IN THE CORONERS COURT

AT MELBOURNE

CORONIAL INVESTIGATION OF 29 LEVEL CROSSING DEATHS[1]

RULING on the Interpretation of Clause 7(1) of Schedule 1 of the *Coroners Act* 2008

Summary

I am the coroner responsible for investigating 29 deaths that occurred in circumstances where a train and a motor vehicle collided on a level crossing in Victoria (the "level crossing deaths"). All these deaths occurred between 2002 and 2009 when the *Coroners Act* 1985 (the "Old Act") was in operation.

On 11 December 2008, the Governor of Victoria assented to the *Coroners Act* 2008 (the "New Act"). On 1 November 2009, it came into operation. The New Act changes the focus of coronial investigations. In particular, it requires the coroner to now consider public health and safety issues and avoid unnecessary duplication of inquiries and investigations.

However, the Saving and Transitional Provisions in Schedule 1 of the New Act have led to some uncertainty about the law governing my on-going investigation of the level crossing deaths because Clause 7(1) provides:

> *"Subject to clause 10, if the hearing of an inquest has begun under the old Act and the inquest is not completed before the commencement day, the old Act continues to apply on and from the commencement day to the inquest."* [2]

On the assumption that no Inquest had commenced on 1 November 2009, I have said that my continuing investigation of the level crossing deaths is now proceeding under the New Act and, accordingly, I expect to focus on public health and safety issues and avoid unnecessary duplication of work undertaken by other organisations and individuals.

[1] Adam Dunnning, Adrian Kiely, Ian Pettersen, Victor Greensill, Gwenda Glasson, Anthony Massaria, James Gordon, Harold Long, Nicholas Parker, Matthew Stubbs, Jean Webb, Rosanne McMonnies, Geoffrey McMonnies, Stephanie Meredith, Danielle Meredith, Chantal Meredith, Jaeseok Lee, Margaret Wishart, Geoffrey Young, Kay Stanley, Fiona Smart, Haldane Nelson, Michael Boyd, Caitlin Angel, Susan Angel, Maram Yousif, Jillian McCormack, Julie Love and Mark Winter.

[2] Clause 7(1) of Schedule 1 *Coroners Act* 2008.

However, if I am wrong and a Directions Hearing held on 15 October 2009 to discuss the on-going management of my investigations of the level crossing deaths constituted the commencement of an Inquest, subsequent Inquests will remain governed by the Old Act. Further, if an Inquest includes all the continuing investigation of the level crossing deaths, these investigations will also come under the Old Act. In practice, the Old Act will limit my capacity to implement the public health and safety provisions of the New Act and to rely on the outcomes of existing investigations of level crossing collisions.

Therefore, these rulings are intended to address any legal ambiguity that may interfere with the on-going management of the coronial investigation of the level crossing deaths.

Ruling 1

I rule that the Directions Hearing held on 15 October 2009 to discuss the on-going management of my investigations of the level crossing deaths did not constitute commencement of a coronial Inquest for the purposes of Clause 7(1) of Schedule 1 of the *Coroners Act* 2008 because it did not include taking of evidence from witnesses or discussion of the facts of the level crossing deaths and no decisions were made about which level crossing death investigations would include taking of evidence at a formal hearing.

Ruling 2

I rule that an Inquest does not include all of a coronial investigation even when that investigation includes a formal hearing. Further, even if I am wrong about the nature of the Directions Hearing held on 15 October 2009 to discuss the on-going management of my investigations of the level crossing deaths, all continuing coronial investigations of the level crossing deaths will be undertaken subject to the New Act.

Accordingly,

Ruling 3

I rule that the *Coroners Act* 2008 applies to all coronial proceedings and administrative and investigative activities that occur after 1 November 2009 as part of the coronial investigation of the level crossing deaths including investigations, inquests, directions hearings and any other interlocutory or preliminary proceedings and related activities.

Background

The role of modern coroners has evolved from an ancient office established in England in 1194 to investigate death and collect taxes. Coroners have had a preventative role in relation to death as far back as the 1300's.

In Victoria, the *Coroners Act* 1985 (the "Old Act") replaced the *Coroners Act 1958.* The Old Act came into operation on 12 February 1986.

The purposes of the Old Act included:

"(a) establish the Office of State Coroner;

(b) require the reporting of certain deaths;

(c) set out the procedures for investigations and inquests by coroners into deaths and fires;…"

Further, the Old Act specifically excluded historical interpretations of the role of coroners:

> ***"Common law rules to cease to have effect***
>
> *A rule of the common law that, immediately before the commencement of this section, conferred a power or imposed a duty on a coroner or a coroner's court ceases to have effect."*

However, it did not exclude the possibility of interpretations of the Old Act by the Supreme Court after 1985.[3]

The Old Act required coroners to investigate reportable deaths unless they were also reviewable deaths[4] to determine if possible the identity of the deceased, how death occurred, the cause of death and the particulars needed to register the death under the *Births Death & Marriages Registration Act* 1996.[5] Although coroners performed an administrative rather than a judicial function[6], they retained a duty to act judicially and were required to comply with the rules of natural justice.[7] Accordingly, exercise of the coronial power was subject to administrative review and the Old Act provided parties with specific avenues of review on the merits to the Supreme Court of Victoria.[8]

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[3] S 4 *Coroners Act* 1985.
[4] S. 15(1) *Coroners Act* 1985.
[5] S.19 *Coroners Act* 1985.
[6] See for example, *Harmsworth v The State Coroner* [1989] VR 989.
[7] *Annetts v McCann* [1990] HCA 57; *Musumeci v Attorney-General of New South Wales* (2003) 57 NSWLR 193.
[8] Ss 5, 18, *28, 29, 30, 35, 59, 59B Coroners Act* 1985.

The Old Act also limited the authority and independence of coroners by providing the State Coroner with the power to give to a coroner directions about an investigation into a death, other than an Inquest and the manner of conducting it.[9] The Supreme Court further limited the breadth of the coroners' jurisdiction to investigate a reportable death by requiring the coroner to hold a reasonable belief that there might be a causal nexus or relationship between the requirements of section 19 of the Old Act and their investigation.[10]

Further, the Supreme Court of the Australian Capital Territory expressed this limitation in relation to similar provisions [11]:

"A line must be drawn at some point beyond which, even if relevant, factors which come to light will be considered too remote from the event to be regarded as causative. The point where such a line is to be drawn must be determined not by the application of some concrete rule, but by what is described as the "common sense" test of causation affirmed by the High Court of Australia in March v E & MH Stramare Pty Ltd (1991) 171 CLR 506. The application of that test will obviously depend upon the circumstances of the case and, in the context of a coronial inquiry, it may be influenced by the limited scope of the inquiry which, as we have mentioned, does not extend to the resolution of collateral issues relating to compensation or the attribution of blame."[12]

On 11 December 2008, the Governor of Victoria assented to the *Coroners Act* 2008 (the "New Act"). On 1 November 2009, it came into operation. In passing the New Act, the Parliament expressed its intention:

"Our coronial system must take a broad public health approach to investigation to clarify on the public record the causes and circumstances of death, to provide public hearings into those matters where it is appropriate and to draw lessons from deaths so as to minimise the risks of recurrence, where possible, in the future."[13]

Further, the Attorney General said:

"The bill highlights, for the first time, that the preventive work of the coroner is an important function of the Coroners Court. The bill contains, as one of its purposes, to

[9] S.16 *Coroners Act* 1985.
[10] *Harmsworth v The State Coroner* [1989] VR 989; *Grace v Saines (as Coroner)* [2004] VSC 229; *R v Doogan* [2005] ACTSC 74.
[11] S. 52(1) ACT *Coroners Act* 1997.
[12] *R v Doogan* [2005] ACTSC 74.
[13] Hulls, Second Reading Speech, Parliament of Victoria, Hansard, 9 October 2008, p. 4033.

reduce the number of preventable deaths and fires through the findings of investigation of deaths and fires.

In addition, the bill provides that the coroner will now be able to make recommendations to any entity rather than being restricted to ministers and public statutory authorities...."[14]

The purposes of the New Act include:

"(a) to require the reporting of certain deaths; and

(b) to provide for coroners to investigate deaths and fires in specified circumstances; and

(c) to contribute to the reduction of the number of preventable deaths and fires through the findings of the investigation of deaths and fires, and the making of recommendations, by coroners; and

(d) to establish the Coroners Court of Victoria as a specialist inquisitorial court..."

Further, as relevant, the New Act established:

- The Coroners Court of Victoria;
- The role of coroner as a judicial officer;
- The coroner's statutory role to now specifically include contributing to reduction of the number of preventable deaths; and
- Coroners' authority to hold an Inquest that investigates two or more deaths.

Section 7 of the new Act also provides:

"Avoiding unnecessary duplication

It is the intention of Parliament that a coroner should liaise with other investigative authorities, official bodies or statutory officers—

(a) to avoid unnecessary duplication of inquiries and investigations;..."

Further, section 8(f) requires the Coroner to have regard for public health and safety in exercising his or her role. Consistent with their new role as judicial officers, the New Act does not provide the State Coroner with power to direct coroners in their investigations or specifically exclude the influence of common law on the way in which they perform their duties and exercise their powers.

[14] Hulls, Second Reading Speech, Parliament of Victoria, Hansard, 9 October 2008, p.4037.

On 22 February 2008, the State Coroner asked me to continue the coronial investigation of a cohort of level crossing deaths that have occurred as the result of a number of collisions between a train and a motor vehicle in Victoria that occurred after 2001 other than the deaths that occurred as the result of the Kerang incident and any subsequent level crossing deaths that arose before 1 January 2010. In April 2009, she also delegated to me responsibility for investigating the 11 deaths arising from the Kerang incident.

This means that I am now responsible for investigating 29 deaths that arose from 15 level crossing incidents in Victoria between 2002 and 16 July 2009 (the "level crossing deaths").[15] The coronial investigation of these incidents all began under the Old Act when they were reported to the State Coroner, usually on the day they occurred.

On 15 October 2009, I held a Directions Hearing in relation to the level crossing deaths (Transcript: Attachment 6). At that time, I had still not received police briefs for three level crossing deaths. In three cases, surviving drivers had been acquitted of criminal charges. In another, criminal charges remained on foot. Since then, the surviving driver has pleaded guilty to dangerous driving causing death and been sentenced to a non-custodial sentence.[16] I have now also completed my investigations of the deaths of Michael Boyd and Julie Love by way of Chambers Findings because, on the basis of the evidence provided to me by pathology, police and other investigators, I determined they were intentional deaths.

On 3 May 2010, I held a further Directions Hearing in which I confirmed that the Inquest which is part of my investigation of the 11 level crossing deaths that arose from the Kerang level crossing incident would proceed and arranged for the first eight days of that Inquest to be listed commencing on 18 January 2011 in Kerang. I also listed further hearing days in the Kerang Inquest commencing in July 2011 and indicated that the Trawalla Inquest would proceed after that, probably in January 2012. Other Inquests would be listed later.

The Saving and Transitional Provisions of the New Act have led to some uncertainty about the law governing the on-going investigation of the level crossing deaths. I have said that I am proceeding as if the New Act applies to all my work after 1 November 2009 and, accordingly, I expect to focus on public health and safety issues in my continuing investigation of level crossing deaths including Inquests.

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[15] The deaths of James Gordon and Haldane Nelson have been investigated by the Geelong coroner but, after discussion with him, they have been included in the cohort in order to reduce duplication of work.

[16] The brief in relation to this incident involving two deaths remains outstanding.

However, if the Directions Hearing on 15 October 2009 constituted the commencement of an Inquest in any of my investigations of the level crossing deaths, subsequent Inquests will remain governed by the Old Act. Further, if an Inquest includes all the continuing investigation of the level crossing deaths, these investigations will also come under the Old Act. In practice, the old Act will limit my capacity to implement the public health and safety provisions contemplated by the New Act and alter my capacity to rely on existing evidence from the trials of surviving drivers and other level crossing investigations.

Accordingly, on 3 May 2010 I indicated that, unless otherwise persuaded, I expected the New Act to apply in all the Inquests associated with the level crossing deaths and called for submissions from interested parties who disagreed with this intention. Submissions in relation to the legislation that applies to the on-going coronial investigation into level crossing deaths have been received from:

- John McDonald for the Safety Institute of Australia
- Ross Ray QC and Robert Taylor for VicRoads
- DS Mortimer and EA Bennett for Public Transport Safety Victoria
- Michael Moorhead for Gwen Bates
- Mary Anne Hartley, SC, Sara Hinchey, Trevor Wraight, Richard Niall and Louise Johnson for VicTrack, the Department of Transport, Ambulance Victoria, VLine and the Department of Human Services (the "joint submission") (Attachment 1).

Submissions in reply were also received from

- Louise Johnson for the Department of Human Services
- Mary Anne Hartley, SC, and Sara Hinchey for Department of Transport and VicTrack
- Ross Ray QC and Robert Taylor for VicRoads (Attachment 2).

This Ruling includes the recent history of my investigation of level crossing deaths in Victoria to provide context to my response to these submissions and my decision about the legal source of my jurisdiction for the on-going investigation of level crossing deaths including the Inquests. This is a crucial decision in my investigation of level crossing deaths because, if I am wrong, the underlying justification for my investigation is wrong

and actions I take which are inconsistent with the alternative legislation could be *ultra vires* and void.[17]

In summary, contrary to the submissions made by lawyers for VicRoads, VicTrack, the Department of Transport, Ambulance Victoria, V-Line and the Department of Human Services and adopted by lawyers for Canny's Carrying Co.,[18] I have determined that the New Act applies to my on-going investigation of the level crossing deaths including Inquests and other formal hearings.

Recent History of the Coronial Investigation of the Level Crossing Deaths

On 14 September 2009, all interested parties and a number of other investigative authorities, official bodies and individuals were notified that I had decided to list a Directions Hearing for 15 October 2009. The invitation to the Directions Hearing stated:

> *"This Directions Hearing is* ***not*** *an Inquest and no evidence will be taken on that day. Rather, at this hearing, Coroner Hendtlass intends to:*
>
> - *Explain that she proposes to hold three individual Inquests as part of her investigation of the 29 level crossing deaths. In these Inquests, Coroner Hendtlass intends to clarify facts that remain uncertain and make recommendations which are intended to help prevent deaths in which one or more of the following issues caused or contributed to the death:*
>
>   1. *Human factors;*
>   2. *Infrastructure factors;*
>   3. *Heavy vehicle combination factors including the emergency medical response to incidents involving multiple deaths in regional Victoria.*
>
> - *Identify the individuals and organisations who will be seeking leave to be represented at or otherwise participate in these three Inquests;*
>
> - *Make clear that information relevant to the investigations of the other 26 level crossing deaths will be included in the information she will consider in the three Inquests. However, she expects to close these investigations with Chambers*

[17] See for example, *R v Kirby; Ex parte Boilermakers' Society of Australia ("Boilermakers' case")* [1956] HCA 10; (1956) 94 CLR 254; *Gantley Pty Ltd & Ors v Phoenix International Group Pty Ltd & Anor* [2010] VSC 106; *Project Blue Sky*.

[18] Email dated 2 June 2010:
"I feel that the issues have all been fully ventilated by other parties and we therefore did not make any submissions on our client's behalf. We look forward to Her Honour's decision in due course."

Findings that review the facts of and identify the issues contributing to the death with the Recommendations from the relevant Inquests attached;

- *Confirm the policy reviews and case based reports and investigations that have been undertaken by relevant road, rail and health agencies;*
- *Ascertain what other on-going research and investigations are continuing and the time-lines for their completion so that they can be integrated into the investigation and Inquest plan;*
- *Seek input into the issues that have not been investigated and/or implemented fully and would attract useful coronial input without further duplication of resources;*
- *Establish a working plan for the procedures to be applied in listing the Inquests and determining witnesses; and*
- *Any other necessary matters that are raised by the Coroner or the parties.*

You are welcome to attend this Directions Hearing or send a representative to attend on your behalf.

However, you do not need to come to this hearing.... "[19]

Further, on 13 October 2009, the State Coroners Office issued a Press Information Statement (Attachment 3) to explain the purpose of the planned Directions Hearing on 15 October 2009. This information statement stated:

"A directions hearing is not an inquest. A directions hearing is an opportunity for all parties to appear before the coroner and raise any issues they believe ought to be included for further investigation at a subsequent inquest. A directions hearing also ensures that all parties wishing to be legally represented have proper, non-conflicting representation.

Dates for the inquests into these matters will not be set until after the directions hearing....

It is not anticipated that separate inquests will be held as part of the coroner's investigation of each individual death.

[19] The joint and VicRoads submissions state that this letter indicates the intention to deal with substantial rather than administrative matters. VicRoads also says that the statement that the hearing was not an Inquest seems more of an explanation that there was no intention to take evidence on the day, than to have been based on a proper use of the word "inquest".

Instead the inquests will follow three main areas of inquiry of the issues that may have caused or contributed to level crossing deaths including;

- *Infrastructure issues*
- *Heavy vehicle combinations including the emergency response to incidents involving multiple deaths in regional Victoria*
- *Human factor issues.*

The inquest process can be very distressing for the families involved and we ask all parties to respect their needs and privacy during this time."

On 15 October 2009, I opened the Directions Hearing by indicating I intended to use it to clarify the current status of my investigation into the level crossing deaths, discuss how the investigation will proceed and explain some of the issues that would arise from the introduction of the *Coroners Act* 2008 (see Transcript, Attachment 6). I also indicated that I had not finally decided which investigations would include an Inquest but my current view was that an Inquest would comprise part of my investigation of the Kerang and Stanley deaths. As Counsel for VicRoads stated:

"The final point, of course, is this; the final breakdown or grouping that Your Honour has foreshadowed, may be the subject of, and I'm sure it will be in fact, the subject of further submission to you from us, so that we can assist you in an appropriate structure to move forward. We can't make that final decision, as you indeed haven't at the moment....[20]."

At the Directions Hearing, I also sought submissions about whether there was any reason not to include these deaths or to include any other deaths in the Inquests that would become part of my investigation of level crossing deaths and I invited parties to make applications for an Inquest in two or three weeks if they had a particular preference. However, in the course of the Hearing, the date for filing these applications and this advice was set at 15 November 2009 to enable parties to access and further review the files of the current documents in the investigations of the level crossing deaths. Further extensions were subsequently granted where appropriate. No issues were raised in relation to applicable legislation.[21]

[20] Transcript, 15 October 2009, p. 13.
[21] VicRoads and the joint submissions say that, by commencing my investigation of substantive matters at the Directions Hearing on 15 October 2009, I began the Inquest.

On about 6 November 2009 and 1 April 2010, the Coroners Court formally requested VicRoads, Department of Transport, VicTrack, Public Transport Safety Victoria, Mainco Signal Maintenance, V/Line Passenger Service Pty Ltd, Ambulance Victoria, Emergency Services Commissioner, Office of the Chief Investigator, Municipal Association of Victoria and the Department of Human Services[22] to provide a number of documents including investigation reports, maintenance records and a statement from a senior manager. Public Transport Safety Victoria, Metro on behalf of Mainco Signal Maintenance, Ambulance Victoria, Emergency Services Commissioner, Office of the Chief Investigator, Municipal Association of Victoria and the Department of Human Services have all complied with these requests. They did not raise any issues in relation to applicable legislation.[23]

On 18 November 2009, DLA Phillips Fox for VicRoads sought clarification of our request for documents and an extension in the time for their delivery. On 25 November, DLA Phillips Fox was served with the Form required under section 42 of the *Coroners Act* 2008 with a letter that granted an extension and included *inter alia*:

> *"The Coroner is aware that her request requires considerable work. However, she reminds you that her role is wider than determining cause of death. In particular, she must also determine if possible the circumstances of the death. Further, the Coroners Act 2008 came into operation on 1 November 2009. Section 8 (f) of the Coroners Act 2008 requires her to have regard for public health and safety in exercising her role."*

On 1 February 2010, VicRoads provided documents which complied with this request. They did not raise any issues in relation to applicable legislation.

Further, on 19 November 2009, Minter Ellison for the Department of Transport and VicTrack wrote to indicate that the briefs provided to them by the Coroners Court were incomplete and requesting access to a number of documents they said were missing. In a second letter dated 19 November 2009, they reserved their rights in relation to the request to provide maintenance records because they said:

> *"...there appears to be no suggestion that maintenance issues were in any way causative of or related to the deaths under investigation by the Coroner."*[24]

They did not raise any issues in relation to applicable legislation.

[22] See s.42 *Coroners Act* 2008.
[23] Information from some of these agencies had also been provided earlier in response to previous requests under the Old Act.
[24] The Coroner was aware from other documents included in the brief and made available to Minter Ellison that a length of track close to the Kerang level crossing had been replaced on the morning of the incident.

On 25 November 2009, the Coroners Court responded to Minter Ellison confirming their request for maintenance records and stating *inter alia*:

"Maintenance Records and other Information

The Coroner accepts that VicTrack Ltd has no role in arranging maintenance at level crossings except that, as registered owner of the land, it must enforce contractual obligations of its lease to the Director of Transport and the Director's further lease of the land to transport operators and others. These contracts include maintenance and infrastructure requirements.

Gwen Bates has already provided the Coroner with copies of a number of documents including the Westinghouse Tender offer dated 27 October 2005, the allocation letter from VicTrack dated 23 December 2005,and the Tender Document VTO213. However, the Coroner is keen to ensure that the documents she works with are a complete record of events.

Therefore, she has asked me to re-word her request to VicTrack for the following documents:

1. *A statement from the appropriate VicTrack senior manager which includes and describes, amongst other things, changes in infrastructure for all level crossings included in the cohort in the year prior to the incident until now.*

2. *Copies of reports to VicTrack from the lessors of VicTrack land about fatal incidents, maintenance and changes to infrastructure for all level crossings included in the cohort in the year prior to the incident until now.*

This request is repeated in the attached Form required under section 42 of the Coroners Act 2008.

Further, the Coroner reminds you that her role is wider than determining cause of death. In particular, she must also determine if possible the circumstances of the death. Further, the Coroners Act 2008 came into operation on 1 November 2009. Section 8 (f) of the Coroners Act 2008 requires her to have regard for public health and safety in exercising her role. In the absence of evidence from your clients, she is unable to determine whether or to what degree maintenance issues arose in the circumstances of the deaths she is investigating and whether or not maintenance is a public health and safety issue.

Accordingly, the Coroner is of the opinion that maintenance records and reports held by your clients and statements from appropriate personnel are required for her investigations..." See Attachment 4.

On 15 January 2010, Minter Ellison partially complied with the request to provide documents and statements but they did not provide any maintenance records. Further, for the first time, they asked to be heard in relation to the applicable statute at a suitable time.

On 28 April 2010, Minter Ellison repeated their request to be heard in relation to the applicable statute and suggested the matter be dealt with by way of written submissions. No other parties made a similar request.

On 17 March 2010, applicants for Inquests in relation to the Kerang and Trawalla incidents, and the Mark Winter and the Kay Stanley deaths were advised that I intended to grant their application to hold an Inquest. Other applicants were informed that I had still not decided whether or not to hold an Inquest in relation to my investigation of the death of their loved one.

On 7 April 2010, the Coroners Court sent a letter inviting the interested parties to a second Directions Hearing and indicating that I had changed my mind with respect the way in which the Inquests in to the level crossing deaths would be listed.

At the Directions Hearing on 3 May 2010, I informed the parties that I had accepted their concerns about listing the Inquests under topics rather than particular incidents or deaths and that I had decided to list sequentially two of the Inquests associated with incidents involving multiple deaths that is those that occurred at Kerang and Trawalla. I also said I had decided to complete the other multiple injury incident by way of a Chambers Finding. Further, I confirmed that I intended to hold Inquests in my investigations of the Stanley and Winter deaths and these would commence after the Kerang and Trawalla Inquests were completed. Therefore, they were unlikely to be listed until at least 2012.

On 3 May 2010, I also indicated that I expected to list other Inquests but I remained undecided about which other deaths would proceed by way of Inquest. In particular, I confirmed I that had received an application for an Inquest into the death of Anthony Massaria and that I had formally indicated to the next of kin that I was still undecided about whether to grant their application.

Accordingly, on 3 May 2010, I directed listing of the Inquest into the Kerang incident in which 11 people died to commence on 18 January 2011 and invited parties to make

submissions by 3 June 2010 about whether the provisions of the New Act or the old Act should apply to the conduct of Inquests which will be part of some of the coronial investigations of the level crossing deaths (see Attachments 1 & 2).

The Law Relating to Coronial Investigation of Level Crossing Deaths

The Saving and Transitional Provisions of the New Act provide, *inter alia*:

> ***"Inquest commenced under old Act***
>
> *(1) Subject to clause 10, if the hearing of an inquest has begun under the old Act and the inquest is not completed before the commencement day, the old Act continues to apply on and from the commencement day to the inquest.*
>
> *(2) Despite subclause (1), the findings of an inquest completed under that subclause are deemed to be findings made under section 67 or 68 (as appropriate) of the New Act...."*[25]

Therefore, if the Directions Hearing on 15 October 2009 constituted the beginning of any or all of the Inquest/s that will be part of my investigation of level crossing deaths, all further hearings including examination of witnesses will be governed by the Old Act.

In the alternative, if the Directions Hearing on 15 October 2009 was part of the work undertaken as part of the preliminary coronial administration and investigation and did not constitute an opening of the Inquest, further investigations including examination of witnesses in an Inquest will be governed by the New Act.

In circumstances where the New Act was assented to on 11 December 2008 and came into operation on 1 November 2009, the law that governs its interpretation and application is contained in the Saving and Transitional Provisions of the New Act as well as the Old Act, the *Interpretation of Legislation Act* 1984, the *Charter of Human Rights and Responsibilities Act* 2006 and the common law.

New Act

1. The Saving and Transitional Provisions of the New Act include:

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[25] Cl.7, Schedule 1 *Coroners Act* 2008.

*"**General transitional provisions***

(1) This Schedule does not affect or take away from the ***Interpretation of Legislation Act 1984****.*

(2) Without limiting subclause (1), in declaring that certain provisions of the New Act are to be treated as re-enacting with modifications certain provisions of the old Act, this Schedule must not be taken to limit the operation of any provision of the ***Interpretation of Legislation Act 1984*** *relating to the re-enactment.*

(3) This Schedule applies despite anything to the contrary in any other provision of the New Act."

Therefore, in determining the meaning and effect of the New Act, the *Interpretation of Legislation Act* 1984 takes precedent over any other rules of statutory interpretation.

2. The definition of Inquest under the New Act is:

   "a public inquiry that is held by the Coroners Court in respect of a death or fire."

   Therefore, it follows that the Directions Hearing on 15 October 2009 could never be described as an "inquest" under the New Act because the Coroners Court did not exist prior to the commencement of the New Act.[26]

3. However, determination of whether or not the level crossing Directions Hearing constituted an Inquest for the purposes of the Saving and Transitional Provisions of the New Act depends on interpretation of the meaning of 'Inquest' in the Old Act in the context of the circumstances which applied on 15 October 2009 including the nature and substance of the hearing.[27]

<u>*Interpretation of Legislation Act* 1984</u>

4. Section 35 of the *Interpretation of Legislation Act* 1984 imposes an interpretation of a statute which gives precedent to the purpose of the legislation:

   Principles of and aids to interpretation

   In the interpretation of a provision of an Act or subordinate instrument—

[26] See VicRoads, Public Transport Safety Victoria and the joint submissions, Attachment 2.
[27] See for example, *CIC Insurance Ltd v Bankstown Football Club Ltd* (1997) 187 CLR 384; *Network Ten Pty Ltd v Channel Nine Pty Ltd* (2004) 205 ALR 1; *Insurance Commission of Western Australia v Container Handlers Pty Ltd* (2004) 206 ALR 335.

(a) a construction that would promote the purpose or object underlying the Act or subordinate instrument (whether or not that purpose or object is expressly stated in the Act or subordinate instrument) shall be preferred to a construction that would not promote that purpose or object...

5. The High Court considered the application of equivalent Commonwealth legislation[28] to inconsistencies between the specific requirements of different provisions of the *Broadcasting Services Act* 1901 (Cth.) ("*Project Blue Sky*").[29]

   The majority of the High Court in *Project Blue Sky* held:

   > *"The primary object of statutory construction is to construe the relevant provision so that it is consistent with the language and purpose of all the provisions of the statute[30]. The meaning of the provision must be determined "by reference to the language of the instrument viewed as a whole"[31]. In Commissioner for Railways (NSW) v Agalianos[32], Dixon CJ pointed out that "the context, the general purpose and policy of a provision and its consistency and fairness are surer guides to its meaning than the logic with which it is constructed". Thus, the process of construction must always begin by examining the context of the provision that is being construed[33]."*

6. Therefore, in interpreting Schedule 1 of the New Act, a construction which promotes the purpose of the New Act as a whole should be preferred over a construction which restricts that purpose.[34]

7. The purposes of the New Act differ from the purposes of the Old Act in their intention:

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[28] S. 15AA of the *Acts Interpretation Act* 1901 (Cth).
[29] *Project Blue Sky* v *Australian Broadcasting Authority* (1998) 194 CLR 355; 153 ALR applied for example in *Goulburn-Murray Rural Water Authority v Rawalpindi Nominees Pty Ltd & Reid* [2010] VSC 166.
[30] See *Taylor v Public Service Board (NSW)* [1976] HCA 36; (1976) 137 CLR 208 at 213 per Barwick CJ.
[31] *Cooper Brookes (Wollongong) Pty Ltd v Federal Commissioner of Taxation [1981] HCA 26;* (1981) 147 CLR 297 at 320 per Mason and Wilson JJ. See also *South West Water Authority v Rumble's* [1985] AC 609 at 617 per Lord Scarman, "in the context of the legislation read as a whole".
[32] [1955] HCA 27; (1955) 92 CLR 390 at 397.
[33] *Toronto Suburban Railway Co v Toronto Corporation* [1915] AC 590 at 597; *Minister for Lands (NSW) v Jeremias [1917] HCA 41;* (1917) 23 CLR 322 at 332; *K & S Lake City Freighters Pty Ltd v Gordon & Gotch Ltd [1985] HCA 48;* (1985) 157 CLR 309 at 312 per Gibbs CJ, 315 per Mason J, 321 per Deane J.
[34] e.g. The Safety Institute of Australia Inc submits that, for policy reasons, the New Act should be adopted as consistent with the public and Parliamentary intention to be preventative rather than punitive. Further, they say that the New Act more comprehensively provides for investigations into multiple deaths and the subtle difference in wording between section 54 of the Old Act and section 56 of the New Act appears to pick upon Recommendation 60 of the Law Reform Committee report, in promoting accident prevention by allowing the participation of interested parties with specialist knowledge.

"to contribute to the reduction of the number of preventable deaths and fires through the findings of the investigation of deaths and fires, and the making of recommendations, by coroners."

8. Further, section 13 of the *Interpretation of Legislation Act* 1984 includes:

"Exercise of powers between passing and commencement of Act

(1) This section applies where an Act or a provision of an Act which does not come into operation immediately on the passing of the Act will, on its coming into operation, confer power or amend another Act so as to confer power under the other Act as so amended to—

(a) make subordinate instruments or any other instruments of a legislative or administrative character; or

(b) give notices; or

(c) make appointments; or

(d) establish a body; or

(e) prescribe forms; or

(f) do any other thing—

for the purposes of that Act or provision or that other Act.

(2) Unless the contrary intention appears, the power may be exercised at any time after the passing of the Act but its exercise does not confer a right or impose an obligation on a person before the coming into operation of the Act or provision except insofar as is necessary or expedient for the purpose of—

(a) bringing the Act or provision into operation; or

(b) making the Act or provision or the other Act as amended fully effective at or after that coming into operation.

(3) Without limiting subsection (2), an appointee may exercise a power, and a body may meet and exercise a power, under that subsection before the coming into operation of the Act or provision in the same manner and subject to the same conditions or limitations (if any) and with an entitlement to payment of the same remuneration or allowances (if any) as if the Act or provision were in operation.

(4) For the purposes of any provision as to the duration of the term of office of an appointee (including a member of a body), that term does not begin until the coming

into operation of the subordinate instrument or provision despite the exercise of any power under this section before that coming into operation."[35]

9. Therefore, in the absence of a contrary intention in the New Act[36], the *Interpretation of Legislation Act* 1984 enables a coroner to exercise new powers in anticipation of the New Act at any time after its assent. Further, it confers a right to exercise those powers insofar as is necessary or expedient for the purpose of bringing the New Act into operation or making the New Act fully effective at or after 1 November 2009.

   By implication, this authority must include the authority to continue investigating a death, obtaining information about health and safety issues associated with the deaths in order to make Findings, Comments and Recommendations consistent with the purposes of the New Act and holding a Directions Hearing in anticipation of Inquests which were expected to be held after 1 November 2009 and could be listed as late as 2012.

   Therefore, the coroner's power to call Directions Hearings and request documents under the New Act was able to be exercised on 15 October 2009. Further, although no specific directions were made at the Directions Hearing on 15 October 2009, a coroner had power to make those directions in anticipation of the operation of the New Act.

10. Construction of the Saving and Transitional Provisions of the New Act and interpretation of the relevant provisions of the Old Act must be undertaken in the context of the imminent operation of the New Act which includes the new purpose to promote health and safety by making Findings and Recommendations.

Charter of Human Rights and Responsibilities Act 2006

11. Section 31 of the *Charter of Human Rights and Responsibilities Act* 2006 requires a Court to:

    "So far as is possible all statutory provisions must be interpreted in a way that is compatible with human rights."

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[35] VicRoads and the joint submissions and the Department of Transport and VicTrack submission in reply submit or imply that Old and the New Acts and s. 35 of the *Interpretation of Legislation Act* 1984 articulate the applicable legislative provisions in determining the questions.

[36] On the contrary, cls 9 – 14, 17& 20 of Schedule 1 of the New Act indicate an active intention to transition to the New Act from 1 November 2009 and no regulations have been made under cl 19 of Schedule 1 of the New Act.

12. Therefore, to the extent that there is any doubt that the New Act applies to Inquests relating to the level crossing deaths, interpretation of the law in the Coroners Court must give effect to the public health and safety provisions of the New Act.[37]

13. Further, consistent with Australia's international obligations under the Universal Declaration of Human Rights and the International Covenant on Civil and Political Rights and section 9 of the *Charter for Human Rights and Responsibilities Act* 2006, the Second Reading speech for the New Act indicated that the new coronial system was intended to give effect to the right to life.

14. The Court of Appeal in England has determined that, in circumstances in which the government is responsible for providing appropriate safety measures, this obligation requires the coroner to conduct an Inquest that investigates not only the immediate circumstances of the death but also the possibility of systemic failure on the part of the authorities to protect life. In England this is called an Article 2 Inquest which refers to Article 2 of the *European Convention of Human Rights* (the right to life).[38]

15. Therefore, by analogy, in order to comply with the State's requirement to protect the right to life, an Inquest in relation to the level crossing deaths must address broader systemic and prevention issues that may have contributed to the death as provided under the New Act.[39]

The Old Act

16. The Old Act defined an Inquest:

    ""inquest" includes a formal hearing;"

    The Directions Hearing on 15 October 2009 was a formal hearing and the plain words of the definition, taken in isolation, would seem to decide the matter.

17. Further, the Old Act defined an investigation:

    ""investigation" includes an inquest;"

    Section 4 stated:

    "Common law rules to cease to have effect

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[37] See Stanley submission Attachment 2.
[38] *Secretary of State for Defence v The Queen (on the application of Mrs Catherine Smith) and others* [2009] EWCA Civ 441.
[39] This interpretation contradicts that in VicRoads submission in reply which argues that an inquest commenced under the Old Act satisfies the requirements of the right to life.

A rule of the common law that, immediately before the commencement of this section, conferred a power or imposed a duty on a coroner or a coroner's court ceases to have effect."

Section 44 also stated:

"A coroner holding an inquest is not bound by the rules of evidence and may be informed and conduct an inquest in any manner the coroner reasonably thinks fit."

Therefore, on its face, the statutory definition of 'inquest' in the Old Act taken together with the definition of 'investigation' and sections 4 and 44, could mean that the entire coronial investigation is an 'inquest' if it ultimately involves a formal hearing.

<u>Common Law</u>

18. The High Court has indicated that the meaning of particular words needs to be considered as 'meaning', 'meaning and context' and 'meaning intention and purpose'. [40]

"Meaning is always influenced, and sometimes controlled, by context...

The words "intention", "contemplation", "purpose", and "design" are used routinely by courts in relation to the meaning of legislation. They are orthodox and legitimate terms of legal analysis, provided their objectivity is not overlooked...

meaning is the ordinary meaning conveyed by the text "taking into account its context in the Act and the purpose or object underlying the Act", or to resolve ambiguity or obscurity, or to determine the meaning of a provision when the ordinary meaning of the text leads to manifest absurdity or unreasonableness." [41]

In particular, the High Court concluded that the essence of the meaning of 'alien' was a shifting concept determined by what they called the "ordinary meaning" at the time it was applied.

19. Therefore, the ordinary meaning of Inquest under the old Act as it applied to the Directions Hearing on 15 October 2009, can be considered by asking two questions:

- Did the Directions Hearing on 15 October 2009 constitute commencement of an Inquest for the purposes of Schedule 1 of the New Act?

[40] *Singh v Commonwealth* (2004) 222 CLR 322.

[41] *Singh v Commonwealth* ibid per Gleeson CJ. And see also Gummow, Hayne and Heydon JJ.

- Does an Inquest mean all of a coronial investigation if it includes a formal hearing?

The answers to these two questions are somewhat inter-dependent but they will be addressed separately wherever possible.

<u>Did the Directions Hearing on 15 October 2009 constitute Commencement of an Inquest for the purposes of Schedule 1 of the New Act?</u>

20. VicRoads and the joint submissions state that the letter of invitation to the Directions Hearing on 15 November 2009 indicated:

> *"that the intention was to deal with substantial matters that were not merely administrative in nature."*

21. VicRoads also assert:

> *"The statement that the hearing was not to be an inquest seems more to be an explanation that there was no intention to take evidence on the day, than to have been based on a proper use of the word the word "inquest"...*
>
> *The use of the word "inquest" appears to refer to an evidentiary hearing...*
>
> *This suggests that the Coroner was using the word "inquest" in a colloquial way, rather than giving it its technical legal meaning".*

22. In contrast, Public Transport Safety Victoria accepts that it is arguable that the Directions Hearing on 15 October 2009, was not the commencement of an Inquest because of :

> *"the clear and express intention of the Coroner that the October directions hearing should not constitute an Inquest."*[42]

[42] See also the press information statement (Attachment 3) and the letter of invitation to the Directions Hearing on 15 October 2009 (See above)

23. VicRoads and the joint submissions and, in the alternative, Public Transport Safety Victoria also say that the Directions Hearing on 15 October 2009 was a formal hearing which dealt with *"substantial matters and were not merely administrative in nature"* and therefore the Directions Hearing constituted the commencement of an Inquest.[43]

24. Public Transport Safety Victoria, VicRoads and the joint submission all submit that, *"by commencing my investigation of substantive matters at that time"* at a formal hearing I began the Inquest. Accordingly, they say the law can be interpreted to mean that the inquest has begun under the Old Act.

25. Public Transport Safety Victoria also cite a Federal Court determination that the word "hearing" can equally refer to a directions hearing or an interlocutory hearing or a hearing on its merits.[44]

    However, I note that this matter was decided in the context of an application for documents prior to the trial and interpretation of s.50 of the *Federal Court of Australia Act* 1976 which provides:

    > *"The Court may, at any time during or after the hearing of a proceeding in the Court, make such order forbidding or restricting the publication of particular evidence, or the name of a party or witness, as appears to the Court to be necessary in order to prevent prejudice to the administration of justice or the security of the Commonwealth."*

    And the Federal Court's determination in *Hadid v Lenfest Communications Inc & Others* was made in the context of and consistent with the Rules of the Federal Court.[45]

26. In contrast, VicRoads and the joint submission accept that there may be circumstances in which it can be said that a Coroner at a directions hearing is clearly not commencing an

[43] Vic Roads and the joint submissions say these substantive/ substantial issues were constituted by the fact that the coroner:
"a. Announced her intended framework for the hearings and issues (by category) into which she intended to inquire.
b. Indicated that she had considered the investigation materials in detail, and formed preliminary views about cause and circumstance of various incidents (which formed the basis for the categorisation of issues) and would shape the form of the inquest.
c. Asked the parties present to provide her with documents.
d. Invited the parties to make submissions about how to categorise the incidents and which incidents ought to be the subject of hearings in each category. (The submissions were required by 31 October 2010, the day before the commencement of the New Act).
e. Identified that one of the matters involved a suicide, and that a finding in that matter would be made in chambers.
f. Asked the parties to provide Her Honour with information about investigations and research that were being carried out by those parties, along with the time lines for their completion.
g. Asked parties to confirm what changes had occurred at level crossings included in this cohort.
*a.(*sic*) Asked the parties for the most relevant and up to date standards and policies."*

[44] *Hadid v Lenfest Communications Inc & Others* (1996) 70 FCR 403.

[45] O1 r 4 of the Federal Court Rules: "*...hearing includes any hearing before the Court, whether final or interlocutory, and whether in open court or in chambers*".

Inquest (for instance, by simply making arrangements for the viewing of exhibits or distribution of a brief, or setting a hearing timetable).

27. However, the plain words of the definition of Inquest under the old Act were inconsistent with use of the word 'inquest' in other parts of the old Act. For example, section 15(2) required a coroner to investigate a reportable death but section 17(2) provided a coroner who has jurisdiction to investigate a death with the discretion to hold an Inquest if the coroner believes it is desirable.

    Further, section 18 of the Old Act provided for applications for an Inquest to be heard and applications to the Supreme Court if this application was refused. It seems inconceivable that this provision intended the Inquest to be constituted by a Directions Hearing of the type held on 15 October 2009.[46]

28. Therefore, applying section 35 of the *Interpretation of Legislation Act* 1984, "inquest" in the Old Act did not include all formal hearings or all investigations and it is necessary to attempt to define "inquest" by its usual or common meaning in the context of the coronial jurisdiction.

29. In 1995 Parliamentary proceedings to amend the Old Act, the Second Reading Speech assumed that the Inquest would address so-called 'public issues':

    > *"Clearly, a coroner's role is different from that of a judge and jury hearing criminal charges. A coroner's investigation is concerned with public civilian issues while the criminal law judicial process is concerned with determining whether a person is guilty or innocent of a criminal charge. However, there is no purpose in conducting an inquest in cases where all the public issues have been resolved by the criminal law judicial process. In many cases, the circumstances of a death, as much as they can be ascertained, will have been fully determined in the criminal proceedings...."* [47]

    The Attorney General's comments can be interpreted to indicate that the Parliament intended an Inquest to include calling of witnesses and, accordingly, it did not include a hearing with the character of that which occurred on 15 October 2009.

30. As a further indicator of common use, the current Macquarie Dictionary[48] definition of Inquest is:

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[46] See also s 17(2)2A) *Coroners Act* 1985
[47] Wade, Second Reading Speech, Coroners (Amendment) Bill 1985, Hansard, Legislative Assembly, 13 April 1995, p 837.
[48] Macquarie Dictionary, Fifth Edition, 2010.

"1. a legal or judicial inquiry, especially before a jury.

2. such an inquiry made by a coroner (coroner's inquest).

3 .the body of people appointed to hold such an inquiry, especially a coroner's jury.

4. their decision or finding....."

31. The current Macquarie Dictionary[49] definition of "inquiry" is:

"1. an investigation, as into a matter.

2. the act of inquiring, or seeking information by questioning; interrogation....".

Therefore, the usual use of the word "inquiry" includes investigation of a matter, questioning and interrogation that is provision of information in response to questions.[50]

32. "Jury" is defined as:

"a body of persons chosen at random from the community, who are engaged for a trial and sworn to deliver a verdict on questions of fact presented to them." [51]

Juries are not relevant to the Victorian coronial jurisdiction. However, their inclusion in the Macquarie definition helps to clarify the usual meaning of the word "inquest" and confirms the expectation that an Inquest will hear evidence upon which the decision maker can determine questions of fact.

33. Further, section 64 of the New Act assumes that an Inquest involves the calling of witnesses:

"Witnesses to be called and relevant issues

The coroner holding the inquest determines—

(a) the witnesses to be called; and

(b) the relevant issues for the purposes of the inquest." [52]

34. Therefore, applying the usual understanding of the words as evidenced by the plain words of the Old Act, the Second Reading Speech and Macquarie Dictionary and their use in the New Act, the proper use of the word "inquest" under the Old Act and the New Act requires a formal hearing at which witnesses are called and evidence is taken or, taken at its lowest,

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[49] Macquarie Dictionary, Fifth Edition, 2010.
[50] cf VicRoads and the joint submissions which also import the definition of "inquisition" to support their thesis that inquiries made by the Coroner are part of the inquisitorial process and therefore part of the "Inquest".
[51] Macquarie Dictionary, Fifth Edition, 2010.
[52] See s. 35 of the *Interpretation of Legislation Act* 1984 and *Project Blue Sky*.

facts are discussed which need to be determined in order for the coroner to fulfil his or her statutory role.

35. The VicRoads, Public Transport Safety Victoria and joint submissions also say that directions made by the coroner at the Directions Hearing on 15 October 2009, will be compromised under the New Act because of the operation of Clause 6 of the Schedule 1 of the New Act, under which they say that any directions the coroner made under the old Act ceased to have effect on and from 1 November 2009.

    However, the Saving and Transitional Provisions of the New Act provide that State Coroner's Directions to coroners about the investigation of reportable deaths made under sections 15A, 16, 17(1), 24, 33 or 34(2) of the Old Act have no on-going effect.[53] It makes no comment as to directions made by coroners and is therefore not relevant to this issue.

36. The Supreme Court of Victoria has also interpreted the definition of "inquest" in the Old Act as involving examination of witnesses:

    > *"An interested party (referred to in the Victorian Act as 'a person with a sufficient interest') has an absolute right to attend the inquest, to examine and cross-examine witnesses, and to be represented by counsel."*[54]

37. Further, the Supreme Court does not regard a Directions Hearing dealt with by consent and the giving of directions of an administrative nature without any controversy or contest as being "hearings".[55]

38. Similarly, the State Coroner has distinguished between a Directions Hearing and an Inquest:

    In her Practice Direction 4 dated 24 August 2009 (see Attachment 5), the State Coroner required all files provided by Coroners to Listings marked for Inquest for two days or more to have a Directions Hearing to address the resolution of preliminary issues such as:

    - The granting of leave to interested parties
    - Identification of issues
    - Confirmation of estimates as to hearing times and witnesses
    - Availability of court appointed witnesses

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[53] Cl.6, Schedule 1 *Coroners Act* 2008.
[54] *Barci v Heffey* 1/2/1995 (SCVic) 4306/95 (Beach J)
[55] *Anon2 v XYZ* [2008] VSC 466.

- Applications for privilege
- Distribution of documentary material
- Elimination of unnecessary witnesses and
- Booking video conferencing facilities.

In so doing, the State Coroner defined the types of issues that should be discussed at a Directions Hearing. Further, if she had not so distinguished between the two types of hearing, she would have been acting outside her statutory authority in directing coroners with respect to the manner of their conducting an Inquest.[56]

39. Further, in the first Directions Hearing of the so-called Broughton Hall coronial investigation, the State Coroner explained to the families:

> *"As is normal in an investigation of this nature by the Coroner, in particular one that has a number of complexities in it, it's very common for the Coroner to ask in the course of preparing for an inquest, to ask all of the interested people to come along to the court, sometimes on more than one occasion, to these directions hearings to try and do exactly that.*
>
> *In other words, give some directions about where the investigation is going, get some understanding of whether or not the issues that I think are the issues that need to be addressed once this investigation gets into its public forum, which is the inquest itself, that I'm aware of what all the issues are, to go through things like discussing the witness list, who should be called to give evidence and that of course will touch upon what the issues are for investigation, what the estimated time is for the hearing, whether there are statements that aren't contained in the brief, the collection of statements that I have already, whether there are statements that still need to come in, whether there are opinions that need to be obtained from experts, whether all of those people who are interested in having access to the documents that I have, know what documents I have and know what access they may or may not have.*
>
> *And that's not meant to be an exhaustive list of the sorts of things that happen at a directions hearing, but it just gives you a little sense of the sorts of issues that are generally raised.*

[56] S.16 *Coroners Act* 1985.

And it's also an opportunity for, in particular, family members who aren't directly represented to perhaps take the opportunity to raise some issues either with me or with counsel assisting me, to give me a sense of any issues that family members want to raise with the Coroner that, in my view, are worth pursuing or appropriate to pursue as part of this investigation. So that's a bit of a sense of what this procedure is about today." [57]

40 Therefore, on that occasion, the State Coroner confirmed her understanding that there is a distinction between a Directions Hearing and an Inquest and discussed the reasons for this distinction. Her opening comments indicate she did not consider she was commencing an Inquest.

41. At a second Directions Hearing on 9 November 2009, Her Honour also assessed applications for interested party status applying section 56 of the New Act, which seems to indicate she was applying the Inquest requirements of the New Act.[58]

42. In both these Broughton Hall Directions Hearings, the State Coroner went on to discuss issues which she subsequently characterised as not purely administrative in nature and starting to shape the Inquest. These issues included discussing the evidence of particular witnesses and hearing submissions on the basis of the existing evidence that certain individuals' deaths ought not be the subject of the inquiry.[59] She also heard comments from family members about the sequence of events surrounding their loved one's death in order to assist her in determining their cause of death.

43. On 17 February 2010, the State Coroner made a Ruling that the Broughton Hall Inquest commenced on 6 October 2009:

"I think the general view that's emerging with respect to the interpretation of these transitional provisions is once matters commence in the courtroom that the formal or public part of the hearing has commenced, unless the Coroner who's commenced the investigation has given a clear indication back to the parties that indeed the Coroner hasn't formed a particular view that there will be an inquest or that the Coroner has made it clear that I'm not commencing the inquest, I'm only conducting a continuing part of my investigation at this stage.

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[57] Transcript, Coroners Court Inquisition Melbourne upon the bodies of Thelma Hilton, Peter Nathan, Alfred Tarren, Murson Duston, Robert Wilson, 6 October 2009, pp. 3-4.

[58] Transcript, Coroners Court Inquisition Melbourne upon the bodies of Thelma Hilton, Peter Nathan, Alfred Tarren, Murson Duston, Robert Wilson, 9 November 2009, p. 60.

[59] For example, whether contaminating bacteria were identified in particular deceased person and whether that was associated with their cause of death.

Now, I certainly didn't do that. In fact, I think I probably did almost the opposite by indicating that I was starting to shape the inquest as at 6 October 2009. And I'd agree absolutely with what Mr Noonan's had to say about that. Some significant discussions took place about scope and the shape of it commenced as at 6 October 2009.

And when one looks at the definition of inquest in the old Act, as I've done, and what's contained in the New Act, I'm comfortable with taking a view in this particular investigation that I commenced on 6 October 2009, which means as far as Clause 7 of the schedule to the New Act states, that the inquest has commenced under the old Act and therefore the old Act continues to apply on and from that commencement date."[60]

44. In the course of this hearing, Her Honour also set down the Inquest for 12 April 2010, that is only two months later.

45. VicRoads and the joint submissions state that the State Coroner's Ruling in Broughton Hall supports their argument that the Directions Hearing on 15 October 2009 constitutes the commencement of the Inquest.

However, the press information statement (Attachment 3) and the letter of invitation to the Directions Hearing listed for the 15 October 2009 (see above) were explicit in my intention not to commence an Inquest. Further, in the course of the Directions Hearing, I indicated that one of the main reasons for holding Inquests in the level crossing deaths was to improve health and safety:

"It seemed to me that once the Kerang prosecution was over, it was time to sort of try and work out where to go next and pick up the momentum from my jurisdiction. So that's why we called the directions hearing today and you're all here as at my request. I also thought that for some people who don't understand the coronial system, I needed to explain a bit, again so we can be more or less as much as we can be on the same page. You need to understand that as a coroner, I operate under the Coroners Act. That's my source of jurisdiction and authority but it's also the limits of my jurisdiction of authority. I am required to find the identity of people who die and in this case, in a level crossing collision - the cause of death and to summarise the active circumstances surrounding the death. I may make recommendations and comments to people who - or organisations, in order to improve the safety of the system in a way.

[60] Transcript, Coroners Court Inquisition Melbourne upon the bodies of Thelma Hilton, Peter Nathan, Alfred Tarren, Murson Duston, Robert Wilson, 17 February 2010, p. 6.

I need to say to you all that the act includes a number of cases of situations where I must hold an inquest. A level crossing collision causing a death is not a mandatory inquest situation. I do not have to hold an inquest in any of these - to investigate any of these deaths and it's a matter of my discretion whether I do hold an inquest.

So that's the first thing to make really clear. There are other circumstances where it might be mandatory but in this case, it's not. I also need to make clear that I intend to investigate in any way that I think is reasonable, in order to find out the things that I am required to find, and that usually an inquest will only include the evidence where oral evidence is needed in order to - where it will assist me in order to clarify other issues.

I have to also say that usually, apart maybe from Kerang because of its size, we wouldn't be having inquests in a lot of these cases because the facts of the case have already been determined very effectively by the police in a way that if we were just doing it just to find the cause of death, the circumstances of the death, an inquest would not be needed. On the other hand, in order to do any of the extra things that we want to do, and particularly to improve the safety of the system, we do need inquests to hear oral evidence...

Also on 1 November, the new Coroners Act comes into place. That is going to change quite a lot - both the focus of all coronial investigations because now we are required to consider prevention and safety issues and rather than it being an adjunct that occurs afterwards. The other thing that will happen after that, after 1 November, is that all findings will be on the internet in inquest cases, so they're available to everybody after 1 November...

My current view is that I intend to hold three inquests to focus on specific prevention issues. I want to hold at least one of those inquests in regional Victoria. But that will in the end be a decision I will make based on which cases and how the administration occurs as well... ."

46. These comments confirm that I remained undecided as to which incidents would proceed by way of Inquest and the subject matter of any Inquest was not yet determined on 15 October 2009.[61] This was consistent with my expectation that the level crossing Inquests would proceed under the New Act.

[61] cf VicRoads submission in response.

47. Public Transport Safety Victoria also accepts that it is arguable that the Directions Hearing on 15 October 2009 was not the commencement of an Inquest because of:

> *"...the fact that the subject matter of any inquest was not yet determined in October 2009."*

48. Further, the reasoning in the State Coroner's Ruling in the Broughton Hall investigation does not apply to the Directions Hearing on 15 October 2009 because she specifically excluded circumstances where the coroner had made it clear that he or she was not commencing an Inquest and had not formed a clear view that there will be an Inquest in any particular investigation.

49. Also, with respect, in making her Ruling, Her Honour, did not seem to take into account the provisions of sections 13 and 35 of the *Interpretation of Legislation Act* 1984. Alternatively, if she did consider these provisions of the *Interpretation of Legislation Act* 1984, they were less relevant than they will be to the level crossing Inquests because the Broughton Hall Inquest commenced within two months of the Ruling. Therefore, the influence of the Old Act would not be perpetuated for a long period of time after commencement of the New Act.

50. Further, all the matters discussed at the Directions Hearing on 15 October 2009 were educative, administrative or procedural in character and all fell within the categories defined by the Supreme Court as preliminary matters and by the State Coroner as relevant to a Directions Hearing rather than an Inquest. None involved discussion of the factual situation in any of the incidents as occurred in the Directions Hearing in the Broughton Hall matter. Although some indications were given about the incidents and the issues that may be subsequently dealt with by way of Inquest, no final decisions were made until 17 March 2010. At that time, for logistical reasons, the plan to hold three inquests dealing with particular topics was also abandoned in favour of case-based inquests. Therefore, the decision about which statute applies in inquests in level crossing incidents applies to all Inquests.[62]

51. For all these reasons, the State Coroner's Ruling in Broughton Hall is distinguished from this Ruling in terms of its content and context.

52. Therefore, the Directions Hearing on 15 October 2009, was a formal hearing but no decision had been made about which deaths would proceed by way of formal evidence, no

[62] See Bates submission Attachment 1.

evidence was taken and planned categories of Inquests were not implemented. The Directions Hearing on 15 October 2009 did not attempt to answer any unanswered questions and dealt with administrative questions with consent of the parties, that is parties were not compelled to attend and administrative arrangements were agreed without objection. No evidence or discussion occurred about of the facts associated with the level crossing deaths. These characteristics of the hearing are not consistent with it being the commencement of an Inquest.[63]

53. Subsequent requests for documents and statements as part of the coronial investigation of the level crossing deaths complied with the requirements of the New Act and were acceded to until 15 January 2010, when Minter Ellison for the Department of Transport and VicRail, objected to providing maintenance records and sought to be heard with respect to the applicable statute.

54. Applying *Project Blue Sky* interpretation, the Directions Hearing on 15 October 2009, was not in breach of and did not constitute an Inquest under the Old Act or New Act. Therefore, under the *Interpretation of Legislation Act* 1984, it could not be construed to constitute commencement of an Inquest under the Old Act for the purposes of the Saving and Transitional Provisions of the New Act.

55. Further, even if the definition of the Inquest in the Old Act encompassed the Directions Hearing on 15 October 2009, the operation of section 13(1)(b) of the *Interpretation of Legislation Act* 1984 enables exercise of the coroner's powers under the New Act as is necessary or expedient for the purpose of bringing the New Act into operation or making the New Act fully effective at or after 1 November 2009.

Ruling 1

56. I rule that the Directions Hearing held on 15 October 2009, to discuss the on-going management of my investigations of the level crossing deaths did not constitute commencement of a coronial Inquest for the purposes of Clause 7(1) of Schedule 1 of the *Coroners Act* 2008 because, it did not include taking of evidence from witnesses, or discussion of the facts of the level crossing deaths and no decisions were made about which level crossing death investigations would include taking of evidence at a formal hearing.

[63] See VicRoads submission in reply.

Does an Inquest Mean All of a Coronial Investigation if it includes a Formal Hearing?

57. VicRoads and the joint submission assert that the Macquarie Dictionary definition of "inquest" includes an inquiry. During the Directions Hearing on 15 October 2009, I asked for:

> *"a. Information about investigations and research that was being carried out by those parties, along with the time lines for their completion.*
>
> *b. Details of the changes that had occurred at level crossings included in this cohort.*
>
> *c. The most relevant and up to date standards and policies"*

Therefore, they say this request constituted an inquiry and an Inquest was commenced by this so-called "inquiry".

58. With respect, this interpretation of the definition of 'inquiry' does not differentiate between a *'legal or judicial inquiry, especially before a jury' made* by a coroner which comprises an Inquest as defined in the Macquarie Dictionary (see above) and this administrative inquiry or a general request for information. It does not take into account the context within which a coroner undertakes his or her investigations. It does not operate to promote the purpose of the New Act as a whole. It presumes that the only evidence available to the coroner is that collected at the Inquest (see above).

Therefore, this request for information at the Directions Hearing on 15 October 2009 is not evidence that the Inquest had commenced.

59. On the contrary, the request for information at the Directions Hearing on 15 October 2009, indicates that the Inquest had not commenced because the information sought is required to allow me to make decisions about whether or not to hold an Inquest and what the scope of an Inquest should be. It is also consistent with the requirement under the New Act that I minimise duplication of investigations.

60. Section 16 of the Old Act also distinguished between coronial investigations and Inquests:

> ***"Directions by State Coroner***
>
> *The State Coroner may give to a coroner directions about an investigation into a death (other than an inquest) and the manner of conducting it."*

61. Similarly, section 17 of the Old Act distinguished between coronial investigations and Inquests:

> "*A coroner who has jurisdiction to investigate a death must hold an inquest if the body is in Victoria or it appears to the coroner that the death, or the cause of death, occurred in Victoria...*
>
> *A coroner who has jurisdiction to investigate a death may hold an inquest if the coroner believes it is desirable...* "

62. Further, although an Inquest can be part of a coronial investigation, the reverse is inconsistent with proper operation of the coronial system and the Old Act cannot be interpreted to mean that an entire investigation constitutes an Inquest because it includes a formal hearing.

63. Further, in the absence of mandatory provisions, the decision as to whether to hold an Inquest is a matter for the discretion of the investigating coroner who must determine whether or not they can fulfil their statutory obligations on the basis of information obtained in their preliminary investigation.

    Not all investigations of level crossing deaths will proceed by way of Inquest, no decisions about which matters will proceed by way of Inquest were taken until after 1 November 2009 and some decisions remain undecided. Therefore, it is in the interests of the activation of the New Act for all deaths in the cohort to be investigated under the same provisions, whether or not an Inquest is involved.

64. The Supreme Court has further defined an inquest as part of an investigative process which is concerned, *inter alia*, to set the public mind at rest where there are unanswered questions about a reportable death.[64] The Supreme Court does not regard a directions hearing dealt with by consent and the giving of directions of an administrative nature without any controversy or contest as being "hearings". [65]

65. Similarly, applying *Project Blue Sky* interpretation, the holding of a Directions Hearing was not in breach of and did not constitute the commencement of an Inquest under the Old Act because that construction would be contrary to a specific intention of the New Act. Therefore, under the *Interpretation of Legislation Act* 1984, it could not be construed to constitute commencement of the Inquest under the New Act.

[64] *Domaszewicz v The State Coroner* [2004] VSC 528.
[65] *Anon2 v XYZ* [2008] VSC 466.

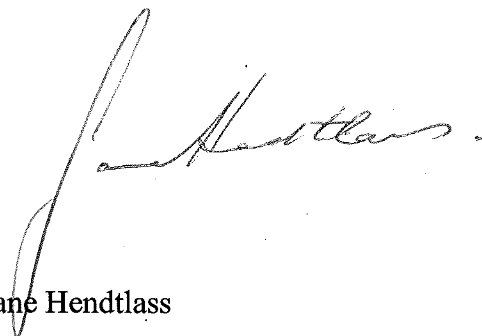
Ruling 2

66. I rule that an Inquest does not include all of a coronial investigation even when that investigation includes a formal hearing. Further, even if I am wrong about the nature of the Directions Hearing held on 15 October 2009, to discuss the on-going management of my investigations of the level crossing deaths, all continuing coronial investigations of the level crossing deaths will be undertaken subject to the New Act.

Accordingly,

Ruling 3

67. I rule that the *Coroners Act* 2008 applies to all coronial proceedings and administrative and investigative activities that occur after 1 November 2009 as part of the coronial investigation of the level crossing deaths including investigations, inquests, directions hearings and any other interlocutory or preliminary proceedings and related activities.



Jane Hendtlass

Coroner

25 June 2010

ATTACHMENT 1

Submissions from interested parties:

John McDonald for the Safety Institute of Australia

Ross Ray QC and Robert Taylor for VicRoads

DS Mortimer and EA Bennet for Public Transport Safety Victoria

Michael Moorhead for Gwen Bates

Mary Anne Hartley, SC, Sara Hinchey, Trevor Wraight, Richard Niall and Louise Johnson for VicTrack, the Department of Transport, Ambulance Victoria, VLine and the Department of Human Services.

ALB

BARRISTER&SOLICITOR

Mr Jon Hildebrand
Coroner's Registrar
Level 1,436 Lonsdale Street
MELBOURNE VIC 3000

ABN 35703610996
95 Cades Drive
Kingston, Tasmania 7050
Phone: 0419 323 181
Email: john8mcdonald(aigmail. com

Ref: team 4

Dear Sir,

Coroner Hendtlass* investigation - level crossing incidents

I refer to the Coroner's invitation, extended at the last directions hearing, to comment upon which coronial Act this inquest should adopt.

After an admittedly fairly cursory review of the transitional provisions of the Coroners Act 2008, read together with the provisions of both coronial Acts generally, and the Interpretation of Legislation Act 1984, it seems that there is (surprisingly) a choice.

Accordingly, I have sought the views of my client, the Safety Institute of Australia Inc., on policy grounds. I am instructed that an essential difference between the 2 Acts, as perceived by the Institute, is that the policy promulgated by the 1985 Act is punitive, whereas that of the 2008 Act is preventative. The Institute is therefore of the view that the New Act both reflects the current public expectation, as expressed by the objectives set out in the 2008 legislation, and accords with the philosophy of the Institute.

As to specific differences between the 2 Acts, there are 2 matters of interest to the Institute, leading to a strong preference for the adoption of the 2008 Act for this inquest. Firstly, in accordance with recommendation # 56 of the report of the Law Reform Committee into the Coroners Act 1985 (September 2006), the 2008 Act more comprehensively provides for investigations into multiple deaths. Secondly, the subtle difference in wording between S.54 of the 1985 Act and S.56 of the 2008 Act appears to pick up recommendation # 60 of the above report, in promoting accident prevention by allowing the participation of interested parties with specialist knowledge.

\s sincerely,
(John McDonald)
21st May 2010

IN THE CORONER'S COURT OF VICTORIA
AT MELBOURNE

IN THE INQUESTS INTO DEATHS AT LEVEL CROSSINGS IN VICTORIA

SUBMISSIONS TO ASSIST THE CORONER TO DETERMINE WHICH CORONERS ACT APPLIES

Background

1. At a directions hearing on 3 May 2010 the Coroner invited parties to make submissions about whether the provisions of the *Coroners Act 2008* (**the new Act**) or the *Coroners Act 1985* (**the old Act**) applied to the conduct of the inquest.

Summary of Submission

2. It is our submission that the old Act applies to this inquest because the inquest began before the new Act commenced. The inquest began at the directions hearing on 15 October 2009. That conclusion can be reached by examining the content of the directions hearing, and by application of principles of statutory interpretation to the old and the new Act. The old Act ceased to have force as of 31 October 2009. The new Act commenced on 1 November 2009.

Directions hearing on 15 October 2009

3. By a series of letters dated 2 September 2009 in relation to each crossing incident in the cohort, the Court notified the interested parties that the Coroner intended to hold a directions hearing on 15 October 2009 (**the directions hearing**). The directions hearing was therefore conducted during the currency of the old Act and the Coroner would have

had power to give directions or make determinations at that hearing only by reason of the old Act.

4. In its introduction, the letter stated:

   > *This is not an inquest and no evidence will be taken on the day.*

5. The letter then set out that the Coroner's intention was to:

   a. Explain that Her Honour intended to hold three inquests under three categories.
   b. Identify potential interested parties.
   c. Make clear that the information relevant to the investigations of the 26 deaths would be considered as part of the three inquests.
   d. Confirm what policy reviews, case based reports and investigations had been undertaken by relevant road, rail and health agencies.
   e. Ascertain what other ongoing research and investigations were continuing and the time frames for their completion.
   f. Seek input into the issues that had not been investigated and/or implemented.
   g. Establish a working plan for the procedures to be applied in listing the inquests and determining witnesses.
   h. Any other necessary matters raised by the parties.

6. It is plain from the face of the letter that the intention was to deal with substantial matters that were not merely administrative in nature. The statement that the hearing was not to be an inquest seems more to be an explanation that there was no intention to take evidence on the day, than to have been based on a proper use of the word "inquest".

7. On dealing with appearances at the hearing, the Coroner announced:

> *This is the directions hearing, not the inquest, so I'm not (sic) going to make that really clear - in terms of leave, I'm granting leave to appear for this particular hearing.*[2]

Again, this use of the word "inquest" appears to refer to an evidentiary hearing. That assumption is supported by a further announcement by the Coroner at the same directions hearing:

> *Usually an inquest will only include the evidence where oral evidence is needed in order to - where it will assist me in order to clarify other issues.*[3]

This suggests that the Coroner was using the word "inquest" in a colloquial way, rather than giving it its technical legal meaning.

8. At the directions hearing, the Coroner in fact:

    a. Announced her intended framework for the hearings and issues (by category) into which she intended to inquire[4].
    b. Indicated that she had considered the investigation materials in detail, and formed preliminary views about cause and circumstance of various incidents (which formed the basis for the categorisation of issues) and would shape the form of the inquest[5].
    c. Asked the parties present to provide her with documents.[6]

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[2] T 3:6

[3] T 5:9

[4] T8:10

[5] T8:1

[6] T9:20

d. Invited the parties to make submissions[7] about how to categorise the incidents and which incidents ought to be the subject of hearings in each category. (The submissions were required by 31 October 2010, the day before the commencement of the new Act).

e. Identified that one of the matters involved a suicide[8], and that a finding in that matter would be made in chambers.

f. Asked the parties to provide Her Honour with information about investigations and research that were being carried out by those parties, along with the time lines for their completion[9].

g. Asked parties to confirm what changes had occurred at level crossings included in this cohort.[10]

a. Asked the parties for the most relevant and up to date standards and policies. [11]

9. We submit that, by commencing her investigation into these substantive matters at that time, the Coroner began the inquest (within the proper meaning of the word). Accordingly, the inquest has begun under the old Act.

Relevant Legal Considerations

Transitional Provisions

10. The relevant transitional provision in the new Act is Clause 7 of Schedule 1 –

7. Inquest commenced under old Act

---

[7] T 7:12

[8] T8:19

[9] T 9:20

[10] T 10:1

[11] T 10:18

> *(1) Subject to clause 10, if the hearing of an inquest has begun under the old Act and the inquest is not completed before the commencement day, the old Act continues to apply on and from the commencement day to the inquest.*

11. It is our submission that the inquest began on 15 October 2009. As the directions hearing was held when the old Act was in force, the old Act must have applied[12] to the directions hearing.

12. Under the old Act, the term *Inquest* was defined as including *a formal hearing*. The directions hearing will properly be characterised as an *Inquest* under the old Act if it was a *formal hearing* under that Act.[13]

13. Many of the matters that were dealt with by the Coroner at the directions hearing were substantial matters and were not merely administrative in nature. The hearing was also an open public hearing of which interested parties and families were notified and which they attended, and it was attended by the usual formality of a hearing in this jurisdiction. For these reasons we submit that the hearing was a *formal hearing* pursuant to s 3 of the old Act and therefore (by definition) was an *Inquest*.

---

[12] Section 46(1)(e) of the old Act provided:

> *46 Powers of coroners at an inquest*
>
> *(1) If a Coroner reasonably believes it is necessary for the purposes of an inquest, the coroner may-*
>
> ...
>
> *(e) give any other directions and do anything else the coroner believes necessary*

It should also be noted that there are no transitional provisions within in the new Act which provide for the exercise of powers contained in it prior to its coming into force. Similarly, what occurred on 15 October 2009 could never be described as an "inquest" under the new Act, since that term is defined as meaning "a public inquiry that is **held by the Coroners Court** in respect of a death of fire." (emphasis added) As a matter of logic, the Coroners Court did not exist prior to the commencement of the new Act, since one purpose of it was to "establish the Coroners Court of Victoria as a specialist inquisitorial court."

[13] It is also noted that "investigation" is defined to include an inquest: see s.3 of the old Act. Therefore the fact that a step is characterised as "investigative" does not preclude it being characterised as an "inquest".

14. Due to the operation of Section 6 of the First Schedule to the new Act, any directions the Coroner made under the old Act ceased to have effect on and from 1 November 2009 unless the matter continues as an inquest under the old Act. If the Coroner were to determine that the matter should proceed to inquest under the new Act, difficult questions about the effectiveness and operation of previous directions could arise.

Statutory Interpretation

15. The application of relevant principles of statutory interpretation[14] result in the same conclusion being reached.

16. It is a fundamental principle of statutory interpretation that the purpose of the legislation be given effect to. The plain purpose of Clause 7, Schedule 1 of the new Act is to preserve the validity of things done and orders made under the old Act. This is consistent with the principles of statutory interpretation in *Project Blue Sky v ABA* [1998] 194 CLR 355 and as set out in Section 35 of the *Interpretation of Legislation Act* 1984.

17. The Maquarie Dictionary (2nd ed. Revd) (**the Maquarie**) is of assistance in this respect. It defines "inquest" (relevantly) as:

> ***inquest**... n, **1.** a legal or judicial inquiry, esp. before a jury. **2**. one made by a coroner (**coroner's inquest**)...*

18. Significantly the word "inquest" is defined by what it does; it "inquires". The act of inquiring is an "inquisition". "Inquisition" is defined not in the Coroners Act 1985 but in the Maquarie as (relevantly):

> ***inquisition**... n, **1.** the act of inquiring; inquiry; research. **2**. an investigation, or process of inquiry. **3**. an inquiry*

[14] Where possible the Court should ascribe their ordinary meaning to the words in the Act.

conducted by judicial officers or such non-judicial officers as coroners.

19. Accordingly, an inquest is a process of inquiry. "Inquire" is defined in the Maquarie as:

> ***inquire...*** *–v.i.* ***1.*** *to seek information by questioning; ask. v.i.* ***2.*** *to seek to learn by asking.*

The effect of this is to render inquiries made by the Coroner part of the inquisitorial process and therefore part of the "*Inquest*".

20. At the directions hearing in this case, the Coroner requested the parties provide Her Honour with:

    a. Information about investigations and research that was being carried out by those parties, along with the time lines for their completion[15].
    b. Details of the changes that had occurred at level crossings included in this cohort.[16]
    c. The most relevant and up to date standards and policies. [17]

21. It is submitted that these requests for information constitute an "inquiry" for the purposes of the old Act.

Other relevant decisions

22. In considering this matter, the Coroner might also be guided by other determinations by other coroners in similar circumstances. In the *Inquest into the Death of Michael Jonson*, Coroner

[15] T 9:20

[16] T 10:1

[17] T 10:18

Jamieson had held a directions hearing in July 2009 (that is, before the commencement date of the new Act).

23. At that directions hearing, Her Honour (among other things) indicated to the parties the issues of interest to her inquiry and made directions about the timing and delivery of written submissions. In response to a subsequent submission made along very similar lines to this submission, the Coroner subsequently accepted[18] that, as the directions hearing had been more than "*procedural*", the old Act applied to the entire matter.

24. Similarly, in the *Broughton Hall*[19] inquest, the State Coroner held a directions hearing during the currency of the old Act on 6 October 2009. The Coroner had previously called for submissions from interested parties in relation to the nature and scope of the inquiry (see page 3 at line 16). At the directions hearing, the scope of the inquest was discussed. At a further directions hearing on 17 February 2010, the question concerning which Act applied to the inquest was considered and determined.

25. At page 4 of the transcript the State Coroner said at line 12 –

> *If one looks at the definition of inquest in the old Act, inquest interestingly is defined as,* ***Inquest includes a formal hearing****. So in other words doesn't exclude other steps taken in preparation for the commencement of.* (sic)

26. Critically, at page 6 Her Honour stated at line 6 –

> *But I think the general view that's emerging with respect to the interpretation of these transitional provisions is once matters commence in the courtroom that the formal part of*

---

[18] On 28 January 2010

[19] A copy of relevant pages of transcript are attached to this submission

the hearing has commenced, unless the Coroner who's commenced the investigation has given a clear view that there will be an inquest or that the Coroner has made it clear that I'm not commencing the inquest, I'm only conducting a continuing part of my investigation at this stage.

Now I certainly didn't do that. In fact, I think I probably did almost the opposite by indicating that I was starting to shape the inquest as at 6 October. And I'd agree absolutely with what Mr Noonan's had to say about that. Some significant discussions took place about scope and the shape of it commenced as at 6 October.

27. There may be circumstances in which it can be said that a Coroner at a directions hearing is clearly not commencing an inquest (for instance, by simply making arrangements for the viewing of exhibits or distribution of a brief, or setting a hearing timetable). However, if the Coroner delves into a more substantial matter at a directions hearing, the inquest will have begun, despite any express announcement to the contrary by the Coroner. The test of when an inquest has begun turns on the substance of any hearing, and not on the Coroner's intent or express desire.

Conclusion

28. In this case, Her Honour dealt with substantial matters that were not merely administrative in nature at the directions hearing. While the Coroner announced that the directions hearing was not an inquest, this does not detemine the matter.

29. The hearing itself in fact dealt with matters which were similar to those matters dealt with by the Coroner Jamieson in the inquest into the death of Michael Jonson, thereby shaping the inquest and commencing the process of a formal hearing.

30. In the circumstances, given that the directions hearing was held on 15 October 2009 was a formal hearing and dealt with substantive issues rather than merely administrative matters, it is submitted that the inquest has begun under the old Act and the old Act should continue to apply to the conduct of this inquest.

Dated: 1 June 2010

Ross Ray QC
Counsel for VicRoads

Robert Taylor
Counsel for Vicroads

IN THE CORONER'S COURT OF VICTORIA

AT MELBOURNE

IN THE INQUESTS INTO DEATHS AT LEVEL CROSSINGS IN VICTORIA

The Operation of the *Coroner's Act* 2008

1. Public Transport Safety Victoria (***PTSV***) is an Interested Party in a series of Coronial inquests concerning deaths at level crossings.
2. A question has arisen whether the provisions of the *Coroners Act 2008* (the **New Act**) or the *Coroners Act* 1985 (the **Old Act**) apply to the conduct of the inquest.
3. Other Interested Parties have taken the view that the Old Act applies. The argument is, as PTSV understands it[66]:
    a. The old Act ceased to have force as of 31 October 2009. The New Act commenced on 1 November 2009.
    b. By letter dated 2 September 2009 notice was given to interested parties of the intention of the Coroner to hold a directions hearing on 15 October 2009 (**the directions hearing**). By that letter, interested parties were invited to attend the directions hearing.
    c. The letter indicated that the purpose of the directions hearing was to discuss the issues relevant to the inquest and the scope of the inquest, as well as the division of the inquest into topics, the possible order of those topics and discussion of how the materials would be dealt with during the hearing.
    d. At the directions hearing on 15 October 2009, the Coroner discussed her intention to choose specific incidents in order to cover issues under specific headings[67]. The various issues were discussed and three areas were identified – infrastructure, heavy vehicle combinations and human factors. Other matters were discussed such as documents to be provided and how materials would be managed. The directions hearing was conducted during the currency of the old Act and the Coroner had power to give directions or make determinations only by reason of the old Act.
    e. The relevant transitional provision in the New Act is Clause 7 of Schedule 1 –

[66] Based on the written submissions of other Interested Parties.
[67] T 11-13

7. ***Inquest commenced under old Act***

(1) Subject to clause 10, if the hearing of an inquest has begun under the old Act and the inquest is not completed before the commencement day, the old Act continues to apply on and from the commencement day to the inquest.

f. The question for determination is whether the hearing of an inquest 'began' on 15 October 2009 or only after 1 November 2009. As the directions hearing was held when the New Act had not begun, the old Act must have applied.[68] Thus, the task is for the Court to determine whether or not the directions hearing is properly to be characterised as the hearing of an "Inquest" under the old Act.

g. Under the old Act, the term "Inquest" was defined as including "a *formal* hearing."

h. Thus, the directions hearing will properly be characterised as the hearing of an "Inquest" under the old Act if it was a "formal hearing" under that Act.[69] There is no reason to construe "hearing" as being limited to the final hearing of the proceeding. Were that so, important provisions such as s 45 (rights of interested persons), 46 (powers of Coroner at inquest) 48 (prohibiting interruptions to inquest) and 58 (restrictions on publication) would not have applied. Each of those matters could readily have been required to be employed in a directions hearing under the Old Act. Indeed, s 46(1)(e) of the Old Act provides that the Coroner may give any directions that the Coroner believes necessary. Plainly that power is apt to be exercised at a directions hearing. That was the construction given by Hill J to the word "hearing" in the context of s 50 of the *Federal Court of Australia Act* in *Hadid v Lenfest Communications Inc* (1996)[70]

---

[68] Section 46(1)(e) of the old Act provided:

46 Powers of coroners at an inquest

(1) If a Coroner reasonably believes it is necessary for the purposes of an inquest, the coroner may-

...

(e) give any other directions and do anything else the coroner believes necessary

It should also be noted that there are no transitional provisions within in the New Act which provide for the exercise of powers contained in it prior to its coming into force. Similarly, what occurred on 15 October 2009 could never be described as an "inquest" under the New Act, since that term is defined as meaning "a public inquiry that is held by the Coroners Court in respect of a death of fire." (emphasis added) As a matter of logic, the Coroners Court did not exist prior to the commencement of the New Act, since one purpose of it was to "*establish the Coroners Court of Victoria as a specialist inquisitorial court.*"

[69] It is also noted that "investigation" is defined to include an inquest: see s.3 of the old Act. Therefore the fact that a step is characterised as "investigative" does not preclude it being characterised as an "inquest".

[70] 70 FCR 403

where his Honour held that the word "hearing" is equally apt to refer to a "directions hearing" or an "interlocutory hearing" (emphasis added), as it is to a hearing on the merits.

i. The matters that were dealt with by the Coroner at the directions hearing were substantial matters (as anticipated in the letter of 2 September) and were not merely administrative in nature. The hearing was an open public hearing where interested parties and families were notified and attended. For these reasons it is submitted that the hearing was a 'formal hearing' pursuant to s 3 of the old Act and therefore (by definition), was an 'Inquest'.

j. Due to the operation of Section 6 of the First Schedule to the **New Act** any directions the Coroner made under the Old Act ceased to have effect on and from 1 November 2009 unless the matter continues as an inquest under the Old Act. If the Coroner were to determine that the matter should proceed to inquest under the New Act, difficult questions about the effectiveness and operation of previous directions could arise.

4. PTSV recognises that there is some force in the view set out above, in particular surrounding the effect of previous orders made under the Old Act. However, there is a contrary argument. The basis for that argument is set out below.

5. PTSV makes no submissions as to which argument the Coroner should accept. It provides the contrary argument to assist the Coroner and to ensure the Coroner is aware that there is a competing view, so that the Coroner can make an informed decision on jurisdiction.

6. It is arguable that the position put forward in favour of the Old Act does not take sufficient account of:

   a. The fact that the subject matter of any inquest was not yet determined in October 2009; and

   b. The clear and express intention of the Coroner that the October directions hearing should not constitute an Inquest.

7. Section 51 of the *Coroner's Court Rules* (2009) (the ***Rules***) contemplates the formal commencement of an inquest preceded by notice. That section provides:

   51. Publication of the details of an inquest

   (1) Unless a coroner otherwise directs, a registrar must publish notice of the inquest at least 14 days before an inquest.

   (2) Notice under subrule (1) must-

(a) be published in a daily newspaper circulating throughout the State or on the Internet; and

(b) contain the date, time, place and subject of the inquest.

8. The publication requirement is a critical requirement, given the nature of an inquest. Given that the matters specified in section 51(1)(b) were not known or identified in October 2009 (and indeed the purpose of the hearing was to determine those issues) it is not clear that the formal conditions precedent to the commencement of the Inquest could have been satisfied (leaving aside the issue of whether such notice was actually given).
9. PTSV does not have the benefit of the reasons or the decision in the *Broughton Hill* case referred to by the other Interested Parties. However, there may be a distinction to be drawn between the "scope and shape" of an inquest referred to at pp5 – 6 of the submissions of the other Interested Parties, and the lack of subject matter in October 2009. It appears it may have been a factor in the *Broughton Hill* case that the Coroner considered it had been made clear the Coroner was commencing the inquest.
10. In the present case, the Coroner's letter of 2 September 2009 specified that the directions hearing set down for October was "*not* an inquest".
11. Thus, it may be arguable that the Inquest had not commenced in October 2009, that the Coroner was still at the investigation stage, and that as a result the New Act applies.
12. If the Coroner accepts that the New Act does not apply, the section 7 & 8 of Schedule 1 will apply, such that the processes for the continuing operation of the present matter would be as per the Old Act, subject to the amendments provided for is s7 of schedule 1, (a) – (d).

DATED 31 MAY 2010

D S Mortimer

8th Floor Melbourne Chambers

E A Bennett

6th Floor Joan Rosanove Chambers

IN THE CORONERS COURT OF VICTORIA

No. 417 of 2008

INQUEST INTO THE DEATH OF KAY STANLEY

31 MAY 2010
<u>SUBMISSION ON BEHALF OF GWENDOLINE BATES</u>

Filed on behalf of the senior next of kin, Ms G Bates.
Date of document: 31 May 2010
MOREHEADS LAWYERS
2/3741 Point Nepean Road
PORTSEA VIC 3944

Solicitor code: 20069
Telephone: 03 5984 4588
Facsimile: 03 5984 2988
Reference: MTM031207

M.

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1. This submission is made in support of the Coroner's position that the Stanley inquest will be investigated or conducted under the provisions of the *Coroners Act* 2008 (Vic) ("the 2008 Coroners Act"). This position has not been supported by the government agencies.

In short

2. We say that the 2008 Coroners Act is the only jurisdiction applicable to the Stanley inquest (see s119 and clauses 6, 7 and 10 of Schedule 1 to the 2008 Coroners Act).

3. Further, and in the alternative, we say that the decision to hold the Stanley inquest was made on 17 March 2010. That decision is attached and marked "A". This decision came after the commencement of the 2008 Coroners Act and the application of that Act to the Stanley inquest is unambiguous.

4. Further, and in the alternative, we say no other level crossing death can be taken into account in determining whether or not the Stanley inquest will be investigated or conducted under the provisions of the 2008 Coroners Act.

5. Further, and in the alternative, we say that there could not have been a "*hearing of an inquest*" in the Stanley inquest before 1 November 2009. In addition, and in the alternative, there could not have been a "*hearing of an inquest*" relating to any of the level crossing deaths the subject of the present investigation. A "directions hearing" is not a "*hearing of an inquest*" within the meaning of the 2008 Coroners Act.

6. Further, we say that the inquisitorial jurisdiction should not be fettered by the archaic restrictions in the *Coroners Act 1985* (the old Act) that have been substantially modified by the 2008 Coroners Act; namely, the **privilege against self incrimination**, the **access to documents regime** and the **implementation of recommendations**.

Background

7. Our client instructs that her inquiries of the Coroner as to when the Stanley inquest would be conducted were consistently met with the proposition that the Stanley inquest was to be held under the 2008 Coroners Act. Our client relied on these representations.

8. This proposition is also subject to an issue estoppel as recorded in the transcript of the 15 October 2009:

M.

Also on 1 November, the new Coroners Act comes into place. That is going to change quite a lot - both the focus of all coronial investigations because now we are required to consider prevention and safety issues and rather than it being an adjunct that occurs afterwards. The other thing that will happen after that, after 1 November, is that all findings will be on the internet in inquest cases, so they're available to everybody after 1 November and that includes cases that are already completed. If the finding's not completed, the finding handed down after 1 November will be on the internet. All the recommendations must be responded to within three months by the organisation to whom the recommendation is directed with comment about whether it's going to be implemented and whether it's not, for instance. That's quite a big difference in terms of how the coroners have been operating up until now and it means that I'm wanting to make sure that everyone is aware that those changes are coming in on 1 November. And I also want to make it clear that my view is that the reason I'm emphasising that this is not an inquest, is that any inquests that commence after 1 November will be held under the new Act, not the old Act. (per DR J.A. HENDTLASS, CORONER 15 October 2009)

9. Our client is the senior next of kin and is responsible to the victim's wider family network all of which have expectations that once the hearing of the Stanley inquest begins the following issues will be adequately addressed and investigated:

(a) Would a grade separated crossing have prevented the fatality? If yes, what was the reason the crossing was not grade separated?

(b) Would boom gates at the crossing have prevented the fatality? If yes, what was the reason they were not installed?

(c) Was the crossing compliant with AS 1742.2007? If not, what were the risk consequences?

(d) Was the train speeding? If so, why was the train speeding? Was the speed of the train properly identified by reporting agencies?

(e) Who was driving the train? Was the driver the same person or different people? Was a person other than the driver originally identified as that driver? Was the driver or drivers drug or alcohol tested?

(f) Was the train horn sounded at the whistle board? If not sounded, why not and what was the impact of the failure?

(g) Did changes to the crossing environment impact the safety system of the crossing, specifically: installation of road traffic signals near the crossing? Construction of units and sound wall adjacent to the crossing? Any modification of speed limits?

M.

(h) Who was responsible for the safety system of the crossing environment? Was there any interface between those responsible? If not, why not?

(i) Was an independent investigation conducted? If not, did Connex investigate itself?

(j) Did the police road traffic fatality officers take witness statements from the train drivers, passengers on the train and public waiting for the train at the station? If not, why not? If so, are those witness statements available?

(k) Were witness statements obtained from people that did not witness the fatality? If so, why?

(l) Was there a media release on 28 January 2008 announcing that the warning lights were working? If so, were the lights then extensively tested and subsequently changed?

(m) Did Public Transport Safety Victoria (PTSV) investigate immediately after the fatality? If not, when did they do an investigation?

(n) Was the Senior Constable responsible for the compiling of the Inquest Brief able to access all relevant government information? What information did he request and from whom? What instructions were given to him concerning the compilation?

(o) What point should be used to measure train speed and warning times – point of train stopping or point of train impact?

(p) Are there discrepancies between the various reports into who was driving the train at the time of the fatality?

(q) Who was responsible for project management of contract VTO213? Was there a delay in the installation of boom gates under contract VT0213? If so, who or what was the reason? Had there been payment under that contract and, if so, how much and when? Was this contract originally withheld from the Auditor General? In any event, has the Auditor General audited this contract and payments made under it?

Human rights

10. The right to life is protected by s9 of the *Charter of Human Rights and Responsibilities Act* 2006 (the Charter):

Every person has the right to life and has the right not to be arbitrarily deprived of life.

M.

11. "*Arbitrarily*" means capricious; arising by accident rather than from rule. This right to life includes an obligation on government to ensure an effective investigation into certain deaths. The 2008 Coroners Act's "*coronial system gives effect to this right*" (see, the Attorney Generals statement of compatibility on the second reading on 9 October 2008).

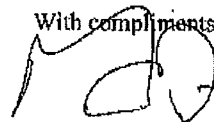
12. Unlike the 1985 Coroners Act, the Coroners Court established by and with jurisdiction from the 2008 Coroners Act is a "*court*" within the meaning of the Charter (see s3(1)).

13. By s32 (1) of the Charter:

    So far as it is possible to do so consistently with their purpose, all statutory provisions must be interpreted in a way that is compatible with human rights.

14. We submit the transitional provisions in the 2008 Coroners Act, to the extent if any that they are ambiguous, must be interpreted in a manner consistent with the Charter.

With compliments



MICHAEL MOREHEAD
31 May 2010

Court Reference: 417 / 08

FORM 28

Rule 50(1)

DECISION BY CORONER WHETHER OR NOT TO HOLD AN INQUEST INTO DEATH

Section 52(6) of the Coroners Act 2008

In the Coroners Court of Victoria at Melbourne

I Jane Hendtlass, Coroner investigating the death of:

Details of deceased:

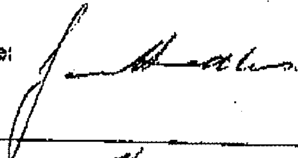
Surname:	Stanley
First name:	Kay
Date of birth:	10/4/1975
Gender:	Female
Date of death/Suspected death:	28/1/2008
Place of death/Suspected death:	Mornington-Tyabb Rd Level Crossing

have decided

- [x] to hold an inquest
- [ ] not to hold an inquest
- [ ] not to make a decision as to whether or not an inquest should be held

for the following reasons:

1. This case fits the criteria of cases to investigate further by way of an inquest.

Signature: 

Date: 17 March 2010.

NOTE: *A copy of this decision must be provided to the person who made the request.*

An appeal can be made to the Supreme Court of Victoria within 3 months after the day on which this determination has been made.

IN THE CORONER'S COURT OF VICTORIA
AT MELBOURNE

IN THE INQUESTS INTO DEATHS AT LEVEL CROSSINGS IN VICTORIA

SUBMISSIONS TO ASSIST THE CORONER TO DETERMINE WHICH CORONERS ACT APPLIES

Background

1. At a directions hearing on 3 May 2010 the Coroner invited parties to make submissions about whether the provisions of the *Coroners Act 2008* (**the new Act**) or the *Coroners Act 1985* (**the old Act**) applied to the conduct of the inquest.

Summary of Submission

2. It is our submission that the old Act applies to this inquest because the inquest began before the new Act commenced. The inquest began at the directions hearing on 15 October 2009. That conclusion can be reached by examining the content of the directions hearing, and by application of principles of statutory interpretation to the old and the new Act. The old Act ceased to have force as of 31 October 2009. The new Act commenced on 1 November 2009.

Directions hearing on 15 October 2009

3. By a series of letters dated 2 September 2009 in relation to each crossing incident in the cohort, the Court notified the interested parties that the Coroner intended to hold a directions hearing on 15 October 2009 (**the directions hearing**).[1] The directions hearing was therefore conducted

[1] Copy of letter attached

during the currency of the old Act and the Coroner would have had power to give directions or make determinations at that hearing only by reason of the old Act.

4. The letter set out that the Coroner's intention was to:

   a. Explain that Her Honour intended to hold three inquests under three categories.
   b. Identify potential interested parties.
   c. Make clear that the information relevant to the investigations of the 26 deaths would be considered as part of the three inquests.
   d. Confirm what policy reviews, case based reports and investigations had been undertaken by relevant road, rail and health agencies.
   e. Ascertain what other ongoing research and investigations were continuing and the time frames for their completion.
   f. Seek input into the issues that had not been investigated and/or implemented.
   g. Establish a working plan for the procedures to be applied in listing the inquests and determining witnesses.
   h. Any other necessary matters raised by the parties.

5. It is plain from the face of the letter that the intention was to deal with substantial matters that were not merely administrative in nature.

6. At the directions hearing, the Coroner:

   a. Announced her intended framework for the hearings and issues (by category) into which she intended to inquire[2].

[2] T8:10

b. Indicated that she had considered the investigation materials in detail, and formed preliminary views about cause and circumstance of various incidents (which formed the basis for the categorisation of issues) and would shape the form of the inquest[3].

c. Asked the parties present to provide her with documents.[4]

d. Invited the parties to make submissions[5] about how to categorise the incidents and which incidents ought to be the subject of hearings in each category. (The submissions were required by 31 October 2010, the day before the commencement of the new Act).

e. Identified that one of the matters involved a suicide[6], and that a finding in that matter would be made in chambers.

f. Asked the parties to provide Her Honour with information about investigations and research that were being carried out by those parties, along with the time lines for their completion[7].

g. Asked parties to confirm what changes had occurred at level crossings included in this cohort.[8]

a. Asked the parties for the most relevant and up to date standards and policies. [9]

7. We submit that, by commencing her investigation into these substantive matters at that time, the Coroner began the inquest. Accordingly, the inquest has begun under the old Act.

---

[3] T8:1

[4] T9:20

[5] T 7:12

[6] T8:19

[7] T 9:20

[8] T 10:1

[9] T 10:18

Relevant Legal Considerations

Transitional Provisions

8. The relevant transitional provision in the new Act is Clause 7 of Schedule 1 –

> *7. Inquest commenced under old Act*
>
> *(1) Subject to clause 10, if the hearing of an inquest has begun under the old Act and the inquest is not completed before the commencement day, the old Act continues to apply on and from the commencement day to the inquest.*

9. It is our submission that the inquest began on 15 October 2009. As the directions hearing was held when the old Act was in force, the old Act must have applied[10] to the directions hearing.

10. Under the old Act, the term *Inquest* was defined as including *a formal hearing*. The directions hearing will properly be characterised as an *Inquest* under the old Act if it was a *formal hearing* under that Act.[11]

11. Many of the matters that were dealt with by the Coroner at the directions hearing were substantial matters and were not merely administrative in nature. The hearing was also an open

[10] Section 46(1)(e) of the old Act provided:

> *46 Powers of coroners at an inquest*
>
> *(1) If a Coroner reasonably believes it is necessary for the purposes of an inquest, the coroner may-*
>
> ...
>
> *(e) give any other directions and do anything else the coroner believes necessary*

It should also be noted that there are no transitional provisions within in the new Act which provide for the exercise of powers contained in it prior to its coming into force. Similarly, what occurred on 15 October 2009 could never be described as an "inquest" under the new Act, since that term is defined as meaning "a public inquiry that is **held by the Coroners Court** in respect of a death of fire." (emphasis added) As a matter of logic, the Coroners Court did not exist prior to the commencement of the new Act, since one purpose of it was to "establish the Coroners Court of Victoria as a specialist inquisitorial court."

[11] It is also noted that "investigation" is defined to include an inquest: see s.3 of the old Act. Therefore the fact that a step is characterised as "investigative" does not preclude it being characterised as an "inquest".

public hearing of which interested parties and families were notified and which they attended, and it was attended by the usual formality of a hearing in this jurisdiction. For these reasons we submit that the hearing was a *formal hearing* pursuant to s 3 of the old Act and therefore (by definition) was an *Inquest*.

12. Due to the operation of Section 6 of the First Schedule to the new Act, any directions the Coroner made under the old Act ceased to have effect on and from 1 November 2009 unless the matter continues as an inquest under the old Act. If the Coroner were to determine that the matter should proceed to inquest under the new Act, difficult questions about the effectiveness and operation of previous directions could arise.

Statutory Interpretation

13. The application of relevant principles of statutory interpretation[12] result in the same conclusion being reached.

14. It is a fundamental principle of statutory interpretation that the purpose of the legislation be given effect to. The plain purpose of Clause 7, Schedule 1 of the new Act is to preserve the validity of things done and orders made under the old Act, including the matters traversed at the directions hearing.

15. The Macquarie Dictionary (2nd ed. Revd) (**the Macquarie**) is of assistance in this respect. It defines "inquest" (relevantly) as:

> ***inquest**... n, 1. a legal or judicial inquiry, esp. before a jury. 2. one made by a coroner (**coroner's inquest**)...*

16. Significantly the word "inquest" is defined by what it does; it "inquires". The act of inquiring is an "inquisition". "Inquisition"

[12] Where possible the Court should ascribe their ordinary meaning to the words in the Act.

is defined not in the Coroners Act 1985 but in the Macquarie as (relevantly):

> ***inquisition... n, 1.*** *the act of inquiring; inquiry; research. 2. an investigation, or process of inquiry. 3. an inquiry conducted by judicial officers or such non-judicial officers as coroners.*

17. Accordingly, an inquest is a process of inquiry. "Inquire" is defined in the Macquarie as:

> ***inquire... –v.i. 1.*** *to seek information by questioning; ask.* ***v.i.*** *2. to seek to learn by asking.*

The effect of this is to render inquiries made by the Coroner part of the inquisitorial process and therefore part of the "*Inquest*".

18. At the directions hearing in this case, the Coroner requested the parties provide Her Honour with:

    a. Information about investigations and research that was being carried out by those parties, along with the time lines for their completion[13].
    b. Details of the changes that had occurred at level crossings included in this cohort.[14]
    c. The most relevant and up to date standards and policies. [15]

19. It is submitted that these requests for information constitute an "inquiry" for the purposes of the old Act.

---

[13] T 9:20

[14] T 10:1

[15] T 10:18

Other relevant decisions

20. In considering this matter, the Coroner might also be guided by other determinations by other coroners in similar circumstances. In the *Inquest into the Death of Michael Jonson*, Coroner Jamieson had held a directions hearing in July 2009 (that is, before the commencement date of the new Act).

21. At that directions hearing, Her Honour (among other things) indicated to the parties the issues of interest to her inquiry and made directions about the timing and delivery of written submissions. In response to a subsequent submission made along very similar lines to this submission, the Coroner subsequently accepted[16] that, as the directions hearing had been more than "*procedural*", the old Act applied to the entire matter.

22. Similarly, in the *Broughton Hall*[17] inquest, the State Coroner held a directions hearing during the currency of the old Act on 6 October 2009. The Coroner had previously called for submissions from interested parties in relation to the nature and scope of the inquiry (see page 3 at line 16). At the directions hearing, the scope of the inquest was discussed. At a further directions hearing on 17 February 2010, the question concerning which Act applied to the inquest was considered and determined.

23. At page 4 of the transcript the State Coroner said at line 12 –

> *If one looks at the definition of inquest in the old Act, inquest interestingly is defined as,* ***Inquest includes a formal hearing****. So in other words doesn't exclude other steps taken in preparation for the commencement of.* (sic)

---

[16] On 28 January 2010

[17] A copy of relevant pages of transcript are attached to this submission

24. Critically, at page 6 Her Honour stated at line 6 –

> *But I think the general view that's emerging with respect to the interpretation of these transitional provisions is once matters commence in the courtroom that the formal part of the hearing has commenced, unless the Coroner who's commenced the investigation has given a clear view that there will be an inquest or that the Coroner has made it clear that I'm not commencing the inquest, I'm only conducting a continuing part of my investigation at this stage.*
>
> *Now I certainly didn't do that. In fact, I think I probably did almost the opposite by indicating that I was starting to shape the inquest as at 6 October. And I'd agree absolutely with what Mr Noonan's had to say about that. Some significant discussions took place about scope and the shape of it commenced as at 6 October.*

25. There may be circumstances in which it can be said that a Coroner at a directions hearing is clearly not commencing an inquest (for instance, by simply making arrangements for the viewing of exhibits or distribution of a brief, or setting a hearing timetable). However, if the Coroner delves into a more substantial matter at a directions hearing, the inquest will have begun; the test of when an inquest has begun turns on the substance of any hearing.

Conclusion

26. In this case, Her Honour dealt with substantial matters that were not merely administrative in nature at the directions hearing.

27. The hearing itself in fact dealt with matters which were similar to those matters dealt with by the State Coroner in the Broughton Hall inquest, thereby shaping the inquest and commencing the process of a formal hearing.

28. In the circumstances, given that the directions hearing was held on 15 October 2009 was a formal hearing and dealt with substantive issues rather than merely administrative matters, it is submitted that the inquest has begun under the old Act and the old Act should continue to apply to the conduct of this inquest.

Dated:

____

Mary Anne Hartley, SC
Counsel for VicTrack and Department of Transport

____

Sara Hinchey
Counsel for VicTrack and Department of Transport

____

Trevor Wraight
Counsel for Ambulance Victoria

____

Richard Niall
Counsel for VLine

____

Louise Johnson,
Director, Legal Services, Department of Human Services

ATTACHMENT 2

Submissions in Reply from:

VicRoads

Department of Human Services

Department of Transport and VicTrack.

Gwen Bates

Department of Human Services

Incorporating: Community Services and Housing

50 Lonsdale Street
GPO Box 4057
Melbourne Victoria 3001
DX210081
www.dhs.vic.gov.au
Telephone: 1300 650 172
Facsimile: 1300 785 859

OUR REF:

YOUR REF:

15 June 2010

Attention: Mark Roberts, Registrar
Coroners Court of Victoria
436 Lonsdale Street
Melbourne 3000

Re: Inquests into deaths at level crossings in Victoria

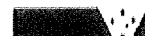
At the directions hearing in relation to the above inquest on 3 May 2010, the Coroner invited submissions regarding whether the inquest should be heard under the *Coroners Act 1985* or the *Coroners Act 2008*.

The Department of Human Services has reviewed the submissions made by the Safety Institute of Australia and Public Transport Safety Victoria and has had an opportunity to consider the reply to those submissions prepared by Counsel for the Department of Transport and VicTrack.

The Department of Human Services supports the reply submitted by the Department of Transport and VicTrack.

Yours sincerely,

Louise Johnson
Director, Legal Services



IN THE CORONER'S COURT OF VICTORIA
AT MELBOURNE

IN THE INQUESTS INTO DEATHS AT LEVEL CROSSINGS IN VICTORIA

SUBMISSIONS OF DOT & VICTRACK IN REPLY

1. This submission is in reply to the submissions filed by the solicitors for the Safety Institute of Australia (**the Safety Institute submission**) and Counsel for PTSV (**the PTSV submission**).

The PTSV submission

2. To the extent that the PTSV submission refers to the Notice provisions applicable under the *Coroners Court Rules* 2009 (**the 2009 Regulations**), the argument could only have force in relation to whether an Inquest which was purportedly commenced under the 2008 Act, was validly commenced in the absence of a Notice complying with regulation 51 of the 2009 Regulations.

3. The argument made by DOT, VicTrack and others is that the Inquest was in fact begun under the old Act. As such, considerations concerning the absence of any Notice complying with the 2009 Regulations are not relevant.

The Safety Institute Submission

4. The transitional provisions of the new Act make clear that either the new Act or the old Act applies in certain circumstances. There is no indication in the new Act transitional provisions that would permit a choice by the Coroner. The task is to apply the transitional provisions to determine which of the two Acts applies in the current circumstances.

5. As set out in the primary submission, the task for the Coroner is to reach a conclusion as to whether the Inquest was begun at the hearing which took place on 15 October 2009. For the reasons articulated in that submission, DOT and VicTrack submit that the Coroner ought conclude that the Inquest was indeed begun on that date. As such, the old Act applies to its future conduct.

Mary Anne Hartley SC
Owen Dixon Chambers West

Sara L. Hinchey
Crockett Chambers

15 June 2010

ME 86471698 1 (W2003)

IN THE CORONER'S COURT OF VICTORIA
AT MELBOURNE

IN THE INQUESTS INTO DEATHS AT LEVEL CROSSINGS IN VICTORIA

SUBMISSIONS IN REPLY

1 VicRoads responds to the submissions of Gwendoline Bates, Public Transport Safety Victoria and the Safety Institute of Victoria.

Submission of Gwendoline Bates dated 31 May 2010

2 Ms Bates submits (in part) that:

2.1 The decision to hold the Stanley Inquest was made on 17 March 2010 by issue of a Form 28 Decision by a Coroner Whether or Not to Hold an Inquest.

2.2 The court is estopped from applying the old Act because of representations made by court staff to Ms Bates and because of comments made by the Coroner at the directions hearing of 15 October 2010.

2.3 The Right to Life (section 9 of the Charter) and section 32(1) of the Charter require the new Act to apply.

3 VicRoads responds as follows:

3.1 The issuing of a Form 28 cannot determine the Act that applies. At its strongest, the form indicates the Coroner's intent only. As VicRoads submitted in its submissions of 1 June 2010, the test of when an inquest has begun turns on the substance of any hearing, and not on the Coroner's intent or express desire. If the Coroner accepts the principles of statutory interpretation described in VicRoads' submissions, the need for a Form 28 falls away.

3.2 Issue estoppel does not apply to a court or a Coroner in a case such as this. It would be an error of law for the Coroner to consider herself estopped in these circumstances.

3.3 Neither the Right to Life nor section 32(1) of the Charter requires the new Act to replace the old Act in these inquests. The Charter requires that courts have regard to international jurisprudence in determining the

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application of the Charter. The international jurisprudence has extended the meaning of the Right to Life to include the examination of the circumstances of death where death results from the application of force by an agent of the State (for instance, a police officer shoots and kills a person in the course of arresting them). There is no suggestion (and no scope for suggesting) that any of the deaths in this cohort was as a result of the use of force by an agent of the state. As such, the Right to Life has no specific application in these cases within the meaning of the Charter. In any event, the leading case of *McCann and Others v The United Kingdom*[1] and various other UK decisions have held that the Right to Life is advanced by holding a Coroner's inquest. An inquest commenced under the old Act satisfies the Right to Life as would an inquest under the new Act. As such, the interpretive requirements of section 32(1) will be satisfied by proceeding with an inquiry under the old Act, if the Right to Life was engaged here.

4 VicRoads has otherwise addressed the matters raised by Ms Bates in its submissions of 1 June 2010, and refers to and relies on those previous submissions in responding to Ms Bates' submissions. To the degree that Ms Bates' submissions go beyond the question of which Act should apply, VicRoads does not seek to respond at this stage, but would seek to be heard on those matters at the appropriate time.

Submission of PTSV dated 31 May 2010

5 PTSV has made submissions in two parts. In what might be described as an exploration of an "alternative" argument, it raised the possibility that:

5.1 Rule 51 requires a notice to be published of, among other things, the subject matter of an inquest. The Coroner had not determined the subject matter of any inquest in October 2009.

5.2 The Coroner gave a clear and express intention that the directions hearing should not constitute an inquest.

6 VicRoads responds as follows:

6.1 Rule 51 only applies if the Coroner decides to proceed under the new Act. The Rules otherwise will not apply under the old Act. Furthermore, the Coroner appears to have made substantial findings in October 2009 about the subject matter of the inquests, including the categories of issues to be addressed and that at least the Kerang and Stanley incidents would be subject to inquests. It is for that reason that VicRoads submits that the

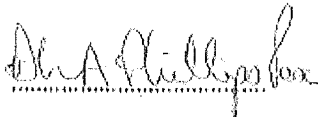
[1] (1995) 21EHRR 96

October 2009 directions hearing dealt with substantial matters and therefore the inquests in the cohort announced at that directions hearing have begun under the old Act.

6.2 As VicRoads submitted previously, it is not completely clear what the Coroner intended by expressing an intention that an "inquest" was not to begin in October 2009, as Her Honour may have sought to use the word in a way that is not in accordance with its strictly legal meaning. Her Honour appears to have used the word to refer to evidentiary hearings. Furthermore, as submitted previously, the test of when an inquest has begun turns on the substance of any hearing, and not on the Coroner's intent or express desire.

Submission of the Safety Institute of Victoria dated 21 May 2010

7 The Safety Institute of Victoria appears to submit that the Coroner should choose between the old and new Acts on a policy basis. This would not be appropriate and would lead the Coroner into legal error. The Coroner is bound by the principles of statutory interpretation in determining which Act to apply. Again, VicRoads refers to and relies on the submissions it has made previously in relation to applying those principles here.



DLA Phillips Fox

Solicitors for VicRoads

15 June 2010

IN THE CORONERS COURT OF VICTORIA

No. 417 of 2008

INQUEST INTO THE DEATH OF KAY STANLEY

22 JUNE 2010

REPLY SUBMISSION ON BEHALF OF GWENDOLINE BATES

Filed on behalf of the senior next of kin, Ms G Bates.
Date of document: 22 June 2010
MOREHEADS LAWYERS
2/3741 Point Nepean Road
PORTSEA VIC 3944

Solicitor code: 20069
Telephone: 03 5984 4588
Facsimile: 03 5984 2988
Reference: MTM031207

1. This reply submission is made in further support of the Coroner's position that the Stanley inquest will be investigated or conducted under the provisions of the *Coroners Act* 2008 (Vic) ("the 2008 Coroners Act").

2. While this position has not been supported by submissions made by the government agencies, the government agencies have failed to address in their submissions the reasons why they do not agree with the Court that the 2008 Coroners Act applies and why they seek the old Act apply.

3. The old Act does not give the Coroner powers to compel the production of information, does not limit the privilege against self-incrimination and does not require implementation of recommendations. These are the differences between the old and new Acts, matters upon which the submissions of the government agencies are silent. These are very substantial differences when it comes to the efficacy of the inquisitorial process in this Court.

4. A "directions hearing" that merely seeks to *"sort of try and work out where to go next and pick up the momentum from my jurisdiction"*, as the Coroner explained on 15 October 2009, is not a "*hearing of an inquest*" within the meaning of the 2008 Coroners Act.

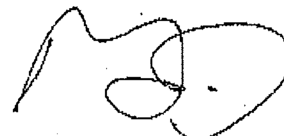
5. The deeming and transitional provisions within the 2008 Coroners Act operate so as to provide for the exercise of powers under the 2008 Coroners Act for the purpose of an inquest into a death that occurred before 1 November 2009. This is not disputed by any government agency submission.

6. The test of whether a "*hearing of an inquest*" has begun turns upon whether or not the Coroner has formed a particular view and not upon some vague notion of "*the substance of any hearing*".

7. In the government agencies submissions, the old Act would apply to inquests that have not even been thought of yet. For example, again as the Coroner explained on 15 October 2009:

> *The three inquests I'm intending to hold at the moment are not in concrete and if there's another whole issue, which I'll identify the issues and the reasons in a minute, then let me know. I'd like to know because that way we can either integrate into those investigations or inquests we're already intending to hold, or we might have **a fourth one.***(emphasis added)

8. If the submissions of the government agencies were to be accepted, the aforementioned "*fourth one*" must also be subject to the old Act. This is, with respect, beyond comprehension.



MICHAEL MOREHEAD
22 June 2010

2

ATTACHMENT 3

Press Information from the State Coroners Office dated 13 November 2009.

Date 13 October 2009

LEVEL CROSSING INVESTIGATIONS

Coroner Jane Hendtlass will conduct a directions hearing on 15 October 2009 in relation to the deaths of 29 people in collisions between trains and vehicles at level crossings across Victoria between 2002 and 2009.

A directions hearing is not an inquest. A directions hearing is an opportunity for all parties to appear before the coroner and raise any issues they believe ought to be included for further investigation at a subsequent inquest. A directions hearing also ensures that all parties wishing to be legally represented have proper, non-conflicting representation.

Dates for the inquests into these matters will not be set until after the directions hearing.

This investigation is expected to be the largest coronial investigation into level crossings deaths ever undertaken in Victoria.

It is not the intention of the coroner to unnecessarily duplicate any reports, investigations or studies already produced by other groups and organisations or evidential material previously submitted to courts of other jurisdictions.

However, the coroner will review and evaluate this material as part of her independent examination of the way in which the complex Victorian railway and road systems influence the frequency and characteristics of level crossing fatalities. She will also take into account all the relevant evidence given in completed prosecution hearings without it having to be repeated in an inquest.

It is not anticipated that separate inquests will be held as part of the coroner's investigation of each individual death.

Instead the inquests will follow three main areas of inquiry of the issues that may have caused or contributed to level crossing deaths including;

- Infrastructure issues
- Heavy vehicle combinations including the emergency response to incidents involving multiple deaths in regional Victoria
- Human factor issues.

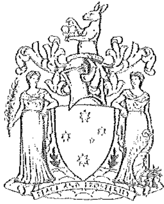
The inquest process can be very distressing for the families involved and we ask all parties to respect their needs and privacy during this time.

ENDS

Sheree Argento
Publications and Communications Officer
State Coroner's Office

ATTACHMENT 4

Letter to Minter Ellison dated 25 November 2009



Coroners Court of Victoria

Level 1, 436 Lonsdale Street Melbourne 3000
T 1300 309 519
F 03 8688 0703
W www.coronerscourt.vic.gov.au

Our ref: Level crossing deaths

25 November 2009

Rosemaree Gullo
Minter Ellison Lawyers
GPO Box 769 G
Melbourne VIC 3001

Dear Ms Gullo

Thank you for your email dated 17 November 2009 and the two letters dated 19 November 2009.

Extension of Time

Coroner Hendtlass confirms that the due date for submissions in relation to deaths, which should proceed by way of Inquest, remains 30 November 2009 so that she can consider the best way to manage the ongoing investigation over the Christmas break and make decisions by 7 January 2009. No extensions to this date have been provided.

However, the Coroner has asked me to tell you that she is willing to extend the date for delivery of the documents she seeks to 15 January 2009.

Maintenance Records and other Information

The Coroner accepts that VicTrack Ltd has no role in arranging maintenance at level crossings except that, as registered owner of the land, it must enforce contractual obligations of its lease to the Director of Transport and the Director's further lease of the land to transport operators and others. These contracts include maintenance and infrastructure requirements.

Gwen Bates has already provided the Coroner with copies of a number of documents including the Westinghouse Tender offer dated 27 October 2005, the allocation letter from VicTrack dated 23 December 2005, and the Tender Document VTO213. However, the Coroner is keen to ensure that the documents she works with are a complete record of events.

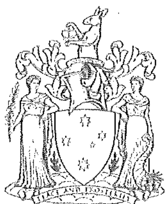
Therefore, she has asked me to re-word her request to VicTrack for the following documents:

3. A statement from the appropriate VicTrack senior manager, which includes and describes, amongst other things, changes in infrastructure for all level crossings included in the cohort in the year prior to the incident until now.

4. Copies of reports to VicTrack from the lessors of VicTrack land about fatal incidents, maintenance and changes to infrastructure for all level crossings included in the cohort in the year prior to the incident until now.

This request is repeated in the attached Form required under section 42 of the *Coroners Act* 2008.

Further, the Coroner reminds you that her role is wider than determining cause of death. In particular, she must also determine if possible the circumstances of the death. Further, the *Coroners Act* 2008 came into operation on 1 November 2009. Section 8 (f) of the *Coroners Act* 2008 requires her to have regard for public health and safety in exercising her role. In the absence of evidence from your clients,



she is unable to determine whether or to what degree maintenance issues arose in the circumstances of the deaths she is investigating and whether or not maintenance is a public health and safety issue.

Accordingly, the Coroner is of the opinion that maintenance records and reports held by your clients and statements from appropriate personnel are required for her investigations.

Therefore, the Coroner redirects her request to the Department of Transport for the following documents:

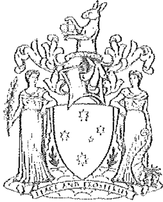
1. Copies of reports on the Department of Transport investigations of all incidents included in the cohort of level crossing deaths under investigation by the Coroner.
2. Department of Transport maintenance records for all level crossings in the year prior to the incident until now including names of any contractors performing the work.
3. A statement from the appropriate Department of Transport senior manager which includes and describes, amongst other things, contracts they have entered into to manage maintenance at level crossings included in the cohort.

This request is also repeated in the attached Form required under section 42 of the *Coroners Act* 2008.

<u>Completeness of Briefs</u>

The briefs provided to you are those provided to the Coroner by the investigating police member with the following provisos:

- Photos have not been included but are available for your perusal at the Coroners Court.
- The Winter and Angel briefs have not yet been provided to the Coroner.
- The Dunning, Kiely and Pettersen brief is available for you to copy by arrangement.
- The Boyd brief is available for you to copy by arrangement.
- The Love finding is not yet completed but the brief will become available you to by arrangement.
- The Chief Investigator has indicated the OCI reports other than Winter are available on the internet.
- The hard copy of the Trawalla brief is at the Coroners Court. It includes photos, autopsy reports and the statements you refer to. These documents are available for you to copy by arrangement. No toxicology seems to have been done but we will check further.
- The hard copy of the Smart brief is at the Coroners Court. It includes photos, exhibits and attachments. These documents are available for you to copy by arrangement. No toxicology seems to have been done but we will check further.
- The hard copy of the Kerang brief is at the Coroners Court. It includes photos, exhibits and attachments. There is also another complete folder that the Coroner has yet to peruse. These documents are available for you to copy by arrangement. No toxicology seems to have been done but we will check further.
- The letter you refer to on the Massaria file is on the brief and is available for you to copy by arrangement.
- The letter you refer to on the Gordon file is on the brief and is available for you to copy by arrangement.
- The Tempest statement is not on our file. He was the relieving driver so is not necessarily relevant.



Coroners Court of Victoria

Level 1, 436 Lonsdale Street Melbourne 3000
T 1300 309 519
F 03 8688 0703
W www.coronerscourt.vic.gov.au

Therefore, the Coroner thanks you for your independent audit of the files. On the basis of your audit, she thinks that the information available to her as of now is almost complete except for the Tempest statement. Please contact me to make arrangements to look at these documents and copy as required.

Yours sincerely

Mark Roberts

Coroners Registrar

Attachment 5

Practice Direction No. 4 of 2009

Directions Hearing

Background

This Practice Direction is relevant to the Melbourne registry of the Coroners Court of Victoria. The practice of listing all Inquests of estimated duration of 2 days or more for a Directions Hearing is to enable:

a) The elimination of the practice whereby the Listings Registrar is spending inordinate amounts of time seeking details of proposed witnesses (some of whom may not be required)

b) Addressing the resolution of preliminary issues such as:

- the granting of leave for interested parties
- identification of issues
- confirmation of estimates as to hearing time and witnesses
- availability of any court appointed witnesses
- applications for privilege
- distribution of all documentary material
- elimination of unnecessary witnesses
- booking video conferencing facilities

c) To enable an assessment of a proper venue (if relevant), that is whether an inquest needs to be listed at Melbourne Magistrates Court or County Court.

To enable this, the following Practice Direction applies:

1. As at July 2009, all files provided by Coroners to Listings marked for Inquest for 2 days or more are to have a Directions Hearing.

2. Upon Listings receiving a Directions Hearing Referral (refer to **Attachment A**), a Directions hearing date will be set down within 6 weeks, unless the Coroner requests a longer period.
3. A Directions Hearing will be listed for one hour unless the Coroner requests that it be listed for a longer or shorter period.

4. The Coroner **must** indicate which parties he/she wishes to be notified of the Directions Hearing.

5. The Coroner **must** let Listings know whether the matter can be dealt with in the Lonsdale Street Hearing Room or will need to be booked into a Court.

6. Listings will send a letter to the parties indicating the time and place and purpose of the Directions hearing (refer to **Attachment B**).

7. SCAU will obtain all of the witness details to provide to the bench clerk for the Coroner at Directions Hearing in the form of **Attachment C** for the coroner to complete and return to the registrar.

8. The Listings registrar will be available during the Directions Hearing to confirm availability of dates and to fix dates for Inquest.

9. Upon completion of the Directions Hearing, the Coroner is to complete the Directions Hearing Form, which will contain the adjournment direction either to another Directions Hearing or to the commencement date of the Inquest and any other directions or orders (refer to **Attachment D**).

10. The completed Directions Hearing Form is to be provided to the Bench Clerk on completion of the Directions Hearing. Bench Clerks must ensure they get a completed Directions Hearing Form from the Coroner.

Judge Jennifer Coate
State Coroner
August 24, 2009

Attachment 6

Transcript of Directions Hearing on 15 October 2009

TRANSCRIPT OF PROCEEDINGS

CORONER'S COURT

INQUISITION

MELBOURNE

THURSDAY 15 OCTOBER 2009

BEFORE HER HONOUR JUDGE HENDTLASS, CORONER

UPON THE BODIES OF: (See following page)

MR G. McFARLANE appeared to assist The Coroner.

UPON THE BODIES OF:

DUNNING, Adam

KIELY, Adrien

PETTERSEN, Ian

GREENSILL, Victor

GLASSON, Gwenda

MASSARIA, Anthony

GORDON, James

LONG, Harold

PARKER, Nicholas

MEREDITH, Stephanie

LEE, Jae

MEREDITH, Danielle

MEREDITH, Chantal

McMONNIES, Geoffrey

STUBBS, Matthew

WISHART, Margaret

McMONNIES, Rosanne

WEBB, Ercil

YOUNG, Geoffrey

STANLEY, Kay

SMART, Fiona

NELSON, Haldane

BOYD, Michael

ANGEL, Susan

ANGEL, Caitlin

McCORMACK, Jillian

YOUSIF, Mariam

LOVE, Julie

WINTER, Mark

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3 mechanical, microcopying, photocopying, recording or otherwise) be reproduced,
4 stored in a retrieval system or transmitted without prior written permission of the
5 Authorised Officer.

6 THE CORONER: Good morning everybody.

7 MR McFARLANE: Good morning, Your Honour. I appear to assist you in these

8 matters.

9 THE CORONER: Thank you very much.

10 MR WRAIGHT: If Your Honour pleases, I will be seeking leave to appear on behalf of

11 Ambulance Victoria.

12 THE CORONER: I'm just looking to see if my list is in the same order. That one is,

13 yes.

14 MR PETROVICH: Your Honour, I'll be seeking leave to appear on behalf of Connex

15 and my name is Petrovich.

16 THE CORONER: Thank you.

17 MR RAY: If Your Honour pleases, I appear with my learned junior on behalf of

18 VicRoads and will be seeking leave in due course.

19 THE CORONER: Thank you very much, Mr Ray.

20 MS HARTLEY: If Your Honour pleases, my name is Hartley and I will be seeking

21 leave to appear on behalf of the Department of Transport and VicTrack.

22 MS WILLEKES: If Your Honour pleases, my name is Ms Willekes and I'll be seeking

23 leave to appear on behalf of VLine Passenger Pty Ltd.

24 THE CORONER: Thank you. Just looking for you on the list - it hasn't got your name.

25 What was your name again please?

26 MS WILLEKES: Willekes.

27 THE CORONER: Thank you. Found you. Yes?

28 MR O'CALLAGHAN: Your Honour, my name is O'Callaghan. I seek leave in due

29 course to appear of behalf of Gwen Bates, the mother of Kaye Stanley.

30 THE CORONER: Thank you.

31 MR O'CALLAGHAN: And possibly the assist the coroner in relation to these things.

32 THE CORONER: Thank you very much. It seems a bit funny for other people who

1 are on this list to just have the lawyers at the front desk. Are the other people
2 who are on this appearance sheet - is this everybody here or is the other
3 people who we couldn't get - - -
4 MR PENNO: Your Honour, I've had this situation before - it's probably the Bertram
5 Bar table, I think we've had and another place - I seek leave to appear on
6 behalf of Canny Carrying Co. I think there are others (indistinct) by myself - - -
7 THE CORONER: Other lawyers? Perhaps we could go through the lawyers and then
8 we'll go through other people who are not lawyers.
9 MR PENNO: So my name's Penno.
10 THE CORONER: Mr Penno, yes, thank you very much and if I forget names, you
11 won't mind, I hope. Thank you, any other lawyers?
12 MR PALMOS: Your Honour, I seek leave to appear on behalf of Ian Glasson, son of
13 Gwenda Glasson and my name is Palmos.
14 MS NORRIS: Madame, my name is Norris; I seek leave to appear of the Municipal
15 Association of Victoria and various councils.
16 THE CORONER: Thank you. Thank you for coming.
17 MR MORAN: Your Honour, I seek leave to appear on behalf of the Transport
18 Workers' Union, I appear as counsel for the Union - my name is Bill Moran.
19 THE CORONER: Sorry, you're up the back in the other - - -
20 MR BADALI: I apologise, Your Honour. I was trying to raise my voice without
21 screaming to you. My name is Badali and I seek leave to appear on behalf of
22 Westinghouse Rail Systems Australia, for the inquest into the death of Kay
23 Stanley.
24 THE CORONER: This is the directions hearing, not the inquest, so I'm not going to
25 make that really clear - in terms of leave, I'm granting leave to appear for this
26 particular hearing.
27 MR BADALI: Thank you, Your Honour.
28 THE CORONER: Any other lawyers? Now, who else is on the list who wants to make
29 themselves known to us? Where are the families first? Thank you. How
30 many of you other families over this side - how many are you from the Kerang
31 families? Right. Is Mrs Glasson's family here?

1 MR PALMOS: I'm here representing the Glasson family.
2 THE CORONER: Yes, but she's not here herself?
3 MR PALMOS: No.
4 THE CORONER: Right, now other people at the Bar table - the second Bar table, the
5 virtual Bar table. Dr Rechnitzer?
6 DR RECHNITZER: Yes, Dr George Rechnitzer. I'm here to appear, if you like, on
7 behalf of the Safety Institute of Australia. We would like to have the
8 opportunity to defend - present, if you like, the scientific engineering aspect - -
9 -
10 THE CORONER: Later - all right, thank you. Is that all? Anyone else think I should
11 know who they are? I know quite a number of other people who are here, so -
12 right, now, I've asked you all to come to this directions hearing. People who
13 have been invited to the directions hearing - are all the interested parties who
14 we've identified from our files plus a whole lot of other people who I knew from
15 reading the information I already have, which is a lot, were involved in one
16 way or another so that we could all make sure that the families and the
17 interested parties and the other experts and people who've been involved in
18 investigating level crossings fatalities in particular over a long period of time,
19 all knew where we were coming from and what was going to happen next and
20 could ask questions if they need to.
21 It seemed to me that once the Kerang prosecution was
22 over, it was time to sort of try and work out where to go next and pick up the
23 momentum from my jurisdiction. So that's why we called the directions
24 hearing today and you're all here as at my request.
25 I also thought that for some people who don't understand
26 the coronial system, I needed to explain a bit, again so we can be more or less
27 as much as we can be on the same page. You need to understand that as a
28 coroner, I operate under the Coroners Act. That's my source of jurisdiction
29 and authority but it's also the limits of my jurisdiction of authority. I am
30 required to find the identity of people who die and in this case, in a level
31 crossing collision - the cause of death and to summarise the active

1 circumstances surrounding the death. I may make recommendations and comments to people who
2
3 - or organisations, in order to improve the safety of the system in a way.
4 I need to say to you all that the act includes a number of
5 cases of situations where I must hold an inquest. A level crossing collision
6 causing a death is not a mandatory inquest situation. I do not have to hold an
7 inquest in any of these - to investigate any of these deaths and it's a matter of
8 my discretion whether I do hold an inquest.
9 So that's the first thing to make really clear. There are
10 other circumstances where it might be mandatory but in this case, it's not. I
11 also need to make clear that intend to investigate in any way that I think is
12 reasonable in order to find out the things that I am required to find and that
13 usually, an inquest will only include the evidence where oral evidence is
14 needed in order to - where it will assist me in order to clarify other issues.
15 I have to also say that usually, apart maybe from Kerang
16 because of its size, we wouldn't be having inquests in a lot of these cases
17 because the facts of the case have already been determined very effectively
18 by the police in a way that if we were just doing it just to find the cause of
19 death, the circumstances of the death, an inquest would not be needed. On
20 the other hand, in order to do any of the extra things that we want to do, and
21 particularly to improve the safety of the system, we do need inquests to hear
22 oral evidence.
23 Now, police, under the Coroners Act and under the Police
24 Act, police normally assist in the investigation of all the deaths that are
25 reported to the coroner and I have to say that in all the deaths that are in the
26 29 deaths we are now considering, the police have prepared briefs - I haven't
27 got them all yet because if they're prosecution briefs, I don't get them until
28 after the prosecution and there are still two outstanding and there's another
29 one outstanding just because it was more
30 recent - I think only one, there might be two - but the police have prepared
31 very, very full briefs for us and the circumstances of the death - the particular

1 circumstances of the death - have been quite well explained.

2 I also need to say that the ones that have gone to
3 prosecution, I will be relying on the transcripts from the prosecution cases to
4 understand the information that's also available to me.

5 Now, why are we having a directions hearing, having
6 explained that, that's the first thing - a lot of people know what I've just said but
7 there's also a lot of information - some people don't know those things and the
8 other thing I need to say to you is the State Coroner in discussion has decided
9 that we should investigate as a group the 29 level crossing deaths that have
10 been identified, together, as a group. Also on 1 November, the new Coroners
11 Act comes into place. That is going to change quite a lot - both the focus of all
12 coronial investigations because now we are required to consider prevention
13 and safety issues and rather than it being an adjunct that occurs afterwards.
14 The other thing that will happen after that, after 1 November, is that all findings
15 will be on the internet in inquest cases, so they're available to everybody after
16 1 November and that includes cases that are already completed. If the
17 finding's not completed, the finding handed down after 1 November will be on
18 the internet

19 THE CORONER: All the recommendations must be responded to within three months
20 by the organisation to whom the recommendation is directed with comment
21 about whether it's going to be implemented and whether it's not, for instance.
22 That's quite a big difference in terms of how the coroners have been operating
23 up until now and it means that I'm wanting to make sure that everyone is
24 aware that those changes are coming in on 1 November. And I also want to
25 make it clear that my view is that the reason I'm emphasising that this is not an
26 inquest, is that any inquests that commence after 1 November will be held
27 under the New Act, not the old Act.

28 Now, I just want to make - the things I'm now going to say
29 are where I'm at now, so you know where I'm at in my head, you know what
30 I'm thinking. What I'm going to ask you to do at the end is make submissions
31 if you need to, but respond in writing by the end of the month, two weeks, but

1 tell me another time if you like, rather than necessarily making all those
2 submissions now.
3 I want to make sure that you understand that this is a
4 cohort of, or cluster if you like, of level crossing fatalities. It is not the only
5 information that I will be looking at in terms of understanding the systems and
6 it how it works. I'll also of course be considering previous recommendations
7 made by coroners in similar circumstances and I will be specifically including
8 the two cases of Webb and Moore that Coroner Saines (?) finalised last year.
9 I think it was last year, down in Geelong. Because there is a lot of information
10 the coroner is saying is got particularly from Vic Roads which is now in my box
11 and I now have and they are both truck accidents, semi-trailer, I think - might
12 be
13 B-double. Anyway they are heavy vehicle collisions and that information will
14 be also included.
15 I intend to hold a limited number of inquests. I had to
16 decide how to do this. I did not want to have an individual inquest for each
17 incident. It seemed to me that that was going to move anything any further on,
18 so I intend to hold a limited number of inquests, which will focus on particular
19 deaths. This is no disrespect to other people's, families, who died. It is to try
20 and make sure that we cover all of the issues that I can cover and use my
21 jurisdiction in a useful way.
22 My current view is that I intend to hold three inquests to
23 focus on specific prevention issues. I want to hold at least one of those
24 inquests in regional Victoria. But that will in the end be a decision I will make
25 based on which cases and how the administration occurs as well. I expect
26 that I will close all the other investigations of all the other deaths by Chambers
27 findings to review the facts and issues contributing to a specific death with the
28 recommendations from the relevant inquests attached or follow it. At the
29 moment my intention would be not to complete those until after the inquests
30 are completed, but I am open to suggestion about that. I certain am - there
31 are two - there is one suicide definitely I have already completed. There is

1 another which I think I will be finding is a suicide which I will also complete.
2 They still raise issues because of the stationary vehicles on the train line and
3 in terms of infrastructure and issues like that. Even a suicide, from that
4 perspective, has something to teach us. But the suicides are being closed
5 anyway in that way, as Chambers findings. And that means I do it on the
6 papers. It means the finding - there's no oral evidence actually in that
7 investigation.
8 But I am very concerned not to repeat the large amount of
9 work that has already been done and has been done across the whole of the
10 Government and the private organisations that are involved, the
11 investigations, the commitment to level cross safety that has been continued
12 over the last several years by the police and certainly since Kerang. A huge
13 amount of work has been done; a lot of investigations have been done; a lot of
14 development has happened. I don't want to repeat all that. It's not my
15 intention to rehash all of those things. I want to rely on the work that has
16 already been done.
17 On the other hand, where things have been put into place, I
18 think I do have a role in terms of evaluating how that is going, making sure
19 that it's doing what it's supposed to be doing or intended to do and checking
20 that it's able to provide the safety benefits that we would expect from it. I see
21 that in a whole lot of ways from the information I already have.
22 I would ask everyone here to review particularly the
23 organisations but everyone, because some individuals have also done a lot of
24 work, to review the ongoing research that they have occurring and the
25 investigations they have occurring at the moment, or that they think that I
26 might not have seen and might not have been provided to me - to provide me
27 with information about those investigations and research and the timelines for
28 their completion. So if I can integrate that information into the decisions I have
29 to make about holding of inquests, calling of witnesses and my investigation
30 into particular deaths.
31 I'd also ask everybody to confirm what changes have

1 occurred at level crossing included in this cohort so that I can see what has
2 happened to compare with the investigations that happened at the time of the
3 deaths. I ask you to consider what other issues I might not have even thought
4 of and let me know why you think they are important. The three inquests I'm
5 intending to hold at the moment are not in concrete and if there's another
6 whole issue, which I'll identify the issues and the reasons in a minute, then let
7 me know. I'd like to know because that way we can either integrate into those
8 investigations or inquests we're already intending to hold, or we might have a
9 fourth one.
10 And in particular could you all have a lot and make sure
11 that I have got, that you've sent me - and I have to say the Department of
12 Transport, Vic Roads, Connex, V Line have all been terrific in providing me
13 with all the information that I've asked for so far. Could you just make sure
14 that the most relevant and up to date standards and policies are already on
15 my desk or in my boxes beside my desk, so that we don't find that I'm going
16 ahead on a presumption that's not correct.
17 Now, I'm going to tell you that so far I've classified the
18 following systems - all the information that's happened - under three headings
19 and my current view, subject to what I've already said, would be to hold three
20 inquests, which will mainly be expert evidence and evidence from the people
21 who provide the services. Because as I've said, the information about a
22 particular incident is already fairly well covered by the information in the briefs
23 I already have.
24 The first one that I identified for myself is the infrastructure
25 of policy issues. This is not first in order. It's just number one, because that's
26 where it is in the - under that are the sorts of issues I'm considering at the
27 moment, so you know where it is, responsibility for infrastructure, including
28 departmental responsibilities, including contracts and sub leases, including
29 particularly responsibility for any of the infrastructure that might either cause or
30 prevent collisions with cars at level crossings.
31 Maintenance and compliance. So issues like who paints

1 the roadside, distances from the triggers. One of the things that I've noticed is
2 that with the changes in the way in which trains are running, the increased
3 frequency of course just by definition increased risk, because there's more
4 trains, but also the increased speeds may be influencing the triggers for some
5 of the safety infrastructure on the train lines as an example.
6 The implements of position and technology. For example
7 whether LEDs or filament bulbs are better at particular light situations.
8 Distractions, site interference, all those sorts of things. Decisions about
9 priorities for implementation of level crossing - I call it paraphernalia, but all of
10 the different things that occur at level crossings. The warning, the physical
11 and also whether or not there's even a decision about what has been put in
12 and where it has been put in.
13 The appropriateness of the Australian Standard, whether
14 there was anything in that that can be fine tuned to make it better. The
15 computers on the trains. The in line recording which is occurring on some of
16 the lines. The driver initiating the operating requirements, the whistle boards,
17 speeds. The influence of commercial requirements and I go back to the
18 timetables, the train speeds, the sprinter services, things like that and the
19 physical relationship between the train lines and the roadways, the angle of
20 approaches, the way in which vehicles might have to turn in order to get on to
21 the road that goes across the level crossing and the influence those sorts of
22 things might have.
23 As an example, I've identified a few of the witnesses who I
24 think might be called if that goes - that one will go ahead. It's just whether
25 there are others as well.
26 The Director of Transport and obviously Public Transport
27 Safety, VicRoads, Western Port Council, United Group, the safety designs.
28 The people who make the in line computers. The technical issues to make
29 sure - and I am concerned about whether the computers are providing
30 accurate speed assessments. If they're relying on them or not. So that's one.
31 Number two, would be heavy vehicle combinations, as in

1 my view that increase will almost certainly be the Kerang Inquest, but I'm open
2 to change on that to include another one or something like that, but that would
3 be my view, that the heavy vehicles issues, they all overlap, but the heavy
4 vehicle issues include the emergency medical response to multiple fatalities,
5 which seems to me to have not been properly investigated under our
6 concentration on the level crossing of itself, rather than the (indistinct) the
7 special issues that would occur because of the way in which a heavy vehicle
8 combination is put together and the way in which it works, the geometry of the
9 prime mover, the restricting visibility, the effect of stopping, stop times, the
10 approaches to level crossings on B-double approved roads. That will be a
11 VicRoads issue.
12 Current warnings placed at level crossings, whether there
13 are alternatives that can make that better, particularly for commercial transport
14 trucks and things like that. Medical response. An injury distribution in trucks.
15 So those are just a few of the things I'm thinking about.
16 They are all things that I think have not been properly looked at in the
17 information I now have in my office, but there may be other investigations
18 going on that I don't know about, which already are doing it and the possible
19 witnesses obviously include the Transport Workers Union and include
20 VicRoads, Ballarat Hospital, presuming we use Kerang and we will I'm sure,
21 Ambulance Victoria, the general practitioners, Country Fire Authority, people
22 who respond at medical services to that Kerang accident.
23 Now the third issue that I've identified is human factor
24 issues. It overlaps with both the other two and it's still tentative, because I
25 don't intend to decide exactly that until I've heard the other evidence, because
26 I think the other evidence will raise the human factor issues, particularly driver
27 familiarity with the route seems to me to be the case in all of the 29 - all of the I
28 think it's 15 incidents. The driver, there's only one where the driver was not
29 very familiar with that route.
30 Judging of speeds, sensitivity to lights and bells in the
31 current passive and the active level crossing paraphernalia, influence on

1 perception, fail safe position at active crossings, continuity of trains, audibility
2 of bells and horns. Some of those things have already been dealt with to
3 some degree, but again I think they can be reviewed.
4 Now my current view as I said, the third, the human factor
5 one, I'm not even going to decide which case I think should be - which deaths I
6 think should be reviewed as an inquest in that case, because it will depend
7 what human factors issues arise out of the other two.
8 As I said my current view is that the heavy vehicle
9 combination inquest should focus on Kerang and my current view - and this is
10 tentative - is that infrastructure and policy issues at best covers most of the
11 issues - is the death of Kay Stanley which was down at the Peninsula.
12 I am open to change on that, but my current view would be
13 that that would be the most appropriate inquest case to look at. A lot of the
14 issues, particularly if we know that some of the ones that arise in Kerang also
15 overlap back into that.
16 I currently have three applications for inquests and under
17 the Act any person can apply, ask me to hold an inquest as part of my
18 investigation of the death of any of these deaths. There are three applications
19 before me at the moment. I will take those applications into account when
20 making the decisions and I am required to write back to the people who make
21 those applications if I decide there will be no inquest and explain why.
22 So if anyone, particularly families, thinks that
23 they should have an inquest and they haven't made an application, given what
24 I'm said, then you should write me a letter.
25 One of the things in having this large number of (indistinct)
26 creates is a bit of a conflict between anyone who might think they're going to
27 represent some of the families, because if two or three families want an
28 inquest, then it's going to be a matter of priority, so that might create a bit of an
29 issue, so just think about that as lawyers when you are thinking about what to
30 do.
31 Now I think that was all the things that I - no, there's one

1 other issue, another little bit. In my analysis, and others of people who have
2 been recorded as being interested parties and particularly where lawyers are
3 registered as acting for particular parties, we've found some organisations
4 have more than one solicitor, so that they've got different legal representation,
5 depending on which death they're dealing with and some solicitors and I'm
6 talking about the solicitors in this case, but even barristers, who is it that's
7 acting for two, you I think, isn't it? You're one at the moment, aren't you?
8 COUNSEL: I've got a (indistinct).
9 MS HARTLEY: You could be thinking of me, VicTrack and Department of Transport.
10 THE CORONER: Yes, it is. It goes both ways. If we were dealing with case by case,
11 of course there's not a conflict, but when we're dealing with them all together,
12 it becomes a difficulty. I'm hoping that, particularly the Government
13 departments, but also you, Mr O'Callaghan, will have to consider it to, think
14 about which solicitors you're going to use for this whole cohort, because
15 otherwise it's not going to work, particularly in terms of the inquest. That's all I
16 needed to say so as to make sure you knew where I was at the moment. I
17 think that other people will have things to say now, and that's good, but in
18 particular I also need to reinforce that I'm hoping that you really want to go
19 away and think about this and get instructions, that you can respond in a
20 fortnight, rather than making huge submissions now.
21 MR RAY: Your Honour - - -
22 THE CORONER: You can start, Mr Ray.
23 MR RAY: Yes, thank you, Your Honour. May we confirm, of course, that VicRoads
24 will continue to assist you with the provision of significant quantities of
25 information, and we'll ensure that the information you receive is, of course,
26 absolutely up to date.
27 THE CORONER: Yes, as they have up until now.
28 MR RAY: Yes, indeed. Your Honour, we also support the notion that we don't wish to
29 repeat the large amount of investigation that's already been carried out,
30 certainly by Parliamentary enquiries and other coronial enquiries et cetera. To
31 that end, Your Honour, we would be very grateful if we could receive the other

1 inquest briefs in due course, and perhaps sooner rather than later. The
2 reason for that is, of course, that we wish to assist you and we can't do so
3 unless we can analyse the facts and then make responsible submissions to
4 you about appropriate groupings.
5 We, of course, understand that at the moment you propose
6 an inquest in relation to the death of Kay Stanley and then the Kerang inquest,
7 and we understand the different issues brought together by that, but we can't
8 comment meaningfully about the sub-components of the infrastructure issues,
9 for example, and the other issues of heavy vehicles, until we're able to read
10 those briefs and look at the component parts. Therefore, we would invite the
11 dissemination of that material soon.
12 The final point, of course, is this; the final breakdown or
13 grouping that Your Honour has foreshadowed, may be the subject of, and I'm
14 sure it will be in fact, the subject of further submission to you from us, so that
15 we can assist you in an appropriate structure to move forward. We can't make
16 that final decision, as you indeed haven't at the moment, but we can't make
17 that final decision about how to assist you until we get those briefs. Are you
18 able to indicate when that might occur?
19 THE CORONER: No. We've gone to a lot of trouble to get the Kerang brief organised
20 and I have to thank from the NCIU who got it now at least in terms of the
21 statements, I think, done - is it done? Yes? Done. So that we can provide
22 you with that very easily and one of the things - I should say that we had a
23 meeting about two years ago now with all of the police investigators at that
24 time and one of the things I asked for was that they would put on to an
25 electronic disc, all of the statements that they had. We can provide those to
26 you too. What I find difficult to do is all the extra stuff that comes in - all the
27 other reports and the other things because they are not - they are not on the
28 electronic statements and the other thing I'd say to you is that in terms of the
29 ones that have gone to prosecution, there is the transcript, which is also
30 electronic.
31 MR RAY: Yes. We'd be very grateful - - -

1 THE CORONER: I'd love to be able to provide you electronically but I'm really
2 hesitant about providing all of these briefs in hard copy because - I mean, one
3 of the things is not to cut down so many trees and our staff, having just
4 photocopy, photocopy, photocopy - - -
5 MR RAY: Yes, we understand that, Your Honour. Perhaps the way forward is this - if
6 you are able to disseminate to interested parties any material that you have
7 electronically, if it could be re-shaped in the form of a coroner's brief, we would
8 be very grateful and for the balance of the material, if you could provide us
9 with an index of what it is you have and the areas were you believe that
10 material has relevance to and perhaps even foreshadowing your preliminary
11 view of the relevance that material might have to specific inquest deaths.
12 Then we as a group an analyse that and seek information from
13 you - - -
14 THE CORONER: Whether I do the second half, Mr Ray, at least I can give you an in-
15 depth of the information I've got because I've got that list myself so that's
16 electronic.
17 MR RAY: Yes.
18 THE CORONER: So I can do that easily.
19 MR RAY: And Your Honour, frequently in the management of large court cases, there
20 is, I think, a great benefit to the appropriate numbering of documents and so if
21 those assisting Your Honour could provide a central computer
22 - perhaps, register of documents and label them so that we don't lose our way
23 in this fast quantity of material.
24 THE CORONER: That's a good idea. Mr McFarlane will be very good at that.
25 MR RAY: Sorry to impose work upon others, Your Honour but there we are.
26 THE CORONER: No, we can do that and I've got the list of all the other documents.
27 MR RAY: Yes. And Your Honour, we do indicate that once we receive that
28 information from you, we will then embark upon an appropriate analysis of all
29 of these issues and it may well be appropriate at that stage to have a further
30 mention because it would be appropriate to assist you with our thoughts at
31 that time.

1 THE CORONER: Well, I think that probably we won't have a further mention until I'v
2 made my decision. I'd rather have that in writing and then have a mention on
3 each particular one.
4 MR RAY: Yes. Well, when you say - - -
5 THE CORONER: Because otherwise - so that if you make your submissions about
6 how - you know, whether or not another case would be useful under my
7 headings or another heading, there should be another heading - something
8 I've forgotten completely - that's fine, I'll make a decision and then have a
9 mention under those things because we can then also set down the dates.
10 MR RAY: The only difficulty with that sequence Your Honour, might be that we can't
11 make those submissions to you until we have all the information from you and
12 an interactive discussion such as this may well be of great benefit in helping
13 you to elicit the nature and topic of the final inquest.
14 THE CORONER: It may but I'll decide how to do the second part but I certainly will
15 have a mention under each heading.
16 MR RAY: Yes.
17 THE CORONER: But whether I have a mention before I decide on
18 - another mention before the four headings or three headings or whatever, I'll
19 decide that.
20 MR RAY: Your Honour, quite clearly it is your intention to produce a coroner's brief in
21 relation to each of the 29 deaths that we're dealing with?
22 THE CORONER: Well, yes, except that where there's multiple, there's one brief for
23 the multiples.
24 MR RAY: Yes, of course, but within that multiple of course - and that will deal with all
25 of the deaths involved in that particular incident - but we would need briefs in
26 relation to every incident and every death.
27 THE CORONER: Well, you can have the electronic ones.
28 MR RAY: Yes. Well, that then puts a limitation on the amount of assistance we can
29 give you.
30 THE CORONER: I understand that.
31 MR RAY: And that ultimately is not very satisfactory for those at the Bar table.

1 THE CORONER: Well, I'm sorry, it's just the way it is because with 29 - sorry, 15
2 incidents, the one that are on electronic are really easy. The ones that will go
3 to inquest - really easy. Normally the ones that don't go to inquest, you
4 wouldn't need the brief.
5 MR RAY: Well, if there are decisions to be made about the relevance of them to the
6 issues that you've raised, they need to be disseminated for you to have that
7 input.
8 THE CORONER: Yes, I understand that.
9 MR RAY: And even if the brief is created - if we can have access to it, perhaps even it
10 could be copied, not at the state's expense - therefore imperil the budget of
11 the Coroner's Court - - -
12 THE CORONER: It's not the budget. It's the time. It's the workload.
13 MR RAY: The workload - - -
14 THE CORONER: Well anyway we'll work out how to do it
15 Mr Ray in a way that best means that you can assist me. Don't get me wrong,
16 one of the reasons for only having three or four or a small number rather than
17 a large number was being really aware that a number of these cases would
18 normally not be going to inquest at all. You would never see that brief.
19 MR RAY: Yes.
20 THE CORONER: And it wouldn't be - - -
21 MR RAY: Yes. Well under those circumstances it may even be that arrangements
22 could be made for people to attend the Coroner's Court and view the brief in
23 situ.
24 THE CORONER: Of course we can always do that. We can always do that and
25 would like you to come and see us for that reason.
26 MR RAY: I'm grateful, Your Honour.
27 MR WRAIGHT: Your Honour, could I just adopt one point of my learned friend Mr Ray
28 about the collation of briefs. Your Honour would be well aware of the problem
29 when there's a number of people at the Bar table. We're looking at the same
30 document. Everyone has got a different page number and it's a very wise
31 suggestion if I could say so to nail this at the beginning. For example, the

1 coronial brief may well be two or three folders now. If a third folder of materia
2 was added that there be some form of - - -
3 THE CORONER: A good idea.
4 MR WRAIGHT: It's usually the odd documents that become the important ones and
5 everyone has got a different page they're looking at, so I adopt that
6 submission.
7 On behalf of Ambulance Victoria, Your Honour, I don't
8 believe you have specifically within requesting materials - I can say that
9 obviously the Kerang incident, it was a major incident and there was a lot of
10 review and discussion in the briefings and there is at this stage one main
11 report which in my submission would be of the most assistance to Your
12 Honour.
13 It was completed back in March last year with a number of
14 recommendations for change within the organisation and many of those have
15 been implemented and are continuing to be adopted and implemented.
16 There's been a change of course where rural Victoria has
17 combined with the Metropolitan organisation and it has become one large
18 organisation and so there have been natural changes and (indistinct) with that
19 change, so those recommendations are in that report and attached to the back
20 of that we'll provide Your Honour with a table of what has happened in relation
21 to those changes up to now.
22 So the report was March last year and we'll provide you
23 with that and closer to the inquest perhaps another
24 upgrade again.
25 THE CORONER: Upgrade.
26 MR WRAIGHT: I don't know whether I may have missed this in Your Honour's
27 comments before, but in terms of the order of the two inquests you've
28 identified, do you now have a certainty as to which will go first?
29 THE CORONER: No, because until I've decided definitely that they are the two - I
30 haven't - my present view at the moment would be probably (indistinct) first
31 and Kerang second, but I have to wait to see whether other people make

1 submissions for an inquest and then decide what order, but my view at the
2 moment would be that Kerang shouldn't be first.
3 MR WRAIGHT: If Your Honour pleases.
4 THE CORONER: There's a lot of work to be done on exactly your issues, the health
5 issues and the medical response and the general emergency response. The
6 information hasn't yet been provided to me. I haven't asked for it. I knew
7 there was a report done, because somewhere in the documentation it refers to
8 that report, but I haven't followed it through yet.
9 MR WRAIGHT: We'll provide that to Your Honour as soon as we can.
10 THE CORONER: There will be other witnesses who will probably have an interest in
11 that which is why I think that there will have to be another directions hearing
12 about that nearer the time when it's worked out.
13 MR WRAIGHT: If Your Honour pleases.
14 THE CORONER: Thank you very much Mr Wraight.
15 MR WRAIGHT: Just one other point, Your Honour - - -
16 THE CORONER: Sorry.
17 MR WRAIGHT: - - - I'd like to raise, sorry. Just in relation to one aspect of the
18 emergency response, you will have read the term the SHERP plan or the
19 State Health Emergency Response Plan, that is actually administered by the
20 Department of Human Services.
21 THE CORONER: Understood.
22 MR WRAIGHT: I only raise it now in that I only act on behalf of Ambulance Victoria.
23 THE CORONER: I understand.
24 MR WRAIGHT: As far as we must implement that plan when it becomes live, of
25 course I can act and assist on that basis. If there is any criticism in relation to
26 Kerang as to the application of that plan, then DHS may have a separate
27 issue.
28 THE CORONER: There are a number of parties who are not here yet and DHS is
29 one, although we did notify them about this. They probably didn't understand
30 why we'd asked them, but this is why and there's a whole lot of medical people
31 from up there, hospitals up there and a number of other agencies like State

1 Emergency Services and CFA and there may be others who will be involved
2 and not just the medical response, but the general response which overlaps in
3 as much as it relates to the injuries and the deaths and there's also the
4 transfers and decisions about transfers and Mr Long was transferred. He was
5 transferred to the Alfred and died at the Alfred, so there's all of that part as
6 well, some of which was ambulance and some of which is not ambulance and
7 I haven't further down the track into that part of it yet.
8 They'll all be asked to provide statements as I see and
9 that's why I'm sure there'll be enough mentioned on that case and that's part of
10 my answer to Mr Ray as well.
11 MR WRAIGHT: Thank you, Your Honour.
12 THE CORONER: Now Ms Hartley, can we just - - -
13 COUNSEL: Sorry, can I be heard briefly in relation to this photocopying and supplying
14 of the briefs?
15 THE CORONER: Can we have that at the end?
16 COUNSEL: Yes, Your Honour.
17 THE CORONER: Ms Hartley, she's been waiting, waiting.
18 MS HARTLEY: Your Honour, firstly might I assure you that in relation to the matters
19 that you've raised as issues on which you would seek further material, those
20 issues have been noted and efforts will be made by the Department and
21 VicTrack to provide you with any relevant further material.
22 THE CORONER: Thank you.
23 MS HARTLEY: Secondly, I wanted to echo the sentiments that have already been
24 expressed that in my submission it would not be possible to make full
25 submissions about which of the accident or accidents should comprise the
26 third inquest until the inquest briefs have been made available and I just
27 wanted to pick up two additional issues, Your Honour, that have not been
28 traversed yet.
29 The first is Your Honour would be aware that my instructors
30 have provided you with three Parliamentary reports on rail level crossing
31 safety.

1 THE CORONER: Two from June this year.

2 MS HARTLEY: Two from June this year and one only from December last year, so
3 each is current.

4 THE CORONER: Yes, absolutely.

5 MS HARTLEY: It would be my client's contention that each is a full and careful
6 analysis of a number of issues relating to rail level crossing safety and it
7 follows from the recency and the comprehensiveness of those reports that my
8 client's would be urging you not to seek to re-invent any of the wheels that
9 have already been invented in that process. Clearly - - -

10 THE CORONER: You can assure them I agree entirely.

11 MS HARTLEY: Thank you, Your Honour. The remaining matter that I just wanted to
12 touch on is Your Honour's proposal that
13 after the completion of inquests the remaining matters will be dealt with in
14 chamber findings. That's a course of action that my client's would endorse,
15 but there are two issues about it that I did want to raise.

16 The first is that once the inquest briefs have been made
17 available, it's possible that we or other parties may be of the view that
18 additional evidence is required before any determination could be made and
19 so we would want at some stage to have the opportunity to make submissions
20 to Your Honour about that.

21 The second is that the process which was adopted by
22 Coroner Saines in Geelong was a process which my clients believe worked
23 very well and we would commend it to Your Honour. In those inquests, after a
24 directions hearing where the issue of the accuracy of the material on the brief
25 was canvassed, Coroner Saines then prepared draft findings and circulated
26 them and then scheduled a day during which submissions could be made on
27 the proposed draft findings. That's something that seemed to my clients to be
28 an economical use of court time but also a process that gave an opportunity
29 for relevant issues to be ventilated properly. Those are the submissions that I
30 would make at this time.

31 THE CORONER: Thank you very much and thank you for the last one. I was aware

1. of that and it was a decision - I'm leaving it to nearer the time that I get there.
2. But I have understood that and I'm hoping that something like that will be able
3 to happen other than physical submissions, written submissions or a day of
4 hearings, I'm not sure but they're a bit too far away but I agree with you.
5 Now, anyone else got anything they want to say? Any
6 other questions? Mr McFarlane is now going to tell us about how difficult it's
7 going to be.
8 MR McFARLANE: Yes, Your Honour. Most police do not have the facility to produce
9 an electronic proof. Very little of the material we have is electronic, just some
10 of the statements. There's no way that counsel are going to be able to
11 understand what's happened in this incident just with what is on the electronic
12 copy. And I don't think an index is going to be of great assistance to them
13 because there's a number of other reports from various bodies that are
14 attached that we don't have electronically to supply.
15 THE CORONER: I think we're going to have to have a big tin of instant coffee.
16 MR McFARLANE: What I was going to suggest was that - there's also a number of
17 reports that Your Honour intends to rely upon, very difficult for the counsel to
18 read the brief in isolation from the reports that Your Honour's considering,
19 including as part of the finding you're considering. We suggest that what may
20 be more appropriate is to utilise an outside printer or something to go through
21 the process of printing all the briefs in similar numbered copies that could be
22 supplied to everybody along with those reports that Your Honour intends to
23 rely upon. I think to try and do it in ad hoc fashion with the small amount of
24 electronic material we have, it's very difficult for counsel to come up with any
25 sort of numbered, comprehensive brief that they can utilise effectively.
26 THE CORONER: I understand that, that's why I'm trying to work out how to do it.
27 We'll have to consider how to do this when we get back to the office but my
28 view is that there are two sets of information there. There's the brief which
29 talks about circumstances and the police investigation and that's the
30 statements really. In a sense, we've got to work out a way of being able to
31 provide that to everybody, given what you've said with the limitation that it's

1 really clear. Then, there's all the other documents which are general and not
2 about the specific case. Those are the ones that we have to work out,
3 whether to provide them or whether you come and look at them or whether we
4 tell - we'll tell you what they are, but they're going to increase any day
5 everyway, the stuff is coming in every day, there's more reports, more
6 information and there's no way. Like, two of the reports that Ms Harley's
7 instructors sent this week - I knew about one of them and read one of them
8 taken into account, the Victorian one, but not the other two.
9 There's going to be more of that. That's what I'm asking
10 you to do, is to provide more of that. Keeping that up to date is going to be
11 pretty hard, even if we get it all done now, which we can't. So I'm quite happy
12 to try and work out how to provide you all with the briefs that if you perhaps
13 give Mark your names if you want the briefs of the statements related to each
14 particular collision and we'll work out a way to do that. Providing all the other
15 information, we can provide you with what we've got now as a list. A lot of it's
16 on the net anyway, and you can come and look at it. I think it's the way but
17 we'll talk about that and let you know.
18 MS HARTLEY: There was one other matter that I should have raised when I was on
19 my feet, Your Honour, and that it is to ask Your Honour whether the three
20 applications that Your Honour has received for inquest will be on the inquest
21 briefs? If not, then I would like information about - - -
22 THE CORONER: No, they won't. I can tell you which ones they are, but no, they
23 won't be on briefs because that's an administration - - -
24 MS HARTLEY: Could we have that information?
25 THE CORONER: One is Glasson, I think. No, Massaria, Pettersen.
26 MS HARTLEY: Sorry, what was the last one, Your Honour?
27 THE CORONER: Pettersen. Which is from 2002, I think. Pettersen's one of the
28 original 2002 ones. Massaria is a death that occurred at a level crossing in
29 the train yards, Tottenham train yards. So it isn't a public level crossing, it's a
30 private level crossing. Then the other one is Stanley. Those are the three
31 formal requests I had.

1 MS HARTLEY: I took that to be four, Your Honour. I thought that Your Honour said
2 Stanley, Glasson, Massaria, Pettersen.
3 THE CORONER: No it's not Glasson. Glasson was my mistake. I noticed that
4 somebody was here representing Glasson.
5 MR PALMOS: That's correct.
6 THE CORONER: Do you think that your clients will be making an application for an
7 inquest?
8 MR PALMOS: They may well, Your Honour. They may well. I'll be seeking
9 instructions on that. I thought there might have been an inquest previously.
10 THE CORONER: I don't think so. I mean I might have made a mistake. But we
11 wouldn't normally be providing you with the reasons for the actual applications
12 for an inquest. We take them seriously, we have to consider them seriously
13 and I will.
14 MS HARTLEY: There is one other matter, Your Honour, and that is Your Honour's
15 mentioned a couple of times this morning that your understanding is there are
16 15 incidents.
17 THE CORONER: I'm not sure about 15, I haven't counted. Just - about 15.
18 MS HARTLEY: Thank you, Your Honour.
19 THE CORONER: But 11 is one. I know 11 is one and there is a three and a two and
20 all the rest are singles.
21 MR RAY: Your Honour, there are two matters that we seek to raise. The first is that
22 we would ask you order a speedy transcript of today's proceedings. If that's
23 not ordered it's our experience that it does take a very long time to appear.
24 THE CORONER: Good idea.
25 MR RAY: Second point is this: that Your Honour has previously referred to hopefully
26 receiving submissions from us so that you can make a further decision within -
27 by the end of the month.
28 THE CORONER: Two or three weeks.
29 MR RAY: Two or three weeks. We're not in a position to do that until we get
30 information and we want to assist you but we can't do so until we cross that
31 threshold.

1 THE CORONER: I hear you.

2 MR RAY: Thank you.

3 THE CORONER: I have to think about how to do that. But probably - I'm not sure

4 how long it will take to at least

get what I've said I can do to you, but hopefully two or three weeks after that.

MR RAY: We were very pleased to hear the suggestion from the police officer assisting, Your Honour. The notion of getting all of the relevant material sent out to a contract copier and the presentation of all of the material - - -

THE CORONER: I'm not in a position to authorise that.

MR RAY: Well, we find that a very simple and appealing prospect so that we can all be given the same level of information. There are a number of people in this room who don't have the resourcing to attend and provide the copy themselves and it would be appropriate in significant issues such as this for the State to accept a degree of responsibility for the sharing of the information so that decisions can be fairly made by people who may not be resourced.

THE CORONER: Thank you.

THE CORONER: I hear you. I will work out to do it. My other point, though, is that the extra information - the other people's information - is coming in every day.

COUNSEL: I understand.

THE CORONER: And so it will never be up to date but we can do the briefs, except for the two that are still outstanding prosecutions. I should also say, if we have any further deaths before the end of the year, my intention is to conclude at either 30, or the end of the year, next stop, so if there's another one it will be in this one but if there's not - hopefully there's not - it will be 29. Anything else? Now, thank you all for coming. I should also say, to people who have information to provide, could you consider, there's people here from a lot of organisations who are doing research and investigations into this sort of incident. Could you try and provide me with a list of anything you have on your files so that I can then ask for it to be provided to me now? I'm looking around - Ms Newark and - who was it you were acting for now, doctor, I forgot? I know you have other reports - I know Dr Wigglesworth - who else

- anyway, if you wouldn't mind providing those to me, and that's my point, then that would be great. Thank you.

TRANSCRIPT OF PROCEEDINGS

CORONER'S COURT

DIRECTIONS HEARING

MELBOURNE

MONDAY 3 MAY 2010

BEFORE DR J.A. HENDTLASS, CORONER

UPON THE BODIES OF:

Adam DUNNING
Adrian KIELY
Ian PETTERSEN
Victor GREENSILL
Gwenda GLASSON
Anthony MASSARIA
James GORDON
Haold LONG
Nicholas PARKER
Stephanie MEREDITH
Jae LEE
Danielle MEREDITH
Chantal MEREDITH
Geoffrey McMONNIES