

# Chapter 11

## Coronial and other agency information

### 11.1 INTRODUCTION

When a death is reported to the coronial system, an investigation of the circumstances is conducted. The investigation is usually conducted by the police department and coordinated by the Coroner's office. Other agencies, such as the Bureau of Air Safety Investigation (BASI) and OHS agencies, are called in for assistance when required, although they sometimes investigate a fatal incident independently of the Coroner.

Once the basic investigation has been conducted, the Coroner can take a number of different actions. That is, a death can be dealt with by the coronial system in a number of ways. The Coroner can conduct a formal inquest in which witnesses are called and evidence taken or can consider the facts without inquest (ie, dispense with the inquest).

Where a person is identified as having committed a prima facie criminal offence associated with the incident, the inquest/investigation is usually terminated and the death becomes a matter for the Department of Public Prosecutions. Coronial investigation may or may not recommence after the conclusion of court proceedings. The circumstances that would result in an inquest being held vary between jurisdictions, but inquests are more common in circumstances with high public interest and those with a number of difficult or complicated factors.

At the completion of the investigation, the Coroner makes a formal finding. This is usually in the form of a statement identifying the name of the deceased, the date and place of death and the pathophysiological cause of death. The circumstances are commonly also described, usually in a very brief fashion, but sometimes in great detail.

In some instances, there is no formal finding other than to state that an inquest has been dispensed with and that the circumstances were as described in the police report. The detail and format of the findings for the deaths considered in this study differed markedly between jurisdictions and between Coroners.

One of the Coroner's tasks is to make recommendations or 'riders' relevant to the case. These should only be made if they might help to prevent the occurrence of similar deaths or address a related matter of public interest<sup>305</sup>. Other investigating authorities also sometimes make recommendations, which may or may not be accepted by the Coroner.

Through this investigation process and the resultant recommendations, the Coroner has the ability to make an important contribution to the understanding and prevention of work-related traumatic death. As part of the coronial process, the Coroner accepts expert reports and testimony from appropriate persons and authorities, and considers any recommendations that they might make. Therefore, the presence of reports and recommendations from an OHS agency or other relevant authority in the coronial files provides an opportunity for important OHS matters to be properly considered by the Coroner. In light of these issues, this Chapter summarises information relevant to the way cases of work-related traumatic death are handled by the coronial system in Australia. Probably several hundred Coroners oversaw at least one of the cases included in the study. Approaches by individual Coroners are not considered in this analysis.

## 11.2 CORONIAL ACTION

Inquests were held in 56% of all working cases. The inquest was dispensed with for most other working cases. Inquests were most common (70% or more) in deaths of persons from the mining (75%), public administration (74%), fishing and hunting (70%) and manufacturing (70%) industries and least common for agriculture deaths (34%) (Table 11.1).

**Table 11.1 Coroner's action by industry - working deaths  
Percent. Australia, 1989 to 1992**

Industry	n <sup>1</sup>	Held <sup>2</sup>	Disp <sup>3</sup>	Term <sup>4</sup>	Other	NK <sup>5</sup>	Total
Agriculture	334	34	55	-	1	9	100
Forestry and logging	44	48	43	-	-	9	100
Fishing and hunting	60	70	20	2	2	7	100
Mining	138	75	20	2	1	2	100
Manufacturing	141	70	26	-	-	4	100
Electricity, gas and water	29	67	24	-	-	10	100
Construction	234	65	22	1	0	12	100
Wholesale and retail trades	118	53	32	3	-	11	100
Transport and storage	370	53	37	1	1	8	100
Communication	13	62	31	-	-	8	100
Finance, property and business services	48	46	44	2	-	8	100
Public administration	43	74	26	-	-	-	100
Defence	50	64	26	-	-	10	100
Community services	71	56	23	3	-	18	100
Recreation, personal and other services	85	65	29	2	-	4	100
Not known	9	33	67	-	-	-	100
<b>Total</b>	<b>1,787</b>	<b>56</b>	<b>34</b>	<b>1</b>	<b>1</b>	<b>8</b>	<b>100</b>

1: Number of persons in each industry category.  
2: Inquest held.  
3: Inquest dispensed with.

4: Inquest terminated.  
5: Coronial action not known.

There was considerable variation in the proportion of inquests for different mechanisms involved in the fatal incidents. Explosions (89%) and contact with electricity (72%) had the highest proportions, while incidents involving hitting objects (33%) and weapons (44%) had the lowest proportions (Table 11.2).

The proportion of cases with inquests also varied markedly between jurisdictions. In Tasmania, virtually all cases were the subject of a formal inquest, whereas New South Wales (38%) and South Australia (33%) had less than 40% of inquest cases. The other jurisdictions had inquests in about 60% to 70% of cases (Table 11.3).

**Table 11.2 Coroner's action by mechanism of fatal incident - working deaths. Percent. Australia, 1989 to 1992**

Mechanism of fatal incident	n <sup>1</sup>	Held <sup>2</sup>	Disp <sup>3</sup>	Term <sup>4</sup>	Other	NK <sup>5</sup>	Total
Falls	170	59	32	1	-	8	100
Hitting objects	15	33	60	-	-	7	100
Being hit by moving objects	505	56	33	2	0	9	100
Contact with heat or cold	16	63	38	-	-	-	100
Contact with electricity	117	72	21	-	1	6	100
Drowning	105	63	29	1	-	8	100
Explosion	19	89	11	-	-	-	100
Chemicals, other substances	29	55	31	-	7	7	100
Weapons	68	44	35	6	-	15	100
Slide/cave-in	17	65	24	-	-	12	100
Vehicle incident	653	53	38	1	1	8	100
Rollover	67	52	37	-	-	9	100
Other	1	100	-	-	-	-	100
Not known	5	40	40	-	-	20	100
<b>Total</b>	<b>1,787</b>	<b>56</b>	<b>34</b>	<b>1</b>	<b>1</b>	<b>8</b>	<b>100</b>

1: Number of persons in each mechanism category.

2: Inquest held.

3: Inquest dispensed with.

4: Inquest terminated.

5: Coronial action not known.

**Table 11.3 Coroner's action by jurisdiction - working deaths  
Percent. Australia, 1989 to 1992**

Jurisdiction	n <sup>1</sup>	Held <sup>2</sup>	Disp <sup>3</sup>	Term <sup>4</sup>	Other	NK <sup>5</sup>	Total
ACT	10	70	30	-	-	-	100
NSW	575	38	41	3	0	18	100
NT	52	71	29	-	-	-	100
QLD	427	59	38	-	0	3	100
SA	131	33	54	1	-	12	100
TAS	70	96	-	-	-	4	100
VIC	336	73	23	-	0	4	100
WA	186	72	24	-	3	1	100
<b>Australia</b>	<b>1,787</b>	<b>56</b>	<b>34</b>	<b>1</b>	<b>1</b>	<b>8</b>	<b>100</b>

1: Number of persons in each jurisdiction.

2: Inquest held.

3: Inquest dispensed with.

4: Inquest terminated.

5: Coronial action not known.

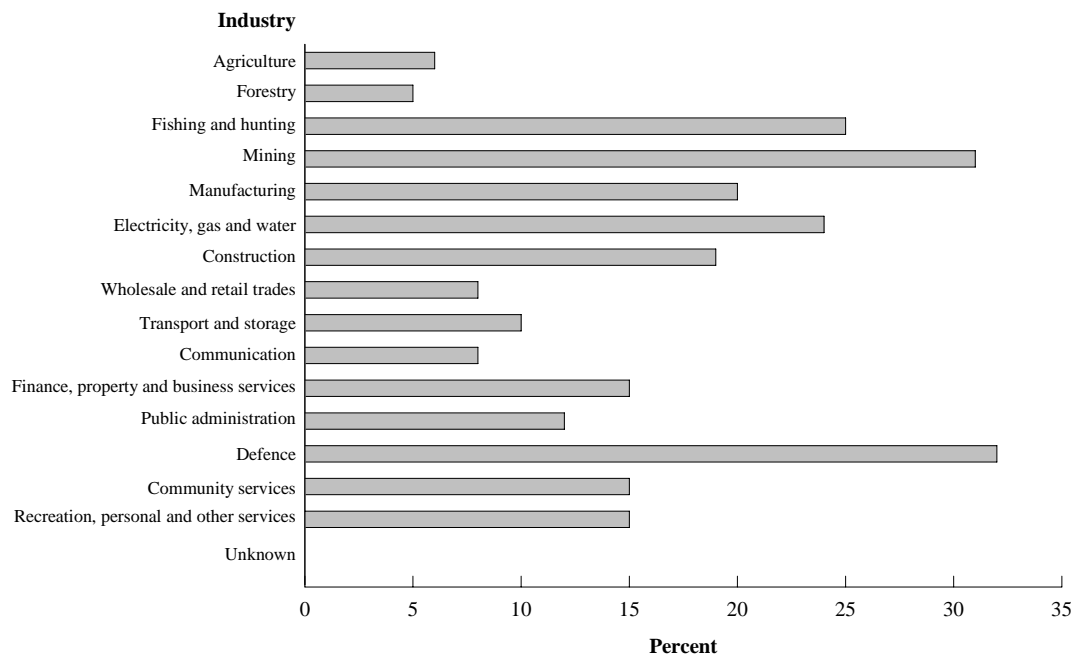
Deaths of employees (60%) were more likely to be the subject of inquest than deaths of self-employed persons (45%).

### 11.3 CORONIAL RECOMMENDATIONS

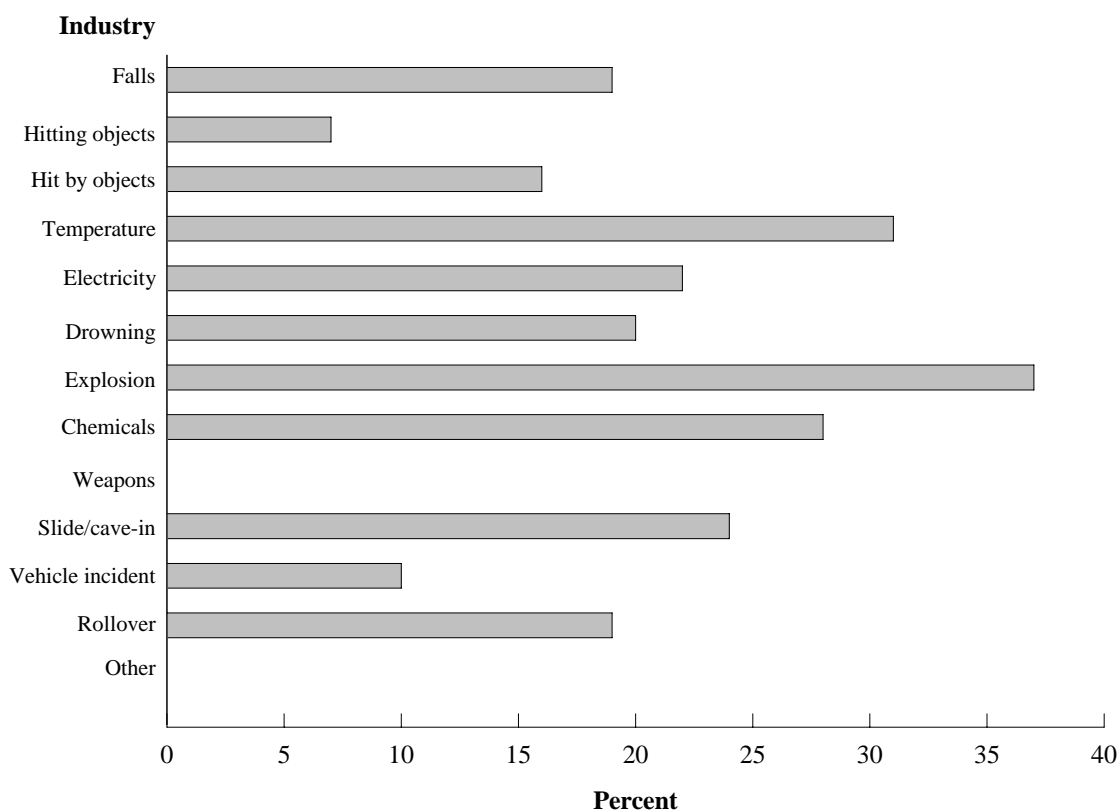
Recommendations were made by the Coroner in 272 working cases (15%). On an industry basis, recommendations were more common in defence (32%), mining (31%), fishing and hunting (25%) and electricity, gas and water (24%), and least common in forestry and logging (5%) and agriculture (6%). Incidents involving explosions (37%), contact with heat or cold (mainly fires: 31%), contact with chemicals and other substances (again commonly in fires: 28%) and slide or cave-ins (24%) had the highest proportion of cases where recommendations were made. Incidents involving weapons (0%), hitting objects (7%) and vehicle incidents (10%) had the lowest proportion of cases with recommendations made. Western Australia (37%), Victoria (28%) and the Northern Territory (23%) had the highest proportion of cases for which recommendations were made, while there were no recommendations made for any of the Australian Capital Territory cases (Figures 11.1 – 11.3 and Tables 11.4 – 11.6). The

recommendations were most commonly made to the employer (42%), the State or Territory government (28%) or the relevant OHS agency (21%). Sometimes the Coroner targeted one particular group with the aim of that group disseminating the recommendations more widely (Table 11.7).

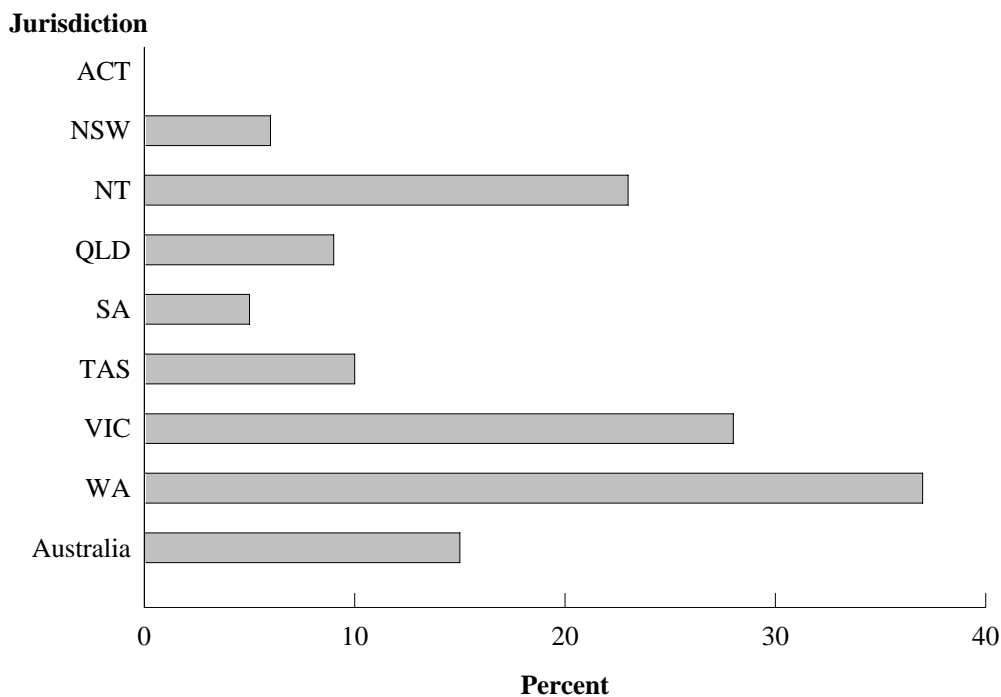
**Fig 11.1 Recommendations by the Coroner by industry - working deaths Percent. Australia, 1989 to 1992**



**Fig 11.2 Recommendations by the Coroner by mechanism of the fatal incident  
Working deaths. Percent. Australia, 1989 to 1992**



**Fig 11.3 Recommendations by the Coroner by jurisdiction - working deaths  
Percent. Australia, 1989 to 1992**



**Table 11.4 Recommendations by the Coroner and other specialist authorities by industry - working deaths. Percent. Australia, 1989 to 1992**

Industry	n <sup>1</sup>	Coroner <sup>2</sup>	Other specialist authority <sup>2</sup>
Agriculture	334	6	3
Forestry and logging	44	5	2
Fishing and hunting	60	25	8
Mining	138	31	33
Manufacturing	141	20	2
Electricity, gas and water	29	24	14
Construction	234	19	6
Wholesale and retail trades	118	8	-
Transport and storage	370	10	4
Communication	13	8	-
Finance, property and business services	48	15	2
Public administration	43	12	-
Defence	50	32	26
Community services	71	15	1
Recreation, personal and other services	85	15	6
Not known	9	-	11
<b>Total</b>	<b>1,787</b>	<b>15</b>	<b>7</b>

1: Number of persons in each industry category.

2: Each case could have recommendations made by both the Coroner and a specialist authority.

**Table 11.5 Recommendations by the Coroner and other specialist authorities by mechanism of fatal incident - working deaths Percent. Australia, 1989 to 1992**

Mechanism of fatal incident	n <sup>1</sup>	Coroner <sup>2</sup>	Other specialist authority <sup>2</sup>
Falls	170	19	5
Hitting objects	15	7	20
Being hit by moving objects	505	16	7
Contact with heat or cold	16	31	6
Contact with electricity	117	22	15
Drowning	105	20	14
Explosion	19	37	21
Chemicals, other substances	29	28	7
Weapons	68	-	1
Slide / cave-in	17	24	12
Vehicle incident	653	10	4
Rollover	67	19	1
Other	1	-	-
Not known	5	-	-
<b>Total</b>	<b>1,787</b>	<b>15</b>	<b>7</b>

1: Number of persons in each mechanism category.

2: Each case could have recommendations made by both the Coroner and a specialist authority.

**Table 11.6 Recommendations by the Coroner and other specialist authorities by jurisdiction - working deaths  
Percent. Australia, 1989 to 1992**

Jurisdiction	n <sup>1</sup>	Coroner <sup>2</sup>	Other specialist authority <sup>2</sup>
ACT	10	-	10
NSW	575	6	6
NT	52	23	12
QLD	427	9	4
SA	131	5	8
TAS	70	10	-
VIC	336	28	4
WA	186	37	19
<b>Australia</b>	<b>1,787</b>	<b>15</b>	<b>7</b>

1: Number of persons in each jurisdiction.

2: Each case could have recommendations made by more than one of the Coroner and a specialist authority.

**Table 11.7 Target groups for coronial recommendations – working deaths  
Number and percent<sup>1</sup>. Australia, 1989 to 1992**

Target groups	Number	%
Employer	115	42
State government	75	28
OHS authority	57	21
Other specialist authority	38	14
Federal government	29	11
Manufacturers	25	9
Unions	21	8
Employer associations	18	7
Local government	13	5
NOHSC	8	3
Standards Australia	8	3
Emergency services	7	3
Employees	7	3
Relevant industry groups	7	3
Retailers	4	1

1: Percentage of cases with recommendations that had recommendations targeted to each group. Each case could have had recommendations made to more than one group.

## **11.4 OTHER SPECIALIST AUTHORITIES**

Other specialist authorities, such as transport groups, BASI, mines inspectorates and marine safety authorities, investigated some of the deaths and made recommendations in 7% of all working deaths. Such recommendations were more common in mining and defence force deaths, fatal incidents involving explosions or hitting objects, and in incidents that occurred in Western Australia.

## **11.5 OHS REPORTS**

In 34% of the 1,787 working deaths, the incident was investigated by the OHS agency in the relevant jurisdiction and the OHS report was present in the coronial file.

Information provided by the OHS agencies showed that they officially recorded 35% of all working deaths (excluding the Australian Capital Territory and Western Australia – see Chapter 10). These results suggest that the OHS agencies investigate nearly all fatal incidents which are officially recorded and the resultant report nearly always is incorporated into the relevant coronial files. (Discrepancies between the results presented in this Chapter and in Chapter 10 arise from the fact that the Australian Capital Territory and Western Australia are excluded from the OHS-compensation analysis but are included in the analysis for this Chapter).

The presence of OHS reports varied widely with duty context, being present in the coronial file of 8% of fatal incidents that occurred on a public roadway and 45% of workplace fatalities. Manufacturing (63%), construction (62%), forestry and logging (55%) and electricity, gas and water (55%) industry deaths had OHS reports in more than half of the relevant coronial files. In contrast, OHS reports were in the coronial file

of 30% or less of the majority of industry groups (Table 11.8), but note that specialist authorities rather than OHS agencies tend to investigate incidents for some industries.

**Table 11.8 OHS reports in the coronial file: presence and recommendations by industry - working deaths. Number and percent. Australia, 1989 to 1992**

Industry group	n <sup>1</sup>	Report present <sup>2</sup>	Recommendations present – all files <sup>3</sup>	Recommendations present – OHS reports <sup>4</sup>
Agriculture	334	34	11	32
Forestry and logging	44	55	18	33
Fishing and hunting	60	22	22	100
Mining	138	30	7	21
Manufacturing	141	63	28	44
Electricity, gas and water	29	55	24	38
Construction	234	62	31	47
Wholesale and retail trades	118	31	11	35
Transport and storage	370	18	6	32
Communication	13	15	8	50
Finance, property and business services	48	27	15	54
Public administration	43	23	9	40
Defence	50	6	4	100
Community services	71	20	8	43
Recreation, personal and other services	85	21	12	50
Not known	9	22	-	-
<b>Total</b>	<b>1,787</b>	<b>34</b>	<b>14</b>	<b>40</b>

1: Number of persons in each industry category.

2: Percentage of coronial files with an OHS authority report present.

3: Percentage of coronial files with recommendations in an OHS authority report.

4: Percentage of OHS authority reports that contained recommendations.

There was also marked variation with the mechanism of the fatal incident, with OHS reports being present in a high proportion of coronial files relevant to rollovers of mobile machinery (76%) and slide or cave-ins (71%), but a low proportion of coronial files relevant to motor vehicle incidents (9%) and incidents involving weapons (3%) (Table 11.9). OHS agency reports were more likely to be present in coronial files in Tasmania (56%) and the Northern Territory (40%) than in the coronial files of other jurisdictions (Table 11.10).

**Table 11.9 OHS reports in the coronial file: presence and recommendations by mechanism of fatal incident**  
**Working deaths. Number and percent. Australia, 1989 to 1992**

Mechanism of fatal incident	n <sup>1</sup>	Report present <sup>2</sup>	Recommendations present – all files <sup>3</sup>	Recommendations present – OHS reports <sup>4</sup>
Falls	170	53	31	57
Hitting objects	15	20	-	-
Being hit by moving objects	505	53	23	41
Contact with heat or cold	16	25	-	-
Contact with electricity	117	61	27	42
Drowning	105	17	8	44
Explosion	19	53	11	20
Chemicals, other substances	29	52	21	40
Weapons	68	3	3	100
Slide/cave-in	17	71	35	50
Vehicle incident	653	9	2	20
Rollover	67	76	22	29
Other	1	-	-	-
Not known	5	-	-	-
<b>Total</b>	<b>1,787</b>	<b>34</b>	<b>14</b>	<b>40</b>

- 1: Number of persons in each mechanism category.
- 2: Percentage of coronial files with an OHS authority report present.
- 3: Percentage of coronial files with recommendations in an OHS authority report.
- 4: Percentage of OHS authority reports that contained recommendations.

**Table 11.10 OHS reports in the coronial file: presence and recommendations by jurisdiction - working deaths**  
**Number and percent. Australia, 1989 to 1992**

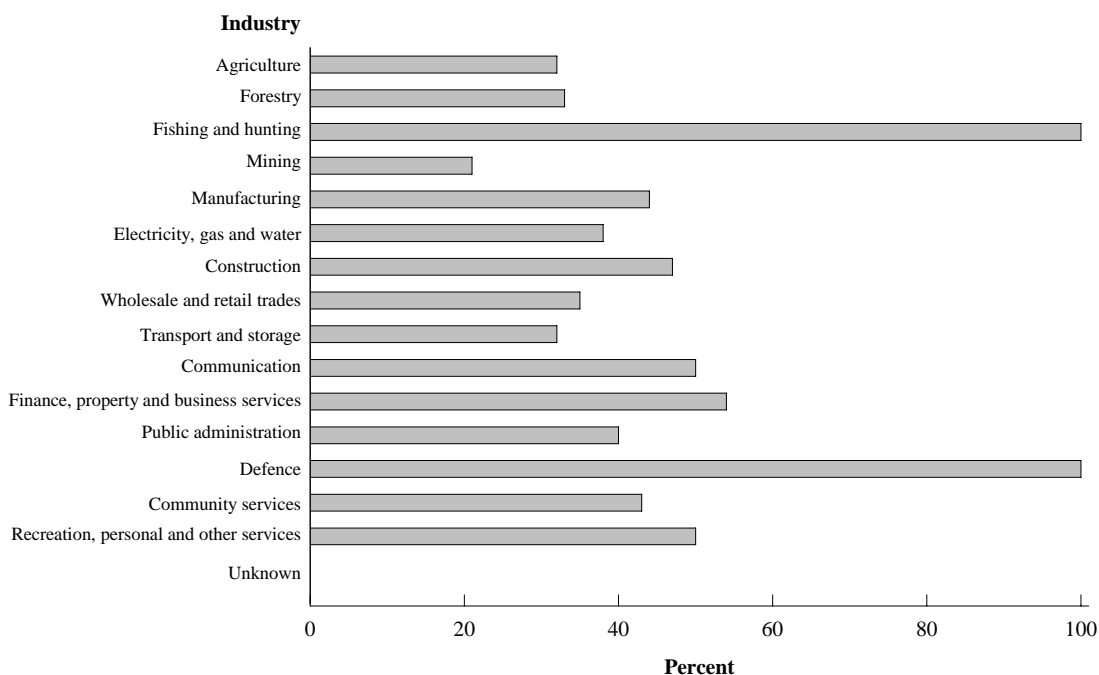
Jurisdiction	n <sup>1</sup>	Report present <sup>2</sup>	Recommendations present – all files <sup>3</sup>	Recommendations present – OHS reports <sup>4</sup>
ACT	10	30	-	-
NSW	575	33	21	59
NT	52	40	27	62
QLD	427	30	7	23
SA	131	29	7	24
TAS	70	56	-	-
VIC	336	38	11	29
WA	186	33	24	71
<b>Australia</b>	<b>1,787</b>	<b>34</b>	<b>14</b>	<b>40</b>

- 1: Number of persons in each jurisdiction.
- 2: Percentage of coronial files with an OHS authority report present.
- 3: Percentage of coronial files with recommendations in an OHS authority report.
- 4: Percentage of OHS authority reports that contained recommendations.

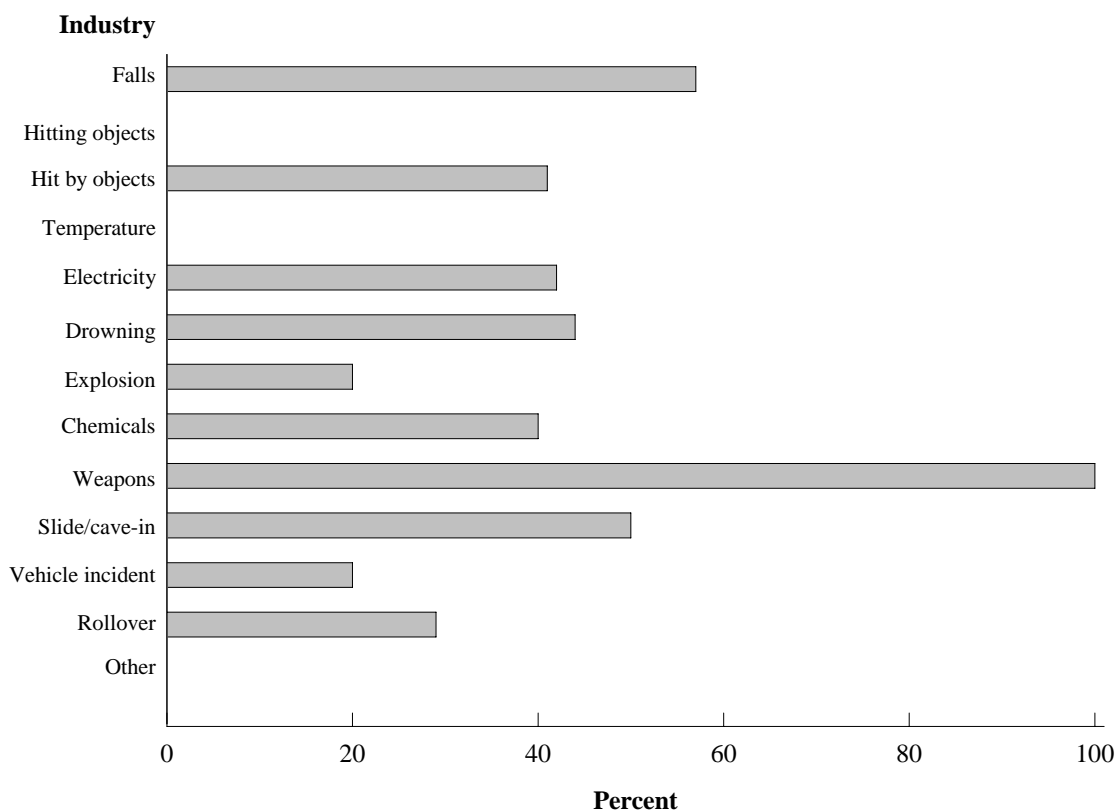
Overall, there were recommendations from an OHS agency in the coronial file for 14% of working cases. The distribution of OHD recommendations by industry was similar to that for coronial recommendations, except that there were rarely recommendations from an OHS agency for defence and mining industry deaths, and more commonly recommendations from an OHS agency for forestry and logging deaths. Explosions, fires (included in the contact with heat or cold category) and drownings were far less likely to have OHS agency recommendations, but the proportions for other mechanisms were fairly similar to that of the coronial recommendations. Western Australia, New South Wales and the Northern Territory had the highest proportions of incidents with OHS agency recommendations.

Since only 34% of coronial files of working deaths contained an OHS agency report, another useful way of looking at the OHS agency recommendations is to look at the proportion of OHS agency recommendations in coronial files which contained OHS agency reports. Recommendations were present in 40% of the OHS reports in the coronial files of working cases. Recommendations were less likely to be in the reports concerning deaths in the mining, agriculture, forestry and logging, and transport and storage industries; and in incidents involving explosions, vehicular incidents and rollovers. Recommendations were much more likely to be in the OHS reports from New South Wales, the Northern Territory and Western Australia (Figures 11.4 – 11.6 and Tables 11.8 – 11.10).

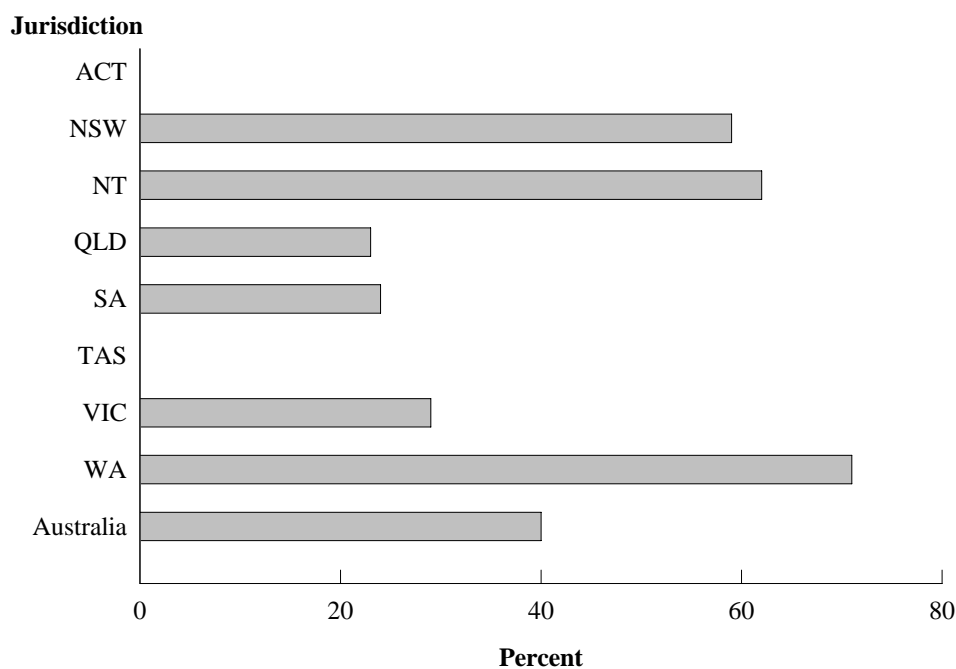
**Fig 11.4 OHS reports with recommendations in the coronial files by industry Working deaths. Percent. Australia, 1989 to 1992**



**Fig 11.5 OHS reports with recommendations in the coronial files by mechanism of the fatal incident - working deaths. Percent. Australia, 1989 to 1992**



**Fig 11.6 OHS reports with recommendations in the coronial files by jurisdiction Working deaths. Percent. Australia, 1989 to 1992**



## 11.6 CONTENTS OF CORONERS' FILES

As described in Chapter 3, there were a large number of different document types in coronial files. The following comments apply only to working cases. Some document types were present in most files in all jurisdictions (eg post mortem report, witness statements). Other document types were present in some of the files in nearly all jurisdictions (eg findings were present in less than half of the files for New South Wales working cases, but in 80% or more of files in other jurisdictions; a police report to the Coroner was present in only 58% of the files for Queensland working cases, but in 80% or more of files in other jurisdictions) (Table 11.11).

**Table 11.11 Documents present in coronial files by jurisdiction – working deaths  
Percent. Australia, 1989 to 1992**

<b>Document</b>	<b>ACT n = 10</b>	<b>NSW n = 575</b>	<b>NT n = 52</b>	<b>QLD n = 427</b>	<b>SA n = 131</b>	<b>TAS n = 70</b>	<b>VIC n = 336</b>	<b>WA n = 186</b>	<b>Australia n = 1,787</b>
Finding	90	45	100	80	81	99	93	97	74
Recommendation	0	6	23	9	5	10	28	36	15
Inquest transcript – all files	30	24	54	48	20	17	45	31	35
Inquest transcript – if inquest <sup>1</sup>	42	59	73	80	60	18	59	42	60
Police notification	70	94	96	64	59	46	85	93	81
Police report to the Coroner	80	81	98	58	90	91	82	92	78
Other police report	30	27	37	20	53	20	22	54	29
Post mortem report	80	93	92	91	97	93	94	95	93
Toxicology report	40	70	62	57	76	87	78	86	71
OHS authority report	30	33	40	30	29	56	38	33	34
Witness statement	70	80	98	62	94	90	89	90	80
Other report	20	24	79	34	29	33	25	32	30
Other document	0	35	58	54	40	63	53	60	48

1: Percentage of coronial files for inquest cases which contained a transcript of the inquest.

## **11.7 BYSTANDERS**

Inquests were held for 170 of the workplace bystander deaths (52%), with the inquest dispensed with for nearly all the rest. Coronial recommendations were made in 57 of the deaths (18%). An OHS report was present in 41 of the relevant coronial files (13%), and 24 of these (59% of OHS reports, 7% of all deaths) contained recommendations in the report. This lack of coverage of bystander deaths by the OHS system is discussed in more detail in Chapter 10.

## **11.8 DISCUSSION**

There was considerable variation in the way that particular types of cases of work-related traumatic death were handled within the coronial system. The proportion of cases for which inquests were held or recommendations made by the Coroner varied depending on the industry, occupation, mechanism and jurisdiction involved in the fatal incident. The usefulness of inquests as opposed to non-inquest investigations for work-related traumatic death is open to debate, since detailed investigations can take place without having to conduct an inquest. Recommendations are usually only made if there is a relevant area that the Coroner feels is in need of change or comment.

If it is accepted that recommendations make a contribution to the prevention of similar incidents, then the results from this study suggest that some areas of OHS are not benefiting as much as they might from the work of the coronial system and that there is scope for improvement.

There was also variation in the presence and quality of documents within the coronial files, which affects the availability of the information, and the reliability of the

information, required to appropriately identify work-related deaths and the surrounding circumstances. This variation in the quantity and quality of information in coronial files has been noted in other coronial systems<sup>20, 65</sup>, and probably partly arises from the variability in the qualifications and experience of Coroners (or their equivalent, such as medical examiners), and the resources available to them<sup>306, 307</sup>. The availability of toxicology results in this study (about 70% of deaths of working deaths) compares favourably with the availability of these results in studies of United States work-related deaths (about 24%)<sup>308</sup>.

Although only about one third of work-related traumatic deaths are investigated by an OHS agency, it appears that in most of these cases the relevant report is made available to the Coroner. This helps to place OHS issues in front of the Coroner for consideration. However, the proportion of OHS reports containing recommendations varied along similar lines to that of the Coroner, again highlighting a difference between the treatment of various types of work-related death by the investigating authorities.

## **11.9 CONCLUSIONS**

The administrative approach to work-related deaths differs between Coroners' systems in different jurisdictions, and appears to vary with the circumstances of the fatal incident. Inquests were held into about half of the work-related deaths of workers, and recommendations were made by a Coroner in 15% of such cases. Recommendations were made by OHS authorities or other agencies in a minority of cases.