palm Island community, on 4 March 2005. Ms Kyle seeks confirmation of the status of these matters by say 24 March 2005, so that the need to seek formal orders can be further assessed.

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For and on behalf of Erykah Kyle, Chair of the Palm Island Aboriginal Council
21 March 2005