Victorian Government Solicitor's Office

Client Newsletter

Coronial inquests

August 2012

Government bodies are often involved as interested parties in inquests conducted by the Coroners Court into deaths which have occurred in unusual circumstances. **We are currently assisting clients in sixty inquest matters.** These include deaths in care or custody, police shootings and suicides, and police pursuits resulting in death. Coroners have wide powers of investigation and often government bodies can find their policies and procedures exposed to rigorous public scrutiny.

The VGSO has a unique perspective in acting for clients in inquests. In addition to acting for government bodies such as Victoria Police, Justice Health and other departments, our office has often been retained by the Coroners Court to assist in particularly complex inquests.

We have also been retained by the Coroners Court to act for it in appeals and applications under the *Coroners Act 2008* (Vic) and in judicial review proceedings in the Supreme Court of Victoria. Our experience in assisting the Coroner has provided us with a detailed knowledge of the procedures of the Coroners Court and we have also developed strong relationships with the Court and its staff.

We also assist clients in the analysis and identification of conflicts of interest which might arise between individuals and the State in inquests.

Summary

The inquest spotlight can shine very brightly on government actions, policies and procedures.

This client newsletter provides a snapshot of some recent inquests in which the VGSO has been involved.

Broughton Hall

We assisted the Coroner in a lengthy and complicated inquest regarding the deaths of a number of residents at the Broughton Hall nursing home. In April 2007, four residents of the Broughton Hall nursing home died following an outbreak of gastroenteritis. Of the 30 residents at the nursing home at the time, 22 residents displayed symptoms of gastroenteritis over the course of the outbreak.

In her recent findings, handed down on 25 June 2012, the Coroner was satisfied that, on the balance of probabilities, a salmonella infection had contributed to the deaths of the four residents. The Coroner pointed to a lack of readiness and procedure regarding infectious outbreaks at the nursing home at the time of the gastroenteritis outbreak as relevant factors.

The Coroner found that while it was unlikely that an earlier response on the part of nursing home management would have prevented the deaths of three of the residents, it may have prevented the fatal outcome of the illness for one of the deceased and could have made a difference to a number of the residents who had contracted the illness.

The State Coroner ultimately emphasised the importance of communication and procedure in minimising infectious outbreaks and recommended the introduction of mandatory gastroenteritis reporting laws, as well as the appointment of infection control managers in all Victorian aged care facilities.

Wilson

The VGSO recently acted for a former police member in the *Inquest into the Death of Hugh Wilson*. Mr Wilson, a retired serviceman, died in Colac in September 1976. An initial inquest in 1977 determined that Mr Wilson had died as a result of a hit-and-run accident. The driver of the vehicle was not identified, however rumours of police involvement in the death persisted in the community long after the original inquest had been finalised. As a result, the Ethical Standards Department of Victoria Police conducted its own investigation into the death in 2006.

In light of new evidence, Victoria Police successfully applied to the Supreme Court to have the original coronial finding set aside and a new inquest ordered. The new inquest, presided over by Coroner Parkinson, found that the cause of Mr Wilson's death was a severe skull fracture and brain injury sustained as a result of him being struck by a motor vehicle. The Coroner found that, despite the rumours of police involvement, the available evidence did not support a conclusion that it was a police vehicle that had struck Mr Wilson. The driver of the vehicle remains unknown.

Bennett Police Pursuit

In the *Inquest into the Death of Shane Bennett*, the VGSO acted for four police members who were involved in a high-speed pursuit with the deceased immediately prior to his death. In March 2008, Mr Bennett was killed and another driver seriously injured when two vehicles collided at the intersection of Frankston-Dandenong Road and Seaford Road, Seaford. The inquest focused on the conduct of the pursuit and whether the actions of police played a role in Mr Bennett's death.

In his findings, Coroner White noted that the occupants of one of the police vehicles involved in the chase had failed to abandon the pursuit of Mr Bennett's vehicle after being directed to do so by the pursuit controller. Rather than pulling over to the side of the road as directed, the police vehicle instead slowed down, continuing to maintain visual and geographical contact with the vehicle until the time of Mr Bennett's fatal accident. However, no conclusive finding was made as to the connection between the conduct of police in this respect and the ensuing collision, and Coroner White cited Mr Bennett's general hostility towards police, his dangerous driving and his use of cannabis prior to the collision as all being potentially relevant factors.

The Coroner also acknowledged the unique pressure placed on police during high-speed chases and the difficulty of weighing the need to bring a suspect to justice against the risk of danger to the public in each pursuit. This is a particularly challenging assessment for police where a police driver is inexperienced.

Robinson

In the *Inquest into the Death of Chase and Tyler Robinson*, the VGSO is also acting as counsel assisting the Coroner. The inquest concerns the deaths of Chase, 9, and Tyler, 7, found deceased in their Mooroopna home in early 2010, after a suspected faulty gas heater had been left on throughout the night.

Although investigations by police and the Coroner are ongoing, the inquest will examine the defect in the gas appliance, or the feature of the Robinson home that was responsible for the accumulation of excessive quantities of carbon monoxide in the air, which caused the death of the young boys.

It is expected that full hearings in the inquest will commence late in 2012.

Kerang rail- crossing disaster

In another ongoing matter, the *Inquest into the Kerang Rail-Crossing Disaster,* the Coroner is investigating, among other things, the adequacy of the emergency services response to a collision between a semi-trailer and a V-Line commuter train in Kerang in June 2007. The accident resulted in the death of 11 people and was the subject of considerable media attention.

The Kerang level crossing inquest is part of a broader inquiry by the Coroner into 22 level crossing deaths in Victoria over the past 5 years. Acting for the Chief Commissioner of Police in respect of the Kerang inquest, the VGSO has assisted in informing the Coroner of the emergency management policies and practices of Victoria Police.

Closing submissions have now been filed by the interested parties to this inquest and the Coroner is in the process of preparing her findings.

This newsletter is provided for general information only. For further information or legal advice on any issues raised in this newsletter please contact:

Stephen Lee, Assistant Victorian Government Solicitor, Litigation & Dispute Resolution on 8684 0410 or stephen.lee@vgso.vic.gov.au

Antonio Mazzone, Managing Principal Solicitor on 8684 0418 or antonio.mazzone@vgso.vic.gov.au

David Ryan, Managing Principal Solicitor on 8684 0417 or david.ryan@vgso.vic.gov.au

Belinda Trevean, Managing Principal Solicitor on 8684 0415 or belinda.trevean@vgso.vic.gov.au

Anna English, Managing Principal Solicitor on 8684 0265 or anna.english@vgso.vic.gov.au

The VGSO is the primary source of legal services to the Victorian State Government and its statutory authorities, providing strategic advice and practical legal solutions.