IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2010 1790

In the matter of Gong Ling Tang

Ruling on Applications under the *Coroners Act 2008*

1. At the commencement of the inquest into the death of Mr Gong Ling Tang applications were made on behalf of a number of the interested parties which require me to rule on the scope of what is relevant to this inquest and the form the inquest should take.

2. The primary application was made by Mr Scott Johns on behalf of his client, Fiona Jones. In addition to a submission that she be excused on the basis of medical grounds (which I shall deal with shortly), Mr Johns submitted that the subject matter his client is able to give evidence about is not a proper matter for inquiry as part of this inquest.

3. The application proceeded on the basis that the expert report of Professor Mark Fitzgerald, which opines that Mr Tang's death was essentially inevitable, is definitive evidence as to the cause and circumstances of death (along with the other evidence currently before me). Mr Johns said that to proceed with evidence concerning Mr Tang's treatment in custody would go beyond what is necessary to establish cause and circumstances of death (and my statutory requirements) and would constitute an inquiry solely for the purpose of making comment and or recommendation.

4. Mr Johns relied upon his written submission, oral submission and a number of authorities.

5. Counsel for other interested parties Kaye Price, Kate Griffiths, Meahgan Whitehead, and Kate Jackson foreshadowed similar applications if Mr John's application was granted by me. Mr Cahill who appears for Ms Jackson did however note that there may be some dispute with respect to the medical evidence.

6. Mr Cahill then made a further application for the proposed concurrent medical evidence to be heard and ruled on before the other evidence is given. In developing his argument Mr Cahill submitted that in fact Mr Tang's death was not a death in custody and that as a result no inquest was required to be conducted.

7. Mr Hore-Lacy SC for the family submitted that the cause of death is a contentious matter and the report of Professor Fitzgerald was far from determinative on the issue of causation. He also noted that even if the medical evidence was clear on the cause of death, the circumstances of the death would remain for consideration. I further note that Mr Hore-Lacy commented that the dividing of an inquest into medical evidence and other matters would be an unusual procedure to adopt.

8. Dr Lyons SC made no submission on the applications.

9. Dr Ian Freckelton SC made no submissions on the scope of the inquest but did however note in response to Mr Cahill's submissions that the Chief Commissioner of Police welcomed an inquest and wanted to learn from the process. He also referred to different authorities supportive of the view that a narrow interpretation should not be adopted when a coroner is considering the circumstances connected with a death.

10. The death of Mr Tang was reported to the Coroners Court on 13 May 2010.

11. It is the practice of the Court upon receipt of a report of death to verify whether the death is in fact a reportable death within the meaning of section 4 of the *Coroners Act 2008* (the Act). I am satisfied that the death of Mr Tang was a reportable death within the meaning of section 4 of the Act.

12. Following the notification of a reportable death, section 67 of the Act requires a coroner to investigate the death and determine, if possible, the identity of the deceased, the cause of death (interpreted to mean the medical cause of death) and the circumstances in which the death occurred, in some cases.

13. In addition, a coroner should consider whether the death raises any issues in relation to public health and safety and whether there are any learnings which could contribute to the reduction of preventable deaths in Victoria.

14. A coroner may hold an inquest into any death they are investigating pursuant to section 52(1) of the Act. This is referred to as a discretionary inquest. The Act also outlines circumstances where an inquest must be conducted, such as where the death was a death in custody. This is referred to as a mandatory inquest.
15. Whether Mr Tang's was a death in custody is a matter I intend to rule on as part of my findings. It is not a matter that need be determined today. Under the Act, I have an 'absolute discretion' as to whether or not to conduct an inquest. I note that there are no guidelines in the Act with respect to the exercise of this discretion but a coroner must however exercise this discretion in a manner consistent with the preamble and purposes of the Act as well as section 7, 8 and 9 of the Act.
16. In deciding whether to conduct an inquest, a coroner should consider factors such as (although not limited to), whether there is such uncertainty or conflict of evidence as to justify the use of the judicial forensic process; whether there is a likelihood that an inquest will uncover important systemic defects or risks not already known about and, the likelihood that an inquest will assist to maintain public confidence in the administration of justice, health services or other public agencies.
17. Having regard to these matters I have determined that it is appropriate to conduct an inquest as part of my investigation and no matters raised today have caused me to alter my view on this matter.
18. All applications before me appear to proceed on the basis of a narrow interpretation of requirements under section 67(1)(c) of the Act – '*the circumstances in which the death occurred*'. The interpretation assumes that circumstances are only relevant where causation is present.
19. This interpretation is clearly not supported by the plain language of the Act, nor the authorities to which I was referred.
20. The thrust of the authorities I was referred to is that, whilst there must be a proper connexion between the death and the inquiry, the inquiry is not confined only to matters of strict causation.
21. Whether or not Mr Tang's treatment in custody caused his death, is a matter for me to determine having regard to the medical evidence.

22. Making findings as the circumstances of his death is a separate matter that I am called upon by section 67 of the Act to consider.
23. I am satisfied that Mr Tang's time in custody is sufficiently proximate to his death to require consideration by me as part of this inquest.
24. It would neither be efficient or appropriate to divide the evidence in the manner suggested by the applicants in this matter.
25. Application is made by Mr Jones that Fiona Jones be excused from giving evidence on medical grounds. The application is supported by a medical certificate from Ms Jones' treating doctor dated 11 November 2013 and stating that she is "unfit to give evidence in court until reviewed by myself." Her medical review followed management issues that occurred in her work place last Friday.
26. Ms Jones was scheduled to attend court tomorrow with a view to giving evidence. In light of the certificate she is excused from giving evidence tomorrow however I will not rule at the moment as to whether she be excused for the entirety of the inquest which is listed for a two week hearing. Accordingly, she remains on the witness list.

IAIN WEST
Deputy State Coroner
11 November 2013