# 2. Key Players in the Process

**The key players in the coronial process are:**

* The coroner
* State Forensic Pathologist
* Coroners’ associates
* Police / coroners’ officers
* Counsel assisting the coroner
* Administrative officers
* Medical researchers
* Forensic Science Service Tasmania
* Tasmania Fire Service
* Senior next of kin
* Interested persons
* Legal practitioners
* Witnesses
* Other key organisations / parties:
	+ Medical practitioners
	+ Religious, cultural and support groups
	+ Registry of Births, Deaths and Marriages
	+ Funeral Directors
	+ Insurance companies
	+ Media

## The coroner

Under the Act, all magistrates are coroners (s 3). The Governor also has the power to appoint any person as a coroner (s 10), but in practice it is almost exclusively magistrates who hold this office. In recent times, specific magistrates have been allocated exclusively or primarily coronial duties. This is to aid consistency, ensure that coroners are experienced and allow them to develop expertise in specific areas of investigation (such as deaths involving medical settings or the deaths of infants). As coroners cannot become experts in all possible areas of coronial investigation, they rely on expert reports and opinions provided by others to guide them in the exercise of their powers.

There are full-time and part-time coroners discharging coronial duties. A full-time coroner heads the jurisdiction and is the delegate of the Chief Magistrate for many aspects of the legislation (ss 7 & 9). The Administrator of Courts holds the role of the Chief Clerk (Coronial Division), as described by section 14 of the Act. The coroners’ office (and state-wide Coronial Division) is managed and co-ordinated by a senior court officer.

There is only one coroner for each inquest and that coroner sits alone on the bench, without a jury (s 6). Unlike the role of a judge (as adjudicator) in adversarial proceedings, a coroner is an investigator in their own right. The coroner makes decisions about the nature and direction of investigations, and requests additional reports or statements if more information is required. Some decisions made by coroners are subject to review and all coronial findings can be the subject of appeal to the Supreme Court.

The functions of the coroner are:[[1]](#footnote-1)

* administrative
* investigative
* judicial
* preventative
* educative.

A coroner has jurisdiction to investigate a death if it appears to the coroner that the death is, or may be, a reportable death (s 21(1)). The Chief Magistrate or their delegate ensures that all reportable deaths are investigated. The aims of any coronial investigation into a death are to find the following (s 28(1)(a-e):

1. the identity of the deceased; and
2. how death occurred; and
3. the cause of death; and
4. when and where death occurred; and
5. the particulars needed to register the death under the [*Births, Deaths and Marriages Registration Act 1999*](http://www.thelaw.tas.gov.au/tocview/index.w3p;cond=;doc_id=58%2B%2B1999%2BGS1%40EN%2B20160512000000;histon=;pdfauthverid=;prompt=;rec=;rtfauthverid=;term=;webauthverid=).

In the case of a fire or explosion, the aims of the investigation are to determine the cause and origin of the fire or explosion, and the identity of any person who contributed to the fire or explosion (s 45(1)).

Coroners also have secondary goals. They seek to protect the public by making recommendations to reduce the incidence of similar deaths, fires or explosions in the future. They aim to further the administration of justice by bringing information to light that may otherwise have remained unknown or unchallenged.

If the mandatory inquest provisions of the Act are triggered, or if the coroner considers it desirable to do so, they will hold an inquest. An inquest is a formal court hearing, where the coroner can compel relevant witnesses to attend and give evidence. Only approximately three per cent of investigations proceed to an inquest.

When a person in the care or custody of a government official dies, justice must be done and be seen to be done. In this regard, the inquest is a public forum where those who may have contributed to deaths are called to account for their actions. The requirement for those in public office to explain deaths in care and custody is essential to government transparency and accountability.

Some of the powers of a coroner are to:

* enter a place and inspect it and anything in it (s 59(1)(a))
* take a copy of any relevant document (s 59(1)(b))
* take possession of an article, substance or thing (s 59(1)(c))
* have legal care, custody and control of any article, substance or thing they take possession of (s 59(7))
* authorise a police officer to do any of the things listed above on their behalf
* restrict access to a place where death occurred (s 34(1)).

Some of the coroner’s powers at inquest (s 53) are to:

* summons a person to give evidence or provide any document or other materials
* inspect, copy and keep any thing so produced
* order a witness to take an oath or an affirmation
* compel witnesses to answer questions
* give any other directions or do any other things they think necessary
* issue a warrant for someone who disobeys a summons, and upon their arrest:
	+ commit the person to prison until they can give their evidence
	+ admit the person to bail
	+ order the person to appear at the inquest.

For more information on the investigation process, refer to ‘Key Elements in the Process: Investigation of deaths’, ‘Key Elements in the Process: Investigation of fires and explosions’.

For more information on inquests and the nature of the court proceedings, refer to ‘Key Elements in the Process: Court Proceedings – general information’ and ‘Key Elements in the Process: Inquests’.

## State Forensic Pathologist

The State Forensic Pathologist assists the coroner by co-ordinating and providing the medical expertise requested by the coroner in order to conduct a thorough investigation. The most important function of the State Forensic Pathologist is to conduct post mortem examinations of deceased persons (including autopsies, which are governed by section 36 of the Act). After their examinations are complete, the State Forensic Pathologist writes a post mortem report, which becomes a key part of the coronial record. The post mortem report aids the coroner to determine the cause of death. Other pathologists can also conduct post mortem examinations as and when required.

The role and powers of the State Forensic Pathologist are set out in Part 3 of the Act. The Macquarie Dictionary defines pathology as ‘the branch of medical science dealing with the origin, nature, and course of diseases’. It also covers ‘the study of diseased body organs, tissues, or cells using laboratory tests’. Forensic pathology goes beyond the traditional confines of this definition, also covering areas such as identification of deceased persons through medical means, and the interpretation and review of medical reports and records.

The State Forensic Pathologist is responsible for ensuring that forensic medical services are provided to the coroner’s court in an efficient and effective manner (ss 17 & 18). The State Forensic Pathologist supervises and co-ordinates pathology across the state, issuing guidelines and ensuring that pathology services are well administered. They also attend scenes of death at the request of coroners, provide expert evidence in court and delegate their functions to approved pathologists when required. Having a State Forensic Pathologist to organise all the services in the state ensures a cohesive approach and strong strategic management of these important services.

## Coroners’ associates

Coroners’ associates are appointed by the Chief Magistrate and may be police officers (s 15(2)) or members of the state public service (s 15(1)).

The role of coroners’ associates is to assist the coroner in investigations by receiving and co-ordinating information, providing quality assurance of investigations, and liaising with families, police, funeral directors, forensics professionals and other key parties to the proceedings. Coroners’ associates maintain an ongoing relationship with the families of deceased persons, offering support and detailed explanations of the coronial process. They also ensure the efficient conduct of the administrative processes that underpin coronial investigations.

The investigation of a death may involve many different State and Commonwealth government agencies, companies and individuals. A high level of co-ordination is required to manage and oversee all the different aspects of the investigation process. Gathering information from the various sources and providing it to the coroner in a clear and comprehensible manner is a task most often conducted by coroners’ associates.

The powers conferred by the Act upon coroners’ associates are to (s 15(4)):

* receive information on behalf of the coroner
* administer oaths and affirmations, and take affidavits
* issue summonses requiring witnesses to attend inquests, to give oral evidence or to produce documents or other materials.

## Police / coroners’ officers

All police officers are also coroners’ officers (s 16(2)). Their role in the coronial process is to investigate deaths, fires and explosions and gather evidence to assist the coroner in making findings of fact. Police are heavily involved in all investigations. The Tasmania Fire Service provides vital extra investigation services in cases of fire or explosion (refer to ‘Key Players in the Process: Tasmania Fire Service’ and ‘Key Elements in the Process: Investigations of fires and explosions’).

The police play an essential role in the coronial process. They notify the coroner of reportable deaths, undertake the investigation and give evidence in inquests that assists the coroner to make findings of fact. Unlike in criminal matters, police are not involved in the prosecution of coronial matters and they do not conduct their investigation to try to prove that events occurred a certain way. Instead, they simply gather evidence for the coroner to use, making sure that the coroner has as much evidence as possible to make the most accurate and complete findings that they can.

During the early stages of the investigation, police often take control of the scene of the death, explosion or fire, and control the flow of personnel and evidence in the area. They will take possession of any document, substance or thing that is relevant to the inquiry on behalf of the coroner (s 59A(1)). They may ask someone who knew the deceased person to identify them at the scene and take affidavits from witnesses and other relevant parties. Tasmania Police guidelines stipulate the use of NAATI (National Accreditation Authority for Translators and Interpreters Ltd) accredited / recognised interpreters if available. It is appropriate for a legal representative to insist on an accredited interpreter for their client if one is required.

All Tasmanian police officers have completed equity and diversity education and training, and will accommodate the needs of people with disability and people with complex communication needs wherever possible (including the use of a contact advocate and / or support person).

The police prepare an ‘investigation file’, which contains key documents that the coroner relies upon when establishing the identity of the deceased person. The file also contains medical reports, photographs and witness statements (refer to ‘Key Elements in the Process: Documents’), and all the other evidence police have gathered in the course of the investigation.

Coroners’ associates co-ordinate the investigations conducted by police on behalf of the coroner. The associates consult with the coroner, follow up any further information and direct police to any areas that require a more detailed examination. All police officers assigned primarily coronial duties are part of Tasmania Police’s Coronial Services Unit.

Tasmania Police also have a number of specialist task forces and units that assist the coroner where appropriate. These include the Tasmania Police Missing Persons Unit, Drug Squad, Firearms Services, Crash Investigation Services and Forensic Services.

The functions and powers conferred on police officers in the role of coroners’ officers are to (s 16 and s 59A):

* assist the coroner to carry out their duties
* carry out all reasonable directions of a coroner
* administer an oath or an affirmation
* take an affidavit
* take possession of an article, substance or thing that is at the scene, which the officer reasonably believes is likely to have evidentiary value in a coroner’s investigation
* enter and inspect a place to secure such an article, substance or thing (if there is a danger that the article, substance or thing could be lost, concealed or destroyed, or its evidentiary value could be ruined or compromised, if it is not secured immediately).

[Tasmania Police](http://www.police.tas.gov.au/useful-links/forensic-science-service-tasmania-fsst/)[[2]](#footnote-2)

## Counsel assisting the coroner

A coroner can be assisted during inquests by a ‘counsel assisting’. The counsel assisting the coroner is an independent government or private legal practitioner, who is appointed to help the coroner to organise and run the inquest. Unlike the coroners’ associates (who are often police officers and deal more with the investigation and the practical aspects of the inquest) a counsel assisting’s role is mostly legal. They examine the evidence and guide the coroner through it, aiding the coroner’s deliberations. Counsel assisting may advise upon and conduct further investigation as necessary, conduct research into relevant areas of the law or advise the coroner on appropriate recommendations. The coroner will seek further direction from counsel assisting if they require more information on an issue. The role of counsel assisting is not at an end until the findings have been handed down.

Counsel assisting may speak with families, friends and witnesses before the inquest to help them to understand the process and find out if there is anything else that they wish to raise. It is important that they develop good communication with families through the inquest. Counsel assisting has their pivotal role in the courtroom, in making submissions, calling witnesses and asking questions on the coroner’s behalf. They may also ask questions on behalf of the families and friends of the deceased person if they are not represented, or if those persons feel uncomfortable speaking in court. It is expected that the counsel assisting will provide information and perform their duties in a fair, unbiased and impartial manner.

In less complex matters, a coroner’s associate may act in the role of counsel assisting.

It is important to note that it is not the counsel assisting’s role to “prove” anything or to represent the deceased person or their families; the role is completely independent. It is to assist the coroner by ensuring that the relevant evidence is put before the Court in an efficient, clear and logical manner in order that the coroner can make the requisite determinations under section 28 of the Act.

The *Coroners Act 1995* (Tas) does not detail the duties and powers of counsel assisting. It does state that a coroner may be assisted by counsel or such other persons as the coroner determines, and may request that the Director of Public Prosecutions provide counsel to assist the coroner at inquest (ss 53(2) & 53(3)).

The functions of counsel assisting include:

* the active pursuit of the truth and the attainment of justice (*R v Doogan* [2005] ACTSC 74 per Higgins CJ, Crispin and Bennett JJ at [162])
* reviewing the investigation conducted by police
* advising the coroner of any further investigation necessary and taking steps to ensure those avenues are investigated
* identifying the issues and scope of the inquest
* identifying persons of interest and relevant witnesses
* appearing at the case management conferences
* conferring with interested parties regarding the scope of the inquest, disclosure of documents and the exhibit list
* identifying possibilities or tentative conclusions relating to matters in s 28 of the Act
* testing evidence with a view to confirming or discounting those hypotheses
* assisting the coroner with reviewing evidence by providing clarification and discussion of the evidence for the purpose of findings and discussing any other matters arising before findings, such as new evidence.

The role of counsel assisting shares some similarities with prosecuting counsel. Such similarities include:

* determining which witnesses are to be called and determining the order in which they are to be called, although ultimately which witnesses are to be called is determined by the coroner
* leading witnesses in a manner that enables them to provide their narrative of events
* making final submissions to the coroner regarding the conclusions open from the evidence, the quality of the evidence and the findings that are open, including the ability to assertively submit for a particular conclusion
* the overriding duty of fairness and the goal of achieving justice (*R v Doogan* [2005] ACTSC 74 per Higgins CJ, Crispin and Bennett JJ at [162]).

However, there are some significant differences between counsel assisting and prosecuting counsel, which include:

* The role of counsel assisting is not to prove a case, but rather to investigate the circumstances of death, and provide findings that can be made in respect of the death.
* The role of counsel assisting may involve a greater deal of flexibility in the approach to the evidence, as the matters in issue may change, and new evidence may become available at any stage of the inquest.
* Unlike in adversarial litigation, counsel assisting meet and have discussions with the coroner throughout the course of the investigation and inquest (*Re Kotan Holdings Pty Ltd; Big Rock Pty Ltd and Colin Saul Rockman v Trade Practices Commission* [1991] FCA 273 per French J at [8]).
* Counsel assisting cannot make submissions to the effect that a person has committed a crime (*R v Tennent; Ex parte Jager* [[2000] TASSC 64](http://www.austlii.edu.au/au/cases/tas/supreme_ct/2000/64.html) per Cox CJ at [7] and [12]).
* Proof of facts is on the balance of probabilities.
* The *Evidence Act 2001* does not bind counsel assisting, as the rules of evidence do not apply to coronial inquests (s 51 of the Act).

### The role of counsel assisting throughout the coronial process

Ideally, counsel assisting is appointed at an early stage. Although exceptions occur, coroners are keen to commence working with counsel assisting when investigations on the coroner’s file are completed but the inquest date has not yet been set.

A typical inquest will involve the following stages:

**Stage 1 - Appointment**

The clerk of the Coronial Division will formally notify counsel that they have been appointed as counsel assisting, and they will be contacted by the coroner or coroners’ associate regarding arranging an initial meeting and allocating tasks. The clerk of the Division may provide counsel with contact emails and details.

In the event of a delay in being contacted, it is appropriate for counsel to contact the coroner or coroners’ associate to enquire as to the progress of the investigation, whether a copy of the file is available, and the current tasks required of counsel.

Once counsel assisting has their first contact with the coroner the tasks they may be required to undertake will include, but are not limited to:

* reviewing the existing evidence
* meeting with the coroner and coroners’ associate for preliminary discussions regarding:
	+ the issues arising, the scope of the inquest and “live” issues of the evidence
	+ whether any further investigation is necessary
	+ identifying the interested persons /organisations
	+ establishing the preferred methods of communication between counsel assisting, the coroner and coroners’ associate, and also clarifying how the coroner wishes to be addressed in informal and formal settings
	+ allocating the general division of tasks between counsel and other staff within the coroners’ office
* preparing and obtaining a ‘to-do’ list, which may include the matters listed above.

Given the relationship between counsel assisting and the coroner is a unique one, differing from the usual “arm’s length” relationship between the judiciary and counsel, it can be a large adjustment for counsel assisting to feel comfortable communicating directly with the coroner and working closely together. Counsel assisting should not be afraid to contact the coroner directly, or to contact them for guidance between arranged meetings.

Whilst counsel assist the coroner, they do not act for the coroner. They are independent, and bring their own legal mind to bear on the proceedings.

**Stage 2 - Preparation**

At this stage, the role of counsel assisting will involve:

* a second meeting with coroner
* preparation of a list of issues in relation to the scope of the inquest, which is prepared in consultation with the coroner
* identifying which witnesses should be called
* preparing a draft timetable and estimated hearing time
* preparing the exhibit list (to the extent possible) and ensuring that exhibits are in order
* determining whether any further affidavit or documentary evidence is required
* ensuring that interested parties have been formally notified in writing of the general nature of the issues to be addressed at inquest (and identifying the nature of evidence that may be subject to adverse comment), and invited to provide email addresses for the delivery of materials and correspondence
* ensuring that documentary evidence has been disclosed to interested parties by staff within the coroners’ office
* arranging a case management conference (ideally this will take place within four weeks from the time the interested parties are notified)
* giving notice of the case management conference to interested parties - this notice may be given orally or in writing (rule 22)
* conducting a scene visit with the coroner if appropriate.

**Stage 3 - Case Management Conference**

For further information regarding the case management conference, refer to ‘Key Elements in the Process: Case management conferences’, and rule 22*.*

Case management conferences can be informal, but in practice they are often held in a traditional court environment as they are an important part of the integrity of the inquest process.

The role of counsel assisting at this stage of the inquest includes the following:

* ensuring that administrative staff or coroners’ associates have arranged a court room and facilities for the date of the conference and that a court clerk is available
* appearing at the case management conference and outlining the issues to be canvassed at inquest as well as the witnesses to be called and estimated hearing time
* ensuring that all parties have relevant documents.

At the end of the conference or conferences (depending on how many are required), there should be agreement as to the scope of the inquest, witnesses to be called, suitable dates for the inquest or the ability to list on a date known to be available, and an estimate of hearing time.

**Stage 4 - Pre Inquest**

Prior to the inquest, counsel assisting should finalise the witness list and prepare an inquest plan. The coroners’ associate will issue summonses for the witnesses, however counsel assisting should confirm that this has occurred. Where possible, witnesses should be advised of a realistic time to appear to avoid waiting or delays.

Other tasks of counsel assisting prior to inquest include:

* considering whether a second or subsequent case management conference is required
* preparing an opening address:
	+ the purpose of the address is to outline the scope of the inquest and the evidence to be adduced
	+ the address should be as detailed and clear as possible, and be focussed on the issues, without making conclusions
	+ counsel assisting can seek review or input from the coroner if appropriate
* ensuring the exhibit list is in order:
	+ the exhibits need not be tendered in the same order as the material appears in the investigation file, however generally the first exhibits are always the same in each inquest, being the Report of Death, affidavit of identification, affidavit of life extinct, affidavit of the forensic pathologist, post mortem report, affidavit of the toxicologist and toxicology report
* ensuring that all questions and requests from other parties are resolved and dealt with, and that all parties have relevant documents.

**Stage 5 - Inquest**

During the inquest, counsel assisting perform the following tasks:

* make an opening address
* call and question witnesses. The manner in which witnesses are questioned can vary, and can be quite different to examination-in-chief in adversarial litigation. A technique that is often employed by counsel assisting it is to have the witness read their affidavit or statement into evidence, rather than just be asked questions. The rationale for this is to ensure that the content of the statement is publicly ventilated and that the witness’ memory is refreshed and the witness has the opportunity to change any evidence
* in matters where a witness’ statement is an electronically recorded interview (that could be of some extended duration), it may be appropriate, with the consent of all parties and the coroner, for the witness to either:
	+ have the interview played back to them, and for them to agree that it was an accurate recording, or
	+ to agree that they were interviewed and answered all questions truthfully. This second course is often the most efficient
* where a party is not represented and there is evidence that is likely to lead to an adverse finding against that party, the rules of natural justice require that counsel assisting should ensure that when leading evidence they explore and test the evidence
* speak with the deceased person’s family members. Often the family members are not represented, in which case counsel assisting should enquire whether there are any questions they have for each witness, and ask the questions for them if they are not comfortable asking questions themselves
* at the conclusion of the evidence, counsel assisting should enquire whether the coroner requires written or oral submissions. If written submissions are required, counsel assisting should ask the coroner to set a timetable for when they need to be filed and a date for the parties to appear and speak to their submissions.

In relation to the submissions, again it is appropriate that counsel assisting confer with the family members of the deceased (if they are unrepresented) to confirm whether there is anything that they wish to say in the submissions.

Counsel assisting should ensure that any submissions regarding recomendations urged are clear and sensible.

Whilst the scope of the inquest and the issues to be canvassed are set well in advance of the inquest, counsel assisting should be prepared for other evidence to come out during the course of the inquest, such as new witnesses coming forward or witnesses changing their accounts. A flexible approach is necessary.

**Stage 6 - Findings**

Prior to delivery of the findings, counsel assisting may be required to assist the coroner by providing summaries of evidence or conducting research.

## Administrative officers

Administrative officers manage the administrative aspects of the coroner’s court, including the in-court aspects of an inquest (as court clerks). Their duties are variable depending on their primary role and on the needs of the coroner’s court at the time.

Some of the duties and functions of administrative officers are:

(in court duties / functions)

* electronically recording the proceedings
* assisting with the management of exhibits
* keeping the coroners’ diary including scheduling inquests and other court proceedings
* administering the oath or affirmation to witnesses

(out of court duties / functions)

* writing correspondence of the Coronial Division
* liaising with the coroners to schedule meetings, inquests and preliminary court proceedings such as case management conferences
* managing files
* fielding general enquiries (through phone and email)
* proofreading findings and other documents produced by the coroners
* organising files for disclosure and viewing
* uploading findings to the web for public access
* coding cases onto the National Coronial Information System (NCIS) database; this information is used as a resource for coroners, researchers and to provide data for ABS statistics
* collecting information and statistics on coronial matters
* culling and archiving closed files
* organising interpreters, security guards and other parties as required for court proceedings
* organising assistance for those with diverse needs.

## Medical researchers

Two part-time medical researchers work with the coroner who specialises in medico-legal investigations: a specialist medical advisor and a clinical research nurse. In medical setting deaths, the clinical and surgical questions that arise are often of a highly specialised nature. Having in-house medical experts to assist the coroner aids accuracy and efficiency in findings.

The duties of these researchers include:

* assessing medical reports, doctor’s statements, scans and test results
* researching the clinically accepted risks associated with particular conditions and procedures
* reviewing treatment given and related outcomes
* reviewing the standard of care provided and the procedures of relevant medical institutions
* assessing whether particular outcomes were reasonably expected, foreseeable or unavoidable in the circumstances of each case
* providing medical reports to coroners.

## Forensic Science Service Tasmania

Forensic Science Service Tasmania (FSST) provides forensic science services to coroners, and to the State Forensic Pathologist. They provide scientific analysis of samples such as fibres taken from clothing, paint flakes, dirt removed from shoes and DNA from under fingernails (or other appropriate biological specimens). FSST also conduct toxicological analyses. Toxicology involves testing blood and other biological samples (when required) for the presence of substances such as alcohol, drugs or medications, and poisons.

Many commonly prescribed medications and illicit drugs, which are potentially significant or important in terms of possible toxicity, are included in routine toxicological screening at FSST. Not all drugs and poisons can be detected during routine toxicology testing. If a substance is not routinely detected during toxicological analyses, sometimes it is possible to outsource forensic toxicology testing to an interstate forensic toxicology laboratory.

Toxicology tests provide information on the specific substances detected and at what concentrations. Identifying specific substances such as alcohol, drugs or poisons is vital in many coronial investigations and supplements the evidence obtained by the forensic pathologist in their post mortem examinations.

FSST also assists in the investigation of fires and explosions. Its staff can provide chemical analysis of explosive compounds and can identify trace accelerants used to initiate fires.

[Forensic Science Service Tasmania](http://www.police.tas.gov.au/useful-links/forensic-science-service-tasmania-fsst/)[[3]](#footnote-3)

## Tasmania Fire Service

The Tasmania Fire Service (TFS) plays a vital role in the investigation of fires and explosions, regardless of whether a death also occurs. TFS personnel are the first responders to the scene of such incidents, and contain any fire and ensure that any explosion site is safe for the public and TFS staff. They also gather evidence at the scene, and identify the cause and origin of the fire or explosion if possible. TFS does not have a dedicated coronial unit.

TFS officers attend all fires and explosions, and additional staff attend and provide support as required. TFS also has access to a network of specialists, such as qualified electrical inspectors and wildfire-qualified investigators, upon whom they can call whenever needed. Once the TFS has completed its investigations, personnel produce a Fire Investigation Report, which is forwarded to the coroner’s court if a coroner is investigating the matter.

It is rare for a coroner to investigate a fire or explosion without a related death. At all fires and explosions, the TFS conducts its own investigations according to its own procedures and may transfer the scene to Tasmania Police if appropriate (as in the case of a suspected crime, such as arson).

For more information on TFS processes of fire investigation, please refer to ‘Key Elements in the Process: Investigation of Fires and Explosions’.

[Tasmania Fire Service](https://www.fire.tas.gov.au/)[[4]](#footnote-4)

## Senior next of kin

**Who / what is the senior next of kin?**

The senior next of kin is a person who has particular legal rights, and these rights activate at discrete stages of the investigation. These rights are the only thing that differentiates the role of the senior next of kin from that of family members and friends who are recognised as interested persons.

The only rights that are exclusive to the senior next of kin under the Act are the rights to:

* object to an autopsy (s 38)
* object to exhumation (s 39)
* be notified of a coroner’s decision not to hold an inquest (s 26(1)(c))
* request a coroner not hold an inquest into a workplace death (s 26A(2)).

Each time one of these rights or matters arises in an investigation, the coroner is required to give the senior next of kin the opportunity to exercise their right(s).

Section 3A of the *Coroners Act 1995* (Tas) explains which person is the ‘senior next of kin’. In summary, the senior next of kin will be the first available person on this list:

1. the current spouse (which includes the other party to a ‘significant relationship’ according to the definition in the *Relationships Act 2003*)
2. a son or daughter who is at least 18 years of age
3. a person in a caring relationship (according to s 5 of the *Relationships Act 2003*)
4. a parent
5. a brother or sister who is at least 18 years of age
6. an executor of the will
7. a personal representative.

Note: If the deceased person is Aboriginal, the senior next of kin can also be an ‘appropriate person’ according to the customs and tradition of the community or group to which the person belonged.

In most cases, it is clear who the senior next of kin is and that legal status will not change throughout the investigation. However, sometimes during the course of the investigation new information comes to light, indicating that another person may be the correct senior next of kin. In this case, the coroner is required to evaluate the information (including seeking submissions from any other person asserting that status) and make the determination afresh the next time there is an opportunity for the senior next of kin to exercise a right.

In some cases, two or more people have equal right to the position of senior next of kin (such as a mother and father, or siblings). To facilitate the investigation, coroners expect families to reach an agreed position as to who is the single point of contact / senior next of kin. If there is no clear channel of communication, investigations can be impeded.

**To make an application for your client to be declared senior next of kin, or to delegate the responsibilities of the senior next of kin to another person**, refer to ‘Key Elements in the Process: Applications – Applications in the coroner’s court (administrative)’.

All family members and friends are able to apply to the coroner’s court to be recognised as ‘interested persons’ to the proceedings. Even though the senior next of kin is the main point of contact between family members and the coroner’s court, in most cases relevant correspondence will also be sent to other close family members or friends who request it.

If you are a legal practitioner representing the senior next of kin then you may apply to access, view and copy the coronial record.

It is important to note that the coroner’s decision as to who is the senior next of kin is only relevant to proceedings in the coroner’s court. A coroner’s decision in this regard does not affect parties legal rights under other enactments which may require a determination as to senior next of kin.

For more information, refer to ‘Key Elements in the Process: How to access documents’.

If you are the senior next of kin and want more information on what this will mean for you, refer to ‘A Guide for Families and Friends: The coroner’s court and me – Who / what is the senior next of kin?’.

## Interested persons

Any person (or organisation) who the coroner considers to have a sufficient interest in the investigation can be an ‘interested person’ (s 52). ‘Sufficient interest’ is not defined in the legislation, but may include people who have information which is relevant to the investigation, people whose interests may be affected by the coroner’s findings, and family members of the deceased person. In *Barci v Heffey* [1995] VSC 13 Beach J stated:

*‘It would seem to me that whether a person has a sufficient interest in an inquest or the outcome of an inquest is a question of fact to be determined after a consideration of the circumstances surrounding the death of the deceased. If a person is closely related to the deceased by birth or marriage or by having lived in a de facto relationship with the deceased, then, in my view, that person would have a sufficient interest. Similarly, if the deceased met his death during the course of his employment, his employer would have a sufficient interest justifying the grant of leave to appear and to be represented. One can envisage many relationships between the deceased and other persons which may entitle those other persons to appear at the inquest and be represented by counsel, eg the teacher of a student killed whilst on a school excursion, the commanding officer of a soldier killed on a peacetime manoeuvre. Any person whose actions may have caused or contributed to the death of the deceased would be entitled to representation. Clearly, a person has a sufficient interest in an inquest or the outcome of an inquest if there is a reasonable prospect that the coroner may make a finding adverse to the interests of that person.’*

Close family members of the deceased person may be automatically deemed interested persons by the coroner’s court.

You can call the coroners’ office at any time to ask if your client is a recognised interested person / party. If they are not yet recognised as an interested person, you can apply to the coroner for them to be recognised.

If the coroner grants your application, or if your client is already an interested person, then they have all the rights of an interested person in the investigation. As their representative, you can apply to view, or have copies of, any statements or affidavits, you may [contact the coroners’ office](http://www.magistratescourt.tas.gov.au/contact/coroners_court) for updates on the investigation and you can ask to receive relevant correspondence from the court. You can appear at the inquest (if there is one) or you can assist your client to appear in person. You can also apply to have another person who is not a legal practitioner speak for your client if they prefer. If you appear at an inquest, you have the right to call and examine or cross-examine witnesses, tender evidence and make submissions.

It is important to note that some people will have a ‘sufficient interest’ in a particular aspect of the matter but not in the investigation as a whole. This interest may entitle that person to access a document, or to make a specific application, but it does not make them an ‘interested person’ under section 52 of the Act.

To make an application for your client to be recognised as an interested person or to be represented by a person who is not a legal practitioner at an inquest refer to ‘Key Elements in the Process: Applications’.

## Legal practitioners

Legal practitioners at inquests may represent any interested person (or organisation) (s 52(4)). This provision allows a legal practitioner to be present in court to represent the interests of the families and friends of the deceased person, or any person whose interests may be affected by the coroner’s findings, amongst others. Often government bodies and professionals such as doctors choose to have legal representation in court. Outside the courtroom, any person may engage a legal practitioner to assist them in their dealings with the coroner’s court.

As a legal practitioner representing your client in the coronial jurisdiction, you may perform a variety of duties, both in and out of court.

Out of court duties include:

* writing correspondence
* conducting legal research
* keeping your client informed of the progress of the investigation
* sourcing any document or evidence relevant to the investigation and providing it to the coroner
* liaising with the coroner’s court to aid the smooth flow of information
* seeking access to and reviewing any document or evidence which is relevant to the interests of your client
* making applications and written submissions on behalf of your client
* speaking on behalf of your client in relation to any preliminary matters
* ensuring that any matter relevant to your client’s interests is considered by the coroner.

In court duties include:

* calling witnesses
* questioning witnesses
* examining the evidence
* defending your client’s position
* making submissions
* tendering evidence
* aiding the court with potential findings and recommendations.

For more information on representing an interested person during a coronial matter, refer to ‘Key Elements in the Process: Investigation of deaths – Representing an interested person in a coronial matter’.

For more information on representing an interested person at inquest (including preparing for court, questioning witnesses and addressing potential adverse findings), refer to ‘Key Elements in the Process: Representing an interested person at an inquest’.

If you are a family member or friend of a deceased person and you wish to contact a legal practitioner to assist you with a coronial matter, refer to ‘A Guide for Families and Friends: Who can help?’.

## Witnesses

A witness is a person who has information that is relevant to the investigation. A witness may be asked to give this information to police verbally, so it can be recorded in affidavit form for the coronial record. A witness may also be called to give evidence at inquest. They may be a professional, a relative of the deceased person or anyone else who can provide relevant information about how the incident occurred.

Interested persons and their representatives may call witnesses but only the coroner has the power to summons them (and compel them to come to court). If you would like a person to give evidence at inquest, write to the coroners’ office and explain who the witness is, what they will say and why their evidence will contribute to the fact-finding capacity of the coroner at inquest. Please specify if you are seeking that the coroner use their power to summons the witness. If you intend on calling a witness to appear yourself, you should also notify the coroners’ office of this.

**If you are summonsed as a witness** to appear at an inquest and you want further information on what will happen, please refer to ‘A Guide for Families and Friends: The coroner’s court and me – I’m a witness at the inquest, what does this mean?’.

If your client is summonsed to appear in court, you can assist them to make a claim for expenses by filing a Witness Expenses Form, which you can find on the Magistrates Court web site, under [Forms](http://www.magistratescourt.tas.gov.au/forms).[[5]](#footnote-5)

If your client requires non-legal assistance in court, please refer to ‘A Guide for Families and Friends: Who can help?’ for help arranging interpreters, assistance for the hearing impaired and other support services. If your client is a person giving evidence and they have a disability or complex communication needs, please refer to the relevant sections below.

**Unable to attend court proceedings?**

If you or your client are located interstate, overseas or are otherwise unable to attend court proceedings for reason of your location or medical situation, you may be able to arrange to appear via telephone conference or video link. If this is the case, please [contact the coroner’s court](http://www.magistratescourt.tas.gov.au/contact/coroners_court) and fill out an Audio Link Bookings or Video Link Bookings Form if required. These are available on the Magistrates Court web site, under [Forms](http://www.magistratescourt.tas.gov.au/forms).[[6]](#footnote-6) There will be a fee involved. All telephone conferences and video links are arranged at the coroner’s discretion.

### Witnesses with disability

People with disability have a right to equal access to justice and are entitled to be heard; they should be given every opportunity to speak *for themselves*. Many people with disability are fully capable and competent in the giving of evidence. A person with disability may give evidence in coronial proceedings as long as they can understand a question about a fact and provide an answer in a format that can be understood.

A person with disability may be assisted to give their evidence in various ways.

These include:

* the use of a professional communication assistant
* the use of a support person (such as a family member or friend)
* the use of appropriate questioning techniques (refer to the link provided below)
* the use of an interpreter (for example, for Auslan)
* establishing ‘ground rules’ for the types of questions that will be asked and the way that questions will be asked and answered
* any other assistance that the coroner believes is necessary.

Case management conferences are an ideal meeting in which to raise any concerns you may have and to ask about options for communication assistance with coroners and their staff. Because the rules of evidence do not apply in coronial proceedings, the coroner’s court is able to be more flexible in accommodating people with diverse needs. If there is something specific which can be done to accommodate the needs of a person, please inform court staff. All reasonable efforts will be made to accommodate requests and to facilitate equality of outcomes.

For more information on this topic, such as questioning techniques to facilitate the giving of evidence by people with disability, please refer to: Attorney-General’s Department, Government of South Australia, [*Supporting vulnerable witnesses in the giving of evidence: Guidelines for securing best evidence*](http://www.agd.sa.gov.au/sites/agd.sa.gov.au/files/documents/Initiatives%20Announcements%20and%20News/DJP/DJP%20Guidelines%20WEB.pdf)(2014).[[7]](#footnote-7)

And also: The Advocates Gateway, The Council of the Inns of Court, [*Responding to Communication Needs in the Justice System*](http://www.theadvocatesgateway.org/) (as at 22 August 2016).[[8]](#footnote-8)

### Witnesses with complex communication needs

Many people have complex communication needs, including some people with disability. Other people who may have complex communication needs include children, people whose first language is not English, Aboriginal people and people with a mental illness. Any of the measures listed under ‘witnesses with disability’ can be put in place to assist people with complex communication needs to give their evidence, if appropriate.

The coroner’s court can be flexible with court arrangements and many aspects of proceedings can be adjusted to enable equal access to justice for all people. If your client is a person with complex communication needs and is required to give evidence in court, please [contact coroner’s court staff](http://www.magistratescourt.tas.gov.au/contact/coroners_court) for assistance.

## Other key organisations / parties

### Medical practitioners

#### The role of medical practitioners in the coroner’s court

When a person dies, a medical practitioner who was responsible for a person's medical care immediately before death, or who examined the body of a deceased person after death, must decide whether they will write out a Medical Certificate of Cause of Death (MCCD) or whether they will report the death to the coroner. They are required to carefully consider the provisions of section 3 of the Act and decide if the death is reportable. If the doctor decides that the death is not reportable, then they must issue a MCCD stating the cause of death and any conditions that were precursors to, or contributed to, the death. If the doctor decides that the death is reportable, then they will report it to the coroners’ associates (or a police officer) and the coronial investigation begins.

Many different medical practitioners assist the coroner’s court. Most often, their role is to provide information about the deceased person’s medical history and the circumstances of their death. These medical practitioners may have been providing care to the deceased at their time of death (such as staff at hospitals and residential aged care facilities) or they may have been treating the deceased person before they died (such as a general practitioner (GP), dentist or physiotherapist).

Sometimes a deceased person may have experienced a specific health complaint that required the assistance of mental health services, drug and alcohol services or disability support services. In cases such as this, the coroner will usually request access to the records of these services, and assistance from treating doctors to understand the nature and progression of the deceased person’s illness or disability.

The coroner may ask a doctor to provide a statement for the coronial file, or to prepare an expert report on the treatment they have provided, or on the patient’s medical condition/s. If families or friends wish to read the post mortem report of a loved one (which is prepared by a qualified pathologist), a doctor may be asked to receive the report and help the families and friends to understand the medical language used.

If a doctor is involved in a coronial proceeding, they may be requested by the coroner’s court to do any of the following:

* review a decision not to issue an MCCD in relation to a death
* provide the complete medical records of the deceased
* provide information on:
	+ family history
	+ the circumstances of death
	+ the progression and treatment of any medical conditions suffered by the deceased
	+ any medical conditions which may have contributed to, or been a precursor to, the death
* provide a statement or report to the coroner
* assist families and friends to understand medical reports and documents (including the post mortem report)
* provide an expert report
* give evidence in court about the death and any event/s which preceded it
* give expert evidence.

The focus of a coronial investigation is to find out what caused and contributed to the death, and in some investigations, to prevent it from happening again. The focus in medical related matters is often on systemic issues. By focussing on the system in which mistakes occurred, a coroner can make recommendations to improve the system and prevent future deaths.

**If you are a medical practitioner** and you are seeking advice on whether a particular death is reportable, please refer to the information provided in ‘When to report a death to the coroner’.

[Department of Health and Human Services](http://www.dhhs.tas.gov.au/)[[9]](#footnote-9)

[Primary Health Tasmania](http://www.primaryhealthtas.com.au/)[[10]](#footnote-10)

[Australian Medical Association – Tasmania](https://ama.com.au/tas)[[11]](#footnote-11)

[Royal Australian College of General Practitioners](http://www.racgp.org.au/home)[[12]](#footnote-12)

#### When to report a death to the coroner

This is a guide prepared for medical practitioners to assist them to determine whether a death is reportable. It is included in the Handbook as the information may be useful to legal practitioners if they are required to advise clients on this and related issues.

When a death occurs, a medical practitioner who was responsible for a person's medical care immediately before death, or who examines the body of a deceased person after death has an important decision to make:

Do I write out a Medical Certificate of Cause of Death (MCCD) or report this death to the coroner?

* If you can issue a MCCD but don’t *within 48 hours*, you are guilty of an offence.
* If you have to report a death to the coroner and you don’t *as soon as possible*, you are guilty of an offence.
* Both these offences carry a penalty not exceeding 10 penalty units ($1,570 in 2016-2017).

So how do you make the right decision?

* Take a reasonable time to review the deceased person’s medical records.
* Ask the police, or other relevant parties, about the circumstances of death.

You do not need to have treated the deceased within a certain period before death, (or ever) to complete a MCCD or report a death.

You do not need to report a death if someone else has already done so.

**Is this death reportable?**

The *Coroners Act 1995* (Tas) contains an exhaustive definition of ‘reportable death’. The most relevant sections of the definition for medical practitioners are:

A death:

**iv.** that appears to have been unexpected, unnatural or violent or to have resulted directly or indirectly from an accident or injury; or

**v.** that occurs during a medical procedure, or after a medical procedure where the death may be causally related to that procedure, and a medical practitioner would not, immediately before the procedure was undertaken, have reasonably expected the death; or

**vii.** the cause of which is unknown; or

**ix.** of a person who immediately before death was a person held in care or a person held in custody; …

Whether a death was “natural” in a medical or a legal sense is often very difficult to ascertain. There are often natural and unnatural causes contributing to a death, which may be present in various degrees. With this in mind, below is a practical checklist to assist medical practitioners to determine whether they are required to report a death to the coroner.

**If you answer “yes” to *any* of the following questions, the death is reportable.**

Does it appear that an injury or an accident contributed to the death?

* The injury / accident does not need to be recent; there is no time limit.
* It includes any injury / accident that contributed to the death in any way that was **not minimal or trivial.**
* Example one: If a motor vehicle crash causes paraplegia and the person dies years later from a complication of the paraplegia, this death is reportable.
* Example two: If an elderly person suffers a **fall** which results in a fractured neck of femur and this accident hastens death, even if natural processes contributed to the fall, it is likely the death is reportable.

Was the death possibly a suicide (or unintentionally self-inflicted)?

* this includes situations where you have concerns that a person may have contributed to their own death by overdose or neglect.

Does it appear that violence contributed to the death?

* Are there suspicious circumstances, or a history of violence, which suggests violence may have contributed to the death?

Was the person in police or government care or custody?

* this includes someone who is being taken into custody or trying to escape from custody
* this includes a prison, a detention centre or a secure mental health unit
* this includes a person under a Mental Health Order
* this includes a child under a Child Protection Order, who is under the custody or guardianship of the Secretary.

Was the person a child under one year of age, and the death *sudden* ***and*** *unexpected*?

* an infant who is born deceased (a stillborn) is not reportable
* a neonate who shows signs of life outside the womb and then dies will be reportable if the death was also sudden **and** unexpected.

Is the cause of death unknown?

Is the identity of the deceased person unknown?

Did the death occur *during* a medical procedure?

* **A ‘medical procedure’ is** any procedure performed on a person by, or under general supervision of, a medical practitioner (including imaging and external examination).
* A death which occurs *during* a medical procedure is reportable if the death would not have been reasonably expected by a medical practitioner immediately before the procedure was undertaken.

Is it reasonably possible that the death is related to a medical procedure, treatment or lack of treatment?

* A death which occurs *after* a medical procedure is reportable, if:
	+ the person would probably not have died at the same time if the treatment had not been provided, **and**
	+ the death would not have been reasonably expected by a medical practitioner immediately before the procedure was undertaken.
* A death may be related to lack of treatment, if:
	+ the death would probably not have occurred at the same time if the treatment had been provided, **and**
	+ a medical practitioner in the same situation would reasonably have expected that the treatment would be provided.

**NOTE for medical setting deaths:**

In deciding what it was reasonable to expect, take account of:

* the state of the deceased’s health at the time medical treatment was sought
* the clinically accepted range of risk associated with the treatment
* the circumstances in which the treatment was sought.

**If you answered “no*”* to *all* these questions and you are confident you are able to attest to the cause of death then you must complete a MCCD.**

**If you have any doubt about whether a death is reportable**, you should seek advice from a coroners’ associate *immediately*. They are available at the coroner’s court during business hours and on-call outside office hours through the police radio room (131 444). The deceased person should be left in place pending advice (as advice can be provided immediately).

**Completing a MCCD**

If you require guidance on how to fill out a MCCD, please see ‘[Information Paper: Cause of Death Certification](http://www.abs.gov.au/AUSSTATS/abs%40.nsf/DetailsPage/1205.0.55.0012008?OpenDocument)’[[13]](#footnote-13) ABS 2008, 1205.0.55.001 and the accompanying Quick Reference Guide.

**Reporting a death to the coroner**

How are deaths reported to the coroner?

* All deaths should be reported *immediately to a coroners’ associate over the phone* (see contact details below). You can also report the death to a police officer if a coroners’ associate is not available or a police officer is already present.
* The *Coroners Rules* say that deaths must be reported in writing, or the report confirmed in writing, within 48 hours. *The coroners’ associates / police will complete the written report for you.*
* **If you are a doctor in a hospital**, that hospital may have its own form to report deaths to the coroner. Seek advice from your supervisor to ascertain if you have to complete a form.

Is there a requirement to provide a requested document or statement to the coroner?

* You are advised to comply immediately with any request for documents as the coroner has the power to authorise a police officer to enter any place, seize the documents and take a copy. This includes medical records and imaging.
* The coroner is not required to pay for copies of documents (once they are requested, they become evidence in a coronial investigation).
* Any requests should be treated as urgent.
* Confidentiality laws do not apply to documents requested by the coroner. Any records or documents provided will only be used for the purpose of the investigation.
* The coroner may request that you provide a statement to aid the investigation. You are not required by law to provide a written statement. However, any person who reports a death must give the coroner any information which may help the investigation (failure to do so is an offence).
* The coroner may send a summons requiring you to attend court and give evidence. Failure to comply with a summons is an offence.

Preparing the deceased person for the coroner:

* Always leave any clinical support equipment / medical apparatus in place.
* If there are any needles or other “sharps” present in the body at death and these are left in place, you must notify the coroners’ associate upon reporting the death.
* Do everything possible to ensure that the deceased person remains in the same condition as they were at the time of death.

Religious and cultural concerns

Certain religions have beliefs regarding burial / cremation that require the body to be released very quickly. Others may object to post mortem procedures such as autopsy or the taking of blood. If you are aware of any such concerns, you should notify the coroner upon reporting the death.

### Religious, cultural and other support groups

Religious, cultural and other support groups play a vital role in assisting the families and friends of deceased persons to negotiate the coroner’s court. People from religious and cultural minorities can sometimes feel uncomfortable expressing their views to public officials. Past experiences, both personal and historical, can cause fear and anxiety and prevent people freely communicating their feelings. Support groups include any group that provides individual or social support to a particular group in society based on ethnic background, sexuality, gender identity, disability or any other attribute.

A religious, cultural or other support group whose members understand the needs and beliefs of affected families and friends can help bridge the gap between the coroner’s court and those individuals. Anyone can contact such a group and they can talk to the court on that person’s behalf, explaining their views. If your client is a member of a particular social group with diverse needs, then the use of a support group as an intermediary may assist them to express their views and concerns in a clear manner.

Religious, cultural and other support groups can also help coroners to understand how a deceased person may have felt about certain issues or in certain situations, giving them a deeper understanding of the deceased person and their life. Understanding the viewpoints of the families and friends of the deceased person can also help the coroner and the coroners’ office to communicate in an appropriate, respectful manner when dealing with the bereaved.

For information on groups that may be able to assist, refer to ‘A Guide for Families and Friends: Who can help?’.

### Registry of Births, Deaths and Marriages

The Registry of Births, Deaths and Marriages (BDM) maintains the Register of all deaths in Tasmania. It also issues death certificates and provides statistical data to government departments and some approved private organisations. Once the coroner’s court receives the initial police Report of Death, a Registration of Death Statement is generated and sent to BDM. The death is then registered and an interim death certificate can be issued. The certificate will have an endorsement stating ‘incomplete registration – cause of death subject to coronial inquiry’. Once the cause of death has been determined, the coroner’s court notifies BDM. BDM then finalise the death registration and the endorsement is removed. After this, anyone who received an interim death certificate can return it to BDM in exchange for a standard death certificate. If you require a copy of a death certificate, you may apply to Service Tasmania.

For more information on death certificates, refer to ‘Key Elements in the Process: Documents’.

The coroner is required to state the particulars needed to register the death under the [*Births, Deaths and Marriages Registration Act 1999*](http://www.thelaw.tas.gov.au/tocview/index.w3p;cond=;doc_id=58%2B%2B1999%2BGS1%40EN%2B20160512000000;histon=;pdfauthverid=;prompt=;rec=;rtfauthverid=;term=;webauthverid=) in their findings if possible (s 28(1)(e)). At this point, there is no legislation stating which particulars are required to register a death. The practice of coroners is to only record the personal particulars which may be appropriate in the circumstances of each case.

For more information on the registering of deaths, refer to ‘Key Elements in the Process: Registering of deaths’.

[Registry of Births, Deaths and Marriages](http://www.justice.tas.gov.au/bdm)[[14]](#footnote-14)

### Funeral Directors

Funeral directors help families and friends of deceased persons to lay their loved ones to rest in a respectful and dignified manner. Family members are welcome to contact a funeral director to arrange care for their loved one at any time. Once the coroner has gathered all the information they require from the deceased person’s body, they will sign a certificate authorising release of the body. If the coroner’s court is aware that family members have contacted a funeral director, then the mortuary staff will call the funeral director when the deceased person is ready to be collected. The coroner’s court will call the senior next of kin and let them know, so the funeral director may also be contacted by families to request that the deceased person be collected. If a family contacts a funeral director, they will liaise with the mortuary to transfer the deceased person into their care as soon as practicable.

For more information, refer to ‘A Guide for Families and Friends: Practical matters’ and ‘A Guide for Families and Friends: Who can help?’.

**Information for funeral directors**

* The deceased person cannot be collected from the mortuary until the coroner signs a certificate authorising their release.
* If the coroner is notified that you have been contracted to care for the deceased person, then mortuary staff will contact you as soon as the body is ready to be collected.
* The senior next of kin will be notified by the court once the certificate authorising release is signed, so they may also choose to notify you.
* The coroners’ office will be able to provide guidance on when the deceased person is likely to be released for burial or cremation.
* The coroner will have named the senior next of kin at various stages in the investigation. The coroner’s decision on who is the senior next of kin has no bearing on any legal proceedings outside the coroner’s court. If there is a disagreement about to whom the body should be released, parties should apply to the Supreme Court under probate law.
* All medical procedures are undertaken with the aim of returning deceased persons to families for cremation or burial as soon as is reasonably possible.
* Once a deceased person is released by the coroner, there are no additional restrictions placed on cremation, manner of burial or location of burial by the coroner (over and above the usual Tasmanian laws surrounding burial and cremation).
* Police will take all the personal effects belonging to the deceased person. If any family member or close friend is seeking return of these items, advise them to contact the coroner’s court.

### Insurance companies

Insurance companies may be involved in coronial proceedings for a number of reasons. These include matters where there has been motor vehicle damage due to a fatal crash, matters involving superannuation and matters where insurance claims are made relating to deceased persons (such as payouts for life insurance). Insurance companies may be granted access to a particular coronial document if they have a ‘sufficient interest’ in that document. For example, if an insurance company genuinely needs to know the cause of death they can notify the coroners’ associates of their interest in the matter. Once the coroner’s findings are ready, they will release a copy to the insurance company. It is not possible for the coroner to issue a ‘preliminary’ or ‘draft’ finding before the investigation is complete.

It is common for an insurance company to have a sufficient interest in one document to receive a copy. Insurance companies rarely have an interest in relation to an entire investigation. Although their interest in a matter is enough to allow access to some documents, it will not usually give them the right to question witnesses in court and exercise other rights of an ‘interested person’. In some cases, the coroner will take custody of an item (such as a motor vehicle) as evidence during an investigation. All items held as evidence remain in the custody of the coroner until they make an order as to care and control, or until the findings are handed down, whichever occurs first. If a coroner does make a care and control order (s 60) the item can be returned, however it remains in the custody of the coroner and so it must not be altered or disposed of until the findings are handed down. For example, if an order is made returning a laptop, the laptop cannot be sold or any files deleted.

Insurance company representatives are asked to note that the coroner does not issue death certificates. A coroner will make findings as to cause of death, but death certificates can only be sourced from Births, Deaths and Marriages (via Service Tasmania). If a bank or other institution requests a ‘death certificate from the coroner’ you should clarify whether they are requesting a copy of the ‘coroner’s findings certifying cause of death’, or whether they are requesting the ‘death certificate’ from Births, Deaths and Marriages.

For more information on how to apply to Service Tasmania for a copy of the death certificate, refer to ‘Key Elements in the Process: Documents’.

### Media

The media play an important role in coronial proceedings, conveying the coroner’s findings into the public arena. It is through media reports that most people become aware of coronial findings and therefore, it is through the media that inquests and findings can make their most significant impact on the public. One of the coroners’ most important roles is to protect the public, and therefore the coroners’ office works with the media so that the public is made aware of coroners’ comments, warnings and recommendations, and their knowledge and wellbeing are increased.

The media can also play an important role for families. If the families and friends of a deceased person feel that the death of their loved one could have been avoided, the public naming of any authorities that may have contributed to the death can have a positive emotional effect. People feel that their voice has been heard and this can help them to cope. The death of a loved one is a tragic event and the knowledge that others have been saved this pain can be a comfort in difficult times.

**Information for the media**

* All coronial inquests are open to the public and the media, unless the coroner orders otherwise. The coroner has the power to exclude a person from court for a part or all of the proceedings, although this does not often occur.
* You are welcome to make notes during inquests including direct quotes; however, you may not record sound or images anywhere in the court building.
* The staff at the coroners’ office are always pleased to assist by providing court dates and information on the status of an investigation where appropriate.
* You may apply to access documents on the court file using the ‘Application to Access Coronial Records’ form on the Magistrates Court web site, under Forms. Access may be granted where you, or the organisation you work for, has a ‘sufficient interest’ in the document in question.
* All information disclosed during an inquest can be published unless a coroner makes an order restricting the publication of proceedings (or evidence tendered at an inquest) in whole or in part. There are penalties for publishing materials restricted in this manner.
* The factors which a coroner will take into account when determining any application to restrict or prohibit publication are, whether publication would:
	+ be likely to prejudice the fair trial of a person
	+ be contrary to the administration of justice, national security or personal security
	+ involve the disclosure of details of sensitive personal matters including, if the senior next of kin of the deceased has so requested, the name of the deceased.
* Some coronial cases are highly sensitive and care must be taken in reporting these matters in a suitable manner. In particular, when reporting on cases where suicide and mental illness are factors, the following document should be consulted: ‘[Reporting Suicide and Mental Illness: a *Mindframe* resource for media professionals](http://www.mindframe-media.info/__data/assets/pdf_file/0011/9983/140519_MindFrame-for-Media_PDF.pdf)’.[[15]](#footnote-15) This resource is available free on the Mindframe web site under ‘For media’.
* Coronial findings are often published, and when this occurs they are made available for public viewing on the coroner’s court section of the Magistrates Court web site, under [Coronial Findings](http://www.magistratescourt.tas.gov.au/about_us/coroners/coronial_findings).[[16]](#footnote-16) Findings made after an inquest are always published online.
1. Dillon, H. & Hadley, M., *The Australasian Coroner’s Manual,* (The Federation Press, 2015). [↑](#footnote-ref-1)
2. http://www.police.tas.gov.au/ [↑](#footnote-ref-2)
3. http://www.police.tas.gov.au/useful-links/forensic-science-service-tasmania-fsst/ [↑](#footnote-ref-3)
4. https://www.fire.tas.gov.au/ [↑](#footnote-ref-4)
5. http://www.magistratescourt.tas.gov.au/forms [↑](#footnote-ref-5)
6. http://www.magistratescourt.tas.gov.au/forms [↑](#footnote-ref-6)
7. http://www.agd.sa.gov.au/sites/agd.sa.gov.au/files/documents/Initiatives%20Announcements%20and%20 News/DJP/DJP%20Guidelines%20WEB.pdf [↑](#footnote-ref-7)
8. http://www.theadvocatesgateway.org/ [↑](#footnote-ref-8)
9. http://www.dhhs.tas.gov.au/ [↑](#footnote-ref-9)
10. http://www.primaryhealthtas.com.au/ [↑](#footnote-ref-10)
11. https://ama.com.au/tas [↑](#footnote-ref-11)
12. http://www.racgp.org.au/home [↑](#footnote-ref-12)
13. http://www.abs.gov.au/AUSSTATS/abs@.nsf/DetailsPage/1205.0.55.0012008?OpenDocument [↑](#footnote-ref-13)
14. http://www.justice.tas.gov.au/bdm [↑](#footnote-ref-14)
15. http://www.mindframe-media.info/\_\_data/assets/pdf\_file/0011/9983/140519\_MindFrame-for-Media\_PDF.pdf [↑](#footnote-ref-15)
16. http://www.magistratescourt.tas.gov.au/about\_us/coroners/coronial\_findings [↑](#footnote-ref-16)