Tasmanian Coronial Practice Handbook

Coronial Division - Magistrates Court of Tasmania, Tasmanian Government (2016)

**Content warning**

Some material contained in the Tasmanian Coronial Practice Handbook (‘the Handbook’) may be distressing to families and friends who have lost a loved one. It includes information about death and mental health that may be upsetting for some people. If you would like guidance on which sections of the Handbook would help you the most, or if you do not want to risk reading content that may upset you, please contact coroner’s court staff.

**Disclaimer**

This Handbook contains information only; do not use it as a substitute for legal advice. The Coronial Division of the Magistrates Court accepts no liability for any loss, damage or injury suffered as a result of reliance on this document. Every effort has been made to ensure that the information contained in the Handbook is correct, noting that legal authority and practice will change with the passage of time. Please direct all legal enquiries to a qualified legal practitioner.

**Enquiries**

If you have any general questions about the coroner’s court or the Handbook, or wish to provide feedback, please contact the coroner’s court.

**Coroner’s court contact details**

Hobart

27 Liverpool Street, Hobart, 7000

(03) 616 57132 (administrative)

(03) 616 57127 (coroners’ associates)

Launceston

73 Charles Street, Launceston, 7250

(03) 677 72920

After hours contact police on: 131 444

Whole of Tasmania email - Coroners.Hbt@justice.tas.gov.au



[Coroner’s court web site](http://www.magistratescourt.tas.gov.au/about_us/coroners) - http://www.magistratescourt.tas.gov.au/about\_us/coroners





**THE   LAW   FOUNDATION   OF   TASMANIA**

English

Our condolences for your loss. Our coronial staff are available to assist you with the coronial process. If you need an interpreter to help you talk to staff or associates, please tell us or ask someone to tell us for you. You can have a meeting with staff or associates with an interpreter present, to explain how the coronial process works. In order to determine the circumstances and cause of death, a coroner will conduct an investigation or inquest (which is a formal court hearing). We can arrange the interpreter to assist you. If you need to make a statement to police, an interpreter can help you to make your statement. Please let us know what we can do to help you.

Arabic

تعازينا لخسارتكم. يتوفر موظفو الطب الشرعي لمساعدتكم في عملية الطب الشرعي. إذا كنتم بحاجة إلى مترجم لمساعدتكم على التحدث مع الموظفين أو الزملاء، يُرجى إعلامنا أو الطلب من شخص إعلامنا بالنيابة عنكم. يمكنكم ترتيب لقاء مع الموظفين أو الزملاء بحضور مترجم، لشرح كيفية عمل عملية الطب الشرعي. من أجل تحديد ظروف وأسباب الوفاة، فإن قاضي التحقيق سيقوم بإجراء التحقيق أو الإستجواب (والتي هي جلسة محكمة رسمية). يمكننا الترتيب لمترجم لمساعدتكم. إذا كنتم بحاجة إلى الإدلاء بإفادة للشرطة، يمكن للمترجم مساعدتكم على عمل إفادتكم. الرجاء إعلامنا بما يمكننا القيام به لمساعدتكم.

Dutch

Gecondoleerd met uw verlies. Onze patholoog-anatomische medewerkers zijn beschikbaar om u te helpen met het patholoog-anatomische proces. Als u een tolk nodig heeft om u te helpen praten met ons personeel en andere betrokkenen, laat het ons dan alstublieft weten of vraag iemand anders om dit voor u aan ons te vertellen. We kunnen een afspraak voor u maken met ons personeel en andere betrokkenen, in aanwezigheid van een tolk, om uit te leggen hoe het patholoog-anatomische proces werkt. Om de omstandigheden en oorzaak van overlijden vast te stellen, voert een patholoog-anatoom een onderzoek of gerechtelijke zitting uit (een formeel juridisch onderzoek). We kunnen regelen dat de tolk u helpt. Als u een verklaring moet afleggen aan de politie, kan een tolk u helpen met het afleggen van de verklaring. Vertel ons alstublieft wat we kunnen doen om u te helpen.

German

Wir möchten Ihnen unser Beileid aussprechen. Das Personal der Coronial Division des Gerichts kann Ihnen bei den anstehenden rechtlichen Vorgängen und Abläufen behilflich sein. Falls Sie einen Dolmetscher benötigen, um mit unseren Mitarbeitern und Partnern zu sprechen, sagen Sie uns dies bitte, oder beauftragen Sie jemanden, dies für Sie zu tun. Sie können sich mit unseren Mitarbeitern und Partnern und Ihrem Dolmetscher treffen, um darüber zu sprechen, wie die Vorgänge der Coronial Division des Gerichts ablaufen. Um die Todesumstände und -ursache festzustellen, wird ein Coroner eine Untersuchung oder eine formale gerichtliche Anhörung (engl. „Inquest“) durchführen. Wir können für Sie die Anwesenheit eines Dolmetschers organisieren. Falls Sie bei der Polizei eine Aussage machen müssen, kann ihnen auch dabei ein Dolmetscher helfen. Bitte lassen Sie uns wissen, wie wir Ihnen helfen können.

Greek

Τα συλλυπητήριά μας για την απώλειά σας. Το προσωπικό της ιατροδικαστικής μας υπηρεσίας είναι διαθέσιμο να σας βοηθήσει με την ιατροδικαστική διαδικασία. Αν χρειάζεστε διερμηνέα να σας βοηθήσει να μιλήσετε με το προσωπικό ή με συνεργάτες, παρακαλούμε ενημερώστε μας ή ζητήστε από κάποιον να μας ενημερώσει εκ μέρους σας. Μπορείτε να έχετε συνάντηση με το προσωπικό ή με συνεργάτες παρουσία διερμηνέα, για να εξηγήσουν πώς λειτουργεί η ιατροδικαστική διαδικασία. Προκειμένου να καθορίσει τις περιστάσεις και την αιτία θανάτου ενός ατόμου, ένας ιατροδικαστής θα διενεργήσει έρευνα ή δικαστική έρευνα (που είναι μια επίσημη ακροαματική διαδικασία). Μπορούμε να κανονίσουμε την παρουσία διερμηνέα για να σας βοηθήσει. Αν χρειαστεί να κάνετε δήλωση στην αστυνομία, ένας διερμηνέας μπορεί να σας βοηθήσει να κάνετε τη δήλωσή σας. Παρακαλούμε ενημερώστε μας τι μπορούμε να κάνουμε για να σας βοηθήσουμε.

Italian

Le porgiamo le nostre condoglianze per la Sua perdita. Il personale del coroner (medico/avvocato legale) è a disposizione per aiutarLa durante le procedure del coroner. Se ha bisogno di un interprete che La assista per comunicare con il personale o i collaboratori, Le chiediamo di farcelo sapere di persona o per mezzo di qualcuno. Può richiedere un appuntamento con il personale o i collaboratori in presenza di un interprete, affinché Le venga spiegata la procedura del coroner. Al fine di determinare le circostanze e la causa di morte, un coroner condurrà un'indagine o un'inchiesta (ovvero un’udienza formale). Possiamo farLe avere un interprete che La assista. Se deve fare una dichiarazione alla polizia, un interprete può aiutarLa a fare la dichiarazione. Le chiediamo cortesemente di farci sapere cosa possiamo fare per aiutarla.

Polish

Proszę przyjąć nasze kondolencje w tym trudnym czasie. Pracownicy biura koronera służą pomocą w czasie trwania dochodzenia prowadzonego przez koronera. Koroner przeprowadzi dochodzenie (które jest oficjalną rozprawą sądową), aby ustalić przyczynę i okoliczności zgonu. Możemy Państwu wyjaśnić, na czym polega proces dochodzeniowy, prowadzony przez koronera. Proszę nas powiadomić, jeżeli potrzebny jest Państwu tłumacz – możemy zorganizować jego pomoc przy procesie. Tłumacz może również pomóc przy składaniu oświadczenia dla policji. Prosimy nas poinformować w jaki sposób możemy Państwu pomóc.

Simplified Chinese

请接受我们诚挚的慰问。我们的验尸工作人员可以为您提供验尸程序的协助。如果您需要口译员帮助您与相关工作人员交流，请告诉我们，或让别人告诉我们。您可以与相关工作人员见面，让口译员到场帮助解释验尸程序。为确定死亡的情形和原因，验尸官将开展调查或正式法庭问询。我们可以安排口译员协助您。如果您需要向警方做陈述，口译员可以帮助你这么做。如果您需要我们提供帮助，请告诉我们。

Spanish

Reciban nuestro más sentido pésame por vuestra pérdida. El personal del servicio de este tribunal está disponible para asistirles con el proceso judicial. Si necesitara un intérprete para asistirles a comunicarse con el personal o los asistentes del juez, avísennos, o pida que otra persona nos informe de sus deseos. Ustedes pueden concertar una reunión con el personal o los asistentes del juez con un intérprete presente para que le expliquen cómo funciona el proceso judicial. Para poder determinar las circunstancias y la causa de una muerte, un juez de instrucción llevará a cabo una investigación o indagatoria judicial, que es una audiencia formal del juzgado. Podemos pedirle un intérprete para que le asista con la prepararción de su declaración. Por favor, dígannos cómo podemos ayudarlos.

Tagalog

Nakikiramay kami sa inyong pagdadalamhati. Ang aming mga tauhan sa tanggapan ng tagalitis ng hukuman sa bangkay ay handang tulungan kayo sa paglilitis na pinamamahalaan ng tanggapan ng tagalitis. Kung kailangan ninyo ng isang interpreter (tagapagsalin) upang tulungan kayong makipag-usap sa aming mga tauhan o kasamahan, mangyaring magsabi sa amin o pakiusapan ang sinuman na magsabi sa amin para sa inyo. Maaari kayo at ang mga tauhan o kasamahan na magmiting na mayroong tagapagsalin upang ipaliwanag sa inyo kung paano pinamamahalaan ang paglilitis. Para tiyakin ang mga pangyayari at dahilan ng kamatayan, mamamahala ang tagalitis ng pagsisiyasat o imbestigasyon tungkol sa kamatayan (ito ay isang pormal na pagdinig ng korte). Maaari kaming kumuha ng tagapagsalin na tutulong sa inyo. Kung kailangan ninyong magbigay ng isang pahayag sa pulis, matutulungan kayo ng isang tagapagsalin sa paggawa ng inyong pahayag. Mangyaring ipaalam sa amin kung ano ang aming magagawa para matulungan kayo.

Traditional Chinese

我們對你的痛失致以深切慰問。我們的驗屍官員將於驗屍過程中為你提供協助。如果您需要一位翻譯員來幫助你與工作人員或有關人士傾談，請告訴我們或找他人來轉告我們。你可以要求一位翻譯員在場與工作人員或有關人士見面，了解進行驗屍的程序。 為了查明當時情況和死因，驗屍官員將會進行調查或要求研訊（這是一個正式的法庭聽證聆訊）。我們可以安排翻譯員來協助你。如果你需要向警察作出陳述，我們亦可以為你安排一位翻譯員來協助你。請讓我們知道我們可以怎樣幫助你。



**The Tasmanian Coronial Practice Handbook**

The Tasmanian Coronial Practice Handbook (‘the Handbook’) provides information to legal practitioners on all major aspects of the coroner’s court. The Handbook focusses on investigations involving sudden deaths rather than investigations into the causes and origins of fires and explosions.

In a state with a low population such as Tasmania, it is rare for legal practitioners to be afforded the opportunity to specialise in coronial practice. The Handbook provides guidance for those unfamiliar with the coroner’s court, or with inquisitorial courts in general.

The Handbook is written to convey suitable legal information to practitioners and to be helpful to the educated layperson. There is a specific section directed to those who have suffered the sudden loss of a loved one (refer to ‘A Guide for Families and Friends’). There are also small sections for non-legal professionals who assist with the work of the coronial jurisdiction: medical practitioners, religious and cultural groups, funeral directors, insurance companies and the media.

The value of the Handbook lies in legal and community education. Providing information in a clear and practical manner enhances people’s capacity to understand the operations and functions of the coroner’s court. If the functions of the court are better understood, then practitioners and members of the public will benefit and be more satisfied with their interactions with the court, and access to justice is enhanced.

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# 1. Introduction - the Coroner’s Court

**The sections in this chapter are:**

* What does the coroner’s court do?
* Flow chart of the process
* How is the coroner’s court different from other courts?
* Court structure - overview
* A day in the coroner’s court
* Jurisdiction of the coroner’s court

## What does the coroner’s court do?

The Coronial Division of the Magistrates Court (or the ‘coroner’s court’) investigates certain deaths, fires and explosions by collecting and examining evidence and making findings. There are a lot of people involved in this process, most importantly, the families and friends of people who have died suddenly. Often the coronial process is an emotional one and friends, families, employees and professionals and others touched by a death need many levels of help and support.

The purposes and objectives of the coroner’s court are to:[[1]](#footnote-1)

* identify deceased persons
* find out how and why a person died
* establish the cause and origin of fires and explosions
* learn from experience to help prevent similar deaths occurring
* improve our systems of public health and safety
* further the administration of justice
* allay suspicions and fears
* hold public agencies to account for deaths in the State’s custody or care; such as police, prisons and health services
* investigate in public where appropriate
* reinforce the rule of law in democratic societies
* provide quality assurance in the death investigation process.

Coronial investigations involve a delicate balance between the rights of the public and the rights of the individual. It is important to protect the privacy of individuals, especially the deceased who can no longer speak for themselves. Families have a right to privacy and a period of grief, but often they feel the need to know what happened to their loved one. The promotion of public health and safety is amongst the most important roles for the coroner’s court and sometimes the knowledge gained from a detailed investigation of a particular death can assist greatly in preventing deaths. In cases involving public agencies, transparency and accountability may be aided by disclosing information to the public in general. Impartial pursuit of the truth is paramount, but coroners also aim to be sensitive to the bereaved. In all aspects of their investigations, coroners strive to find balance.

## Flow chart of the process

Figure 1 is a flow chart of the most common way in which a coronial matter proceeds following a recent death.



Figure 1 is a flow chart explaining a coronial investigation into a recent death. When a death occurs, either a doctor will write a Medical Certificate of Cause of Death or the death will be reported to the coroner. If the death is reported, a pathologist conducts post mortem examinations on the deceased person. If the death remains in the category of reportable deaths after this, the coroner will conduct a full investigation. If the legislation mandates it, or the coroner believes it is necessary, the coroner will hold an inquest. After the inquest or investigation, the coroner will write “findings” which may be published on the Magistrates Court web site.

## How is the coroner’s court different from other courts?

**The coroner’s court is generally inquisitorial, with few adversarial elements**

* Most courts are “adversarial” in nature; this means that there are two opposing sides (such as prosecution and defence). Both sides argue that the judge should accept their own case.
* In an “inquisitorial” court, there are no sides: there is simply a search for the truth in which all parties collaborate. Each party may still wish to emphasise certain facts over others. Judges in inquisitorial courts do not rely on others to give the information to them; rather they investigate actively and find things out for themselves.

**The rules of evidence do not apply**

* The *Coroners Act 1995* (‘the Act’), specifies in section 51 that the rules of evidence do not apply to coronial proceedings. Instead, coroners may inform themselves in any manner the coroner reasonably thinks fit.
* This flexibility allows coroners to take into account materials that would not be admissible in a criminal trial, such as hearsay and non-expert opinion evidence.
* Relevance is still paramount in coronial matters: the relevant issues define the scope of the investigation (and of the inquest, if one is held).
* Enquiries made by the coroner must be relevant to the manner and cause of death; therefore, all parties are prevented from pursuing causation to its extreme (refer to ‘Key Elements in the Process: Inquests – Causation, scope and relevance’).

**The common law has less effect**

* Section 4 of the Act states that ‘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’.
* This provision removes the common law jurisdiction of the coroner’s court.
* It is most likely that ‘duties imposed on a coroner’ are procedural duties. A similar provision in the *Coroners Act 2003* (Qld) expressly states as examples that coroners are not required to view a body or sit with a jury.
* Coroners remain bound by the authorities and judicial pronouncements of courts in interpreting the legislation.

**The coroner’s court is neither criminal nor civil in nature**

* A coronial inquest is an inquiry not a trial. Coroners are concerned with fact-finding, not determining guilt and delivering punishment.
* Coroners are not permitted to include in their findings a statement that a person is, or may be, guilty of committing an offence (Act ss 28(4) & 45(3)).
* Coronial proceedings are not criminal or civil in nature, but they may open the way for proceedings of either type.
* Criminal proceedings may result through referral of the case to the Attorney-General and the Attorney-General / Director of Public Prosecutions preferring charges.
* Civil proceedings may result through the disclosure of evidence that potentially supports the argument that a person or entity was negligent or responsible in some way for the death, fire or explosion.
* There may also be repercussions as to internal disciplinary proceedings, tribunals, commissions and similar.
* It is important that practitioners do not discount the consequences that coronial proceedings may have for their clients or treat an inquest as a mere precursor to future court proceedings.

**The civil standard of proof applies**

* The coroner must establish facts on the balance of probabilities.
* The standard expressed in the matter of [*Briginshaw v Briginshaw* (1938) 60 CLR 336](http://www.austlii.edu.au/cgi-bin/sinodisp/au/cases/cth/HCA/1938/34.html?stem=0&synonyms=0&query=Briginshaw%20near%20Briginshaw) at 362 is also relevant where a serious allegation is made, which it is necessary to determine, and the determination of that allegation will (or could) reflect adversely on a person:

*‘…reasonable satisfaction is not a state of mind that is attained or established independently of the nature and consequence of the fact or facts to be proved. The seriousness of an allegation made, the inherent unlikelihood of an occurrence of a given description, or the gravity of the consequences flowing from a particular finding are considerations which must affect the answer to the question whether the issue has been proved to the reasonable satisfaction of the tribunal. In such matters ‘reasonable satisfaction’ should not be produced by inexact proofs, indefinite testimony, or indirect inferences. Everyone must feel that, when, for instance, the issue is on which of two dates an admitted occurrence took place, a satisfactory conclusion may be reached on materials of a kind that would not satisfy any sound and prudent judgment if the question was whether some act had been done involving grave moral delinquency.’*

**The focus can be on the system, the individual or both**

* Unlike in criminal proceedings, some coronial investigations will focus on the acts of individuals, where others will focus on systemic issues.
* Many coronial investigations into deaths involve mistakes and accidents by professionals, rather than deliberate acts of malice.
* In such situations, coroners realise that:
	+ mistakes and accidents are part of the execution of professional duties
	+ good people make mistakes
	+ most mistakes do not have negative consequences.
* When the coroner makes recommendations in these matters that are aimed at prevention, there is often less focus upon individual blame and error. The accidents and mistakes of individuals are often the least controllable aspects of a sequence of events.
* A systemic focus enables recommendations that anticipate, compensate for, detect, correct and prevent the mistakes that can lead to tragic events.
* These coronial matters involve learning lessons from systemic errors and creating environments in which those errors, on average:[[2]](#footnote-2)
	+ are less likely to occur
	+ will have less severe consequences if they do occur
	+ are more likely to be detected and
	+ can be more easily corrected.
* The criminal and civil aspects of the legal system are ‘blame-based’ and it can be challenging for legal practitioners to change their focus from the criminal or civil responsibility of individuals.

## Court structure - overview

**Legislation**

The main framework for the coroner’s court is found in the following Tasmanian legislation:

* [*Coroners Act 1995*](http://www.thelaw.tas.gov.au/tocview/index.w3p;cond=;doc_id=73%2B%2B1995%2BAT%40EN%2B20160707000000;histon=;pdfauthverid=;prompt=;rec=;rtfauthverid=;term=;webauthverid=) (Tas), hereafter referred to as ‘the Act’. All references to ‘sections’ in this document refer to the Act unless otherwise stated. The Act establishes the Coronial Division of the Magistrates Courtand requires the reporting of certain deaths, sets out the procedures for investigations and inquests by coroners into deaths, fires and explosions, and provides for related matters.
* [*Coroners Rules 2006*](http://www.thelaw.tas.gov.au/tocview/index.w3p;cond=;doc_id=%2B51%2B2006%2BAT%40EN%2B20160707000000;histon=;pdfauthverid=;prompt=;rec=;rtfauthverid=;term=;webauthverid=) (Tas), hereafter referred to as ‘the Rules’. All references to ‘rules’ in this document refer to the Rules unless otherwise stated. The Rules provide administrative information, including the form of various applications and directions, and procedures for investigation and inquests.
* [*Coroners (fees, expenses and allowances) Regulations 2016*](http://www.thelaw.tas.gov.au/tocview/index.w3p;cond=;doc_id=%2B37%2B2016%2BAT%40EN%2B20160707110000;histon=;pdfauthverid=;prompt=;rec=;rtfauthverid=;term=;webauthverid=) (Tas). The Regulations contain the relevant fees schedules that apply to the Coronial Division.

For more information on other legislation that affects the coroner’s court, refer to ‘Other: Legislation’.

**Coroners**

Coroners investigate sudden deaths, and fires and explosions. Most coroners are magistrates and they perform functions similar to the head of a tribunal. They investigate in order to gather as much information as they can and then they make “findings”, which are contained in a written document. Coronial investigations are all about fact-finding; the coroner cannot punish people. If the coroner holds an inquest (a public court hearing), relevant witnesses will be required (usually by summons) to attend and give evidence.

An important role of the coroner is to make recommendations. When someone dies unexpectedly, the coroner can investigate how they died and recommend changes to save other lives. In this way, coroners administer justice and protect the health and safety of the public.

**Coroners’ office**

The business of the coroner’s court is conducted from the coroners’ office where all the staff work, gathering information and managing files. There are coroners’ offices in Hobart and Launceston, situated within the Magistrates Court buildings. If you have any questions about the coronial process, or about a particular matter, you can [contact the relevant office](http://www.magistratescourt.tas.gov.au/contact/coroners_court) between 9am and 5pm on weekdays. The offices are closed on public holidays.

You are able to phone, email, write or come in to the office, whichever you prefer. The coroner’s court also has a [web site](http://www.magistratescourt.tas.gov.au/about_us/coroners) with relevant information and this Handbook covers many areas of coronial practice.

You can find the contact details here: ‘Other: How to contact the coroner’s court’.

**Magistrates Court**

The coroner’s court is a division of the Magistrates Court of Tasmania. Coroners hold inquests in the Magistrates Court in Hobart, Launceston, Burnie and Devonport. Generally, larger courtrooms are preferred for coronial inquests to allow for the additional legal practitioners and members of the public who attend.

The Magistrates Court is fully wheelchair accessible and is committed to providing equal access to justice for all people.

For more information about the layout of courtrooms, refer to ‘Key Elements in the Process: Court Proceedings – general information’.

For more information on extra assistance that the court can provide for those with diverse needs, refer to ‘A Guide for Families and Friends: Who can help? – If you need extra assistance’.

**Police**

All police officers are designated ‘coroners’ officers’ under the Act (s 16(2)). When an unexpected death, a fire or an explosion occurs, police are generally the first on the scene. It is their responsibility to gather all relevant evidence and present it to the coroner for consideration. There are also specially appointed police officers who are assigned coronial duties only, providing a state-wide resource for the co-ordination and management of coronial investigations. These officers are known as coroners’ associates and are part of the Tasmania Police Coronial Services Unit.

## A day in the coroner’s court

Every day is different in the coroner’s court. Sometimes there is an inquest (a formal court hearing) but most of the time, there is not. Sometimes there are several sudden deaths from the night before and sometimes there are none. Being flexible and adaptable to whatever the day brings is a part of working in the coroner’s court. So what does an “average” weekday look like?

* The coroners’ associates arrive at about 7:00 am and begin to assess the deaths from the night before. They check things such as whether:
	+ a formal identification has been conducted
	+ the correct senior next of kin has been notified
	+ the senior next of kin has been asked if they object to an autopsy.
* At the Royal Hobart Hospital, the State Forensic Pathologist commences the first autopsy for the day at approximately 8:30 am. Other pathologists at the Royal Hobart Hospital and Launceston General Hospital also begin any autopsies early in the day. There is a limit to how many autopsies can be completed each day and some may be postponed to the next weekday.
* The coroners, division manager and administrative officers arrive at work shortly before 9:00 am.
* During the day, coroners’ associates and administrative officers receive enquiries from the public, doctors, police, funeral directors and government offices. These may be phone calls or emails. A lot of time and effort goes into ensuring that the families and friends of deceased persons have their questions answered and are aware of what is happening in investigations.
* The coroners research legal matters, read investigation files and liaise with the coroners’ associates to make sure that current investigations progress. There are numerous in-chambers findings produced by coroners, which are findings in matters where there is no inquest. Coroners spend a lot of time reviewing files, making notes and writing findings.
* The coroners’ associates spend a lot of time co-ordinating investigations and gathering evidence for the coronial record. They follow up evidence, making sure that all the documents the coroner requires are provided and that everyone is doing their bit to keep investigations moving forward.
* There are always inquests scheduled in the future. Coroners and their associates plan when the inquests will be held, organise the evidence and arrange witnesses.
* Administrative officers have a wide range of roles and tasks to attend to during the day. These include managing records, writing correspondence, archiving files, uploading findings to the coroner’s court web site and coding cases onto NCIS (the National Coronial Information System).
* The manager of the coronial division oversees the operation of the office, answering staff questions and co-ordinating all the different people involved in the coroner’s court. They manage legislative and policy reform, attend meetings with stakeholders and assist the coroners with any difficult issues that arise during the day.
* At the Office of the Director of Public Prosecutions, and at other law firms, counsel assisting read coronial files and conduct legal research to prepare for their upcoming inquests.
* For cases involving medical settings, often specialist medical reports and research are required. Two part-time medical researchers spend their time carefully assessing medical records, scans, reports, statements and other documents. Once their review of the records is complete, they write detailed reports for the coroner on the care provided and the outcomes of treatment given.
* Out in the field, coroners’ officers (police) gather evidence. They attend the scene of most deaths and collect statements from families, friends, doctors and members of the public to assess whether a particular death is reportable to the coroner. If they decide that a death is reportable, they fill out a form and contact the coroners’ associates to start the investigation. The mortuary ambulance then collects the deceased person and takes them to the mortuary.

## Jurisdiction of the coroner’s court

The Coronial Division of the Magistrates Court (the coroner’s court) is established by section 5 of the Act. The jurisdiction of the coroner’s court is solely statutory, as section 4 of the Act nullifies the common law jurisdiction. The majority of matters investigated by the coroner’s court are deaths, with fires and explosions making up a very small percentage of the caseload. In Tasmania, there is no State Coroner. In effect, the Chief Magistrate holds this position (ss 7, 8 & 9) and can hold inquests if they consider it desirable to do so (s 24A). In practice, the Chief Magistrate has delegated a large portion of their coronial powers to one full-time coroner, who heads the coronial jurisdiction. The Chief Magistrate continues to exercise some powers, including those that are non-delegable.

For a coronial finding that presents a discussion of the jurisdiction and the aims and limits of the coroner’s court in Tasmania, refer to paragraphs 1 – 17 of [Butterworth, Lucille 2016 TASCD 96](http://www.magistratescourt.tas.gov.au/__data/assets/pdf_file/0007/344833/Butterworth%2C_Lucille_2016_TASCD_96.pdf).

### Jurisdiction to investigate a death

The coroner has jurisdiction to investigate a death only if it is, or may be, a *reportable death* (s 21(1)). For the definition of a ‘reportable death’ refer to section 3 of the Act. The coroner also has jurisdiction to investigate where there is a *suspected* reportable death (for example, in the case of a long-term missing person). In section 3, the definition of death includes suspected death. The coroner is not required to investigate a death at any time if the death is being investigated in another state or territory (s 21(2)).

In matters involving the death of military personnel, deaths of Tasmanian residents overseas and any death that occurs during travel to or from Tasmania, more complex jurisdictional issues may arise.



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

### Jurisdiction to investigate a fire or explosion

The coroner has jurisdiction to investigate a fire or explosion if the fire or explosion occurred in Tasmania, and the coroner believes it is desirable to conduct an investigation (s 40(1)). The coroner must investigate a fire or explosion if directed to do so by the Attorney-General or the Chief Magistrate (s 40(2)). In practice, investigations of this nature rarely occur if there is not an associated death.

For an example of an inquest into a fire, refer to [Inquest into the Myer Fire 2009 TASCD 239](http://www.magistratescourt.tas.gov.au/decisions/coronial_findings/m/myer_fire_-_2009_tas_cd_239).

### Jurisdiction to hold an inquest

**Inquests into deaths**

Under section 24 of the Act, a coroner who has jurisdiction to investigate a death *must also* hold an inquest in specific circumstances. These are: where the body is in Tasmania or it appears to the coroner that the death, or the cause of death, occurred in Tasmania or that the deceased ordinarily resided in Tasmania at the time of death *and* where the death falls into one of the following categories:

* where there is a suspected homicide
* where a person was held in custody or care immediately before death
* where a person died escaping or trying to escape from custody or care
* where a person died while someone was trying to take them into custody or care
* where the identity of the deceased person is unknown
* where there is a workplace death, not due to natural causes
* if the death occurs in a manner in which an inquest is required under any other Act
* if the Attorney-General or the Chief Magistrate directs.

The coroner also has the power to hold an inquest if they have jurisdiction to investigate the relevant death and they consider it desirable to do so.

Under section 25, if the coroner becomes aware that someone has been charged with a specified offence in relation to the death, fire or explosion when an inquest has commenced, but before the findings are handed down, then the inquest must be suspended until after the offence has been finalised (and any appeal period has expired). They are required to notify the Attorney-General that this has occurred. The section that governs this is section 25 of the Act, which also specifies the types of offences that trigger this process (s 25 (2)). Once the criminal proceedings are at an end, the coroner may decide to resume the inquest if there is sufficient cause to do so. An inquest resumed under this section proceeds from the beginning as if it were a new matter. Any findings that the coroner then makes cannot be inconsistent with the decision of the criminal court.

**Inquests into fires and explosions**

A coroner who has jurisdiction to investigate a fire or an explosion may hold an inquest if they believe it is desirable to do so (s 43(2)). A coroner must hold an inquest if directed by the Attorney-General or the Chief Magistrate (s 43(1)).



For more information, refer to ‘Key Elements in the Process: Inquests’.

# 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:[[3]](#footnote-3)

* 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/)[[4]](#footnote-4)

## 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/)[[5]](#footnote-5)

## 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/)[[6]](#footnote-6)

## 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).[[7]](#footnote-7)

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).[[8]](#footnote-8) 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).[[9]](#footnote-9)

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).[[10]](#footnote-10)

### 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/)[[11]](#footnote-11)

[Primary Health Tasmania](http://www.primaryhealthtas.com.au/)[[12]](#footnote-12)

[Australian Medical Association – Tasmania](https://ama.com.au/tas)[[13]](#footnote-13)

[Royal Australian College of General Practitioners](http://www.racgp.org.au/home)[[14]](#footnote-14)

#### 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)’[[15]](#footnote-15) 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)[[16]](#footnote-16)

### 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)’.[[17]](#footnote-17) 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).[[18]](#footnote-18) Findings made after an inquest are always published online.

# 3. Key Elements in the Process

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

* Reporting of deaths
* Registering of deaths
* Investigation of deaths
* Investigation of fires and explosions
* Representing an interested person in a coronial matter
* Documents
* How to access documents
* Case management conferences
* Applications
* Evidence
* Court proceedings – general information
* Inquests
* Representing an interested person at an inquest
* Findings, comments and recommendations

## Reporting of deaths

Approximately 600 deaths are reported to the coroner in Tasmania each year (the [Magistrates Court of Tasmania Annual Reports, 2014 – 2015](http://www.magistratescourt.tas.gov.au/about_us/publications) are available on the Magistrates Court web site, under Publications).[[19]](#footnote-19) All deaths that are reported are investigated (s 7(c)), with the depth of the investigation depending on the circumstances of the case. Of the deaths that coroners investigate, approximately 40 per cent are natural deaths. A natural death does not fall under the jurisdiction of the coroner’s court. The concept of a ‘natural death’ is very complicated both medically and legally, therefore the determination that a death was “natural” can occur at any stage in the investigation. As a result, the amount of time and resources required for each natural death varies. Once a death is confirmed as natural, the investigation is completed as soon as is practicable. In the remaining 60 per cent of deaths, a comprehensive investigation is undertaken. These matters are conducted either by a coroner making findings in chambers or, in a minority of cases, by a public inquest.

For more information, refer to ‘Key Elements in the Process: Investigation of deaths’ and ‘Key Elements in the Process: Inquests’.

*Section 3 of the Act states that a reportable death occurs when:*

**The deceased person is in Tasmania, or connected to Tasmania, that is,**

a. a death where –

i. the body of a deceased person is in Tasmania; or

ii. the death occurred in Tasmania; or

iii. the cause of the death occurred in Tasmania; or

iiia. the death occurred while the person was travelling from or to Tasmania –

**AND one of the following applies:**

being 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

vi. .  .  .  .  .  .  .  .

vii. the cause of which is unknown; or

viii. of a child under the age of one year which was sudden and unexpected; or

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

x. of a person whose identity is unknown; or

xi. that occurs at, or as a result of an accident or injury that occurs at, the deceased person’s place of work, and does not appear to be due to natural causes; or

b. the death of a person who ordinarily resided in Tasmania at the time of death that occurred at a place outside Tasmania where the cause of death is not certified by a person who, under a law in force in the place, is a medical practitioner; or

c. the death of a person that occurred whilst that person was escaping or attempting to escape from prison, a detention centre, a secure mental health unit, police custody or the custody of a person who had custody under an order of a court for the purposes of taking that person to or from a court; or

d. the death of a person that occurred whilst a police officer, correctional officer, mental health officer or a prescribed person within the meaning of section 31 of the [*Criminal Justice (Mental Impairment) Act 1999*](http://www.thelaw.tas.gov.au/tocview/index.w3p;cond=;doc_id=21%2B%2B1999%2BGS1%40EN%2B20160720000000;histon=;pdfauthverid=;prompt=;rec=;rtfauthverid=;term=;webauthverid=)was attempting to detain that person.

*There are some relevant definitions in section 3 of the Act:*

***correctional officer*** means a correctional officer within the meaning of the [*Corrections Act 1997*](http://www.thelaw.tas.gov.au/tocview/index.w3p;cond=;doc_id=51%2B%2B1997%2BGS1%40EN%2B20160720000000;histon=;pdfauthverid=;prompt=;rec=;rtfauthverid=;term=;webauthverid=);

***detention centre*** has the same meaning as in the [*Youth Justice Act 1997*](http://www.thelaw.tas.gov.au/tocview/index.w3p;cond=;doc_id=81%2B%2B1997%2BGS1%40EN%2B20160720000000;histon=;pdfauthverid=;prompt=;rec=;rtfauthverid=;term=;webauthverid=);

***medical procedure*** means a procedure performed on a person by, or under the general supervision of, a medical practitioner and includes –

1. imaging; and
2. an examination whether internal or external; and
3. a surgical procedure;

***mental health officer*** means a mental health officer within the meaning of the [*Mental Health Act 2013*](http://www.thelaw.tas.gov.au/tocview/index.w3p;cond=;doc_id=2%2B%2B2013%2BAT%40EN%2B20160922000000;histon=;pdfauthverid=;prompt=;rec=;rtfauthverid=;term=;webauthverid=);

***person held in care*** means –

1. a child, within the meaning of the [*Children, Young Persons and Their Families Act 1997*](http://www.thelaw.tas.gov.au/tocview/index.w3p;cond=;doc_id=28%2B%2B1997%2BGS1%40EN%2B20160720000000;histon=;pdfauthverid=;prompt=;rec=;rtfauthverid=;term=;webauthverid=), in the custody or under the guardianship of the Secretary, within the meaning of that Act;
2. a person detained or liable to be detained in an approved hospital within the meaning of the [*Mental Health Act 2013*](http://www.thelaw.tas.gov.au/tocview/index.w3p;cond=;doc_id=2%2B%2B2013%2BAT%40EN%2B20160922000000;histon=;pdfauthverid=;prompt=;rec=;rtfauthverid=;term=;webauthverid=) or in a secure mental health unit or another place while in the custody of the controlling authority of a secure mental health unit, within the meaning of that Act;

***person held in custody*** means –

1. a person in the custody or control of –
2. a police officer; or
3. a correctional officer; or
4. a mental health officer; or
5. the controlling authority of a secure mental health unit; or
6. a prescribed person within the meaning of section 31 of the [*Criminal Justice (Mental Impairment) Act 1999*](http://www.thelaw.tas.gov.au/tocview/index.w3p;cond=;doc_id=21%2B%2B1999%2BGS1%40EN%2B20160720000000;histon=;pdfauthverid=;prompt=;rec=;rtfauthverid=;term=;webauthverid=); or
7. a person who has custody under the order of a court for the purposes of taking the person to or from a court; or
8. a person detained –
9. in a prison as defined in the [*Corrections Act 1997*](http://www.thelaw.tas.gov.au/tocview/index.w3p;cond=;doc_id=51%2B%2B1997%2BGS1%40EN%2B20160720000000;histon=;pdfauthverid=;prompt=;rec=;rtfauthverid=;term=;webauthverid=); or
10. in a building or part of a building at a police station used for the confinement of persons under arrest or otherwise lawfully detained in custody; or
11. in a detention centre;

***secure mental health unit*** means –

1. a secure mental health unit within the meaning of the [*Mental Health Act 2013*](http://www.thelaw.tas.gov.au/tocview/index.w3p;cond=;doc_id=2%2B%2B2013%2BAT%40EN%2B20160922000000;histon=;pdfauthverid=;prompt=;rec=;rtfauthverid=;term=;webauthverid=); or
2. any other place in which a person is being detained while in the custody of the controlling authority of a secure mental health unit.

Anyone who becomes aware of a reportable death *must* report it to the coroner or the police, if they believe it has not been reported (s 19(1)). A death can be reported orally but the report must be confirmed in writing within 48 hours (rule 4). Usually the coroners’ associates or police will complete the written notification on behalf of a person who makes an oral report of death. Almost all deaths are reported to the coroner by police officers or medical practitioners.

If a person was in care or custody, was trying to escape from care or custody or was about to be placed in care or custody when they died, the person in whose care or custody they were held must report the death as soon as possible. In all cases, the person who reports the death, and any police officer, must provide as much information as they can to help the coroner in the investigation (s 20).

There are special provisions in the Act which relate to ‘Aboriginal remains’; this refers to *historical* remains and does not apply to a recently deceased Aboriginal person. Section 23 applies to human remains that the coroner suspects may be the remains of an Aboriginal person buried in accordance with Aboriginal custom. If the coroner suspects this to be the case at any stage after the death is reported, they must immediately cease all investigations and refer the matter to an Aboriginal organisation approved by the Attorney-General. This organisation then conducts its own investigation to establish if the human remains are Aboriginal. If it determines that the remains are Aboriginal, then the Aboriginal organisation takes over the investigation. If it determines that the remains are not Aboriginal, then the matter is referred back to the coroner for the usual investigation to occur.

**If you are a medical practitioner** and you’re seeking information on reporting deaths and the issuing of Medical Certificates of Cause of Death, please refer to the information provided in ‘When to report a death to the coroner’.

## Registering of deaths

Under the *Births, Deaths and Marriages Registration Act 1999* s 35 (1), 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,

**must**, within 48 hours after the death, notify the Registrar of Births, Deaths and Marriages (BDM) of the death and of the cause of death in a form approved by the registrar.

This notice / form is called a Medical Certificate of Cause of Death (MCCD). The medical practitioner need not give notice to the registrar if a coroner or a police officer is required to be notified of the death under the *Coroners Act 1995* (i.e. if the death is reportable).

If a police officer or the coroner is notified of a death under the Act, then a coronial investigation begins. If, after medical examinations, the coroner determines that the death was in fact the result of natural causes, they will issue a letter notifying the senior next of kin of this and informing them that the coroner’s jurisdiction is at an end and the investigation will cease as soon as is practicable. This letter will also be sent to any other family members who request to be kept informed.

If the result of the medical examination is that the death continues to be in the category of reportable deaths, then the investigation continues. If the coroner is involved, then the registrar of BDM is notified of the death by the coroners’ office through a Registration of Death Statement, which is generated from the initial police report. The registrar will register the death and BDM can issue an interim death certificate, which will state that the coronial investigation is still ongoing.

Section 28(1)(e) of the Act requires coroners to find, if possible, the particulars needed to register the death under the *Births, Deaths and Marriages Registration Act 1999* (Tas). At the time of publishing the Handbook, there is no legislation stating which particulars are required to register a death. The coroners are thus not legally required to record specific particulars. The practice of coroners is to only record the personal particulars which may be appropriate in the circumstances of each case. Other details about the deceased person, their family members and their life will often be recorded in the findings; however, they will not usually be stated separately in the section of the findings that deals with the registration of the death.

Some of the details that a coroner may record in their findings are:

* full name (including any previous legal names if known)
* last residential address
* place of birth
* date of birth (or if not known, age at date of death)
* sex (male / female / X)
* date of death
* place of death
* whether of Aboriginal or Torres Strait Islander descent (or both)
* if 18 years old or over - whether, immediately before death, the deceased person was married, in a significant relationship (*Relationships Act 2003*), divorced, widowed, in a de facto relationship or single
	+ full name (including, if applicable, the original surname) of current or former spouse
* if 15 years old or over - the usual occupation before death and whether or not the deceased person was a pensioner or was retired immediately before death
* the full names, sex and date of birth (or age) of any children (including any children who are deceased)
* and any such other information as the coroner deems reasonably necessary to provide an accurate and complete picture of that person’s death.

Under section 36 of the *Births, Deaths and Marriages Registration Act 1999*, the coroner must also provide the registrar with a copy of the certificate of burial issued for the deceased person as well as the cause of death, when they become available. Once this occurs, BDM will finalise the registration and can issue a standard death certificate.

## Investigation of deaths

All deaths that are reported to a coroner are investigated (ss 7 (c) & 21(1)). A coroner may also hold an investigation in relation to a missing person, if they have reason to believe that the missing person is dead (as the term ‘death’ also includes suspected deaths). There is no time limit set for the investigation of a death. It is sometimes the case that coroners investigate deaths decades after they occurred, or are suspected to have occurred, as they are not reported to the coroner for many years. Coroners play an active role in investigations, determining which issues are most relevant and deciding how investigations are to proceed. The legislative framework for the investigation of deaths is located in Part 5 of the Act and in Part 2 of the Rules.

The aim of an investigation into a death is to provide the coroner with as much information as possible, to enable the coroner to make the most accurate findings possible. Unlike in a criminal court, the coroner does not punish people or institutions. The coroner does play an important role, however, in ascertaining the cause and circumstances of death. The coroner also makes recommendations, the aim of which is to prevent similar deaths. In this way, the jurisdiction is a positive one, focussed on truth, accountability, transparency, and the health and safety of the public.

The aim of an investigation into a death is to make all the findings set out in s 28(1)(a-e) of the Act:

A coroner investigating a death must find, if possible –

* + 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%2B20160413000000;histon=;pdfauthverid=;prompt=;rec=;rtfauthverid=;term=;webauthverid=).

Section 28(2) also states that, where appropriate, the coroner must make comments or recommendations in their findings on any matter aimed at preventing future deaths, matters of public health and safety, or the administration of justice. The coroner uses this power to review safety procedures, responses, training and other factors that may have contributed to or prevented the death.

### Identification procedures

* One of the coroners’ duties is to correctly identify the deceased person.
* ‘Visual identification’ is carried out by someone who knew the deceased person when they were alive, and who views the deceased person (for more information, refer to ‘A Guide for Families and Friends: Practical matters’).
* If visual identification is not possible, or requires supplementing, then other procedures may be used to confirm identity such as:
	+ fingerprinting (which is conducted by police)
	+ matching features against medical records (such as matching a dental examination and a dental x-ray to dental records, a process which is carried out by forensic odontologists, or matching the serial numbers of implants such as pacemakers)
	+ DNA testing of close blood relatives, or personal items such as a toothbrush.

### Exhumation

If a deceased person is buried and the Chief Magistrate reasonably believes it is necessary for the investigation, they may order that the deceased person be unearthed to be examined by a pathologist. The process of bringing a deceased person out of the ground is called ‘exhumation’. In practice, exhumation is extremely rare.

If a deceased person is to be exhumed, 48 hours’ notice must be given to the senior next of kin and to the owners of the place of burial. The senior next of kin may apply to the Chief Magistrate (and also to the Supreme Court) to prevent the exhumation.

For more information on making an application of this nature, please refer to ‘Key Elements in the Process: Applications’.

### The investigation file / coronial record

Police attend almost all deaths and assess whether they are reportable. In the case of deaths in medical settings, police may not attend. Once police are notified of a reported death (or attend the scene and ascertain the death is reportable), they will collect statements and evidence to create an initial ‘report to the coroner’. As soon as possible, the deceased person is moved to a mortuary where they are examined.

A trained pathologist (a medical specialist) examines the deceased person carefully and respectfully. The pathologist will use a combination of medical records, scientific tests, scans and physical examination to gather as much evidence for the investigation as possible of how the person died. The Report of Death made to the coroner and other documents that have been added to the investigation file assist them in this task. They will also try to establish if anything may have contributed to the death, made the death more likely, or prevented the death. All the medical examinations are performed with great respect to preserve the dignity of the deceased person.

The pathologist prepares a ‘post mortem report’, which explains the results of any post mortem examinations. In most cases, the coroner will authorise an autopsy and the report will also include the results of the autopsy. An autopsy cannot occur unless it is authorised by a coroner or the Chief Magistrate.

While the deceased person is in the care of the pathologist, they are under the control of the coroner. The coroner has control of the deceased person from the time that a reportable death occurs until they issue a certificate allowing the body to be released for burial or cremation (ss 31 & 32). The coroner must issue the certificate for the disposal of human remains as soon as possible, immediately after the necessary investigations are complete.

In cases where the coroner determines that the death was by natural causes, the police will conduct a limited investigation and the coroner will send a letter to the senior next of kin notifying them that the death was natural and the coroner’s jurisdiction is at an end. This letter can also be sent to other family members who request to be kept informed. This may take several months to occur as a full post mortem report and toxicological testing are still required. The only exception to this is where the identity of the deceased person is unknown, in this case the investigation will continue with the sole goal of establishing identity. An investigation may also end if the coroner becomes satisfied in any other way that a reported death was not actually “reportable” under the legislation (s 3).

For more information on the medical procedures that may be involved in the investigation, please refer to ‘Key Elements in the Process: Investigation of deaths – Post mortem examinations’.

The investigating officers continue to add to the evidence, compiling an ‘investigation file’. The investigation file is returned to the coroners’ office once the first round of investigations is complete; this may take several months or more depending on the complexity of the matter.

For more information, refer to ‘Key Elements in the Process: Documents – Investigation file’.

An investigation into a death involves gathering information from many sources. Police will gather samples, things and documents from the scene of the death. They will talk to witnesses to the incident or anyone who has information about events leading up to it. All of these statements are written down and then sworn as formal affidavits, and included on the file. In most cases, the coroner will request the deceased’s medical records be included on the investigation file. Once the request is made, the documents become evidence in the investigation. If records are not provided promptly then the coroner may authorise a police officer to seize a copy of the records directly (s 59).

Tasmania Police guidelines stipulate the use of NAATI (National Accreditation Authority for Translators and Interpreters Ltd) accredited / recognised interpreters, if available. If an interpreter is required in any dealings with Tasmania Police, please notify them at the earliest opportunity. It is appropriate for a legal representative to insist on an accredited interpreter for their client. 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).

Many organisations can be involved with, or be asked to provide information for, coronial investigations depending on the nature of the death. The most frequently involved are:

* [Aged and Community Services Tasmania](http://agedcaretas.org.au/)[[20]](#footnote-20)
* [Births, Deaths and Marriages](http://www.justice.tas.gov.au/bdm)[[21]](#footnote-21)
* [Chief Forensic Psychiatrist](http://www.dhhs.tas.gov.au/mentalhealth/chief_psychiatrist)[[22]](#footnote-22)
* [Child Protection Services](http://www.dhhs.tas.gov.au/children/child_protection_services)[[23]](#footnote-23)
* [Corrective Services](http://www.justice.tas.gov.au/correctiveservices)[[24]](#footnote-24)
* [Department of Health and Human Services](http://www.dhhs.tas.gov.au/)[[25]](#footnote-25)
* [Forensic Science Service Tasmania](http://www.police.tas.gov.au/useful-links/forensic-science-service-tasmania-fsst/)[[26]](#footnote-26)
* hospitals, including:
	+ [Royal Hobart Hospital](http://www.dhhs.tas.gov.au/hospital/royal-hobart-hospital)[[27]](#footnote-27)
	+ [Launceston General Hospital](http://www.dhhs.tas.gov.au/service_information/services_files/launceston_general_hospital)[[28]](#footnote-28)
	+ [Mersey Community Hospital](http://www.dhhs.tas.gov.au/hospital/mersey-community-hospital)[[29]](#footnote-29)
	+ [North West Regional Hospital](http://www.dhhs.tas.gov.au/tho/nw/north_west_regional_hospital)[[30]](#footnote-30)
* [Marine and Safety Tasmania](http://www.mast.tas.gov.au/)[[31]](#footnote-31)
* mortuary ambulance contractors
* [Motor Accidents Insurance Board](http://www.maib.tas.gov.au/)[[32]](#footnote-32)
* residential aged care facilities
* [Safe at Home Tasmania](http://www.safeathome.tas.gov.au/)[[33]](#footnote-33)
* [Tasmanian Health Service](http://www.dhhs.tas.gov.au/tho)[[34]](#footnote-34)
* [WorkSafe Tasmania](http://worksafe.tas.gov.au/)[[35]](#footnote-35)

Depending on the nature of the investigation, some of the other organisations that may be involved include:

* airline companies
* airport operators
* [Ambulance Tasmania](http://www.dhhs.tas.gov.au/ambulance)[[36]](#footnote-36)
* Attorney-General
* [Australian Aged Care Quality Agency](https://www.aacqa.gov.au/)[[37]](#footnote-37)
* [Australian Defence Force](http://www.defence.gov.au/)[[38]](#footnote-38)
* [Australian Federal Police](https://www.afp.gov.au/)[[39]](#footnote-39)
* [Australian Maritime Safety Authority](https://www.amsa.gov.au/)[[40]](#footnote-40)
* [Australian Transport Safety Bureau](https://www.atsb.gov.au/)[[41]](#footnote-41)
* [Civil Aviation Safety Authority](https://www.casa.gov.au/)[[42]](#footnote-42)
* [Department of Premier and Cabinet](http://www.dpac.tas.gov.au/)[[43]](#footnote-43)
* [Department of Justice](http://www.justice.tas.gov.au/)[[44]](#footnote-44)
* [Director of Public Prosecutions](http://www.crownlaw.tas.gov.au/dpp/about_us)[[45]](#footnote-45)
* [Forensic Mental Health Services](http://www.dhhs.tas.gov.au/service_information/services_files/mental_health_services/forensic_mental_health_service)[[46]](#footnote-46)
* health care professionals
* [Mineral Resources Tasmania](http://www.mrt.tas.gov.au/portal/home)[[47]](#footnote-47)
* port corporations
* radiation health physicists
* shipping companies
* specialist recovery services
* [Tasmania Fire Service](https://www.fire.tas.gov.au/)[[48]](#footnote-48)
* transport inspectors
* [Transport Tasmania](http://www.transport.tas.gov.au/)[[49]](#footnote-49)
* [Unions Tasmania](http://unionstas.com.au/index.php/en/)[[50]](#footnote-50)

Here are some examples of how different groups assist coroners in their investigations:

* **WorkSafe Tasmania inspectors** carry out investigations into workplace deaths in order to:
	+ discover what may have caused or contributed to the death
	+ find out whether the workplace was complying with all relevant health and safety laws and regulations
	+ ensure action is taken to fix any hazards
	+ provide reports to the coroner.
* They have powers to enter workplaces, examine conditions, conduct tests, and gather statements as well as documentary and physical evidence, to aid them in their functions.
* They also have vital inspection functions to ensure workplaces comply with the law to prevent deaths. In the event of non-compliance inspectors have the power to issue improvement notices, prohibition notices or non-disturbance notices. They can also take direct action in court to seek injunctions and breaches may be prosecuted in a criminal court.
* **Transport inspectors** are qualified vehicle mechanics who have experience enforcing vehicle standards regulations. They examine motor vehicles to determine a vehicle’s condition; any evidence of mechanical failure and if the vehicle was legally compliant pre-crash.  This includes examining all the vehicles systems: brakes, tyres, steering, suspension, safety systems (airbags and seat belts), lights and general vehicle condition. When assisting a coronial investigation, they will provide the coroner with an opinion on the contribution of any defect to the crash.
* **Marine and Safety Tasmania (MaST)** is the relevant authority for recreational vessels in Tasmania. It oversees domestic commercial vessels, however this role ceases in June 2017. In the case of a maritime incident involving a death, MaST will provide expert advice to Tasmania Police (and through them, to the coroner) on vessel condition, safety equipment and the competency of the operator.
* **Australian Maritime Safety Authority (AMSA)** takes over responsibility as the relevant authority for domestic commercial vessels in Tasmania from July 2017.

Once the investigating police officer has completed the investigation file, they send it to the coroner. At the coroners’ office the coroners’ associates review the file. They look at the evidence that has been collected and decide if there is any further evidence or extra information that is required. The investigation file provided by police becomes the basis for the coronial record and all further documents obtained are added to it. The coroner oversees this process and may choose to ask for the provision of expert reports or additional statements. A request for more information by the coroner does not necessarily mean that there is anything suspicious about the death. The coroner is required to make the most thorough and accurate findings that they can and so sometimes, they will need more information to do this.

### Concurrent investigations

Most organisations involved in the coronial process do not conduct concurrent investigations (investigations into the same death, at the same time) into matters that a coroner is investigating. There are some exceptions to this. For example, whenever there is a death in custody, the Tasmania Prison Service (TPS) conduct an internal review. The Director of Prisons appoints a senior manager to gather information and determine if there are any immediate changes that need to be made. In some circumstances, the Department of Police and Emergency Management will also commission an independent investigation. Copies of all reports that result are made available to the coroner. Hospitals involved in unexpected deaths will often conduct internal investigations and Child Protection Services will always investigate the deaths of children known to the child protection authority (a ‘child death review’).

### Coroners’ powers in an investigation

As part of an investigation, the coroner:

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

### Post mortem examinations

The State Forensic Pathologist arranges all post mortem examinations. The State Forensic Pathologist and other qualified pathologists in the Royal Hobart Hospital and Launceston General Hospital conduct the examinations. The term ‘post mortem examinations’ covers all medical investigations of the deceased person, both external and internal. External examinations are not expressly detailed in the Act, which only deals specifically with autopsy (s 36).

The senior next of kin will be consulted about which post mortem examination procedures are to occur. However, the ability to object is only relevant to procedures that are categorised as being a part of the autopsy (see the section below - Autopsy).

#### External examinations

In some cases, the cause of death can be satisfactorily determined without conducting an autopsy. In other cases, it may be determined that an autopsy is not likely to provide any additional information as to the cause of death. In these situations, the pathologist will only conduct an external examination of the deceased person. The coroner uses the suite of investigative tools, which are collectively called ‘external examinations’, in consultation with the pathologist to determine the cause of death. These do not involve any invasive procedures.

The standard procedures for an external examination are:

* review of the circumstances of death (including the Report of Death)
* review of the scene of death photographs
* review of medical records (and family history where relevant)
* external visual examination of the deceased person
* taking photographs of the deceased person
* collection of forensic evidence such as fibres, paint, soil, hair and other traces left on the body of the deceased person
* fingerprinting of the deceased person (which is conducted by police after the medical and forensic examinations are complete).

Radiological examinations such as x-rays and CT scans of the deceased person may also occur as a part of the external examinations if the coroner deems them necessary to establish cause of death.

If an autopsy is not required, within 24 hours after the pathologist has completed their examinations, they will provide the coroner with a ‘Provisional Cause of Death’ or ‘interim post mortem report’. Once this occurs, the coroner will sign a certificate authorising the release of the deceased person for burial / cremation. The pathologist will then prepare a formal post mortem report and send it on to the coroner.

#### Autopsy

An autopsy is a medical procedure that involves a careful examination of the internal parts of the body, which is governed by section 36 of the Act. The aim of any autopsy is to identify the medical cause of death and anything that might have contributed to death; this will often involve searching for signs of illness, injury or disease. Autopsies can provide a lot of information that cannot be gathered in any other way. An autopsy cannot proceed unless a coroner or the Chief Magistrate make an appropriate order. All autopsies are conducted in a respectful and dignified manner.

In Tasmania, the term “autopsy” is used to describe the medical procedure of internally examining the deceased person. Some medical procedures that are not commonly thought of as ‘an autopsy’ are still part of an autopsy under the Act. These procedures will only occur when a coroner or the Chief Magistrate makes an order for an autopsy. These are:

* samples being taken of urine, blood and other fluids for testing
* the taking of tissue samples for testing.

Autopsies in Tasmania are performed by the State Forensic Pathologist with a proportion conducted by other pathologists.

In Tasmania, the term ‘post mortem’ is used in two ways:

* to cover all medical examinations of the deceased person, whether internal or external
* for the report that the pathologist writes after they have completed the examination.

The types of tests that are conducted on samples taken in an autopsy include toxicology (testing for alcohol, drugs, poison and medications), histology / microbiology (testing for disease and infection) and DNA tests.

In most cases of reportable deaths in Tasmania, a full autopsy is ordered. Often, a full autopsy is the only way to satisfactorily determine the cause of death. Reasons for requiring a full autopsy include:

* *the circumstances of death*: for example, if the death may have been directly or indirectly caused by a deliberate act of another person, it will be very important to have a clear picture of all of the medical evidence
* *the likely cause of death*: there are some causes of death which can only be accurately determined using an internal examination
* *to exclude alternate possible causes of death*: in a case where there are multiple possible causes of death, a pathologist will usually be required conduct a full autopsy to identify the actual cause of death
* *concerns about medical care*: if family members raise concerns about the standard of medical care given to the deceased, the pathologist must ensure that they have a complete picture of the circumstances of death including any surgical procedures conducted or medications administered to the deceased person
* *in drug or medication related deaths*: in situations involving poisons, illicit drugs or medication, cause of death may not be able to be determined until toxicological tests are completed; a process that may take months - in these cases, without a full autopsy, there is a risk that those tests will come back normal and the cause of death will be unknown.

In almost all cases requiring autopsy, the pathologist will keep small samples of tissue and bodily fluids and send them to Forensic Science Service Tasmania (FSST) for testing. This is to ensure that the deceased person is released for burial or cremation as soon as possible, with no need to wait for the results of tests to come back. In the case of retained samples, the coroner will make an order for the disposal of the sample once the investigation is complete.

In a rare instance, entire organs may be retained. This will only happen if the State Forensic Pathologist believes it is necessary to determine the cause of death or the circumstances surrounding the death. In the case of retained organs, the organ will usually be repatriated with the body before a certificate for release of the body is issued. If this is not possible, the coroner will make a separate release order for the organ / body part and it will be returned or buried in consultation with the senior next of kin.

Coroners have the power to authorise a ‘limited autopsy’. The procedures that are used in a limited autopsy vary according to the circumstances of the case. It may include taking tissue and fluid samples from the deceased person only, or include internal examination of just one part of the body. When there is an objection to autopsy, the wishes of the senior next of kin are taken very seriously. The pathologist will review all the circumstances of the death and make recommendations to the coroner about which medical procedures are absolutely necessary to determine the cause of death. In some cases, the coroner will decide that an autopsy is not necessary, or that a limited autopsy will be sufficient. The coroner has a legal duty to determine the cause of death, so in cases where this cannot be determined without a full autopsy, the coroner will make an order for a full autopsy (s 38(1)).

Within 24 hours of the completion of the autopsy, the pathologist will provide the coroner’s court with a ‘Provisional Cause of Death’ or ‘interim post mortem report’. Once this occurs, the coroner will sign a certificate authorising the release of the deceased person for burial or cremation. The senior next of kin is notified that this has occurred and the mortuary staff will call the funeral director and inform them.

*If there is a* *dispute about who to release the body to*, then parties must apply to the Supreme Court under probate law. There is no rule that specifies that the person whom the coroner names senior next of kin has a right to collect the deceased person. Once the coroner makes an order for release, their jurisdiction is at an end.

Once the full post mortem report is prepared (which may take several months), families and close friends may request to have the document sent to a general practitioner (GP) or other medical practitioner of their choice. This allows the document to be discussed with the families / friends by a medical professional who can explain the medical terminology used by pathologists.

Sometimes the cause of death cannot be determined by an autopsy. The coroner may still be able to determine the cause of death once all the evidence in the investigation is considered. The pathologist will always make every effort to make the most accurate report as to cause of death that they are able to on all of the evidence.

**Benefits of an autopsy**

* An autopsy allows the most accurate findings upon the medical cause of death (often the cause of death cannot be determined at all without a full autopsy).
* An autopsy may assist families by providing the most information possible upon the factors which contributed to or caused the death.
* An autopsy can give families information on genetic illnesses or predispositions, which can be valuable to them in the future.

#### Objection to autopsy – information for senior next of kin & their representative

If there is an objection by the senior next of kin to an autopsy being performed, please notify the attending police officer or [contact the coroner’s court](http://www.magistratescourt.tas.gov.au/contact/coroners_court) immediately. If you are unable to notify attending police or the coroner’s court (for example, because it is outside business hours and the coroner’s court is not open) you should notify police via the police radio room (131 444). It is very important that the coroner be made aware of the objection as soon as possible, as autopsies are generally carried out as soon as practicable to allow the deceased person to be returned to family quickly (Rule 8(a)).

An affidavit or written objection must be completed and returned to the coroners’ office or Tasmania Police within 24 hours of making a verbal objection (r 6(c)). The affidavit should specify the relationship of the applicant to the deceased person and explain the reasons for the objection. If the coroner receives an objection but decides that a limited or full autopsy is absolutely necessary, they will send out a notice informing the senior next of kin. The senior next of kin is then able to apply to the Supreme Court (within 48 hours of receiving the notice) for an order to prevent this: refer to ‘Key Elements in the Process: Applications’.

In rare circumstances, the coroner may proceed immediately to autopsy without the opportunity for the senior next of kin to object. This will only occur if the coroner believes that delay will prejudice the interests of justice.

### Medical requests

If you have questions about any of the following procedures, please [contact the coroner’s court](http://www.magistratescourt.tas.gov.au/contact/coroners_court) and / or seek independent legal advice:

* accessing samples taken during an autopsy for use in a paternity test
* collecting sperm from a deceased person for IVF
* collecting ova (eggs) from a deceased person for IVF.

### Delays during the investigation

Delays during an investigation can occur for a variety of reasons. Some of these include:

* waiting on the provision of reports such as medical reports, engineering reports, health and safety reports and expert opinions
* delays in receiving toxicology reports, as some medical tests take a long time to prepare and conduct to ensure that the result is accurate
* pressure on court lists, where there are many matters waiting to be heard and coroners must deal with them in turn
* the large volume of work in the coroner’s court generally
* the suspension of the investigation (or the handing down of the findings), which usually occurs if a person is charged with an offence related to the death, fire or explosion (ss 30(3) & 47(4))
* if witnesses are not available (they may have other professional commitments or be overseas), or if Tasmania Police are unable to locate an important witness
* high work load of investigating officers, who have many investigations to conduct at the same time
* annual leave and sick leave taken by investigating officers and court staff.

Delays in the finalisation of coronial matters can cause stress and logistical difficulties. Coroners, coroners’ associates and staff strive to complete all investigations as quickly as possible. If you have any questions about why a particular matter or process is taking so long, please [call the coroner’s court](http://www.magistratescourt.tas.gov.au/contact/coroners_court). If you represent an interested person, we can provide you with information on what stage the investigation has reached and advise the reasons for any delay.

### Will there be an inquest?

There are two situations in which a coroner will hold an inquest into a death after conducting an investigation. The first is where the mandatory inquest provisions of the Act are triggered (s 24(1)); the second is when the coroner considers it desirable to do so (s 24(2)). Any person with a ‘sufficient interest’ in a death can apply to the coroner’s court for an inquest to be held (Act s 27(1) and Rules r 5).

For more information on the inquest process, refer to ‘Key Elements in the Process: Inquests’.

For information on applications, refer to ‘Key Elements in the Process: Applications’.

### Mass Fatality Management

In the tragic event of a mass fatality incident, the Tasmanian Emergency Management Plan comes into effect. This plan details the government response (on the state level) to a wide variety of different types of potential emergencies such as large-scale bush fires and floods. It lists all the different committees and plans in place to prepare for, respond to, and recover from such emergencies.

The Emergency Management Unit oversees and co-ordinates these service on a state level.

The [Emergency Management Unit Web Page](http://www.ses.tas.gov.au/h/em)[[51]](#footnote-51)

The [Tasmanian Emergency Management Plan](http://www.ses.tas.gov.au/assets/files/Plans/State/Tasmanian%20Emergency%20Management%20Plan%20-%20Issue%208.pdf)[[52]](#footnote-52)

As a part of the Tasmanian Emergency Management Plan, the coroner’s court has devised a Mass Fatality Management Plan. This plan lays out what action will be taken by the coroner’s court in the event of a mass fatality incident. It covers areas such as the allocation of responsibilities between departments and the management of incident sites.

#### Disaster Victim Identification (DVI)

If a mass fatality incident occurs, Tasmania Police utilise the techniques of disaster victim identification to ensure that victims are identified and reunited with their families as soon as possible. Identification procedures such as matching dental records, fingerprints and DNA are used rather than visual identification. Each state in the country has a dedicated Disaster Victim Identification Unit. A coroner will sit on a ‘reconciliation panel’ and oversee the process of identification and repatriation. It may not be possible for any of the deceased persons to be released to their families until the identification process is complete for all deceased persons.

For more information, refer to the [Australia New Zealand Policing Advisory Agency](http://www.anzpaa.org.au/nifs/resources/disaster-victim-identification) web site.[[53]](#footnote-53)

## Investigation of fires and explosions

Coroners in Tasmania have the authority to investigate any fire or explosion, even if no death has occurred. The jurisdiction to investigate covers any fire or explosion that happens in Tasmania as long as the coroner believes it is desirable to conduct an investigation. There is no time limit set for such an investigation, so in theory a fire that occurred many decades ago could still be investigated today. As with the investigation of deaths, coroners play an active role in directing the investigation: defining the relevant issues, calling for expert opinions and determining how the investigation is to proceed. In practice, coroners in Tasmania rarely investigate fires or explosions without a related death. For the most part, investigations into fires and explosions are conducted in the same way as investigations into deaths. The legislative framework for the investigation of fires and explosions is located in Part 6 of the Act and in Part 3 of the Rules.

The aim of an investigation into a fire or explosion is to make all the “findings” set out in s 45(1)(a-c) of the Act:

A coroner investigating a fire or an explosion must find if possible –

a. the cause and origin of the fire or explosion; and

b. the circumstances in which the fire or explosion occurred; and

c. the identity of any person who contributed to the cause of the fire or explosion.

Section 45(2) also gives the coroner the power to make comments or recommendations in their findings on any matter connected with the fire or explosion including public health or safety or the administration of justice. The coroner uses this power to review safety procedures, responses, training and other factors which may have contributed to or prevented the fire or explosion occurring. The recommendations made are aimed at preventing similar events in the future and / or mitigating the damage caused if they do occur.

An investigation into a fire or explosion is very similar to an investigation into a death. The type of evidence gathered is necessarily different, but the process of gathering physical evidence, documents and witness statements is usually the same. A key difference is the involvement of the Tasmania Fire Service (TFS), as they conduct their own investigations. The police still forward an investigation file to the coroners’ office and the coroner calls for additional information, which is then added, and the file becomes the coronial record.

TFS does not have a specific coronial unit. TFS officers attend all fires and explosions, and additional staff are tasked to attend and provide support as required. When TFS attend the scene of a fire, an incident controller / crew leader examines the scene to establish the cause and origin of the fire. These senior officers also conduct a risk assessment to ensure the health and safety of TFS staff, volunteers and members of the public. TFS also notify Tasmania Police of the fire. If the incident controller / crew leader is unable to determine the cause and origin of the fire, a fire investigation officer (FIO) will attend the scene to assist. FIOs are called to attend initially in the case of serious incidents.

Specialised staff and staff from other organisations are called in if required (such as qualified electrical inspectors and wildfire-qualified investigators). TFS personnel record observations, collect witness statements, take photographs and collect other evidence to support the Fire Investigation Report. In the case of an explosion caused by flammable materials such as petrol, the same investigation procedures apply as for a fire. In the case of an explosion caused by a bomb, clandestine drug-lab or similar, the investigation is handled by Tasmania Police with assistance from TFS as required. In the case of a suspected crime or other police-related matter, evidence and control of the scene is transferred to Tasmania Police once they arrive and the TFS investigation officers have gathered the information they require.

The coroner does not usually become involved in the investigation of fires and explosions until some time after the incident has occurred and the damage has been assessed. If a coroner investigates a fire or explosion, the Fire Investigation Report is forwarded to the coroners’ office. Members of TFS may also be requested to provide further statements, or to give expert evidence and opinions at an inquest.

The coroner has many of the same powers during the investigation of a fire or explosion as they do during the investigation of a death. These include the power to restrict access to a place (s 49), power to enter a place and inspect it and anything in it (s 59(1)(a)), power to take a copy of any relevant document (s 59(1)(b)) and power to take possession of an article, substance or thing (s 59(1)(c)).

If the coroner has the jurisdiction to investigate a fire or explosion, they may also conduct an inquest (s 43).

Any person with a ‘sufficient interest’ can apply to the coroner and request that they investigate a fire or explosion.

For more information, refer to ‘Key Elements in the Process: Applications’.

## Representing an interested person in a coronial matter

Representing an interested person (or organisation) in a coronial matter is a very different experience to representing a client in a criminal or civil matter. Coronial proceedings have collaborative aspects; parties are encouraged to work together to ensure that all potentially relevant information is available to the coroner. Coronial proceedings are also inquisitorial; the coroner defines the issues, directs the investigation and decides which information is relevant to the proceedings.

The focus in coronial matters is on establishing the facts required by section 28 and, in relevant cases, making comments and / or recommendations with the aim of preventing similar deaths. Through their recommendations, coroners can address any systemic issues that their investigations have uncovered. The ability to examine the system as well as the individual, to look to the future as well as at the past, makes the coronial jurisdiction unique.

The role of counsel in coronial matters is two-fold: to protect the interests of their client and to assist the coroner in their fact-finding. In order to best protect the interests of your client, it is important to be aware of the coroner’s control of proceedings. You will need to be active in advocating for the inclusion of evidence that supports your client’s position from the beginning. For practical tips on how to accomplish this, refer to the section below.

It is most important to be *respectful and sensitive* when dealing with parties to coronial matters. Investigations can be highly emotive. Patience, tolerance and understanding are vital.

This section contains general information on representing an interested person throughout the entire investigation process. For information specific to representing an interested person at inquest, refer to ‘Key Elements in the Process: Representing an interested person at an inquest’ and ‘Key Players in the Process: Counsel assisting the coroner’.

**Things to consider**

What is your client’s role in the investigation? Are they the senior next of kin, an interested person or a person or organisation that may have adverse findings made against them?

* The nature of your client’s involvement in the proceedings has a strong bearing on their rights and responsibilities.
* Check the corresponding sections of the Handbook (senior next of kin, interested persons etc.) for relevant legislation and further reading.
* For more information on potential adverse comments and findings, refer to ‘Key Elements in the Process: Representing an interested person at an inquest – Potential adverse comments and findings’.

Do you have copies of all documents that may be relevant to your client’s interests?

* Make sure you write to the Coronial Division early in the proceedings and apply for copies of all relevant documents.
* It can be helpful to ask for a list of the documents on the file to ensure that you are aware of all the material the coroner will be considering to enable you to make appropriate applications.
* As the matter progresses (and particularly if an inquest is foreshadowed) it is advised that you check that no further relevant documents have been received by the coroner.

Is all the documentary and physical evidence you wish the coroner to consider available to them?

* You are always able to forward any additional information to the coroners’ office.
* To do this, simply attach a cover letter to the relevant document and send it to the coroners’ office.
* Please include in your correspondence your client’s role in the investigation and why the information will assist the coroner in their fact-finding.
* If the evidence is physical, [call the coroners’ office](http://www.magistratescourt.tas.gov.au/contact/coroners_court) and discuss it with the associates, and arrange a time to bring it in to the office (this ensures that the coroners’ associates are aware of what the article is and why you wish the coroner to consider it).

Have you talked through the major points of the investigation with your client? Have you prepared them (insofar as is possible) for the findings?

* This enables you to make submissions promoting your client’s position in relation to potential findings.
* You may do this in writing, or verbally if there is an inquest.

If you are representing a government employee, public authority or other body it is recommended you advise the coroners’ office (before the findings are handed down) of any of the following that has occurred:

* any relevant changes to procedure that have been implemented after the death, fire or explosion occurred
* any practical measures that the organisation is currently implementing, or that are due to be implemented in the future, to mitigate against any risks discovered in the course of the investigation
* any internal inquiries or investigations that have occurred which aim to establish protocols which will mitigate against any risks discovered in the course of the investigation.

Ask for any information concerning the recommendations that the coroner may be considering and discuss these with your client. Your client will have valuable information on the organisational structures and realities in which the incident occurred. Your client therefore has the potential to enhance and assist the coroners’ preventative role by providing advice on what the most practical and effective changes may be. Recommendations are not an end in themselves; the best recommendations are practical, effective and *likely to be implemented.*

It is appropriate for parties to write to the coroner in order to offer potential recommendations in the interests of preventing similar deaths, fires or explosions. Please include in your correspondence why it is submitted or suggested that the recommendation should be accepted, and will work.

**Does your client require referral to counselling or support services?**

* It is a good idea to keep this issue in the back of your mind during the investigation process. Even professionals may become distressed during the course of an investigation, particularly if their actions are subject to close scrutiny.
* There are a number of professional bodies who can offer assistance listed in ‘A Guide for Families and Friends: Coping with Grief’ and ‘A Guide for Families and Friends: Who can help?’. There may also be ‘in house’ counselling services provided if your client is involved in the proceedings through events that occurred at their place of work.

**Does your client have complex communication needs?**

* Classes of people who may have complex communication needs include children, Aboriginal people, people from non-English speaking backgrounds, people with mental health issues and people with disability.
* If they do, you can access special assistance to ensure that the court process accommodates their needs.
* For more information on the services available to assist those with complex communication needs, or diverse needs generally, refer to ‘Key Players in the Process: Witnesses’ and ‘A Guide for Families and Friends: Who can help? – If you need extra assistance’.

Waller’s has a useful section on representing government agencies at I.129 (Abernethy, J., Baker, B., Dillon, H. & Roberts, H., *Waller’s Coronial Law and Practice in New South Wales* (LexisNexis Butterworths, 4th ed, 2010)).

 For other helpful information, refer to Dillon, H., *Practical Advocacy: The roles of counsel in the coronial jurisdiction*, (2010) 33 Australian Bar Review 293 and Freckelton, I., & Ranson, D., *Death Investigation and the Coroner’s Inquest* (Oxford University Press, 2006) – Chapter 16, Advocacy.

## Documents

The coroner’s court collects and retains many types of documents as part of the investigation process; these documents are all a part of the ‘coronial record’. Anyone can apply to the coroner’s court for access to documents. Please note that you will only be able to access a document if you have a ‘sufficient interest’ in the particular document you want to look at.



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

### Findings

At the conclusion of an investigation, the coroner will make “findings” which may include comments and recommendations in relation to the death. The findings include details such as the cause of death and any factors that may have contributed to the death. A copy of the coronial findings is sent to the senior next of kin without charge once the investigation is complete. Anyone else who wishes to receive a copy of the findings is required to make a request to the coroner’s court. In some cases (such as where there is an inquest) the findings will be published 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).[[54]](#footnote-54)



For more information on findings, please refer to ‘Key Elements in the Process: Findings, comments and recommendations’.

### Medical records

Often coroners will require the medical records of a deceased person to be sent to the coroners’ office, to be included in the investigation file. These records may include files held by a general practitioner (GP), a hospital such as the Royal Hobart Hospital or Launceston General Hospital, a residential aged care facility and / or any treating medical specialists.

### Investigation file

The police officers tasked to investigate the death, fire or explosion complete the investigation file and return it to the coroners’ office. The investigation file contains all the photographs, statements, reports and records the police have gathered (predominantly in affidavit form). When the investigation file arrives at the coroners’ office, it is reviewed by the coroners’ associates and they decide (usually under the direction of the coroner) if any further information is required to complete the findings. The investigation file can be referred back to police at any stage if further information is required. Once the coroner has the information they require, they then write their findings. In approximately three per cent of cases, the coroner will hold an inquest before the findings are delivered.



For more information, refer to ‘Key Elements in the Process: Inquests’.

The investigation file will generally contain the following indexed documents:

* Tasmania Police Subject Report of the investigating officer (includes background history, the circumstances leading up to and including the death, who attended the scene and what function they performed, any opinions of the investigating officer and a list of potential witnesses including what evidence they can give)
* Report of Death
* life extinct affidavit
* identification affidavit
* post mortem affidavit (report)
* government analyst affidavit (toxicology)
* specialist affidavits and / or reports (these may include ambulance, medical, ballistic, transport, photographic, fingerprints and others)
* civilian affidavits (from families, friends, witnesses and associates)
* investigating police documents
* photographs.

### Post mortem report

After they conduct their post mortem examinations, the pathologist will write a report about the results. In the report, the pathologist provides an opinion on the cause of death (if one was determined). The post mortem report is a highly specialised document and contains complex medical terminology. If the families or friends of the deceased person wish to view the post mortem report, a coroner may authorise its release to a medical practitioner of their choosing, who will guide them through the report and explain the contents. Medical practitioners have access to free interpreting services and so this can be very helpful in the case of a person whose first language is not English.

### Reports

Coroners often request other reports during investigations, depending on the nature of the death, fire or explosion. These are usually provided in affidavit form. Toxicology reports provide information on poisons, drugs or medications that were in a deceased person’s system at the time of death. WorkSafe Tasmania inspectors provide reports when a death occurs at the deceased person’s workplace. Crash investigators provide opinions in the case of a fatal crash as to how the crash occurred and transport inspectors provide opinions on any defects in the vehicle/s. Firearms experts provide reports where a death involved a firearm. The Tasmania Fire Service provides a Fire Investigation Report in investigations into fires and some explosions. Government bodies that regulate health and safety in specific areas such as pools, residential aged care facilities and airports also provide reports when required. Interested persons are generally able to have their own experts examine evidence and provide reports to the court if they wish.

### Photographs

The police photographer or investigating officers take photographs at the scene of death. Photographs may also be taken during the autopsy process. Some of these photographs can be very graphic and upsetting for families and friends. They will always be placed in a separate section of the investigation file to prevent them from being viewed by accident. If the families or friends of the deceased person wish to view photographs on file, the court recommends that they speak with coronial staff and seek counselling before taking this step.

### Transcripts and recordings

All inquests are recorded by the administrative officer in court, producing an audio file of all the evidence that can be copied onto a CD. A copy of this recording is kept for one year (if the recording has been typed up into a written document called a “transcript”) and for six years if no written copy has been made (rule 27). You may apply to receive a copy of the recording, or a copy of the transcript if one has been prepared. You are also able to apply to have a recording typed up, but there is a set fee per page (refer to ‘Other: Fees’).

### Annual report

Each year, the Chief Magistrate provides the Attorney-General with an Annual Report which includes the operation of the *Coroners Act 1995* (Tas) during that year. The report must include details of any deaths of persons held in custody and the findings and recommendations made by the coroner/s in relation to those deaths. The report is tabled in both houses of parliament each year within ten sitting days of being received (s 69). Copies of the Annual Reports are available on the Magistrates Court web site under [Publications](http://www.magistratescourt.tas.gov.au/about_us/publications).[[55]](#footnote-55)

### Death Certificate – apply to Service Tasmania

The coroner does not issue death certificates. A coroner may make findings as to cause of death, but death certificates are only issued by, and 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.



You may apply to any Service Tasmania shop for a copy of a death certificate (for a fee).

* Information on how to find the [Service Tasmania shop closest to you](http://www.service.tas.gov.au/about/shops/)[[56]](#footnote-56) and on how to [apply for a death certificate](http://www.justice.tas.gov.au/bdm/deaths/applyforcertificate)[[57]](#footnote-57) is available online, or you can phone Service Tasmania and ask.
* Service Tasmania: 1300 135 513
* You may only be able to get an ‘interim death certificate’ while the coronial investigation is ongoing. This certificate may not be accepted by financial institutions and other organisations, so check whether they will accept it before you apply.
* If you do receive an interim death certificate, it will clearly state ‘incomplete registration – cause of death subject to coronial inquiry’. Once the coronial investigation is complete, Births, Death and Marriages can exchange the interim death certificate for a standard death certificate.
* If your client has contacted a funeral director, you should check whether they are getting a copy of the death certificate (as it is sometimes included in the cost of a funeral).

## How to access documents

The following information is designed to assist legal practitioners. For a short summary of how to access documents please refer to ‘A Guide for Families and Friends: Practical matters – Access to documents’.

Electronic copies of some findings (including all findings that relate to inquests) are published 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).[[58]](#footnote-58) The list of published findings is fully searchable. Most often, a coroner will chose to publish findings from an investigation without inquest if they feel that the information would enhance public health and safety, or if there has been significant public concern about the matter.

For other documentation, you are required to apply to the coroner’s court in order to view the document or receive a copy. Access to coronial documents is only granted to people with a sufficient personal or professional interest *in the particular document*, so it may be necessary to prove to the coroner that your client has a ‘sufficient interest’ first.

There is no legislative definition of sufficient interest, but the coroner will take into account factors such as the level of professional / personal interest in the investigation and whether giving the person the access or the copy is likely to unfairly prejudice the interests or reputation of another person (rule 26(4)). Being granted access to a particular document does not automatically mean that your client is an ‘interested person’ under the Act. Some parties will have a sufficient interest in one particular document, but not in the investigation as a whole.

For a statement on the meaning of ‘sufficient interest’ in the context of interested persons, refer to *Barci v Heffey* [1995] VSC 13.

Whether your client is granted access to a particular document will depend on their personal or professional interest in the document, but it may also depend on the current stage of the investigation. Some documents contain information that must be kept confidential until the coroner has made their findings. Other documents may be explained but not given to parties to read. Coroners receive a large amount of documentation with each case, some of these documents are relied upon heavily, other are not considered relevant. Often the coroner will not know how much weight they will give a particular document until they have had the opportunity to consider *all* of the evidence. If you are granted access to parts of the coronial record, it is important to realise that those documents are not the ‘full story’. The coroner critically scrutinises all information received in light of the evidence in its totality.

The coroner’s court has originals (or copies) of documents connected with current and historical investigations. Often families and friends involved in a coronial matter will not be emotionally prepared to look at this documentation until some years have passed. They are always able to make an application to access coronial documents no matter how many years ago the investigation occurred. Which documents are still available will depend on the nature of the investigation, and how long ago the death, fire or explosion occurred.

Once an investigation is complete, the file is stored in Hobart. If the investigation occurred more than 25 years ago, the records are held at the Archives Office of Tasmania. If you are seeking access to these records, you will still need to apply through the coroner’s court. The rules for access to documents are set out in Rule 26. Once a record is 75 years old, it is publically available and there is no requirement that the coroner approve access (*Archives Act 1983* (Tas) s 15). Accordingly, for files older than 75 years, enquiries should be made with the Archives Office directly.

For more information on accessing coronial documents, refer to ‘How do I make an application to access documents’.

### How do I make an application to access documents (Rule 26)?

To gain access to any of the documents on the coronial file, please use the online or paper form provided by the coroner’s court. The online form ‘Application to Access Coronial Records’ can be found on the Magistrates Court web site, under Forms. Paper copies are available at the coroner’s court).

* + Any person can make an application to view, access, or receive a copy of a coronial record.
	+ A *coronial record* includes any document on the court file, any oral evidence or recordings of the inquest if there has been one and any physical evidence seized for the investigation.
* The type of documents you are permitted to access will depend on whether you or your client has a ‘sufficient interest’ in *that document* and on what stage the investigation is in.
* Often the coroner does not grant access to documents during an active investigation.
* If your client requires the assistance of an interpreter (or translator) to understand the content of a document, please include that information in the application. If access is granted and the coroner authorises it, an interpreter or translation will be provided at the court’s expense.
* The coroner will be given information about the application and decide whether to grant access. An application can be refused or access prohibited if necessary.

**Copies of documents**

* + The senior next of kin will receive a copy of the coroner’s findings at no cost and they are not required to apply.
	+ As a general rule copies are only provided to legal representatives, whereas other parties may be allowed to view the file.
	+ If you are requesting a copy of a document, there will be a fee payable upon receipt.



For more information on the fees payable, refer to ‘Do I have to pay for documents?’ below.

**Viewing the file**

* + If you are given permission to view the file, a time and date will be arranged for you to come in to the appropriate coroners’ office and look at the file.
	+ Please keep in mind that some of the material may be distressing and even detached professionals may not wish to look at all of it.
	+ If you are unsure about whether to advise your client to look at the file, please discuss the matter with court staff and / or direct them to a grief counsellor (please refer to ‘A Guide for Families and Friends: Who can help?’).
	+ Photographs of a distressing or graphic nature and post mortem reports will be removed from the file before viewing. If you specifically wish to view these documents, please let the staff at the coroners’ office know, as special procedures apply.
* A view can enable you to assess the evidence before the coroner and establish which documents, if any, you would like to request a copy of.

### Do I have to pay for documents?

The coroners’ office does not charge a fee for access to, and viewing of, coronial records. Where a copy of document is requested, a fee will be payable. The senior next of kin will automatically receive a copy of the coronial findings without charge.

**Fees**

If your application for a copy of a coronial record is granted, you will be required to pay a fee. The fee is charged per page and it may not be possible for staff to give an exact amount until the documents are prepared. The fee pays for the copy itself and for the staff time taken to generate the document and provide it to you. For a copy of the fees schedule for the coroner’s court, please refer to ‘Other: Fees’.

**Waiver**

If you wish to receive a copy of a document but your client cannot afford to pay the fee, then you may apply to the coroner to “waive” the fee. This means that you will receive the documents at a reduced price or at no cost. You must prove that your client is suffering severe financial hardship (as well as proving that they have a sufficient interest in the document / proceedings to be granted access).

To request that a fee be waived, write to the coroner’s court and provide all relevant information on the application, including full details of your client’s financial situation and their ability to pay.

## Case management conferences

Coroners have the power to gather some or all of the parties in an investigation together so that they can plan out the rest of the investigation or the inquest. This meeting is called a ‘case management conference’. It allows parties to understand what has been done in the investigation, what is currently occurring and what is still to come. These conferences can occur at any stage in the proceedings. The conference is a two-way process where parties can ask questions, advise the coroner of any issues and provide information relevant to the investigation. Conferences are most often held when an inquest is planned and they help parties to understand what the issues in an inquest are and what they may need to do to prepare for the inquest.

A coroner may send a written notice of a case management conference to parties or the coroners’ office may make telephone contact. Whichever method they use, parties will always be told the date, time and location of the conference. Legal practitioners may attend with their clients. The conference is usually chaired by a coroner, who may direct the parties to do one or all of the following (Rule 22(5)):

a. identify any issues that the person expects to arise in the investigation

b. identify anybody who the person considers might be a potential witness in the investigation and indicate the probable nature of their evidence

c. produce any document or thing that the person considers might be relevant to the investigation

d. confer with any other person about the investigation

e. find out information or procure documents that might be relevant to the investigation

f. take any other reasonable action that it is within the person’s power to take for the purpose of facilitating the investigation.

In order to ensure that the investigation runs as smoothly as possible, the chair of the conference may also:

* set a date and time for an inquest (and indicate how long it may take)
* invite other people to attend the conference if they think those people may be able to contribute something of value to the conference
* if privacy requires it, direct a person to leave for some or all of the conference
* adjourn the conference (postpone it to another time and / or day) to enable further information to be provided.

In the unusual case where the chair of the conference is not the coroner conducting the investigation, a report will be provided to the investigating coroner informing them of the progress made at the conference and any issues raised.

Case management conferences can also be used to:

* ensure parties are aware of / provided with copies of any documents which may invite adverse findings against them, this assists to:
	+ ensure parties have adequate time to prepare for any inquest
	+ avoid any unnecessary adjournments
* identify all recognised ‘interested persons’
* clearly define the issues (and therefore identify and narrow the scope of any inquest)
* identify all witnesses to be called (and check / confirm their availability)
* ensure that the coroner is aware of all the documents that parties wish to tender
* identify primary documents to be tendered
* deal with preliminary and administrative applications (leave to appear, access to documents and such)
* talk families and friends though the inquest process and check if there are any areas they would particularly like explored
* identify any areas where further information or investigation is required
* raise issues such as de-identification, exclusion of persons from proceedings, restrictions of publication of evidence and other matters that should be discussed before any inquest commences.

## Applications

During an investigation, parties may wish to make various applications to the coroner’s court. The general rules are that an application *should be written* and should:

* be made as soon as possible after any relevant event
* explain the relationship between the person making the application and the subject investigation
* specify clearly the reasons why the application is being made
* specify clearly the orders that are sought.

**A ‘General Application Form’ is available on the Magistrates Court web site under Forms, and at all coroners’ offices, for use where there is no set form.** You are not required to use this form but it is preferred. There are no ‘filing fees’ on applications made in the coroner’s court.

### Applications in the coroner’s court

#### Legislative applications

The most common applications made in the coroner’s court are set out below. For practical reasons, less common applications are simply listed, together with the relevant legislation.

*Application to access documents (Rule 26)*

Any person with a sufficient interest in a particular document can apply for access to that document. **The ‘Application to Access Coronial Records’ form is available on the Magistrates Court web site under Forms, and at all coroners’ offices.**



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

*Application for leave to appear as an interested person (Act s 52)*

Any person can apply to a coroner to appear as an interested person. There is no set form.

You may make this application on behalf of your client at any stage of the proceedings, however the earlier the application is made, the greater the party’s potential impact upon the investigation. You may make your application verbally, but an application in writing is preferred.

Your client must have a ‘sufficient interest’ in the proceedings generally to activate the rights of an interested person (close family members, close friends or persons whose interests may be affected by the findings will usually qualify). For a statement on the meaning of ‘sufficient interest’, refer to *Barci v Heffey* [1995] VSC 13. If your application is refused, you may apply to the Chief Magistrate to have the decision reviewed.

*Applications under s 58: to reopen an investigation and re-examine the findings*

Any person with a sufficient interest in the findings of an investigation can apply to reopen a coronial investigation and have some or all of the findings re-examined. **The ‘Application to reopen an investigation and re-examine some or all of the findings’ form is available on the Magistrates Court web site under Forms, and at all coroners’ offices**.

If the application is successful, the Chief Magistrate or the Supreme Court reopens the coronial investigation and examines the findings (Act Part 7A). The Chief Magistrate also has the jurisdiction to reopen an investigation on their own motion. The Chief Magistrate may direct a coroner to reopen the investigation and re-examine the findings.

An investigation can be reopened if the Chief Magistrate is satisfied that (s 58(1)(a-e)):

* + 1. the investigation was or may have been tainted by fraud; or
		2. the investigation was not sufficiently thorough or was compromised by evidentiary or procedural irregularity; or
		3. there are mistakes in the record of the findings; or
		4. new facts or evidence affecting the findings have come to light; or
		5. the findings were not supported by the evidence; or
		6. there is another compelling reason to reopen the investigation.

A coroner who is reopening an investigation or re-examining findings under this section has the power to affirm the findings, vary the findings or quash the findings (s 58(5)). If a person makes an application to the Chief Magistrate to reopen an investigation and that application is refused, the person may appeal to the Supreme Court (s58(7)). The Supreme Court also has the power, upon application, to declare that any or all of the findings of an inquest are void (s 58A). If this occurs, the inquest may be reopened, or even started again from the beginning by a different coroner.

One of the important principles of a democratic judicial system is that people can test the results in a higher court. The ability to have another judicial officer examine the coronial process adds to public confidence in the coroner’s court and ensures that proceedings are conducted with the highest level of accountability and transparency.

*Application for care and control of articles (Act s 60 / Rules r 24)*

Any person with a legal or equitable right to an article, substance or thing that is in the custody of the coroner may apply for care or control of that article. There is no set form.

A coroner can take legal custody of any article, substance or thing for the purpose of an investigation. If you wish to apply for care or control of such an article, you will be required to prove your client’s legal / equitable right to the article as part of the application process.

The coroner has power to make orders (and to hear applications) at any time the articles are in their custody. Any application must be in writing and specify the reasons why the order is sought. The Director of Public Prosecutions and any person to whom this section applies are entitled to be heard on any such application; therefore, they must be served with any application. In this context, ‘any person to whom this section applies’ means any other person who may have a legal or equitable right to the article, substance or thing.

If the coroner makes an order granting your client care and control of an article, it is important to note that the coroner retains legal custody of the article until the findings are handed down. As such, these articles cannot be altered or disposed of until the investigation is at an end. Alteration includes deleting electronic files.

If you make an application to a coroner under this section and it is refused, you may apply to the Chief Magistrate to have the decision reviewed.

*Application for an inquest into a death (Act s 27(1) and Rules r 5)*

Any person with a sufficient interest in a death may request that a coroner hold an inquest into that death. There is no set form.

This application must be made as soon as practicable after the relevant death. The request is to specify the reasons why the application is being made and, if it is not made in writing, it must be confirmed in writing within 24 hours.

If the application is refused, the coroner must send a notice to the person who made the request informing them of the refusal. Within 14 days of receiving the notice, that person can go to the Supreme Court and apply for an order that an inquest be held (Act s 26(2) and Act s 27(3)).

*Application that an autopsy not be performed (Act s 38(1) and Rules r 6)*

For information on the procedures which form an autopsy and how to object to an autopsy, refer to ‘Key Elements in the Process: Investigation of deaths – Post mortem examinations, Autopsy’.

**Less common legislative applications that can be made in the coroner’s court include application:**

* for an investigation into a fire or explosion (Act s 42 and Rules r 14)
* to access a fire or explosion area (Act s 49)
* to access the place where death occurred (Act s 34)
* that an inquest not be held into a workplace death (Act s 26A(2))
* that the publication of a report be restricted (Act s 57)
* for custody of articles (Act s 61)
* to vary or revoke an order as to custody of articles (Act s 62)
* that an inquest be held into a fire or explosion (Act s 42(1) & s 44(1))
	+ may apply to Supreme Court if application refused (Act s 44(2))
* that an autopsy be performed (Act s 37(1) and Rules r 5)
	+ may apply to Supreme Court if application refused (Act s 37(3))
* that a body not be exhumed (Act s 39(3)) – Note: it is recommended to apply to the Supreme Court and to the Chief Magistrate within the same time frame.

#### Administrative applications

*Application to have a fee waived or reduced*

If your client is unable to pay a court fee, you may apply to the coroner to “waive” some or all of the fee so that they do not have to pay, or they pay less. To request that a fee be waived, write to the coroner’s court and provide all relevant information on the application, your client’s financial situation and their ability to pay.

*Application to appear in a matter by telephone or via a video link*

Please use the current forms, which are available on the Magistrates Court web site, under [Forms](http://www.magistratescourt.tas.gov.au/forms).[[59]](#footnote-59)

*Application to give evidence from a protected witness room*

In certain circumstances, an especially vulnerable witness (such as a child) may be permitted to give their evidence from another room. The witness sits in front of a television screen where they are able to view the courtroom and those in the courtroom can see them. If you wish to discuss your client’s use of the ‘protected witness room’ to give evidence, please [contact the coroner’s court](http://www.magistratescourt.tas.gov.au/contact/coroners_court).

*Application to be declared senior next of kin*

Any person can apply to be recognised as the senior next of kin. There is no set form.

If you wish to assert that your client is the correct senior next of kin under the legislation, you can make an application to the coroner. It is important to note that the question of who is senior next of kin is only relevant when the opportunity arises to exercise a right that is exclusive to that role.

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

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

Each time one of these matters arises, the coroner is required to give the senior next of kin the opportunity to exercise their right/s. It is before these points that any application should be made. To make an application, you must provide the coroners’ office with any information, along with any submissions, which tend to prove that your client is the correct senior next of kin. The method of providing this information will depend on which right the senior next of kin is to exercise. In the case of objection to autopsy, time is of the essence and so applications should be made orally by telephoning the coroners’ associates *immediately* (after hours, please call 131 444 and speak with police).

In each case where there is a dispute as to the identity of the senior next of kin, any other parties asserting the same status will be invited to provide information to aid the coroner’s decision. Once again, the nature of the right to be exercised will determine whether this is done orally or if there is time for letters to be sent explaining the process and submissions to be made in writing.

There is no right under the Act to challenge the coroner’s decision as to who is the senior next of kin. Appeal under administrative avenues may be possible.

*Application to request that someone else be declared the senior next of kin*

The senior next of kin can apply to delegate their responsibilities to another person. There is no set form.

If your client is *unable* to exercise the rights of the senior next of kin due to medical or other reasons, the designation of senior next of kin may pass to the next most qualified person under the definition in section 3A. In this case, please [contact a coroners’ associate](http://www.magistratescourt.tas.gov.au/contact/coroners_court) to discuss the matter.

If your client has been designated senior next of kin but does not want to take on the role, they can delegate the role by asking another person to take on the role. You should prepare a statutory declaration or affidavit to this effect, signed both by your client and by the person they choose and forward it to the coroners’ office. Please explain the role of senior next of kin to the delegate before they sign, to ensure that they fully understand this role.

### Applications to the Supreme Court

In some cases, a party that does not agree with a finding or decision made by a coroner can apply to the Supreme Court to have that finding or decision overturned. The coroner’s court advises any person making an application to the Supreme Court to seek legal advice first.

The legislation contains provision to apply in the Supreme Court for an order:

* that an autopsy not be performed (Act s 38(3))
* that an autopsy be performed (Act s 37(3))
* that an inquest be held into a death (Act s 26(2) and Act s 27(3))
* that an inquest be held into a fire or an explosion (Act s 44(2))
* that a body not be exhumed (Act s 39(4) and Rules r 10)
* that any or all of the findings of an inquest are void (Act s 58A(1))
* that an investigation be reopened (Act s 58(7))
* to review orders as to custody of articles (Act s 63).

**Please note: there are many potential applications to the Supreme Court that are not specified in the legislation.**

In most legislative matters, you will be required to apply to the coroner’s court in the first instance, and only if that application is refused do you then apply to the Supreme Court.

To apply for, vary or revoke an order of the coroner’s court in the Supreme Court (including ‘appeals’ and ‘reviews’), please file a ‘Form 3: Originating application intending to be served’ from the [Supreme Court Forms List](http://www.supremecourt.tas.gov.au/practice_and_procedure/forms/sc_forms_1-20) in the Supreme Court Civil Registry closest to you.[[60]](#footnote-60) If you file a Form 3, you will also need to serve the application **and** serve a ‘Form 6: Notice to be given to persons ordered to be served with notice of application’ on the coroner’s court, directed to the coroner who made the decision you wish to challenge.

Any applications made in the Supreme Court are to be made in accordance with Rules of Court in force under the [*Supreme Court Civil Procedure Act 1932*](http://www.thelaw.tas.gov.au/tocview/index.w3p;cond=;doc_id=58%2B%2B1932%2BAT%40EN%2B20160726000000;histon=;pdfauthverid=;prompt=;rec=;rtfauthverid=;term=;webauthverid=) (Act s 68). There will also be fees associated with any application to the Supreme Court.

For further information, refer to the [Fees Schedule](http://www.supremecourt.tas.gov.au/practice_and_procedure/fees) of the Supreme Court of Tasmania.[[61]](#footnote-61)

#### Judicial and administrative review

In addition to rights of review conferred by the Act and set out in the previous section, prerogative relief is available in circumstances where a coroner has made a decision that is in excess or want of jurisdiction. As to the Supreme Court’s power to grant prerogative relief (or judicial review) in respect of coronial matters, refer to *R v Matterson; ex parte Moles* (1994) 4 Tas R 87.

No application for review is able to be made pursuant to the *Judicial Review Act* *2000* (see section 4 (2) and schedule 1 of that act).

An application for prerogative relief may be made by a person with a sufficient interest (or standing). The question of sufficiency of interest was dealt with by the High Court in *Annetts and Anor v McCann and Ors.* (1990) 170 CLR 596.

The most common prerogative writs issued by superior courts to lower courts (including coronial courts) are writs of *certiorari* and *mandamus,* which are in effect orders holding a purported exercise of power to be invalid and orders requiring the exercise of a power in accordance with the law. The *Supreme Court Rules 2000* now specify the relief granted is ‘similar to’ *certiorari* and *mandamus*.

The authorities make it clear that superior courts exercise a high degree of restraint against interfering with coronial decisions.

It should be emphasised that judicial review is only available where an error of law is alleged.



For more information, please contact the Supreme Court of Tasmania.

## Evidence

The coroner’s court is generally inquisitorial in nature and the rules of evidence do not apply (s 51). Most evidence at inquest is tendered to the coroner through counsel assisting or the coroners’ associate. Parties may also tender evidence; however, the coroner decides which evidence will be admitted.

The type of evidence is also slightly different to that used in a criminal or civil court. As the coroner is not bound by the rules of evidence, they have greater discretion as to what types of evidence they will admit (i.e. coroners can admit hearsay and non-expert opinion evidence). This does not mean everything will be admitted. The scope of an inquest is defined by the issues, and the question of whether the evidence is relevant to those issues is paramount. The rules of natural justice apply, including all aspects of procedural fairness such as the right of parties to be informed of, and given the opportunity to answer, any evidence that may invite adverse findings against them (*Annetts and Anor v McCann and Ors.* (1990) 170 CLR 596).

Evidence can be oral (given by reading statements and answering questions in court) or written (in the form of a document) or even physical (such as an article of clothing). Most commonly, evidence is given orally by anyone who has relevant information to provide the coroner about the death, fire or explosion under investigation.

### Oral evide*n*ce

Oral evidence is evidence that is spoken aloud in court. Any witness who gives oral evidence must take an oath or an affirmation, which is a promise to tell the truth. Oral evidence includes evidence given by witnesses in examination-in-chief, cross-examination and re-examination. It also includes a deposition or affidavit read to the court (r 3, definition of deposition and r 20). Most oral evidence is subject to a prior affidavit. The witness is given an affidavit containing the statement they made earlier in the investigation, and then asked to read it aloud to the court and answer questions about it. Sometimes a witness is not required to come to court and their affidavit will be read into evidence by the counsel assisting or coroners’ associate, or taken as read.

For more information on being a witness in the coroner’s court, please refer to ‘A Guide for Families and Friends: The coroner’s court and me’.

### Written evidence

Written evidence can be any document that is relevant to the proceedings; the majority of these documents are affidavits. The documents may include witness statements, the post mortem report, expert reports and any relevant regulations or codes of practice. There is no formal discovery process in coronial proceedings; distribution of documents is usually arranged on application. Any person with a ‘sufficient interest’ in a particular document can apply to access that document or to have a copy made for a fee. Please note that a person with a sufficient interest in one document is not the same as an ‘interested person’ for the purposes of section 52.

Most documents will be tendered from the coronial file to the court by the counsel assisting or coroner’s associate. Parties may also tender documents; however, it is the decision of the coroner which documents will be admitted. Unlike in criminal proceedings, witness statements, depositions and affidavits are often tendered without the maker being present in court (r 20).

### Physical evidence

Physical evidence is any evidence that is not oral or written – “things” which the coroner may use to aid them in their fact-finding. More bulky items are collected by the police and held at a police station, with photographs of the items added to the investigation file. Examples of physical evidence include photographs, clothing and samples of fibres. Medical physical evidence such as blood samples are not tendered in court. Instead, expert reports are prepared by persons such as toxicologists, pathologists and treating specialists explaining the results of their examination of the samples.

For more information on how to provide information to the coroner, please refer to ‘A Guide for Families and Friends: How can I give information to the coroner?’.

### Items seized by police

Police will retain items in a coronial investigation in two situations, the first is for safekeeping and the second is as exhibits / evidence. All items taken by police are held at the ‘police property store’ at the relevant police station (most commonly Hobart or Launceston).

Items taken for safekeeping, such as a deceased person’s wallet, keys, jewellery or watch, can be returned upon request as they are not held ‘in the custody of the coroner’. For the return of these items, please [contact the coroner’s court](http://www.magistratescourt.tas.gov.au/contact/coroners_court) and speak with an associate to arrange a time to collect the items.

Items seized by police as exhibits / 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. Any item that the coroner reasonably believes to be relevant to the investigation can be seized by police under the authority of the coroner (s 59), including items such as motor vehicles or mobile phones.

At the conclusion of an investigation, the coroner will generally release property to the person from whom the item was seized, or the senior next of kin. If there is a dispute over ownership of an item then you may apply to the coroner for custody, care, control or disposition of the item under section 61 of the Act.

For more information on applications in the coroner’s court, refer to ‘Key Elements in the Process: Applications’.

## Court proceedings – general information

### Court etiquette

Court is a formal environment and, like many other formal places, there are some general rules that must be followed. It may be useful to inform your client of the following matters if they are unfamiliar with the court environment:

* neat casual or semi-formal dress is appropriate for court
* turn your mobile phone and any other electronic devices off before you enter a courtroom
* when you enter a courtroom, bow slightly towards the coroner if the court is in session. It is also customary to bow toward the coroner when you leave
* if you address the coroner, refer to them as ‘Your Honour’
* do not talk in the back of the courtroom. All evidence is important and it can be difficult for the coroner to hear clearly when there is background noise. Unless you are giving evidence or on your feet at the time, you are always welcome to leave the courtroom to have a discussion. Legal practitioners should seek leave to be excused temporarily from the bar table if they need to leave the room while court is in session.

### Court set-up / layout

* The coroner sits at the back of the room at a high table (called the **bench**) so that they can see everyone in court clearly.
* Directly in front of the coroner there is a table of medium height, where the administrative officer and any coroners’ officers present in court will sit and organise administrative matters.
* In front of the administrative officer there is a long table (called the **bar table**) where all the legal practitioners sit facing the coroner, including the counsel assisting. If there are interested persons who are asking questions or making submissions, they will also sit at this table.
* To one side of the bar table there is a **witness box**, which is where witnesses sit to give their evidence.
* Also at the side of the bar table there is a **media box**, where any members of the media may sit to take notes.
* Some courtrooms also have a **dock** on the other side of the bar table, where any witnesses who are currently in custody may give their evidence.
* The front of the room has rows of chairs (called the **public gallery**) for families, friends and the general public to use.
* Next to the door there is one chair reserved for a security guard to sit, if one is required, to ensure that everyone in the courtroom is safe at all times.

### People in the court

* **Media** may be present if the coronial matter has attracted public attention. The coroner can order that all, or any part, of the proceedings not be published (s 57).
* **Interpreters** (or other communication support people)may attend if they are required by a party to the proceedings and the coroner approves the request (the coroner’s court will usually pay for the interpreter in this case).
* **Members of the public** may attend. Almost all coronial inquests (and preliminary court appearances, if there are any) are open to the public. This means that anyone who wants to can come to court. Section 56(2) of the Act states, ‘a coroner may order the exclusion from an inquest of any person or all persons if the coroner considers that it is in the interests of the administration of justice, national security or personal security’. If you are concerned about a particular person attending, it may be appropriate to notify the coroners’ office (if you think security will be an issue), or to advise your client to arrive late or early so they can be seated separately.
* **Interested persons** will often be present in court, including the families and friends of the deceased person.
* **Witnesses** provide evidence to the coroner, most of the time they do this by reading a statement they made to the court and answering questions about it.
* The **administrative officer** (or ‘court clerk’) will sit in front of the coroner and record the proceedings, swear in witnesses and ensure the smooth running of the court.
* The **counsel assisting** the coroner will sit at the ‘bar table’ and ask questions, make submissions and tender evidence to the coroner.
* **Legal practitioners** may be present to represent any interested persons / organisations to the proceedings such as relatives or statutory bodies. They sit at the ‘bar table’, question witnesses, adduce evidence and make submissions on behalf of their clients.
* The **coroner** sits at a high table at the back of the room, and hears all the evidence and guides the proceedings.

****For more information on the roles played by different parties in coronial proceedings, refer to Chapter 2 of the Handbook ‘Key Players in the Process’.

### Security

* The court arranges security guards to attend coronial matters as and when required.
* If you (or your client) have any concerns about security, please [contact the coroner’s court](http://www.magistratescourt.tas.gov.au/contact/coroners_court) and be as specific as possible about the nature of your concerns.
* If it is appropriate, additional security can be arranged for particular dates or times.
* There are always additional security officers present in the court building. These officers will attend court at a moment’s notice if required and are all trained to administer First Aid.

### Offences in court

* Obstruction (s 65): A person cannot hinder or obstruct a coroner, or a person acting under a coroner’s authority in exercising powers under the Act.
* Contempt (s 66): a person must not:
	+ insult a coroner in relation to the exercise of their functions or powers
	+ interrupt an inquest
	+ create a disturbance (or continue a disturbance) in or near a place where an inquest is being held.

### Notes

* A coroner is not a compellable witness in relation to anything that came to their knowledge in the performance of their duties under the Act (s 64).
* Coroners (and persons acting under an authority given by the Act) are not liable to legal proceedings in relation to anything done under the Act, unless it was done in bad faith (s 67).
* A failure to comply with any of the Rules of the court does not render void any proceedings under the Act (rule 28).

## Inquests

### What is an inquest?

An inquest is a public hearing. It involves a detailed inquiry into a death, fire or explosion with evidence being tendered in court. The aim of an inquest is to put as much information before the coroner as possible, so that they can make the most accurate findings possible. Instead of aiming to punish (such as a criminal court does) the coroner seeks to establish the facts of the matter and prevent similar deaths. Inquests are conducted in public, so that anyone who wishes to view the proceedings can attend. The legislative framework for the conduct of an inquest can be found in Part 7 of the Act and in Part 4 of the Rules.

Most coronial investigations do not involve an inquest. The facts that the coroner seeks are usually able to be found through investigation only, and the mandatory inquest provisions of the Act are not triggered. In the approximately three per cent of cases where an inquest is mandatory, or deemed desirable, the coroner takes an active role in directing the coronial staff, ensuring that the evidence they require will be presented at the inquest.

 *‘An inquest is intended to be an independent, objective, fair examination of the available evidence relating to the circumstances of a person’s unexpected or unnatural death. It follows from the fact that an inquest is a search for the truth, that it is neither a witch-hunt nor a whitewash.’* [[62]](#footnote-62)

### When is an inquest held into a death?

A coroner will hold an inquest into a death in two situations. The first is where the mandatory inquest provisions of the Act are triggered (s 24(1)); the second is when the coroner considers it desirable to do so (s 24(2)).

#### 1. Mandatory inquest provisions (s 24(1))

A coroner who has jurisdiction to investigate a death *must* hold an inquest if:

The deceased person is in Tasmania, or connected to Tasmania:

* the body is in Tasmania; or
* it appears to the coroner that the death, or the cause of death, occurred in Tasmania; or
* the deceased ordinarily resided in Tasmania at the time of death

AND one of the following applies:

a. the coroner suspects homicide; or

b. the deceased was immediately before death a person held in care or a person held in custody; or

c. the identity of the deceased is not known; or

d. the deceased died whilst escaping or attempting to escape from prison, a detention centre, a secure mental health unit, police custody or the custody of a person who had custody under an order of a court for the purposes of taking that person to or from a court; or

e. the death occurred in the process of a police officer, correctional officer, mental health officer or prescribed person, within the meaning of section 31 of the *Criminal Justice (Mental Impairment) Act 1999*, attempting to detain a person; or

ea. the deceased died at, or as a result of an accident or injury that occurred at, his or her place of work and the coroner is not satisfied that the death was due to natural causes;\* or

f. the death occurred in such a place or in such circumstances that require an inquest under any other Act; or

g. the Attorney-General directs; or

h. the Chief Magistrate directs.

\* if the coroner decides to hold an inquest into a workplace death (s 24(1)(ea)), as soon as practicable after making the decision, they must notify the senior next of kin of the deceased person, in writing, of the decision, including the reasons for the decision (s 26A). The senior next of kin may then request that the coroner not hold the inquest.

For more information on the meaning of ‘person held in care’, ‘person held in custody’ and other relevant definitions, please refer to section 3 of the Act and ‘Key Elements in the Process: Reporting of deaths’.

In some cases, a person dies in circumstances which trigger the mandatory inquest provisions, but the coroner is satisfied that an inquest with oral evidence is not required. An example of a situation where this may occur is when a person dies in custody as a result of the natural progression of a terminal illness and an autopsy confirms this as the cause of death. In these cases, the coroner may hold an ‘inquest on the papers’, which involves the relevant documentation being tendered in court but no witnesses being called.

The mandatory inquest provisions require the coroner to hold an inquest into any death relating to a person held in the custody or care of the State. This includes people who are being held in a prison, detention centre or a secure mental health unit. The State has a special duty of care to all people who are in its custody or care. This responsibility results in a duty to thoroughly investigate all deaths of people in State custody or care and to ensure that others in the same situation are protected and adequately cared for. The requirement for those in public office to publically explain deaths in care and custody is essential to government transparency and accountability.

#### 2. When the coroner considers it desirable to hold an inquest (s 24(2))

Section 24 (2) of the Act states that a coroner may hold an inquest into a death, which the coroner has jurisdiction to investigate, if the coroner considers it desirable to do so. Section 24A also gives the Chief Magistrate the same power to hold an inquest personally. Although the Act gives no specific guidance, there are some factors that the coroner may take into account when deciding if it is desirable to hold an inquest:

* whether the coroner can gather all the information they require to make their section 28 findings from an investigation alone
* whether there is a high level of publicity and public concern surrounding the death
* whether there are suspicious or concerning circumstances
* whether there are potential ongoing dangers to public health and safety indicated by the death
* whether there is a public interest in the death (and surrounding circumstances) being explored in an open, public forum
* whether the procedures only available at inquest (and not during investigation, such as compelling witnesses to give oral evidence) will provide important additional information
* whether the administration of justice requires it
* whether there is conflicting evidence in the investigation (such as eyewitness accounts)
* whether the potential benefits of an inquest outweigh the difficulties to the parties and the court: emotional, financial and otherwise
* in the case of a matter also dealt with in the criminal jurisdiction:
	+ whether all the relevant public interest issues have been dealt with in the criminal jurisdiction
	+ whether there is significant relevant evidence which would be admissible in coronial proceedings (but was not admissible in the criminal proceedings).

Any person with a sufficient interest in a coronial investigation may request that the coroner hold an inquest by making an application under section 27 of the Act (refer to ‘Key Elements in the Process: Applications’).

If a coroner has jurisdiction to hold an inquest into a death and makes a decision not to do so (or if the Chief Magistrate decides not to make a direction in the same circumstances), the coroner or Chief Magistrate must (s 26):

* record the decision in writing, specifying the reasons for that decision; and
* notify the senior next of kin in writing of that decision and the reasons for it, as soon as possible.

Within 14 days of receiving this notice, the senior next of kin may apply to the Supreme Court for an order that an inquest be held.

For more information on how to make an application, refer to ‘Key Elements in the Process: Applications’.

### When is an inquest held into a fire or explosion?

A coroner will hold an inquest into a fire or explosion in two situations. The first is if the Attorney-General or the Chief Magistrate directs that an inquest be held (s 43(1)); the second is if the coroner considers it desirable to do so (s 43(2)). In deciding whether it is desirable to hold an inquest, similar considerations apply as to an inquest regarding a death (refer to the previous section).

If a coroner who has jurisdiction to hold an inquest into a fire or an explosion makes a decision not to hold an inquest after being requested to do so by a person, the coroner must (s 44):

* record the decision in writing, specifying the reasons for that decision; and
* notify the person who made the request in writing of that decision and the reasons for it, as soon as possible.

Within 14 days of receiving this notice, the person may apply to the Supreme Court for an order that an inquest be held.

For more information on how to make an application, refer to ‘Key Elements in the Process: Applications’.

### How is an inquest held? (Act Part 7 and Rules Part 4)

Inquests are conducted in an open court (s 56(1)), with a single coroner presiding. During the inquest, a coroner may be assisted by a ‘counsel assisting’ who will ask questions, tender documents and liaise with families on the coroner’s behalf. An interested person / organisation may appear or be represented at the inquest. The coroner may make any statements or affidavits they intend to consider available to interested persons. Interested persons have the right to call and examine or cross-examine witnesses and to make submissions (s 52).

An inquest begins with an opening statement by the coroner. The counsel assisting or coroners’ associate may also make an opening statement summarising the investigation. Most of the documentary evidence will be tendered and admitted into evidence by the coroner at this stage. After this, witnesses are called one by one and they give their evidence. The witnesses are usually given the statement they made to police and then asked questions about it by the counsel assisting (on behalf of the coroner), as well as by any legal practitioners or interested persons. The coroner may also ask questions and will check with unrepresented families and friends if there is anything they would like to ask or anything they would like explained. During the question-and-answer process, documents and physical evidence are tendered by the counsel assisting / coroner’s associate and by parties.

Unlike a judge in a criminal trial, the coroner may be informed and conduct an inquest in any manner they reasonably think fit (s 51). The coroner decides which evidence will be admitted, which witnesses will be called, who will be permitted to ask questions and how the matter will proceed. Of most importance, the coroner decides which issues are most relevant to the proceedings. The issues to be explored define the scope of the inquest.

Inquests are run in a very different way to criminal trials; some of the most important differences are:

* in an inquest, the rules of evidence do not apply (s 51) - this means that a coroner has more flexibility as to the types of evidence they can consider than other judicial officers
* the application of the common law is limited in an inquest, particularly as to procedure (s 4)
* coroners apply the rules of natural justice so they make use of principles of procedural fairness such as the rule against bias, acting only on logically probative evidence and the right to be informed of, and given the opportunity to answer, any evidence that may invite adverse findings against you
* relevance remains the primary consideration (to the issues which define the scope of the inquest)
* an inquest can be held into any number or combination of deaths, fires and explosions (s 50)
* a statement or disclosure made by any witness in the course of giving evidence before a coroner at an inquest is not admissible in evidence against that witness in any civil or criminal proceeding in any court (other than a prosecution for perjury) in the giving of that evidence (s 54).

Once all witnesses have been heard, the counsel assisting, legal practitioners and / or interested persons will make their closing submissions. Closing submissions are a statement about the inquest, and may include facts that the coroner might find, recommendations the coroner might make, legal issues that require consideration and any other matter relevant to the interests of the person making the submission. Once the closing submissions are complete, the coroner will adjourn the proceedings so that they can consider the evidence thoroughly and make written findings.

The inquest process may take a few hours or many months depending on how many witnesses the coroner requires evidence from, how ready the parties are for the inquest and how much evidence has to be tendered. A very long and complex inquest often involves a delay for parties to make submissions, and again for the coroner to hand down their findings. The time frame will depend on the extent of the evidence and on the coroner’s workload.

Inquests are very important to the families and friends of deceased persons for a number of reasons:

* families and friends can better understand that their views are heard and respected
* families and friends can better understand the large amount of time and effort that has gone into investigating the matter
* the inquest process can allow families and friends a greater understanding of what happened
* where an apology or acknowledgement of harm is offered by a person who contributed to the death, this can assist with the grieving process
* procedures and practices which contributed to the death may be revised and changed to prevent similar deaths
* any systemic problems are exposed
* outcomes such as public education, procedural change, media coverage, referral to the Attorney-General and the exposing of facts and circumstances leading to death may all be viewed as positive by friends and families.

### Causation, scope and relevance

In coronial investigations, causation, scope and relevance are distinct yet highly related legal principles. The primary objective of an investigation is to determine the cause and manner of death, so where does one find the end of a finite chain of causation? The scope of an inquest is determined by the issues, but how are those issues selected? Whether evidence will be admitted by a coroner depends on whether it is relevant to the issues. The rules of evidence do not apply (s 51), so how is relevance ascertained? Causation assists to define scope and scope determines relevance.

**Causation**

The requirement to find the identity of any person who contributed to the cause of a death was abolished in April 2015 with the repeal of section 28(1)(f) of the Act.  Being a procedural provision, the repeal of the former section 28(1)(f) operates prospectively from the date of the repeal; therefore  the  provision does not apply to findings made after that date even if the death occurred before that date (section 16 of the *Acts Interpretation Act 1931*; *State of Tasmania v Thorpe* [2011] TASSC 18).

It is nevertheless the fundamental function of the coroner to ascertain ‘how death occurred’ (s 28(1)(b)).  Such an inquiry will involve scrutiny of the particular circumstances surrounding each death to ascertain the operative cause or causes of death. The relevant circumstances for examination in each case will differ depending upon the factual investigation.  Some investigations and inquests will involve only scrutiny of events temporally close to the occurrence of the death and in a limited sphere. Others will involve an analysis of causation for death, involving a wider compass and from a much earlier time before death.

The phrase ‘how death occurred’ involves the test of ordinary legal causation (*R v Doogan*; *ex parte Lucas* - *Smith and Ors* (2006) 158 ACTR 1 at [24]). The question of causation is determined by applying common sense to the facts as found, not resolved by philosophical or scientific theories (*E & MH March v Stramare Pty Ltd* (1991) 171 CLR 506; *Campbell v The* *Queen* (1981) WAR 286; *Chief Commissioner of Police v Hallenstein* [1996] 2 VR 1).

The question of how death occurred involves the ascertainment of sufficient causal connection with the death. As part of the coroner’s fact-finding role, this process will often require the coroner to identify any person whose actions were a cause or contributing cause of death. This is a factual determination identifying persons involved in the chain of circumstances leading to the death in question.  However, it is important to bear in mind that the question is concerned with actions of relevant persons that are causative of death, not with any determination of matters of legal or moral responsibility. Such a determination is a matter for the criminal courts or other bodies.  In *R v Tennent; ex parte Jager* [2000] TASSC 64, Cox CJ at paragraph 7 said that the coroner’s function is the ‘*ascertainment of facts without deducing from those facts any determination of blame…’*

However, sometimes the coroner is required to assess whether any individual’s actions were causative of death by considering *‘whether the act departed from a norm or standard or the omission was in breach of a recognised duty’* (*Keown v Khan* [1999] 1 VR 69). Some of the principles applicable to assessing causation in this regard are:

* whether the actions of the person are a substantial contributing cause of death. The concept of “substantial” means an operative cause - not too remote, not merely part of the history of events, and more than *de minimis* (*Royall v The Queen* [1991] HCA 27; (1991) 172 CLR 378 per McHugh J at 442; *R v Smith* (1959) 2 QB 35)
* the actions of the person need not be the direct or immediate cause of death and there can be more than one cause of death (*Keown v Khan,* (supra); *Royall v The Queen* (supra))
* when the death is not caused directly by the actions of the person there may be a consideration of whether the chain of causation has been broken (*Pagett* [1983] EWCA Crim 1; (1983) 76 Cr App R 279)
* ‘cause of death’ means the real cause of death (the disease, injury or complication) not the mode of dying (for example, heart failure, asphyxia or asthenia):  *Ex parte Minister of Justice; Re Malcolm; Re Inglis* [1965] NSWR 1598 at 1604.

**Scope**

The scope of an inquest may also be informed by causation. If it is plainly clear that a fact or circumstance did not cause or contribute to the death then the scope of the inquest will not extend to dealing with those issues.

However, the Act is not intended to limit the inquiries of coroners to matters of mere formality ‘*but to require the finding of the coroner to be of social and statistical importance in a modern community’* (*Ex parte Minister of Justice; Re Malcolm; Re Inglis* [1965] NSWR 1598 at 1602). It has also been held that another purpose of an inquest is to satisfy ‘*the legitimate concern of relatives’* (*Bilbao v Farquhar* [1974] 1 NSWLR 377 at 388).

Specifically under the Act, the scope of an inquest may encompass:

* making recommendations with respect to ways of preventing further deaths and on any other matter that the coroner considers appropriate (s 28(2))
* commenting on any matter connected with the death, including public health or safety, or the administration of justice (s 28(3))
* reporting on the care, supervision or treatment of a person who died while being held in care or custody, or while escaping from custody (s 28(5))

The relevant question to ask in most coronial investigations to determine scope therefore becomes, ‘was this matter connected with the death?’  In the case of the findings that the coroner must make under section 28(1), the answer is usually clear once the principles of causation are applied. However, the question of how far a coroner may inquire into matters (and consequently which issues are within scope) for the purpose of making comments or recommendations (s 28(2) & (3)) requires further analysis.

The term ‘connected with’, and the associated term ‘relates to’, have been subject to substantial judicial scrutiny in Australia. Notably, speaking of legislation similarly phrased to our own, Nathan J stated in *Harmsworth v The State Coroner* [1989] VR 989 at 996:

*‘The power to comment, arises as a consequence of the obligation to make findings: see s19(2). It is not free-ranging. It must be comment “on any matter connected with the death”. The powers to comment and also to make recommendations pursuant to s21(2) are inextricably connected with, but not independent of the power to enquire into a death or fire for the purposes of making findings. They are not separate or distinct sources of power enabling a coroner to enquire for the sole or dominant reason of making comment or recommendation. It arises as a consequence of the exercise of a coroner’s prime function, that is to make “findings”.’*

Speaking of *Harmsworth*, Dr Freckelton QC and Associate Professor Ranson note: ‘*this determination narrows the extent to which an Australian inquest can be directed towards facilitating a coroner’s wish to delve and to make recommendations or comments. The question is one of remoteness and is not readily susceptible to definition*.’[[63]](#footnote-63)

The strength of connection required is accordingly to be determined on a case-by-case basis. As was made clear in *Doomadgee and Anor v Deputy State Coroner Clements*; *Hurley v Deputy State Coroner Clements Ors* [2005] QSC 357 at [30]:

*‘The expressions “connected with” and “relates to” are of wide import and connote a connection or relationship between one thing and another. The closeness of the connection or relationship is to be “ascertained by reference to the nature and purpose of the provision in question and the context in which it appears”* (cf PMT Partners Pty Ltd (in Liquidation) v Australian National Parks and Wildlife Service (1995) 184 CLR 301 at 313). *The expressions are “capable of including matters occurring prior to as well as subsequent to or consequent upon” as long as a relevant relationship exists* (See Claremont Petroleum NL v Cummings (1992) 110 ALR 239 at 280).’

It is clear from the cases discussed above that the coroner is not confined either temporally or spatially in ascertaining connection to death but rather must ask with each potential issue ‘did this impact in a reasonably direct manner upon the particular death now under investigation?’ Thus in *Harmsworth* (a case relating to a fire in prison which resulted in the deaths of several inmates) it was held that:

*‘in so far as (the coroner’s) line of investigation sought to pursue the management structure of the Coburg Complex in order to make comments about it, then those investigations would be without jurisdiction. If the enquiries were limited to investigating why the management structure at Pentridge was incapable of responding to a request from the Reception Prison for fire equipment, then the investigations could be attached to an enquiry relating to the fire or causes of death.’*

**Relevance**

The coroner will admit evidence which is relevant to the determination of the issues within the scope of the inquest. Evidence is always admitted at the coroner’s discretion. Section 51 of the Act states that ‘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.’

When dealing with a near-identical provision (s 49(1)(a) of the *Workers Rehabilitation and Compensation Act 1988* (Tas)) in *Alison Jane Connelly v P and O Resorts Pty Ltd T/A Cradle Mountain Lodge* [1996] TASSC 132 (7 November 1996), Wright J stated at [20]:

*‘As Zeeman J observed in White v FAI General Insurance Co Ltd and Tomlinson Steel Pty Ltd T/as Clyde Riley Dodds* [1991] TASSC 121 (10 May 1991)*, this provisions gives "considerable latitude to (the Commissioner) in determining proceedings before him". However it does not give the Tribunal carte blanche to act in a completely unfettered manner, in my opinion. At the very least the Tribunal must have before it evidence which is relevant to the issue in dispute. Material which is not logically capable of bearing upon that issue cannot be regarded as relevant evidence.’*

There is no restriction on the admission of evidence as is found in the *Evidence Act*. The coroner may admit hearsay, non-expert opinion evidence and other categories of evidence that are generally excluded in criminal proceedings.  In *Connelly v P and O Resorts* (supra) Wright J stated at [22]:  *whilst sometimes cogent and reliable, hearsay is frequently of little, if any, weight, but that is not the determinative factor. So long as the material relied upon satisfies the test of being evidence rather than a mere supposition, guess or intuitive hypothesis, it may be received…’.*

### A coroner’s powers at inquest

Coroners have specific powers they can use during an inquest (s 53). If a coroner reasonably believes it is necessary for the purposes of an inquest, the coroner may:

* summons a person to give evidence or provide any document or other materials (for service and related provisions refer to rule 17)
* inspect, copy and keep any thing so produced
* order a witness to take an oath or affirmation
* compel witnesses to answer questions
* give any other directions or do any other things they think necessary
* fine or imprison a person who disobeys a summons
* 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
* defer provision of information under the *Right to Information Act 2009* for a specified period (s 53A)
* exclude any or all persons from an inquest on certain grounds (s 56(2))
* order a person who disobeys an exclusion order to be removed from the court (and imprisoned for not more than 24 hours if the coroner reasonably believes that the person will continue to disobey) (s 56(3))
* order that a report of an inquest or a report of any part of the proceedings of, or any evidence given at, an inquest not be published (s 57(1)), if:

a. it would be likely to prejudice the fair trial of a person; or

b. it would be contrary to the administration of justice, national security or personal security; or

c. it would 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.

### Suspension of an inquest

An inquest must be suspended, if:

1. certain criminal charges are laid (s 25)

2. the coroner forms the belief that an indictable offence has been committed (ss 30(3) & 47(4)).

The criminal charges specified in section 25(2) are:

a. murder of the deceased; or

b. manslaughter of the deceased; or

c. infanticide of the deceased; or

d. causing grievous bodily harm of the deceased; or

e. causing the death of the deceased by dangerous driving; or

f. an offence under section 32 (1) of the *Traffic Act 1925* arising out of an accident that resulted in the death of the deceased; or

g. arson in relation to the fire; or

h. unlawfully causing the fire; or

i. unlawfully causing the explosion.

In the case of an inquest suspended under section 25, after the conclusion of the criminal proceedings the coroner may resume the inquest if they are of the opinion there is sufficient cause. The coroner may decide not to resume the inquest and if they do so, they must inform the Attorney-General in writing. An inquest resumed under this section proceeds from the beginning as if it were a new matter, any findings made cannot be inconsistent with the decision of the criminal court. Suspension of an inquest is rare, any charges have usually already been laid prior to commencement of an inquest.

For further information on inquests and related criminal proceedings, refer to ss 25(3) – 25 (9). For a discussion around the formation of a coroner’s belief that an indictable offence has been committed, refer to *Maksimovich v Walsh* (1985) 4 NSWLR 318.

### Inquests of interest

**Inquests focussed on how death occurred and who was responsible for death:**

[Lucille Gaye Butterworth](http://www.magistratescourt.tas.gov.au/__data/assets/pdf_file/0007/344833/Butterworth%2C_Lucille_2016_TASCD_96.pdf)[[64]](#footnote-64)

Long term missing person - precise medical cause of death unknown - homicide - referred to the Attorney-General - person of interest

[Tony Zachary Harras aka Judah Zachariah Reuben Wolfe Mattathyahu](http://www.magistratescourt.tas.gov.au/__data/assets/pdf_file/0008/326942/Mattathyahu%2C_Judah_2015_TASCD_286_docx.pdf)[[65]](#footnote-65)

Long term missing person - precise medical cause of death unknown - homicide

**Inquests focussed on how death occurred and on prevention of similar deaths:**

[Jayden Craig Field](http://www.magistratescourt.tas.gov.au/__data/assets/pdf_file/0005/335570/Field%2C_Jayden_Craig_2015_TASCD_373.pdf)[[66]](#footnote-66)

Exiting a moving taxi - death by severe head injury - recommendations on: pre-paid fares and taxi cameras - comments on: alcohol consumption by youth and risk taking behaviour

[Jasmine Rose Pearce](http://www.magistratescourt.tas.gov.au/__data/assets/pdf_file/0006/317148/De-identified_Finding-Pearce_-_27_May_2015.pdf)[[67]](#footnote-67)

Sudden infant death - bed sharing - death by suffocation - recommendations on: Child Protection Services, Gateway, family violence assessments - comments on: bed sharing

[Barbara Westcott](http://www.magistratescourt.tas.gov.au/__data/assets/pdf_file/0007/354724/Westcott%2C_Barbara.pdf)[[68]](#footnote-68)

Death in care - aged care - death by hanging - recommendations on: first aid training, staffing, records - comments on: internal investigation, systemic failure

[Aidan Andrew Dawson](http://www.magistratescourt.tas.gov.au/__data/assets/pdf_file/0004/342940/Dawson%2C_Aidan_Andrew_2016_TASCD_091.pdf)[[69]](#footnote-69)

Family violence - death of partner by stab wound - homicide - person of interest previously charged and proceedings discontinued - recommendations on: amendments to Police Family Violence Manual, audit of police responses to the relevant family violence incidents, amendments to the police Family Violence Management System

**Inquests focussed on the prevention of similar deaths:**

[John Ernest Mansell](http://www.magistratescourt.tas.gov.au/__data/assets/pdf_file/0005/336929/MANSELL_John_Ernest_2016_TASCD_001_docx.pdf)[[70]](#footnote-70)

Targa Tasmania Rally - death by injuries sustained in a motor vehicle crash - recommendations on: safety regulations, alcohol testing, safety assessors, safety equipment

[Joint Inquest into Youth Suicide](http://www.magistratescourt.tas.gov.au/__data/assets/pdf_file/0010/328384/Youth_Suicide_2015_TASCD_298%2C299%2C300%2C301%2C302%2C303.pdf)[[71]](#footnote-71)

Separate findings for each of six de-identified children - wide ranging recommendations on youth mental health and suicide prevention

**For more information on the following areas, refer to:**

* how to apply to access coronial documents: ‘Key Elements in the Process: How to access documents’
* the role of counsel assisting: ‘Key Players in the Process: Counsel assisting the coroner’
* how to apply to be recognised as an interested person or apply to represent an interested person: ‘Key Elements in the Process: Applications’
* the types of evidence at an inquest: ‘Key Elements in the Process: Evidence’
* providing information / evidence to the coroner (for families and friends): ‘A Guide for Families and Friends: How can I give information to the coroner?’
* what to expect if you are called as a witness: ‘A Guide for Families and Friends: The coroner’s court and me – I’m a witness at the inquest, what does this mean?’
* advocacy at inquest: ‘Key Elements in the Process: Representing an interested person at an inquest’.

## Representing an interested person at an inquest

Please refer to the introduction to the section ‘Key Elements in the Process: Representing an interested person in a coronial matter’ for a summary of the general approach to, and unique aspects of, advocacy in the coronial jurisdiction.

### Things to consider before the inquest

* Has your client been recognised by the coroner as an ‘interested person’ in the proceedings? You and your client will have different rights depending on their status in the investigation. There are limits to the right to be involved in the proceedings imposed by the coroner on a case-by-case basis and considerations include whether you represent an interested person. A person who has a ‘sufficient interest’ in a particular document or aspect of the investigation is not necessarily the same as an ‘interested person’ under section 52 for the inquest.
* Which issues does your client want examined in detail?
	+ There may be many potential issues, some your client will want vigorously pursued, others they will want to address only cursorily if possible.
	+ It is advisable to have a clear idea of which issues are most important to your client and the approach they want you to employ with each (before any case management conference if possible).
	+ It is important to provide your client with advice as to which issues should be pursued as relating to how death occurred or possible recommendations.
	+ The words of Chester Porter QC (an eminent Australian criminal defence barrister) are worth considering, ‘*Is it really desired that a particular subject matter should be opened? Many good advocates say very little at inquiries.*’
* Ascertain the issues that the coroner has deemed relevant. These may be discussed at any case management conference and you will have the opportunity to make submissions as to the scope of the inquest. The scope of the inquest will guide the evidence admitted and the direction that the inquest is expected to take.
* Are all the witnesses required to explore those issues proposed to be called? You are able to call witnesses if your client is an interested person (s 52(4)), however you should inform the coroner at the earliest opportunity if you intend to do so. Whether your proposed witness is permitted to give evidence at inquest is ultimately the coroner’s decision.
* Will all the documentary and physical evidence you require to examine those issues be before the court? Once you have assessed the material on the coronial record, you may need to source additional statements or reports to support your client’s position. You should advise the coroners’ associates of any evidence you seek to have admitted at inquest.
* Do you have copies of all documents that may invite adverse findings against your client? i.e. have you applied for access to all relevant documents?
	+ For information on how to make an application, refer to ‘Key Elements in the Process: How to access documents’.
* Is there any additional evidence that you consider would assist your client and the coroner?
	+ You are able to write to the coroners’ associates before the inquest to provide any documentary evidence, physical evidence, or the names of any witnesses that you wish to have before the court. This approach minimises the chance of delays occurring as a result of the coroner being presented with new evidence to consider during the inquest.
	+ Please provide the reasons in your correspondence why this evidence will assist the coroner in fact-finding.
	+ You may call witnesses yourself (s 52 (4)) or request that the coroner do so under their own authority. Only the coroner has the power to *summons* witnesses and sanction them for non-compliance so it may be preferred to make a request to the coroner and ask that they use this power.
	+ Note that the coroner may not permit you to call a witness if they are not considered to be able to provide relevant evidence.
	+ You may tender evidence at the inquest. The coroner will then decide if the evidence is relevant, and admit it if appropriate.
* Will your client seek a restriction on the publication of the report of an inquest or a report of any part of the proceedings, or of any evidence given?
	+ This includes a request to de-identify the deceased person or any other person.
	+ The factors that are relevant to the coroner’s decision are specified in section 57.
* Do you need to request a case management conference or further case management conference to clarify / arrange any of the matters mentioned previously, before the inquest begins?
	+ For matters that can be raised (and may be important to consider) at a case management conference, please refer to ‘Key Elements in the Process: Case management conferences’.
* Is your client aware of their rights, privileges and protection in relation to evidence given before the coroner?
	+ Note the Act ss 29(2), 46(2) & 54.
* Is your client aware of the risks inherent in giving evidence in coronial proceedings, where the rules of evidence do not apply?
	+ These include risks such as forensic disadvantage in any related future proceedings.

**Does your client require referral to counselling or support services?**

* It is a good idea to keep this issue in the back of your mind during the inquest process. Even professionals may become distressed during the course of an inquest, particularly if their actions are subject to close scrutiny.
* There are a number of professional bodies who can offer assistance listed in the ‘A Guide for Families and Friends: Coping with Grief’ and ‘A Guide for Families and Friends: Who can help?’ sections of the Handbook. There may also be ‘in house’ counselling services provided when your client is involved in the proceedings through events that occurred at their place of work.

**Does your client have complex communication needs?**

* Classes of people who may have complex communication needs include children, Aboriginal people, people from non-English speaking backgrounds, people with mental health issues and people with disability.
* If they do, you can access special assistance to ensure that the court process accommodates their needs.
* For more information on the services available to assist those with complex communication needs or special needs generally, refer to ‘Key Players in the Process: Witnesses’ and ‘A Guide for Families and Friends: Who can help? – If you need extra assistance’.

### Potential adverse comments and findings

* Procedural fairness requires that a person who may face adverse comments be provided with the opportunity to be heard on those matters (*Annetts and Anor v McCann and Ors.* (1990) 170 CLR 596). In order to be sufficiently prepared to do this, such a person is entitled to be given reasonable access to coronial documents upon application (refer to ‘Key Elements in the Process: How to access documents’).
* It is important to ensure your client is aware of their rights, privileges and protection in relation to evidence given before the coroner, particularly that found in section 54 of the Act:
	+ s 54: A statement or disclosure made by any witness in the course of giving evidence before a coroner at an inquest is not admissible in evidence against that witness in any civil or criminal proceeding in any court other than a prosecution for perjury in the giving of that evidence
	+ also note ss 29(2) & 46(2).
* Ensure that your client is aware of the risks inherent in giving evidence in coronial proceedings, where the rules of evidence do not apply (refer to the related section, ‘The privilege against self-incrimination’).
* During an inquest, an interested person who faces potential adverse comment can question witnesses in order to defend their position or assert the contrary.
* If your client is to be called as a witness, you may request that they be called last so as to have the opportunity to hear all of the evidence which may be led against them prior to giving evidence.
* You are able to lead your client’s evidence, rather than leaving it to counsel assisting.
* There will also be the opportunity in making closing submissions to address any areas of potential adverse comment. If you are representing a government employee, public authority or other organisation it is recommended that you address the following in your submissions:
	+ any relevant changes to procedure that have been implemented after the death, fire or explosion occurred
	+ any practical measures that the organisation is currently implementing, or that are due to be rolled out in the future, to mitigate against any risks discovered in the course of the inquest
	+ any internal inquiries or investigations that have occurred which aim to establish protocols which will mitigate against any risks discovered in the course of the inquest
	+ if you are able to anticipate the type of recommendations that the coroner may make, you should discuss these with your client - your client will have valuable information on the organisational structures and realities in which the incident occurred
	+ submissions on which measures are the most achievable, practical and likely to make the biggest impact will be well received.

**Expressions of remorse and regret**:[[72]](#footnote-72)

People involved in coronial proceedings are encouraged to make expressions of remorse and regret where appropriate.

* This is beneficial for all parties, as acknowledgement of harm to others is frequently restorative for all people involved in the coronial process who were affected by the death. A sincere demonstration of empathy and regret – even where there is no concession of fault – can have a healing effect on those who have lost family members and on those who have, for example, lost patients.
* Apologies or expressions of remorse frequently increase satisfaction with the inquest process.
* Admissions of errors by those who make them involves taking responsibility and encourages positive behaviours.
* These expressions do not have to involve any admissions as to fault.

### Questioning witnesses

* At the start the inquest, you should introduce yourself and formally seek leave to appear.
* You are permitted to ask leading questions. Often a combination of leading questions and open questions is most effective, keeping in mind the benefits of leading questions (such as control of the narrative) and the benefits of open questions (such as allowing the witness to tell the story at their own pace and in their own words). Bear in mind that excessive leading questions may undermine the value of the evidence. The coroner may ask that your questions be framed to elicit the most valuable evidence for the inquest.
* The rules of evidence do not apply in the coroner’s court; as such there are no restrictions on, for example, hearsay and non-expert opinion evidence. However, a coroner is likely to exclude evidence that they consider to have negligible weight, or to be irrelevant.
* Rather than ‘is this evidence admissible?’ a coroner may ask ‘what weight is it appropriate to give this evidence?’
* Questions must be relevant to the issues at inquest – i.e. aimed at answering the questions which the coroner is bound to attempt to answer, set out in the Act s 28 (1) in the case of a death and in s 45(1) in the case of a fire or explosion.
* The coroner may request clarification on which point in s 28 (1) the evidence is directed to, i.e. they may ask how the evidence is relevant.
* s 28(1) provides that a coroner investigating a death must find, if possible –
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.*
* Ensure you have a plan for your appearance at inquest to maximise the interests of your client. This may involve questioning witnesses to elicit the desired evidence, or not questioning a witness at all in accordance with your pre-prepared plan.

Waller’s has a useful section on representing government agencies at I.129 (Abernethy, J., Baker, B., Dillon, H. & Roberts, H., *Waller’s Coronial Law and Practice in New South Wales* (LexisNexis Butterworths, 4th ed, 2010)).

For other helpful information, refer to Dillon, H., *Practical Advocacy: The roles of counsel in the coronial jurisdiction*, (2010) 33 Australian Bar Review 293; C. Porter, *Appearing at a coronial inquest: The function of an advocate*, Coronial Law and Practice: Seminar Papers, College of Law, Sydney, 1993 and Freckelton, I., & Ranson, D., *Death Investigation and the Coroner’s Inquest* (Oxford University Press, 2006) – Chapter 16, Advocacy.

For more information on evidence in coronial proceedings, refer to ‘Key Elements in the Process: Evidence’.

### The privilege against self-incrimination

The privilege against self-incrimination is a long-standing and fundamentally important common law principle.

In *Petty v The Queen* (1991) 173 CLR 95 at 99 the High Court said:

*‘A person who believes on reasonable grounds that he or she is suspected of having been a party to an offence is entitled to remain silent when questioned or asked to supply information by any person in authority about the occurrence of an offence, the identity of the participants and the roles which they played. That is a fundamental rule of the common law which, subject to some specific statutory modifications, is applied in the administration of the criminal law in this country. An incident of that right of silence is that no adverse inference can be drawn against an accused person by reason of his or her failure to answer such questions or to provide such information. To draw such an adverse inference would be to erode the right of silence or to render it valueless.’*

The High Court recently dealt with the issue of the privilege against self-incrimination in *X7 v Australian Crime Commission* (2013) 248 CLR 92 and *Lee v The Queen* (2013) 251 CLR 196. Although neither case concerned coronial inquests (and especially Tasmanian ones), and even though both judgements demonstrate the court was (at least in 2013 – 2014) fundamentally split on how the privilege against self-incrimination operates in practice, the principle that can be drawn from the judgements seems to be that the privilege continues to exist unless it is abrogated by clear statutory expression.

Section 4 the *Coroners Act* *1995* provides that a rule of the common law that, immediately before the commencement of the section, conferred a power or imposed duty on the coroner or a coroner’s court ceases to have effect. Thus, it is at least arguable that the common law privilege against self-incrimination did not survive the commencement of that section. This is especially so given that the Act seems to deal expressly with the issue.

Section 53 (1)(c) of the Act empowers a coroner to order a witness to answer questions. The power to compel answers of a witness is not qualified in any way.

Section 54 provides:

*‘a statement or disclosure made by any witness in the course of giving evidence before a coroner at an inquest is not admissible in evidence against that witness in any civil or criminal proceedings in any court other than a prosecution for perjury in the giving of that evidence’.*

The immunity with respect to secondary use of any evidence given by witness at an inquest (except with respect to a prosecution for perjury against that witness) is complete, at least with respect to criminal or civil proceedings. Whether that immunity also extends to use in administrative tribunals, commissions or the like is uncertain. The section is however silent with respect to derivative use generally.

**Conclusion:** the issue of the extent to which the privilege against self-incrimination continues to exist under the *Coroners Act* *1995* in Tasmania has not been settled.

For further reading on this subject, refer to Ian Freckelton QC, *The Privilege Against Self-Incrimination in Coroners’ Inquests*, (2015) 11 Journal of Law and Medicine 491; *Baff v New South Wales Commissioner of Police* [2013] NSWSC 1205; R v Slaney (1832) 5 C & P 213 and *Correll v Attorney General of NSW* [2007] NSWSC 1385.

### Submissions

* Despite the broad power to ‘make submissions’ given to legal representatives (and interested persons) in the legislation, it is generally expected that counsel will limit their submissions to these discrete areas:
	+ matters relevant to the interests of their own client, including addressing potential adverse comments against their client
	+ if representing the families and friends of the deceased person, this may include matters relevant to the interests of the deceased person.
* The coroner, if appropriate, may provide latitude to family members and friends of the deceased person who are appearing in person (or are represented) in final submissions.
* Interested persons at inquests have the potential to enhance and assist the coroner’s preventative role. It is appropriate for parties to offer potential recommendations to the coroner in the interests of preventing similar deaths, fires or explosions.
* No coroner can be an expert in every field. If you represent an interested person or an organisation which may have recommendations directed to them, your client may in fact be in the best position to advise on what the most practical and effective changes may be. Recommendations are not an end in themselves; the best recommendations are practical, effective and *likely to be implemented.*
* It was held in *R v Tennant; Ex Parte Jager* [2000] TASSC 64 that it is not appropriate for any party to make submissions on whether a matter should be referred to the Attorney-General for the possible laying of criminal charges.

For a discussion of the limitation on interested person’s rights to make submissions under the *Coroners Act 1995* (Tas) refer to *R v Tennant; Ex Parte Jager* [2000] TASSC 64.

## Findings, comments and recommendations

### What are coroners’ findings?

“Findings” are the facts that the coroner has found upon the evidence. They are contained in a document created by the coroner at the end of an investigation or inquest. Findings produced after an investigation only are called ‘findings without inquest’, also known as ‘in chambers’ findings. ‘Findings with inquest’ usually take longer to write and are more detailed, as the coroner has more information, including significant oral testimony, to consider. The legislation specifies which facts a coroner must find, if possible, in the case of a death, fire or explosion.

In the case of a death, the coroner must find if possible (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*.

In the case of a suspected death (the coroner may also investigate suspected deaths due to the definition of death in s 3 of the Act), the coroner is also required to make a finding as to whether the person has, in fact, died.

In the case of a fire or explosion, the coroner must find if possible (s 45(1)(a-c)):

a. the cause and origin of the fire or explosion; and

b. the circumstances in which the fire or explosion occurred; and

c. the identity of any person who contributed to the cause of the fire or explosion.

Findings may also include comments and recommendations made by the coroner. The aim of coroners’ comments and recommendations is to improve public health and safety, or to further the administration of justice. All comments and recommendations must be connected to the death that the coroner is investigating. Coroners’ findings must not include any statement that a person is or may be guilty of an offence (ss 28(4) & 45(3)). It is also not the coroner’s role to attribute civil liability.

For more information on comments and recommendations, refer to ‘What are coroners’ comments?’ and ‘What are coroners’ recommendations?’.

In finding facts, coroners identify any contributing factors and do not shrink from clearly stating those factors and the manner in which they caused or contributed to death. There is a distinct difference between expressing that a person’s actions directly caused the death of another person, and stating that there has been a murder. Factors such as lawful self-defence may play a part; therefore, a finding that a person factually caused death is not the same as a finding that an offence has been committed. Coroners only determine facts, and they do not touch on the legal consequences that may flow from those facts. Such matters are left up to other courts to decide. For a judicial statement on the reasons for this approach refer to *Attorney General (NSW) v Maksimovich* (1985) 4 NSWLR 300 at 314.

If a coroner is of the belief that an indictable offence may have been committed in relation to a death, fire or explosion that they have investigated, they must refer the matter to the Attorney-General (ss 30 & 47). It is then up to the Attorney-General / Director of Public Prosecutions to decide what charges will be laid, if any. The coroner has no influence over this decision.

For a coronial finding which discusses the ambit and nature of the prohibition against coroners making statements that an offence has occurred, refer to paragraphs 194 – 196 of [Butterworth, Lucille 2016 TASCD 96](http://www.magistratescourt.tas.gov.au/__data/assets/pdf_file/0007/344833/Butterworth%2C_Lucille_2016_TASCD_96.pdf).

Principles such as procedural fairness and hindsight (as to recommendations) guide coroners in their findings. A coroner must apply procedural fairness and give any party who may be the subject of adverse findings the opportunity to respond to the evidence which forms the basis of those findings.

In the case of a death, a copy of the findings is always sent to the senior next of kin as soon as it is available (rule 25). A person with sufficient interest in the matter may apply to the Chief Magistrate to have the findings amended, or apply to the Supreme Court to have any or all of the findings declared void.



For more information, refer to ‘Key Elements in the Process: Applications’.

All findings that relate to an inquest are published on the Tasmanian Magistrates Court web site in the coroner’s court section, under [Coronial Findings](http://www.magistratescourt.tas.gov.au/about_us/coroners/coronial_findings). [[73]](#footnote-73) Sometimes coroners will choose to publish findings that relate to an investigation that did not proceed to inquest.

### What are coroners’ comments?

Coroners’ findings contain statements of fact but they can also contain comments and recommendations. A coroner can make comments on any matter connected with the death, fire or explosion (ss 28(3) & 45(2)). Generally, these comments are focussed on the enhancement of public health or safety or the administration of justice. A coroner may use their comments to commend a practice that has the potential to save lives, or to condemn a practice that endangers them. Coroners’ comments can draw attention to areas that may be under-regulated and areas in which regulations are not applied or not widely known.

For information on the meaning of ‘connected with’, refer to ‘Key Elements in the Process: Inquests – Causation, scope and relevance’.

### What are coroners’ recommendations?

Coronial recommendations have the potential to be a powerful force for the improvement of public health and safety. Investigating deaths is the vital primary function of the coronial process; however, recommendations allow the coroner to transcend this purpose and to actively work towards preventing similar deaths. The legislation states that if it is appropriate, a coroner mustmake recommendations with respect to ways of preventing further deaths (Act s 28(2)). The coroner also has the power to make recommendations on any other matter they consider appropriate. The recommendations can be directed towards any person or organisation. Examples of the organisations subject to recommendations are: hospitals, regulatory bodies, private companies and government departments.

Examples of recommendations made by coroners to prevent deaths include:

* enhancement of community education on sudden infant deaths and the dangers of co-sleeping
* promotion of driver safety
* the compulsory use of life jackets
* a redesign of Risdon Prison to reduce hanging points (amongst other things)
* changing medication dispensing regimes in hospitals
* a dedicated mental health outreach and out-patient services for at-risk youth
* strengthening pool fencing regulations (and increasing public awareness as to the application of these regulations to inflatable pools).

Unlike some other jurisdictions, there are no legislative requirements in Tasmania for government entities to respond to, or actively implement, coronial recommendations. In 2009, the Premier of New South Wales issued a Memorandum to ensure a consistent process across the New South Wales government to respond to coronial recommendations. In Tasmania, we rely on the good will and energy of individual government entities and private organisations to take on coronial recommendations and implement them (or the closest, most practicable alternative). In this way, we have seen significant reforms that have saved lives.

Recommendations aim to be positive and practical. Often interested persons will have valuable insight into the organisational structures and realities in which the incident occurred. Anyone with this knowledge has the potential to enhance and assist the coroner’s preventative role by providing advice on what the most practical and effective changes may be. *Coroners welcome input into potential recommendations from interested persons.*

*The best recommendations in matters involving systemic errors:*

* **prevent**: other similar deaths. How can mistakes that may have contributed to the death be prevented?
* **anticipate and compensate**: if mistakes are not preventable, how can we ensure that they do not have tragic consequences?
* **detect and correct**: if mistakes are not preventable, how can we ensure that they are detected and remedied as soon as possible?
* **are likely to be implemented**: as they fit with current practice. They may be cost effective, and clarify and simplify procedures.

In the particular case of a person who dies in government care or custody, recommendations are important. The coroner may make comments and recommendations regarding improvements to any systemic issues that would enhance safety in the future. Independent and public scrutiny by the coroner of government practice and procedures encourages continual improvement in those procedures. This enhances accountability, transparency and responsible government. The making of recommendations directed to government practice and procedures creates a strong incentive to prevent future tragedies and related public criticism.

For more information on the requirement for governments to respond to coronial recommendations in other states, for example SA, Vic & ACT, refer to: *Coroners Act 2003* (SA) s 25(5), *Coroners Act 1997* (ACT) s 57(5) & *Coroners Act 2008* (Vic) s 72 and *What happens to coroners' recommendations for improving public health and safety? Organisational responses under a mandatory response regime in Victoria, Australia,* Georgina Sutherland, Celia Kemp, Lyndal Bugeja, Graham Sewell, Jane Pirkis and David M Studdert, BMC public health 14(732) 2014.

#### Best practice in responding to coronial recommendations

* Although there is no legislative requirement to respond to or enact coronial recommendations in Tasmania, there are many good reasons to do so.
* Recommendations are aimed at saving lives and offer an independent and informed perspective on changes that can be made to achieve this end.
* For government organisations: positive action that results from recommendations enhances accountability, responsibility and public trust in government.
* If a coroner makes recommendations and no changes result, similar deaths may occur in the future and adverse findings in those circumstances may draw attention to that fact.
* If an organisation is the subject of coronial recommendations, the best practice for representatives of the organisation in responding to those recommendations may be as follows.
	+ Acknowledge receipt of the recommendations and refer them to the relevant officer or department in a timely manner.
	+ The officer responsible should analyse and cost the recommendations; including the costs of any proposed alternatives. Alternatives should only be considered where they are able to achieve the outcome intended by the recommendation, and where there is a logical reason to implement an alternative such as practicality, prohibitive cost or increased benefit.
	+ The officer responsible should provide a report on the recommendations, which is referred to the executive or decision-making arm of the organisation.
	+ It may be that, after considering all aspects of the recommendation, it is not feasible in terms of cost or practicality to implement the recommendation.
	+ Strategies should be put in place to implement the recommendations or the proposed alternatives.
	+ Consider forwarding correspondence to the coroners’ office and the Attorney-General outlining the measures taken to implement the recommendations, and the measures that are intended to be taken in the future. If alternative measures are employed, give details and the reasons for implementing those measures.

### Publication of findings

There is nothing in the legislation that specifies the manner in which findings are to be published or which requires their publication. In the case of a death, the senior next of kin will be given a copy of the findings (rule 25) and others may apply to the coroner’s court to receive a copy (refer to ‘Key Elements in the Process: How to access documents’).

Findings formally published by the court can be located on the Magistrates Court web site in the coroner’s court section, under [Coronial Findings](http://www.magistratescourt.tas.gov.au/about_us/coroners/coronial_findings).[[74]](#footnote-74) All findings relating to inquests are published as they result from a public hearing involving significant issues. Findings relating to investigations without inquest may be published if there is public concern surrounding a matter, or where public health and safety is furthered by disclosure of the findings. When findings are published in this manner, the senior next of kin is notified.

When findings are published, sometimes they are ‘de-identified’. This is a technique used to protect the identity of persons referred to in the findings, in certain circumstances. Instead of the person’s name, an initial such as “K” will appear. Findings may be de-identified on the coroner’s own motion, or at the request of a family member. If you or your client wish to have findings de-identified, please [contact the staff at the coroner’s court](http://www.magistratescourt.tas.gov.au/contact/coroners_court) at any time prior to the findings being published to make your request (as early as possible in the proceedings is best).

Waller’s has a good short section on Findings, Comments and Recommendations from I.121 (Abernethy, J., Baker, B., Dillon, H. & Roberts, H., *Waller’s Coronial Law and Practice in New South Wales* (LexisNexis Butterworths, 4th ed, 2010)).

# 4. A Guide for Families and Friends

## Message from the Chief Coroner

The death of a loved one is one of the most traumatic experiences of life. I extend my sympathy if you have experienced such loss.

When a death is sudden and unexpected, the shock of loss can be felt even more keenly. If you need help to cope, please do not hesitate to ask. There is a list of support groups in this guide that can provide assistance at no cost.

Most people do not have any contact with the coroner’s court unless a person close to them dies suddenly. They do not understand why a coroner is involved and what the coroner is required to do. This uncertainty can add to the stress felt at this already difficult time.

This guide will help families and friends of people whose deaths are being investigated by the coroner to understand what is happening and why it has to happen. It will answer a lot of the questions you have about the coronial process.

If there is anything else you want to know, please contact the coroners’ office. It is very important to us that you understand what is happening and we will always provide information if it is possible.

I thank all those in the legal, government, medical and community sectors who provided input into the writing of this guide. I also acknowledge the valuable contribution of my fellow coroners and staff. In particular, I express my gratitude to Mrs Marion Clarke, the project officer and author, for her intelligent and dedicated work in bringing this guide to fruition.

Olivia McTaggart

Chief Coroner

**The sections in this chapter are:**

* Message from the Chief Coroner
* The first 24 hours
* FAQ (frequently asked questions)
* Coping with grief
* Who can help?
* The coroner’s court and me
* Practical matters
* How can I give information to the coroner?

The coroner’s court of Tasmania investigates sudden deaths to establish how a person died and what caused their death. We appreciate that the coronial process comes at a time of great pain and loss for family members and friends. If you have recently lost someone close to you, we offer our sincere condolences.

This guide provides information for the families and friends of deceased persons as well as for members of the community as a whole. The guide will answer some of the question you may have about what that coroner’s court does, and explain how to get answers that are not actually in the guide itself. There is no need to read the whole guide unless you want to. Reading the bits that apply to you will help you to understand what is happening and to know what to expect in a coronial investigation.

**Content warning**: this guide contains information about death and mental health that may be upsetting for some people. You are welcome to [contact the coroner’s court](http://www.magistratescourt.tas.gov.au/contact/coroners_court) directly to ask questions if you prefer.

When someone close to you passes away suddenly, you might not know how to react. Everyone responds to this kind of tragedy differently. There is no ‘right way’ to feel. You may feel sad, angry, numb or find it very difficult to focus. Different cultures have different beliefs about death and different needs. Your grieving process will be unique to you and your life. At the coroner’s court, we respect all cultures and beliefs, and work hard to support everyone equally.

If you feel that this guide does not answer your questions, or if you feel overwhelmed by the amount of information, please call the coroner’s court and we can help. You can tell other people about this guide if they want information on the coroner’s court. It can be good to tell other people to read the guide if they are asking you questions and you don’t want to talk about it.

**Most of the deaths investigated by coroners are not suspicious.** Coroners still have to investigate certain types of deaths, just in case. Coroners often find out that a death they are investigating was natural, and they don’t need to investigate any more. The coronial process is all about gathering information and checking facts.

Being involved in a coronial investigation can be stressful and upsetting. If you ever need help, please ask. There are groups that can give you legal advice, help you cope and offer financial advice. It is normal to need support at a difficult time like this and, no matter what your needs are, someone can help you and your family make it through.

If you need help, such as someone to talk to or legal advice, please go to ‘A Guide for Families and Friends: Coping with grief’ and ‘A Guide for Families and Friends: Who can help?’.

#### Coroner’s court - Southern Tasmania

27 Liverpool Street, Hobart, 7000

(03) 616 57132 (administrative)

(03) 616 57127 (coroners’ associates)

Property Office

(03) 6230 2277

#### Coroner’s court - Northern Tasmania

73 Charles Street, Launceston, 7250

(03) 677 72920

Property Office

(03) 6336 3818

**Whole of Tasmania**

After hours contact police on: 131 444

Fax: (03) 6173 0221

Email: Coroners.Hbt@justice.tas.gov.au

[Coroner’s court web site](http://www.magistratescourt.tas.gov.au/about_us/coroners) - http://www.magistratescourt.tas.gov.au/about\_us/coroners

## The first 24 hours

This section will help you to focus on what you might need to think about in the first 24 hours after a sudden death.

### A quick guide for families and friends

* The deceased person will be taken to the mortuary at the Royal Hobart Hospital or the Launceston General Hospital.
* You may wish to contact a support person, friend or family member to help you to cope, and who can make arrangements with or for you, in the first few days.
* If you do not have a support person, you may want to contact a professional for support. You can find people to help you in ‘A Guide for Families and Friends: Who can help?’.
* It is a good idea to write down any important information, as shock can make it hard to remember things later on.
* You may want to contact a funeral director to discuss the funeral, and while this can be done right away you should let them know that the coroner is involved.
* You may want to visit the deceased person when they are moved to a funeral home. They will not go to the funeral home right away because the coroner must be careful to get all the evidence they need first. Usually it will take 2-4 days for the deceased person to be released for burial / cremation, depending on if there is a weekend in the middle.
* Police may ask you to identify the deceased person. Any person who knew the deceased person in life can do this, so if you do not want to do it, tell the police.
* The coroner will decide if an autopsy is necessary. If they make an order, the autopsy will usually happen within 48 hours (once again, this depends on if there is a weekend in the middle). If you don’t want an autopsy (if you “object”), tell the attending police or the coroner’s court *right away*. After business hours you can phone 131 444 to notify a police officer of your objection. An autopsy may be the only way to get a clear picture of how the person died.
* The police or coroners’ office may contact you to get more information about the circumstances of the death or the person’s medical history.

For a list of services available to you, please go to ‘A Guide for Families and Friends: Coping with grief’ and ‘A Guide for Families and Friends: Who can help?’.

For more information on objecting to an autopsy, please go to ‘A Guide for Families and Friends: The coroner’s court and me - What is an autopsy?’.

### Identification

The coroner must be sure of the identity of the deceased person. The police or coroners’ office may ask you to identify the deceased person by looking at them. Any person who knew the deceased person in life can do this. If the deceased person cannot be identified by sight, the coroner may use things such as fingerprints, dental records or DNA samples to confirm identity.

### Support person

Finding out that a loved one has died suddenly is a huge shock, and affects everyone differently. It may help to call a person who is close to you and ask them to come to your house and support you. Families may find comfort in gathering together and supporting each other. Some people want to take time off work and others want to stay at work or continue with their plans. You should do whatever makes you feel most comfortable.

A support person can help you with things you might need to do in the first few hours or days, including:

* telling other people that the person has passed away
* making appointments with doctors:
	+ you might need a medical certificate to get time off work
	+ you might need advice on how to cope with the shock of what has happened
* telling others at the deceased person’s place of work what has happened
* contacting a funeral director
* making appointments with counsellors, insurance companies or lawyers.

For a list of groups that can support you in this difficult time, go to ‘A Guide for Families and Friends: Who can help?’.

### Religious and cultural practices

Please tell the coroner’s court if you have religious or cultural concerns about any part of the coronial process.

Many different cultures and religions have rules and beliefs about death, burial and cremation. It is our job at the coroner’s court to do the best we can to make sure that the coronial process takes account of your beliefs and values. The more information we have, the better we can do this. Please tell us your concerns as soon as you can. The coroner will always do everything possible to allow for requests.

**If you have a religious or cultural practice** that:

* does not allow medical procedures, such as an autopsy
* requires burial or cremation in a certain time (for example, within 24 hours of death)
* objects to samples being taken from the deceased person, such as blood samples

please [contact the coroner’s court](http://www.magistratescourt.tas.gov.au/contact/coroners_court) *right away*. If you object to an autopsy, please go to ‘A Guide for Families and Friends: The coroner’s court and me – What is an autopsy?’ for more information.

If you don’t want to talk about your beliefs with police officers or people who work for the government, you can ask someone else to speak to the court for you. You can ask a religious or cultural representative, a friend or a relative. You, or the person who is talking for you, can [call the coroner’s court](http://www.magistratescourt.tas.gov.au/contact/coroners_court) any time. If time is an important factor, the sooner we know about your needs, the more likely we are to be able to help you. The after-hours phone number for police is 131 444, they will pass on any messages to the coroners’ associates. No autopsies or medical examinations will happen on the weekend.

It is the coroner’s job to make sure that the findings they make are correct. If the coroner cannot get the information they need in the time you request, or without doing an autopsy, then it may not be possible to do things the way you request.

### Organ and tissue donation

Organ and tissue donation is a life-saving medical process that can help save someone who is very ill or dying from organ failure.  The opportunity to become an organ donor is very rare, only approximately one per cent of people who die in hospitals can possibly become donors.

When a person dies in a situation where they can become an organ and / or tissue donor, the hospital medical team will raise the possibility of donation with families. The Australian Organ Donor Register is checked, this information is shared with families and the senior next of kin is then asked to give the final written consent for organ donation. Organ donation in Australia is governed by law and if a coroner is investigating the death, they must give permission for donation to occur.

If you would like further information about organ donation, please ask the treating medical team; alternatively, DonateLife Tasmania can be contacted during business hours on:

* Phone number: (03) 6270 2209
* Email: donatelife.tasmania@dhhs.tas.gov.au
* Or visit [the DonateLife web site](http://www.donatelife.gov.au/donatelife-tasmania)[[75]](#footnote-75)

## FAQ (frequently asked questions)

* What services are available to help my family and I to cope?
	+ A Guide for Families and Friends: Coping with grief
* What do coroners do?
	+ A Guide for Families and Friends: The coroner’s court and me – What do coroners do?
* Where can I get legal advice?
	+ A Guide for Families and Friends: Who can help? – Legal help
* Where can I get a death certificate?
	+ A Guide for Families and Friends: Practical matters – Access to documents
* When will we be able to have the funeral?
	+ A Guide for Families and Friends: The coroner’s court and me – When will we be able to have the funeral?
* How can I get back items taken by the police?
	+ A Guide for Families and Friends: Practical matters – Items taken by police
* I am the senior next of kin, what does this mean?
	+ A Guide for Families and Friends: The coroner’s court and me – Who / what is the senior next of kin?
* Do I need a lawyer?
	+ A Guide for Families and Friends: The coroner’s court and me – Do I need a lawyer?
* How long will this take?
	+ A Guide for Families and Friends: The coroner’s court and me – How long will this take?
* If the coroner investigates a death, does that mean it is suspicious?
	+ **Most of the deaths investigated by coroners are not suspicious.** There is a list of different types of deaths that coroners have to investigate just in case. Coroners often find out that a death they are investigating was natural, and they don’t need to investigate any more. The coronial process is all about gathering information and checking facts.

## Coping with grief

This section of the guide has lists of services and information that can help you to cope with grief and loss.

Losing a loved one is always hard, but when the death is sudden and unexpected, the feeling of loss can be even greater. There is no ‘normal’ way to feel when you suddenly lose someone close to you. Dealing with these emotions is always very difficult, but it may be harder for some people to cope than others. What *is* normal is to need support to get through a difficult time like this. You may be able to get the support you need through your family and friends, or you may want to talk to a professional or someone who has no knowledge of what has happened. Do what makes you feel most comfortable.

Below is a list of services you can access including counsellors, specialist teams and 24-hour support services. There is also a list of information sheets to help you cope with grief and loss. They include information on how to help other people (such as children and teenagers) to get through the grieving process.

If you need legal, administrative or financial help, please go to ‘A Guide for Families and Friends: Who can help?’.

### Services that can help

* **Grief and Loss Counsellor (business hours)**
	+ South (Royal Hobart Hospital) – (03) 6166 8344
	+ North (Launceston General Hospital) – (03) 6777 6245
* Lifeline (immediate counselling and assistance, 24 hours a day): 13 11 14
* Kids Help Line (immediate counselling and assistance, 24 hours a day): 1800 55 1800
* Mens Line Australia (immediate counselling and support, 24 hours a day): 1300 78 99 78
* QLife line (support for LGBTQI, other sexuality, sex and gender diverse people – 3pm to 12am every day): 1800 184 527
* Standby Response Service (crisis response for people bereaved by suicide):
	+ Monday to Friday call (03) 6282 1519
	+ To access a 24 hour mobile: 0400 183 490
	+ Email: standby.south@lifelinetasmania.org.au
* GPs (doctors / general practitioners) can:
	+ set up a Mental Health Treatment Plan, to help people improve their mental health after a traumatic event, and
	+ refer people to a psychologist, psychiatrist or social worker so that they can receive ongoing support (you can get rebates for ten individual and ten group psychology sessions per calendar year).

For more information on this service, go to the Australian Government Department of Health web site, and read the [Better Access to Mental Health Care: fact sheet for patients](http://www.health.gov.au/internet/main/publishing.nsf/content/mental-ba-fact-pat).[[76]](#footnote-76)

* Suicide Call-back Service (free counselling for anyone affected by suicide): 1300 659 467
* SIDS and Kids (bereavement support and education, 24 hours a day): 1300 308 307
* [Australian Centre for Grief and Bereavement](https://www.grief.org.au/),[[77]](#footnote-77) information and support services for those suffering through grief and bereavement
	+ Phone: 1800 642 066
* [Road Trauma Support TAS](http://www.roadtraumasupport.org.au/)[[78]](#footnote-78) offers assistance and support for people affected by motor vehicle crashes
	+ Phone: (03) 6777 6252
* [Victims of Crime Service](http://www.justice.tas.gov.au/victims/services/victimsofcrime)[[79]](#footnote-79) provides personal support and counselling. The service office hours are 8:45 am to 5 pm, Monday to Friday
	+ Hobart: (03) 6165 7524
	+ Launceston: (03) 6777 2939
	+ Burnie: (03) 6477 7133
* [Tasmanian Aboriginal Centre Inc](http://tacinc.com.au/)[[80]](#footnote-80) provides support services for Aboriginal Australians
* The [Migrant Resource Centre Hobart](http://mrchobart.org.au/)[[81]](#footnote-81) and the [Migrant Resource Centre Launceston](http://mrcltn.org.au/)[[82]](#footnote-82) provide support services for migrants, humanitarian entrants and refugees
* [The Trauma and Grief Network](http://tgn.anu.edu.au/)[[83]](#footnote-83) provides support for families dealing with grief and loss
* The [National Missing Persons Coordination Centre](https://www.missingpersons.gov.au/someone-i-know-missing/support-services)[[84]](#footnote-84) provides support and assistance for friends and relatives of missing persons
* The Tasmanian Department of Health and Human Services [Mental Health](http://www.dhhs.tas.gov.au/mentalhealth) page has links to lots of different support services and advice.[[85]](#footnote-85)

**For an immediate emergency, contact emergency services: 000**

For more links for mental health help and support, go to the Tasmanian Department of Health and Human Services [DHHS useful links and contacts page](http://www.dhhs.tas.gov.au/mentalhealth/useful_links_and_contacts).[[86]](#footnote-86)

### Information that may help you cope with grief and loss

All of the information sheets listed below can be found on the Tasmanian Department of Health and Human Services web site.

[Sudden Loss Support Kit](http://www.dhhs.tas.gov.au/__data/assets/pdf_file/0005/47354/DHHS_Sudden_Loss_Kit_Booklet_v3.pdf)[[87]](#footnote-87)

* This is a booklet with lots of advice and contacts to help people dealing with sudden loss. You can get a copy at the coroner’s court on request.
* You can also find this booklet online on the Department of Health and Human Services, Mental Health Documents page.[[88]](#footnote-88)

[Grief, Loss and Depression](http://www.dhhs.tas.gov.au/__data/assets/pdf_file/0020/38423/grief_loss_and_depression.pdf)[[89]](#footnote-89)

[Sudden Loss: Grieving the Aboriginal Way](http://www.dhhs.tas.gov.au/mentalhealth/suicide_risk_and_prevention/documents/sudden_loss_grieving_the_aboriginal_way)[[90]](#footnote-90)

[Sudden Loss: Information for LGBTI People](http://www.dhhs.tas.gov.au/mentalhealth/suicide_risk_and_prevention/documents/sudden_loss_lgbti)[[91]](#footnote-91)

[Sudden Loss: Supporting someone experiencing Sudden Loss](http://www.dhhs.tas.gov.au/mentalhealth/suicide_risk_and_prevention/documents/sudden_loss_supporting_someone_experiencing_sudden_loss)[[92]](#footnote-92)

[Sudden Loss: Have you suffered the loss of a child?](http://www.dhhs.tas.gov.au/mentalhealth/suicide_risk_and_prevention/documents/sudden_loss_suffered_the_loss_of_a_child)[[93]](#footnote-93)

[Sudden Loss: Helping Children and Teenagers](http://www.dhhs.tas.gov.au/mentalhealth/suicide_risk_and_prevention/documents/sudden_loss_helping_children_and_teenagers)[[94]](#footnote-94)

[Suicide Risk and Prevention](http://www.dhhs.tas.gov.au/mentalhealth/suicide_risk_and_prevention/documents/sudden_loss_helping_children_and_teenagers)[[95]](#footnote-95)

[Lifeline: Loss and Grief](https://www.lifeline.org.au/Get-Help/Facts---Information/Loss-and-Grief?gclid=CJfWp7awzswCFVMIvAodSP8E4Q)[[96]](#footnote-96)

Further information and support is available on the Tasmanian Department of Health and Human Services [DHHS Mental Health web site](http://www.dhhs.tas.gov.au/mentalhealth).[[97]](#footnote-97)

### Grief after suicide

Grief after suicide is similar to grief after other types of death, but it also raises additional complex issues because of its suddenness and traumatic nature. These may include the following:

**Trauma**

Suicide may be violent and leave the bereaved traumatised. Intrusive images of the death can recur, even if the death was not witnessed. The initial grief reactions of shock and numbness may also be stronger and last longer.

**Asking ‘Why?’**

For the bereaved there is often a desperate need to know why it happened. The search for answers may seem relentless, but it is important you reach a point where you feel you have struggled long enough with the question. You may have enough answers to satisfy yourself, or recognise that the reasons for the suicide will never be completely understood.

**Guilt**

Guilt is a common reaction in bereavement. Research suggests that guilt is often felt intensely by those bereaved by suicide. Family members and friends often feel guilty about not having foreseen the suicide or prevented it. Bereaved families often feel guilty in some way for the death: that there was something ‘wrong’ in their family or with their parenting skills. Bereaved people often replay the events over and over again in their heads. There can be a long list of ‘if onlys’: ‘If only I had been home’, ‘If only I had recognised how they were feeling’ and ‘If only I hadn’t said that’. There is a limit to your responsibility: no one is responsible for another person’s decisions or actions.

**Relief**

For families and friends who have been through many years of chronic mental illness with their loved one, there may be feelings of relief. They may feel ‘At least now they are at rest’ and they may sense freedom from ongoing worry for their loved one. It is okay to feel this way; it does not mean you wished your loved one dead.

**Blame**

It is common for people to react to a sudden death by looking for someone to blame. Family members bereaved by suicide may blame each other. Initially blame can be a way for some people to make sense of what happened. Try to remember that no one is responsible for another person’s decisions or actions.

**The StandBy Response Service**

StandBy Response Service provides a 24 hour co-ordinated crisis response to assist families, friends and associates who have been bereaved through suicide. The StandBy Response Service provides a reliable, single point of contact co-ordinating existing services to enable an immediate response.

Contact the StandBy Response Service:

Monday to Friday 9am to 5pm

* (03) 6282 1519

To Access the 24-hour Mobile:

* 0400 183 490 (South)
* 0439 556 660 (North)
* standby.south@lifelinetasmania.org.au

**Should I tell people if it was suicide?**

Some people find it difficult to tell others about the cause of death and choose not to do so. Initially this may be easier. However, it may result in experiencing a sense of unease in your relationships with others and may lead to a lack of support. It is helpful to be honest.

Telling the story can be healing. If you avoid the truth it will take extra energy and worry to maintain the lie and this will complicate the grief process. It is also important to be honest when telling children about the death. For a detailed discussion of talking with children about a suicide death go to the section in the Sudden Loss Support Kit on Helping Children with Grief (there is information on where to get a copy below).

**What do I say when people ask me about the suicide?**

It can be helpful to work out ahead of time what to say to people. You may want to share more with some people than others. If you do not want to discuss it at that time, let them know. You can say something like ‘I don’t want to go into that at the moment’. It may be better not to discuss the method (the way the person died) in too much detail. Some people are more vulnerable and may be influenced by this.

For information on how to tell children and teenagers about suicide, go to the *Telling Children and Teenagers About Suicide* section of the Sudden Loss Support Kit.

[Sudden Loss Support Kit](http://www.dhhs.tas.gov.au/__data/assets/pdf_file/0005/47354/DHHS_Sudden_Loss_Kit_Booklet_v3.pdf)[[98]](#footnote-98)

* This is a booklet with lots of advice and contacts to help people dealing with sudden loss. You can get a copy at the coroner’s court on request.
* You can also find this booklet online on the Department of Health and Human Services, Mental Health Documents page.[[99]](#footnote-99)

[Suicide Risk and Prevention](http://www.dhhs.tas.gov.au/mentalhealth/suicide_risk_and_prevention/documents/sudden_loss_helping_children_and_teenagers)[[100]](#footnote-100)

[Sudden Loss: Have you suffered the loss of a child?](http://www.dhhs.tas.gov.au/mentalhealth/suicide_risk_and_prevention/documents/sudden_loss_suffered_the_loss_of_a_child)[[101]](#footnote-101)

Information in this section has been reproduced with permission from the Department of Health and Human Services (Tasmanian Government) Sudden Loss Support Kit.

## Who can help?

### Administrative help

If you have questions about the coronial process or want information about an investigation, please [contact the coroner’s court](http://www.magistratescourt.tas.gov.au/contact/coroners_court).

### Financial help and general advice

* The Australian Government web page ‘[What to do following a death](http://www.humanservices.gov.au/customer/subjects/what-to-do-following-a-death)’[[102]](#footnote-102) can help with the following:
	+ benefits you may be able to claim after the death of someone close to you
	+ insurance policies, funeral plans and Wills
	+ who to notify
	+ removing someone’s name from mailing lists
	+ social media accounts
	+ financial information services
	+ support for you after someone has died
	+ other government and community support services.
* If the death occurred as a result of a vehicle crash, you may be able to claim benefits through the Motor Accidents Insurance Board (MAIB). The following information is available on their web site:
	+ the complete list of [Benefits and Claims](http://www.maib.tas.gov.au/benefits-and-claims/)[[103]](#footnote-103)
	+ information on [Funeral and Death Benefits](http://www.maib.tas.gov.au/benefits-and-claims/benefits-available/funeral-death-benefits/).[[104]](#footnote-104)

### Legal help

**Legal advice**

The coroner’s court cannot give you legal advice. Community Legal Centres and Legal Aid offer *free legal advice* but usually are unable to represent people in court (in an inquest). If you have legal questions, Community Legal Services and Legal Aid advice services are good places to go to get help if you are unable to pay for legal services.

Community Legal Centres:

* [Hobart Community Legal Service](http://www.hobartlegal.org.au/)[[105]](#footnote-105)
	+ Phone: (03) 6223 2500
	+ 166 Macquarie Street, Hobart
* [Launceston Community Legal Centre](http://www.lclc.net.au/)[[106]](#footnote-106)
	+ Phone: (03) 6334 1577
	+ 1/97 York Street, Launceston
* [North West Community Legal Centre](http://www.nwclc.org.au/)[[107]](#footnote-107)
	+ Phone: (03) 6424 8720
	+ 62 Stewart Street, Devonport
* [Women’s Legal Service Tasmania](http://www.womenslegaltas.org.au/)[[108]](#footnote-108)
	+ Phone - advice line: 1800 682 468
	+ Phone - administrative: (03) 6231 9466
* [Tasmanian Aboriginal Community Legal Service](http://www.legalaid.tas.gov.au/referral-list/listing/tasmanian-aboriginal-community-legal-service)[[109]](#footnote-109)
	+ Phone: 1800 064 865
	+ Suite 402, Level 4, 152 Macquarie Street, Hobart
* [Tasmanian Refugee Legal Service](http://rlstas.com/)[[110]](#footnote-110)
	+ Email: info@rlstas.com
	+ Postal address: GPO Box 988, Hobart, Tasmania, 7001

Legal Aid Commission of Tasmania:

* Telephone advice line – 1300 366 611
* Email advice – webquery@legalaid.tas.gov.au

**Representation in court**

The coroner’s court is not able to give you legal advice and assistance. If you want a lawyer to represent you in coronial proceedings (and come to an inquest for you), you will usually need to pay for a private lawyer. The Law Society offers a referral service and they can direct you to a lawyer who knows about coronial matters if you are not sure who to contact. The Law Society also provides a ‘pro bono clearing house’ (at no cost), which may be able to help people who cannot afford legal advice.

* [Law Society referrals](http://lst.org.au/about/contact-us/)[[111]](#footnote-111)
* Phone: (03) 6234 4133
* Email: info@lst.org.au
* [Law Society Pro Bono Clearing House](http://lst.org.au/public-info/pro-bono-clearing-house/)[[112]](#footnote-112)
	+ Contact details as listed above.

In some cases, Legal Aid will represent people at an inquest if they cannot afford a private lawyer, and it is useful to note that:

* assistance for an inquest is not normally granted unless there are exceptional circumstances
* if you want to claim that there are exceptional circumstances and you should receive aid, you will need to contact Legal Aid to make an application
* the definition of ‘exceptional circumstances’ is not set and each application will be considered on a case-by-case basis
* [Legal Aid](http://www.legalaid.tas.gov.au/)[[113]](#footnote-113)
* Hobart: (03) 6236 3800
* Launceston: (03) 6328 4000.

### If you need extra assistance

#### General information for people with diverse needs

* At the coroner’s court we are committed to providing equal outcomes for all people regardless of their social or personal attributes.
* If there is something that will help you, please tell us.
* Court staff can help you to fill out court forms.
* Court staff can help you to make applications.
* You can always bring a support person with you, or have a support person contact the court for you.
* If you need help understanding what is happening, please ask us.
* If you need help giving evidence at an inquest, please talk to court staff or ask someone else to contact the court for you.

#### Interpreters

* If you, or someone you support, need an interpreter to help communicate with the coroner’s court, please let us know.
* If the coroner approves it, court staff can arrange an interpreter for you and the court will cover the full cost.
* The court will only use NAATI (National Accreditation Authority for Translators and Interpreters Ltd) accredited / recognised interpreters if there is one available for your language.
* The coroner’s court can arrange an interpreter to attend the coroners’ office and meet you there to talk about the investigation.
* The coroner’s court can also arrange for an interpreter to attend an inquest to help the families to understand the proceedings, or to help a person to give evidence.
* Interpreters can be arranged to translate into Auslan or another form of communication.
* For meetings, client consultations and similar, please contact the Telephone Interpreter Service: 13 14 50.



#### Translators

* In some cases, it will possible for the coroner’s court to get a document translated into another language so that family members can understand it.
* If you want a coronial record translated, please apply to the coroner’s court for access to the document using the ‘Application to Access Coronial Records’ form and let them know that you will need it translated into another language when you apply. The form can be found on the Magistrates Court web site, under [Forms](http://www.magistratescourt.tas.gov.au/forms)[[114]](#footnote-114) or you can pick up a copy at the coroners’ office.

#### Assistance for the hearing impaired

* A ‘hearing loop’ is available in both the Launceston and Hobart Magistrates Court (including the coroner’s court). This small adjustable device is connected to an earpiece, which amplifies the court proceedings. If you need access to the hearing loop during an inquest, please ask a court security guard to assist you when you arrive at court.
* Interpreters can be arranged to interpret into Auslan. If you require this service at an inquest, you should [contact the coroner’s court](http://www.magistratescourt.tas.gov.au/contact/coroners_court) at least a couple of weeks in advance to allow us time to arrange it.

#### Assistance for those with physical difficulties getting to court

* All Registries of the Magistrates Court (including the coroner’s court) are wheelchair accessible.
* If you are unable to attend court due to medical issues, please [contact the coroner’s court](http://www.magistratescourt.tas.gov.au/contact/coroners_court) and tell us.
* If you are sent a ‘summons’ to attend court to be a witness, you will have to come to court unless you make a different arrangement with the coroner’s court staff.
* Sometimes it is possible to arrange for people to “attend” court by being on the telephone so that they can speak and hear everything that is happening.
* Sometimes it is even possible to give evidence in court through the telephone, but it is up to the coroner whether it is allowed.

#### Court support - emotional assistance and guidance

[Victims Support Service](http://www.justice.tas.gov.au/victims/about/contact)[[115]](#footnote-115) for those whose loved ones have been victims of violent crime

* + Hobart: (03) 6233 5002
	+ Launceston: (03) 6336 2581
	+ Burnie: (03) 6477 7133

[Court Support and Liaison Service - Safe at Home](http://www.safeathome.tas.gov.au/services/legal#courtsupportandliaison)[[116]](#footnote-116) provides support for victims of family violence

* + Toll free: 1300 663 773
	+ Hobart: (03) 6165 7524
	+ Launceston: (03) 6777 2937
	+ Burnie: (03) 6477 7133

[Salvation Army - Court and Prison Chaplaincy](http://www.salvationarmy.org.au/find-help/court-and-prison-services/)[[117]](#footnote-117) emotional and spiritual support through the court process

* + Hobart: (03) 6278 8140
	+ Launceston: (03) 6323 7500

[Migrant Resource Centre](http://www.mrchobart.org.au/)[[118]](#footnote-118) for migrants who have entered Tasmania in the last five years

* + Hobart: (03) 6221 0999
	+ Launceston: (03) 6332 2211

[Aboriginal Court Support Officer](http://www.justice.tas.gov.au/victims/about/contact)[[119]](#footnote-119) provides support for Aboriginal Australian victims of family violence in a culturally aware and sensitive manner

* + Toll Free: 1300 663 773
	+ Hobart: (03) 6165 7524
	+ Launceston: (03) 6777 2939
	+ Burnie: (03) 6434 7268 or (03) 6477 7133

### Other useful contacts

* [Equal Opportunity Tasmania](http://equalopportunity.tas.gov.au/)[[120]](#footnote-120)
* [Disability Services](http://www.dhhs.tas.gov.au/service_information/disability/disability_services)[[121]](#footnote-121)
* [Alcohol and Drugs Services](http://www.dhhs.tas.gov.au/mentalhealth/alcohol_and_drug)[[122]](#footnote-122)
* [Australian Funeral Directors Association](http://www.afda.org.au/)[[123]](#footnote-123)
* [Australian Aged Care Quality Agency](https://www.aacqa.gov.au/)[[124]](#footnote-124)
* [Health Complaints Commissioner Tasmania](http://www.healthcomplaints.tas.gov.au/).[[125]](#footnote-125)

## The coroner’s court and me

### What do coroners do?

* Coroners investigate deaths, fires and explosions, helped by police and a team of their own investigators.
* The aim of coronial investigations is to gather as much information as possible, in order to allow the coroner to make the most accurate findings possible. The term “findings” refers to certain facts that the coroner discovers, which are contained in a written decision.
* The coroner examines all the facts and makes findings at the end of their investigation that cover (if possible) exactly what happened and how it happened.
* Because investigations are focussed on getting facts, the coroner may have to wait for medical tests and reports before they can make their findings, and sometimes this takes a long time. If you are concerned about how long an investigation is taking, you are always welcome to call the court for an update and / or an explanation.
* Sometimes coroners hold inquests, which are public hearings where people come to court and answer questions.
* Coroners also make recommendations aimed at preventing other deaths.
* These recommendations can be directed to a wide range of organisations and can cover many different topics. Coronial recommendations have helped to make rules about compulsory pool fencing, wearing life jackets and drink driving, as well as many other things.

### What don’t coroners do?

* The coroner’s court is not like a criminal court, and the coroner cannot punish anyone.
* In their findings, coroners are not permitted to say that someone has committed an indictable offence (a crime).
* If a coroner makes recommendations telling an organisation that they should do something (for example, recommending that a hospital change its diagnostic procedures), the coroner cannot force the organisation to make the changes.
* In some other states such as South Australia and Victoria, the law says that governments have to respond to the coroner’s recommendations, but this is not the case in Tasmania.
* Often government departments and other organisations do change their procedures to avoid future deaths.
* It is important that inquests are conducted in public: if a person dies when they are in the care or custody of the government (for example, if they were in prison), the people who may have contributed to the death will have to answer to the public, accounting for what they did and explaining why they did it. This process enhances accountability, transparency and government responsibility.
* Sometimes a coroner will not be able to find the cause of death. There are instances where there is just not enough certainty for a coroner to make a definite statement about what occurred. This is very hard on families who have endured the coronial process only to be told that the coroner does not have all the answers that they seek. Families can be assured that coroners will do everything in their power to provide all the answers that they can and to help them get through this tragedy.

### How involved can I be in the process?

* You control your level of involvement. You can choose to simply wait and find out what the outcome is or you can be in regular contact with the coroner’s court and ask to be kept informed.
* You can make applications to the coroner’s court if you want certain things to happen. For example, you can apply to access coronial documents.
* If there is an inquest (a court hearing), you can attend the inquest in person. It is important to keep in mind that some of the information discussed in court may be upsetting for those close to the person whose death is being investigated. It is up to you to decide if you want to come along. Unless you are a witness giving your evidence, you are able to leave at any time.
* If you are the senior next of kin, you may be more involved in the process. If you would like more information on the role of the senior next of kin, please go to the next section of the guide.

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

The senior next of kin is the person that the coroner’s court will usually contact with information and questions about the deceased person. Other family members and friends can also ask to be kept updated.

The senior next of kin is 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.

* If you are not sure if you are the senior next of kin, please [contact the coroner’s court](http://www.magistratescourt.tas.gov.au/contact/coroners_court) and they will tell you.
* There are four things the senior next of kin has a right to do, which no one else does. In all other ways, being the senior next of kin is just like being a family member who is an ‘interested person’.
* The only rights which are exclusive to the senior next of kin under the Act are the rights to:
	+ object to an autopsy
	+ object to exhumation
	+ be notified of the coroner’s decision not to hold an inquest
	+ request the coroner not hold an inquest into a workplace death.
* The coroner’s decision about who is senior next of kin only applies to the coroner’s court. It doesn’t give that person any legal rights or special status in any other legal proceedings to do with the will, property or anything else.

If you are the senior next of kin:

* The coroner’s court will contact you when the deceased person is ready to be collected by a funeral director. The mortuary staff at the hospital will contact the funeral director as well.
* Each time the investigation reaches the point where the senior next of kin has a right to do something, the coroner’s court will notify you.
* If the coroner decides to hold an inquest, the coroner’s court will write to you and tell you when and where the inquest will be held. They will also tell you the date, time and location of any case management conferences that are being held to organise the inquest.
	+ If you have any questions about the inquest, a case management conference is a good place to discuss them.
	+ You are allowed to ask questions at the inquest or have a lawyer do this for you.
	+ If you have any questions about the inquest process, please [contact the coroner’s court](http://www.magistratescourt.tas.gov.au/contact/coroners_court).
* The coroner’s court will send you a copy of the findings once they are prepared.
* The coroner’s court may ask you to provide information such as details about the circumstances of the death or medical records for the deceased person.

*What if I don’t want to be senior next of kin?*

You can “delegate” your responsibilities as senior next of kin by asking another person to do it for you. You should send the court a ‘statutory declaration’ saying this is what you want, signed both by yourself and by the person you choose. Statutory declaration forms can be found on the Magistrates Court web site, under [Forms](http://www.magistratescourt.tas.gov.au/forms)[[126]](#footnote-126) or collected from the Magistrates Court. Coroner’s court and Magistrates Court staff can assist you to fill out this form.

*What if I think I should be senior next of kin but I’m not?*

You can apply to the coroner if you think you should be the senior next of kin. It is important to remember that there are only four rights that the senior next of kin has that other interested persons don’t (refer to the list above). To apply, contact the coroner’s court. You will be given the opportunity to give the coroner any information you have about why you are the correct senior next of kin. If the investigation is just beginning and you want to exercise the right to object to the autopsy, you need to contact the coroner’s court *right away* by telephone. If it is after hours, you can get in touch with police by calling 131 444. Police will pass on any messages to the coroners’ associates; autopsies do not happen on the weekend.

Once the coroner has your information, they will get information from anyone else who says they are the senior next of kin. The coroner will then decide who is the correct senior next of kin. If you don’t agree with the coroner’s decision you should get legal advice as you may want to apply to the Supreme Court to have the decision reviewed.

There is more information on the role of the senior next of kin in the Tasmanian Coronial Practice Handbook, under ‘Key Players in the Process: Senior Next of Kin’.

There is more information on how to make an application to the coroner’s court or the Supreme Court in the Tasmanian Coronial Practice Handbook, under ‘Key Elements in the Process: Applications’.

### What is an autopsy?

An autopsy is when a specialist doctor (a pathologist) carefully examines the internal parts of a deceased person’s body. If a pathologist takes a blood or other sample from a deceased person, this is also an autopsy. Other procedures such as physically examining a deceased person, reading their medical records and taking photographs of them are not a part of the autopsy.

The aim of any autopsy is to identify the medical cause of death and anything that might have contributed to death. Autopsies can provide a lot of information that cannot be gathered in any other way. All autopsies are conducted in a respectful and dignified manner.

The coroner will decide if an autopsy is necessary. If they make an order, the autopsy will usually happen within 48 hours. Autopsies do not happen on the weekend. If you *are the senior next of kin* and you don’t want an autopsy to happen (if you “object”), tell the attending police or the coroner’s court *right away*. After business hours you can phone 131 444 to notify a police officer of your objection.

If you object, the coroners’ associates will talk to you about the different procedures the pathologist might do so you can explain exactly which procedures you object to. When there is an objection to autopsy, it is taken very seriously. The coroner will consider whether they can get all the information they require without an autopsy. The coroner may decide that an autopsy is not required, that only some procedures are necessary or that a full autopsy must happen.

If you object and the coroner decides that an autopsy is required, the coroners’ office will give you a notice. You can then apply to the Supreme Court within 48 hours for an order that the autopsy not go ahead.

### Do I need a lawyer?

* It is always up to you whether you seek legal advice.
* The coroner’s court is designed to be more accessible than criminal courts, so you may find that you do not need a lawyer.

If you think that you might want or need a lawyer to:

* + help you understand the proceedings
	+ assist with paperwork
	+ speak for you in court (at an inquest)
	+ answer legal questions

you can seek advice on this from a Community Legal Service, Legal Aid, or from a private lawyer or law firm (contact details are listed in ‘A Guide for Families and Friends: Who can help? - Legal help’). These people can give you a better idea whether you will need a lawyer or not, and help you to contact one if you want.

### When will we be able to have the funeral?

* Until the coroner signs a ‘Certificate of Burial’ authorising the release of the deceased person, they remain in the custody of the coroner (ss 31 & 32).
* This is just to make sure that the coroner can gather all the information they need to make the most accurate findings about how the person died.
* We understand that it is upsetting for families and friends to have to wait to be able to collect their loved one.
* Because of this, the law says that the coroner must release the deceased person’s body ‘as soon as reasonably possible’.
* Every effort will be made to ensure that any investigations are carried out quickly and that your loved one is returned for burial / cremation as soon as they can be.

### Should I go to the inquest?

* It is always up to you whether you go to the inquest, unless you are sent a summons to be a witness.
* Some people find attending the inquest very helpful. They can hear all the evidence and better understand for themselves the time and effort that has gone into helping to discover the truth about what happened. The inquest can help them to get answers if they have a lot of questions.
* Other people may find attending the inquest upsetting and the level of detail in the evidence to much to bear.
* If you need help making a decision about whether to attend the inquest, then talk it over with friends and family members, coronial court staff, or perhaps a counsellor to help you to decide (refer to ‘A Guide for Families and Friends: Who can help?’).
* Going to a different inquest may help you to understand the process and know what to expect.

### I have decided to go to the inquest, what do I need to know?

It can be upsetting to attend an inquest where you will be faced with detailed evidence about the death of someone close to you. You can take a support person with you and you can leave at any time (unless you are giving evidence). Your support person can be a friend or family member, or a professional (refer to ‘A Guide for Families and Friends: Who can help?’).

Make sure you allow extra time to get to court just in case and ask the court staff which room the inquest will be held in so you know where to go. Once you get to court, you will need to go through a metal detector and security check, and then you can go to the courtroom.

If you require an interpreter to assist you or your family at the inquest, please tell the staff at the coroner’s court at least a couple of weeks in advance. If the coroner approves the use of an interpreter, the court will pay for an interpreter to attend or be present on the phone. The Magistrates Court (and the coroner’s court) is fully wheelchair accessible. If you need any extra help during the inquest process, please [contact the coroner’s court](http://www.magistratescourt.tas.gov.au/contact/coroners_court) and let us know.

What to bring:

* any documents you have been asked to provide
* your statement (if you are a witness) - this will also be on the coroner’s file, so contact the coroners’ office if you do not have a copy and they can send it to you or give it to you in court
* a list of questions you want to ask (if you are speaking at the inquest)
* a support person
* pen and paper (to write down anything that you might want to remember)
* tissues
* something to eat or money for lunch (you cannot take your food and drink into a courtroom, so please be aware of this when you plan your lunch)
* money for parking if you are driving (it may be good to arrange to call someone to pick you up if you are worried the proceedings will be upsetting for you)
* a book, newspaper or something else non-electronic to do when you are waiting.

During the inquest, the coroner will explain the proceedings and check with close family members about any questions they may have.

There is more information about court proceedings (such as the layout of courtrooms and court etiquette) in the Tasmanian Coronial Practice Handbook, under ‘Key Elements in the Process: Court proceedings – general information’.

There is more information on inquests (such as what an inquest is and how inquests are held) in the Tasmanian Coronial Practice Handbook, under ‘Key Elements in the Process: Inquests’.

### I’m a witness at the inquest, what does this mean?

Witnesses are people who attend formal court hearings and tell the court anything that they know that is relevant to the hearing. A person will ask you a question and you then answer them, and this process is known as ‘giving evidence’. In most cases, the questions will be based on written statements that you have already made to police. Nothing new will be discussed, but you might be asked to give more details about the events in your statement.

Giving evidence in court can be stressful. The courtroom and building are very formal and may be an unfamiliar environment. The subject matter of an inquest (usually a sudden death) is upsetting. No one expects you to be relaxed and at your best. If you need a minute to have a breath or a glass of water, or if you need a tissue, please say something. It is our role to make the experience of giving evidence as easy for you as we can.

As a witness, you will provide valuable information to help the coroner to make the most accurate and useful findings that they can. Your help is greatly appreciated.

**If you are a person with complex communication needs**, please contact the coroners’ office for assistance. There is also more information on some of the ways the court can accommodate your needs in the Tasmanian Coronial Practice Handbook, under ‘Key Players in the Process: Witnesses – witnesses with disability’ and ‘Key Players in the Process: Witnesses – witnesses with complex communication needs’. People with complex communication needs can include people with disability, people whose first language is not English, people under the age of 18 and people suffering from a mental illness.

#### Before court

* First you will be sent a summons, which is a document that requires you to come to court and ‘give evidence’ on the date and time specified. If someone other than the coroner is calling you to give evidence, then you may be simply asked to attend instead of being sent a summons.
* If you are *sent a summons* and you cannot come to court on that day, you must [contact the coroner’s court](http://www.magistratescourt.tas.gov.au/contact/coroners_court) as soon as possible to explain - this is because you are legally required to come to court. It is possible for the coroner to issue a warrant for people who are summonsed and do not attend court, and if this happens they can be arrested and taken to court.
* If you are called as a witness, you may be recognised by the court as an ‘interested person’. If you are an interested person, then you may ask a lawyer to represent you in court. If you are not sure whether you are an interested person, you can call the coroner’s court to ask them if you are an interested person, or to make an application to be an interested person.
* If coming to court will cost you money in lost wages or salary, travel or accommodation please contact the coroner’s court who can assist you in making a claim for expenses.
* If you have any special needs attending court or need assistance (such as an interpreter, or use of the ‘hearing loop’ which is a court hearing aid) then please contact the coroner’s court and let them know as soon as possible. All Magistrates Courts in Tasmania are wheelchair accessible.
* You can bring a support person to court with you (they can be a friend, family member or a professional – go to ‘A Guide for Families and Friends: Who can help?’).

#### At court

* You are welcome to wait in the courtroom or outside the courtroom until you are called to give your oral evidence. If you choose to wait outside the courtroom, make sure that the counsel assisting knows that you are there.
* If you have a support person, they can wait with you and then sit in the back of the court while you are giving your evidence.
* You will be called into court by name and directed to the ‘witness box’, where you can sit and give your evidence. It is customary to give a small bow / nod to the coroner when you enter the courtroom.
* You will be asked to take an affirmation or swear an oath on the Bible (the Qur’an and Torah are also available for oaths if the request is made to the court clerk in advance). Both the affirmation and the oath are promises to tell the truth. An oath is religious, where you swear by God to tell the truth. An affirmation is non-religious and you “affirm” that you will tell the truth.
* Your promise to tell the truth is a serious undertaking. It is possible for criminal charges to be laid against you if you are found to have lied in court.
* You will be asked questions about your statement/s by the counsel assisting, the coroner, lawyers and perhaps also by interested persons.
* Answer clearly and without rushing, to the best of your knowledge and memory. The coroner will probably make notes as you talk.
* If you speak to the coroner directly, please refer to them as ‘Your Honour’.
* If you do not know or remember something, it is fine to say you do not know or remember.
* You may have been asked to bring items or documents with you, or to supply them in advance. These items or documents may be shown to you during your evidence so that you can tell the court what they are and answer any questions about them.
* If all your evidence cannot be given in one sitting, you may be asked to return to finish it at a particular time on the same day, or on another day or days.

#### After court

* Once you have finished giving your evidence, you are allowed to stay in the courtroom and listen to the proceedings if you like.
* You are welcome to leave as soon as you have given your evidence if you prefer.
* Please let the coroner’s court know if you would like to be told when the findings are ready.
* Evidence you give in an inquest cannot be used against you later in a criminal / civil proceeding, except if you are prosecuted for perjury (perjury is lying when you give your evidence, Act s 54).

If you want more information on the risks and possible consequences of giving evidence at an inquest, please seek legal advice. For a list of legal services, please go to ‘A Guide for Families and Friends: Who can help? - Legal help’.

### How long will this take?

Coronial investigations take months or sometimes years to be finalised. The coroner has to wait for expert reports to be written, medical tests to be conducted and all the evidence to be gathered. The more complex the matter is, the longer the investigation will take and the more likely it is that there will be an inquest. In a case where there is an inquest, witnesses must be arranged, court time has to be allocated and lawyers need time to look at all the evidence.

We understand that waiting is very hard for families and friends, especially when you do not know what happened to your loved one or cannot find out if their death could have been avoided. The coroner will work hard to get answers for you as soon as they are able. The coroner cannot issue any ‘preliminary’ or ‘draft’ reports. They can only hand down their findings once they have had time to consider all the evidence and make sure that everything has been done.

### Equity and diversity

The coroner’s court is committed to providing equal access to justice to all members of society. We are committed to providing a service free from discrimination, which respects all people equally regardless of age, sex, sexuality, gender identity, ethnicity, religious belief or any other social or personal attribute. If there is something we can do to help you participate equally in the coronial process, please let us know.

The coroner’s court is a division of the Magistrates Court of Tasmania, which is in turn a part of the Department of Justice of the Tasmanian Government. The Magistrates Court ‘Code of Ethics of the Non-judicial Officers of the Magistrates Court of Tasmania’ covers all our professional conduct and requires impartiality, personal integrity and prohibits harassment (including of a sexual, verbal, physical or psychological nature).

For more information, refer to the Code of Ethics of the Non-judicial Officers of the Magistrates Court of Tasmania (which is available on the Magistrates Court web site) and [State Service Code of Conduct](http://www.thelaw.tas.gov.au/tocview/index.w3p;cond=;doc_id=85%2B%2B2000%2BGS9%40EN%2B20160906000000;histon=;pdfauthverid=;prompt=;rec=;rtfauthverid=;term=;webauthverid=) for Tasmania (which is available on the Tasmanian Legislation web site).[[127]](#footnote-127)

### Feedback

If you wish to provide positive or negative feedback on the coroner’s court please send it to us at Coroners.Hbt@justice.tas.gov.au, or write us a letter or call us. You can also send your feedback to the [Department of Justice](http://www.justice.tas.gov.au/contact)[[128]](#footnote-128) or complain to the [Ombudsman](http://www.ombudsman.tas.gov.au/)[[129]](#footnote-129) if you prefer.

## Practical matters

### Identification of the deceased person

A deceased person can be identified by any person who knew them in life. In some cases, a family member or friend will be asked to identify the deceased person for the coroner.

For more information, please go to ‘A Guide for Families and Friends: The first 24 hours’.

### Viewing and touching the deceased person

If you agree to identify the deceased person, then you will look at them very early in the investigation. At this point, a police officer will go with you and you will not be allowed to touch the deceased person.

After the initial part of the investigation, you can arrange with the funeral home to view the deceased person for the first time or again.

For some people it is a very important part of the grieving process to view or touch their deceased loved one. Others do not wish to do so. Both are perfectly normal and understandable responses to the shock of sudden death.

* It is recommended that all viewings are arranged with the funeral home. At a funeral home you will not be rushed. You can take support people with you and spend your time with the deceased person in soothing surroundings. The way people look changes after death and funeral homes are able to provide cosmetic services that can make viewing the deceased person more comforting.
* In special cases, the coroners’ office may authorise a viewing of the deceased person before they are released from the Royal Hobart Hospital or the Launceston General Hospital.
* If you are viewing the deceased person at the hospital, it is important to remember that mortuaries cannot provide the kinds of cosmetic services that funeral homes can to make the deceased person look more life-like.
* If the coroner has not yet made an order releasing the deceased person, then you might not be able to touch them as evidence may still be being gathered.
* If there are health risks involved in touching the deceased person, you may not be able to touch them.

### Funeral arrangements

* It is usual for the deceased person to be released to the funeral director who has been contracted by the senior next of kin.
* The law which includes who the deceased person is released to is known as probate law and the coroner does not control this. If there is a dispute about who the deceased person should be released to, you will need to apply to the Supreme Court.
* You are welcome to start making funeral arrangements as soon as you want, but it may be better not to set a date for the funeral until you are notified that the deceased person is ready to be released (either by the coroner’s court or by your funeral director).
* You can choose any funeral director you like and arrange a service that you feel is most suited to you and your family. It is a good idea to contact a funeral director early on, let them know that the coroner is involved and ask them what services they provide.
* A contract to provide a funeral is usually a contract between the funeral director and the senior next of kin, or an available responsible person. By signing a contract with a funeral director you are undertaking responsibility for the funeral expenses. If you wish for the funeral account to be sent to a solicitor, for others to contribute to the funeral, or if you are not sure if you can cover the full cost, you should seek some legal advice before signing an agreement.
* The coroner’s court is not able to recommend a funeral director for you to use. Information and contact details for funeral directors in Tasmania can be found here:
	+ [Australian Funeral Directors Association](http://www.afda.org.au) web site[[130]](#footnote-130)
	+ [Yellow pages – Funeral Directors](http://www.yellowpages.com.au/see/funeral-directors-category)[[131]](#footnote-131)
* There is often a fee involved when the deceased person has to be transported from the mortuary to a funeral home that is a long way from the mortuary.
* If you want advice on how to arrange for the deceased person to be moved to another state or country for burial or cremation, please seek legal advice.

The Department of Health and Human Services manages an Essential Care Funeral Policy to reduce any risks to public health.  The Policy provides for a publicly funded direct committal (a cremation without a service), where the deceased person has not been claimed because they don’t have enough money in their estate to pay for burial / cremation and either:

* there is no one willing to claim the body **or**
* their relatives are unable to claim the body because they cannot pay for burial / cremation.

The Policy is not an assistance package for low-income earners and can only be used when a deceased person is not claimed.  A deceased person is “claimed” when a relative takes responsibility for them and starts to organise a funeral.   At the time of publishing the Handbook this Policy is under review, so the rules may change in the future.

For organisations that provide free legal advice, please go to ‘A Guide for Families and Friends: Who can help? - Legal help’.

### Access to documents

**Access to coronial documents**

If you want to access any of the documents on the coronial file, you can make an application using an online or paper form. You can find the online form ‘Application to Access Coronial Records’ on the Magistrates Court web site, under Forms. Paper forms are available at the coroner’s court.

Useful notes for accessing documents:

* + Any person can make an application to view, access, or receive a copy of a coronial record.
	+ A *coronial record* includes any document on the court file, and any oral evidence or recordings of the inquest if there has been one.
	+ The coroner will only give you access to documents if you have a good reason for wanting to read them. This is to protect the privacy of the people involved, including family members.
* Sometimes it is not possible to give access to certain documents during an active investigation.
* If you need an interpreter (or a translation) to assist you to understand a document, please tell the staff at the coroners’ office and write or have someone help you write that in your application. If the coroner grants you access to documents and approves the use of the interpreter, the court will pay their costs.
* The coroner’s court does not provide Death Certificates. If you want a copy of a Death Certificate, you can contact Service Tasmania (refer to ‘Death Certificates’ below for more information).
* Usually only lawyers can take away copies of coronial documents.
* If you want a copy of a coronial document or a recording of an inquest, you will need to pay a fee.
* In the case of post mortem reports, the coroner will send the copy to a doctor so that the doctor can explain all the medical terms used. The person requesting access to the report gets to choose which doctor they want to use.
* Once you make an application, the coroner will be shown your application and then decide whether to give you access using rule 26 of the *Coroners Rules 2006*.
* It might be upsetting to read some of the documents on the file, especially if you learn things about the death that you did not know beforehand. It might be a good idea to take a support person with you or to arrange to talk to a counsellor afterwards to ‘debrief’. You will not see any photographs unless you ask for them.

**The post mortem report / Provisional Cause of Death**

Within 24 hours of the post mortem examinations, the pathologist will provide the coroner’s court with a ‘Provisional Cause of Death’. This information is then provided to the senior next of kin.

Once the full post mortem report is prepared, family members or close friends may request to have the document sent to a general practitioner (GP) or other medical practitioner of their choice. This allows a medical professional to explain the medical terminology used by pathologists to families / friends. Medical practitioners also have free access to interpreting services, if you need an interpreter to help you understand the post mortem report.

A full post mortem report may take many months to finalise if scientific (toxicological) testing and medical research is also required.

**Coroners’ findings**

Coroners’ findings are sent out to the senior next of kin as soon as they are finalised. Other parties will need to apply to the coroner’s court if they want a copy. Please go to ‘Access to coronial documents’ above for information about making an application. All findings relating to inquests are published, and some findings relating to investigations only are also published. You can find published findings 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).[[132]](#footnote-132)

**Death Certificates**

You can get a copy of the death certificate from Service Tasmania for a fee. If you have contacted a funeral director, then they may get a copy of the certificate for you so always check with them before you pay to get a copy yourself.

* Information on how to find the [Service Tasmania shop closest to you](http://www.service.tas.gov.au/about/shops/)[[133]](#footnote-133) and on how to [apply for a death certificate](http://www.justice.tas.gov.au/bdm/deaths/applyforcertificate)[[134]](#footnote-134) is available online, or you can phone Service Tasmania and ask.
* Service Tasmania: 1300 135 513
* You may only be able to get an ‘interim death certificate’ while the coronial investigation is still going. This certificate may not be accepted by banks and other organisations, so check whether they will accept it before you apply.
* If you do get an interim death certificate, it will say ‘incomplete registration – cause of death subject to coronial inquiry’. Once the coronial investigation is finished, Births, Death and Marriages can swap the interim death certificate for a standard death certificate.

### Items taken by police

There are two types of items taken by police for a coronial investigation: (a) items taken for safekeeping and (b) items taken as evidence.

All such items taken by police are held at the ‘police property store’ at the relevant police station (usually Hobart or Launceston). If the police take items for *safekeeping* (for example, a deceased person’s wallet or keys) these can be returned to families and friends very quickly. Sometimes items such as clothing may be disposed of if they are soiled, damaged or wet, or if occupational health and safety could be negatively affected. If the police take something as *evidence* for the investigation, it stays in the custody of the coroner until their findings are complete.

In some situations, the coroner can make orders allowing *evidence* to be returned to its owner before the findings are finished. Unless an order like this is made, all evidence has to stay with the police. If the coroner does make an order returning evidence (an order for ‘care and control’), then any item returned cannot be modified or sold until the investigation is finished. For example, if a laptop is returned to you this way, you cannot lend it to someone else or delete files from it.

Once the findings are handed down, the coroner will usually release any evidence taken by police to the senior next of kin. If the evidence is something given to the coroner by a particular person or group for the investigation, it will be returned to that person or group. Unclaimed property is kept for a reasonable time and then disposed of by police. If there is a dispute about who something belongs to, any person can make an application to the coroner to have an item returned to them.

You can find more information on the different types of evidence at inquests in the Tasmanian Coronial Practice Handbook, under ‘Key Elements in the Process: Evidence’.

You can find more information on how to make an application in the Tasmanian Coronial Practice Handbook, under ‘Key Elements in the Process: Applications’ or you can contact the coroner’s court.

### Wills and estates

If you have questions about the will or about the estate of the deceased person, please contact the Executor of the will, or seek legal advice.

If there is a dispute about the ownership of valuables or personal items belonging to the deceased, you will need to contact the Executor of the will or seek legal advice.

If there is no will it is recommended that you seek legal advice, or alternately you may contact the [Public Trustee](http://www.publictrustee.tas.gov.au/) for assistance.[[135]](#footnote-135)

For organisations that provide free legal advice, please go to ‘A Guide for Families and Friends: Who can help? - Legal help’.

The following web site provides useful information: [What to do following a death](https://www.humanservices.gov.au/customer/subjects/what-do-following-death#a2)[[136]](#footnote-136)

### Access to the scene where death (or a fire or an explosion) occurred

**Public place**

If you wish to access a public place, you can attend at any time unless police or the coroner are still conducting investigations at the scene. If the scene is still an active part of the investigation, the police will not let people in until they have gathered all the evidence and made sure everything is safe for the public. You can ask the staff at the coroner’s court to notify you once access to the scene is open.

**Private place**

If the scene you wish to access is a private residence, building or on private property then there are two considerations. First, you need to ensure that access to the scene is not restricted (refer to ‘public place’ above). Second, you will need to seek permission from the owner of the property, or the person leasing the premises if they are being rented. If you are able to contact owner or lessee directly, then you are welcome to do that. If you are unsure who owns the premises, you can [contact the coroner’s court](http://www.magistratescourt.tas.gov.au/contact/coroners_court) and ask them to seek permission for you.

You can find information on how to make an application to access a restricted scene, in the Tasmanian Coronial Practice Handbook, under ‘Key Elements in the Process: Applications’.

## How can I give information to the coroner?

### In an investigation

If the coroner is holding an investigation, it is their duty to locate as much information as they can to enable them to make accurate findings.

If you have relevant information that will assist the coroner in the investigation process, please send it to the coroners’ office. You can write the information down in an affidavit or a statutory declaration (available on the Magistrates Court web site, under [Forms](http://www.magistratescourt.tas.gov.au/forms)[[137]](#footnote-137)) and send it to the coroners’ office. Please also send a letter that gives your contact details, states your relationship to the deceased person and explains why you think that the information is important to the investigation. If you are unsure about how to fill out the affidavit or statutory declaration form, the staff at the coroner’s court or the Magistrates Court can assist you.

You are also able to:

* provide a document explaining how the loss of the deceased person has affected you and your family
* provide the name and contact details of anyone that you think the coroner’s court should contact about the matter
* send any reports, documents or other evidence to the coroners’ office for the coroner to consider.

### In an inquest

Families have an important role in an inquest. They can provide valuable information about the circumstances of the death or the deceased person’s medical history. They provide insight into who the deceased person was, giving the inquest another layer of meaning. Families and friends can be directly involved in inquests in a number of ways:

* by keeping in contact with the coroner’s court (to know what is happening)
* by sending information / suggested recommendations / prepared statements to the coroner
* by attending the inquest and watching the proceedings.

If you are the senior next of kin or if you are an interested person, you will have the opportunity to be more involved in the inquest process:

* You can have a lawyer speak for you at the inquest (and ask questions, cross-examine witnesses, tender evidence and make submissions).
* If you cannot hire a lawyer or do not want to, you can speak in court for yourself. You can also make an application before the inquest to have a person who is not a lawyer speak for you.
* There are often many matters to organise before an inquest. The coroner will usually have a case management conference before the inquest to talk about any issues that might come up at the inquest or that need to be organised beforehand. Families, lawyers and some professionals will be invited to come to the conference.
* You may want to have input into what issues should be raised at the inquest or which witnesses should be called. These matters will be discussed at a case management conference.
* Interested persons have the right to call witnesses to give evidence at inquests but the coroner has the final say on which witnesses will talk at the inquest.
* Only the coroner has the power to “summons” a witness to court, which is a legal order that means they have to attend or risk being arrested. Because only the coroner can use this power, if you want someone to give evidence it is better to ask the coroner to summons them than to call them yourself. To make this request to the coroner, write to the coroners’ office or raise the matter at a case management conference.
* You are welcome to call or write to the coroner’s court prior to the inquest to make any suggestions or to provide any information. If you do write to the court, please include your contact details, your relationship to the deceased person and why you think that the information is important to the investigation.

#### How to give oral evidence

Oral evidence is telling the coroner in court about what happened and answering questions, usually based on a written statement or affidavit.

For more information on the court process and what to expect if you are giving evidence, please go to ‘A Guide for Families and Friends: The coroner’s court and me – I’m a witness at the inquest, what does this mean?’

You can find information on how to question a witness in court in the Tasmanian Coronial Practice Handbook, under ‘Key Elements in the Process: Representing an interested person at an inquest’.

#### How to give evidence in a statutory declaration or an affidavit

Under rule 19, the coroner has the power to accept evidence given by deposition or affidavit. It may be possible to give your evidence to the court by writing down what you wish to say in these documents, instead of by giving oral evidence in court. Coroners usually prefer oral evidence because it allows the person giving the evidence to be questioned, so that the details in their statement can be explored. A coroner may still allow evidence to be given in deposition or affidavit form if the evidence is not in dispute. If you want to give your evidence this way, please write a letter explaining why you wish to give your evidence in this way and discuss it with the coroners’ office staff.

#### How to tender a document in court

To “tender” a document is to present it in court so that the coroner can decide if it should be included in the official evidence (“admitted”). In court, the counsel assisting or coroner’s associate will tender the documents on the coronial record for the coroner to consider.

If you have a document that contains relevant information on a matter before the coroner, please post or email it to the coroner’s court before the inquest. Documents can include medical records, financial records, reports, guidelines, regulations or any other record. Sometimes parties may want to provide an expert report to the court that they have sourced and paid for themselves.

Depending on your role in the investigation, you might be able to tender the document yourself at the inquest instead of sending it to the court beforehand. If you are permitted to tender documents at the inquest, the best way to do this is to hand them to the counsel assisting or coroner’s associate and explain what they are and why they are important. The coroner will then decide if the document will be a part of the official evidence. It is always better to show the document to court staff some time before the inquest so that the coroner does not see the document for the first time in the middle of the inquest.

#### How to call a witness

Only interested persons can call witnesses to attend court. To find out if you are an interested person, please [contact the coroner’s court](http://www.magistratescourt.tas.gov.au/contact/coroners_court).

To call a witness to attend court, you should write down the place, date and time when you want the witness to attend court and give this notice to the witness. The notice should be given to the witness in person, or left at their house. It is always best to hand the notice to the witness, or arrange for someone else to do this, if possible.

#### How to tender a physical exhibit

If you are an interested person, you can tender a physical exhibit (such as a photograph or a piece of clothing) in the same way as you would a document.

The counsel assisting the coroner or coroner’s associate will tender all of the physical exhibits on the coronial file and also any that have been kept at the police station. Interested persons are usually able to view these items before the inquest and can ask questions about them in court.

# 5. Other

**The sections in this chapter are:**

* How to contact the coroner’s court
* Legislation
* Fees
* Forms
* Glossary
* Bibliography

## How to contact the coroner’s court

The coroner’s court is a division of the Magistrates Court of Tasmania (sometimes called the Coronial Division). It is part of the Department of Justice, Tasmania and can be found through the Magistrates Court web site and phone numbers, or contacted directly using the contact details below.

The coroner’s court can assist you with the following services:

* explaining coronial investigations
* explaining inquests
* explaining legal and medical terminology
* arranging access to coronial documents
* assisting with contacting counsellors and other grief specialists
* providing assistance for people with disability and diverse needs
* arranging administrative matters
* arranging interpreters for inquests
* general enquiries.

The Magistrates Court (including the coroner’s court) is wheelchair accessible.

#### Coroner’s court - Southern Tasmania

27 Liverpool Street, Hobart, 7000

(03) 616 57132 (administrative)

(03) 616 57127 (coroners’ associates)

Property Office

(03) 6230 2277

#### Coroner’s court - Northern Tasmania

73 Charles Street, Launceston, 7250

(03) 677 72920

Property Office

(03) 6336 3818

**Whole of Tasmania**

After hours contact police on: 131 444

Fax: (03) 6173 0221

Email: Coroners.Hbt@justice.tas.gov.au

**Web sites**

[Magistrates Court](http://www.magistratescourt.tas.gov.au/divisions/coronial)[[138]](#footnote-138)

The [Coroner’s court](http://www.magistratescourt.tas.gov.au/about_us/coroners) section of the Magistrates Court web site.[[139]](#footnote-139)

## Legislation

The main legislative framework for the coroner’s court is found in the following Tasmanian legislation:

* + [*Coroners Act 1995*](http://www.thelaw.tas.gov.au/tocview/index.w3p;cond=;doc_id=73%2B%2B1995%2BAT%40EN%2B20160707000000;histon=;pdfauthverid=;prompt=;rec=;rtfauthverid=;term=;webauthverid=) (Tas)
	+ [*Coroners Rules 2006*](http://www.thelaw.tas.gov.au/tocview/index.w3p;cond=;doc_id=%2B51%2B2006%2BAT%40EN%2B20160707000000;histon=;pdfauthverid=;prompt=;rec=;rtfauthverid=;term=;webauthverid=) (Tas)
	+ [*Coroners (fees, expenses and allowances) Regulations 2016*](http://www.thelaw.tas.gov.au/tocview/index.w3p;cond=;doc_id=%2B37%2B2016%2BAT%40EN%2B20160707110000;histon=;pdfauthverid=;prompt=;rec=;rtfauthverid=;term=;webauthverid=) (Tas)

Note: the *Coroners Regulations 1996* and *2006* have been repealed.

Information from the relevant sections of the legislation above has been incorporated into the body of this document.

There are sections relevant to the coroner’s court contained in other legislation, including but not limited to:

* *Births, Deaths and Marriages Registration Act 1999* (Tas)
	+ s 32 – deaths to be registered under this Act
	+ s 34 – circumstances in which death not to be registered
	+ s 35 – notification of death by doctor
	+ s 36 – notification by coroner
	+ s 37 – notification by funeral director
* *Burial and Cremation Act 2002* (Tas)
	+ s 38 – exhumation of human remains
	+ s 39 – reopening of graves
	+ s 40 – use of Aboriginal land for Aboriginal cremations
	+ s 41 – interment otherwise than in cemetery
	+ s 42 – disposal of human remains at sea
* *Burial and Cremation Regulations 2015* (Tas)
* *Corrections Regulations 2008* (Tas)
	+ s 30 – procedure on death of a prisoner or detainee
* *Human Tissue Act 1985* (Tas)
	+ s 3 – interpretation
	+ s 23 – authority to remove tissue where body of deceased at a hospital
	+ s 24 – authority to remove tissue where body of deceased not at a hospital
	+ s 26B – authority to perform non-coronial autopsy
	+ s 26C – removal of tissue during non-coronial autopsy
	+ s 28A – consent by coroner
	+ s 30 – offences
* *Magistrates Court Act 1987* (Tas)
	+ s 15 – arrangement of business of courts, and administrative matters
	+ s 15AE – committee may make rules of court
* *Obstetric and Paediatric Mortality and Morbidity Act 1994* (Tas)
	+ s 6A – information to coroner
* *Promissory Oaths Act 2015* (Tas)
	+ s 10 – coroner
* *Supreme Court Civil Procedure Act 1932* (Tas)
* *Supreme Court Rules 2000* (Tas).

## Fees

Please note that some of the applications / requests you make to the coroner’s court will involve the payment of a fee.

If you are unable to pay the fee, you may apply to the coroner to “waive” some or all of the fee so that you do not have to pay, or you pay less. To request that a fee be waived, you will need to write to the coroner’s court and provide all relevant information on the application, your financial situation and your ability to pay.

A copy of the coroner’s findings will automatically be sent to the senior next of kin at no cost.

The current fees for the coroner’s court are located on the Magistrates Court web site, under [Fees](http://www.magistratescourt.tas.gov.au/fees).[[140]](#footnote-140)

**As at the time of publication (July 2016 – July 2017):**

|  |  |
| --- | --- |
|  |  |
| Fee for a copy of any other document relating to an investigation or inquest (each page) | 1.53 |
| Fee for a copy of coroner's findings (each page) | 1.53 |
| Fee for a copy of post mortem report (each page) | 1.53 |
| Fee for a copy of any other document relating to an investigation or inquest (each page) | 1.53 |
| Transcript (each page)   (a) if the Court does not require a transcript | 3.06 |
|    (b) if the Court does require a transcript | 1.53 |
| Fee for a copy of audio recording of proceedings (each disc or tape) | 30.60 |

**Coroners (Fees, Expenses and Allowances) Regulations 2016:**

**SCHEDULE 1 - Fees, Expenses and Allowances**

**PART 1 - Fees**

|  |
| --- |
|  |
|  |  | **Fee units** |
| 1.   | Copy of coroner's findings  | 1 (per page) |
| 2.   | Copy of post mortem report | 1 (per page) |
| 3.   | Copy of any other document relating to an investigation | 1 (per page) |
| 4.   | Copy of transcript where transcript not required by direction of the court | 2 (per page) |
| 5.   | Copy of transcript where transcript required by direction of the court | 1 (per page) |
| 6.   | Copy of audio recording of proceedings | 20 |

**PART 2 - Expenses and allowances payable to witnesses**

|  |
| --- |
|  |
|  |  | **$** |
| 1.   | Professional or expert witness – |  |
|  | (a) 4 hours or less | 79.50 |
|  | (b) more than 4 hours  | 79.50 + 20.60 for each additional hour or part of an hour |
|  | (c) maximum payable per day (exclusive of any other expenses or allowances payable) | 158.80 |
|  | (d) travelling expenses – |  |
|  | (i) in own motor vehicle | 0.23 (per kilometre) |
|  | (ii) otherwise | Actual expenses incurred |
| 2.   | Other witnesses, if employed – |  |
|  | (a) per day or part of day | 60.00 |
|  | (b) travelling – |  |
|  | (i) in own motor vehicle | 0.23 (per kilometre) |
|  | (ii) otherwise | Actual expenses incurred |
| 3.   | Meal and accommodation allowances | As set by the Tasmanian State Service Award |

**PART 3 - Expenses and allowances payable to certain coroners**

|  |
| --- |
|  |
|  |  | **$** |
| 1.   | For being engaged in, or in connection with, the holding of an inquest – |  |
|  | (a) 2 hours or less |  36.00 |
|  | (b) more than 2 hours  | 36.00 + 18.00 for each additional hour or part of an hour |
| 2.   | For conducting an investigation to determine whether an inquest should be held, when no inquest is in fact held by the coroner conducting the investigation | 20.00 |
| 3.   | For travelling in connection with an investigation – |  |
|  | (a) in own motor vehicle | 0.23 (per kilometre) |
|  | (b) otherwise | Actual expenses incurred |
| 4.   | For meals and accommodation when duties require the coroner to be away from home overnight | The lessor of the following: |
|  |  | (a) actual expenses incurred; or |
|  |  | (b) the meal and accommodation allowance as set by the Tasmanian State Service Award |

## Forms

All forms used by the Magistrates Court and the coroner’s court can be located on the Magistrates Court web site, under [Forms](http://www.magistratescourt.tas.gov.au/forms).[[141]](#footnote-141) These include:

* statutory declaration form
* video link booking form
* witness expenses form
* coroner’s court forms.

All forms used by the Supreme Court of Tasmania can be located on the Supreme Court web site, under [Supreme Court Forms List](http://www.supremecourt.tas.gov.au/practice_and_procedure/forms/sc_forms_1-20).[[142]](#footnote-142)

## Glossary

[*Coroners Act 1995*](http://www.thelaw.tas.gov.au/tocview/index.w3p;cond=;doc_id=73%2B%2B1995%2BAT%40EN%2B20160715000000;histon=;pdfauthverid=;prompt=;rec=;rtfauthverid=;term=;webauthverid=) s 3 - Interpretation

[*Coroners Rules 2006*](http://www.thelaw.tas.gov.au/tocview/index.w3p;cond=;doc_id=%2B51%2B2006%2BAT%40EN%2B20160715000000;histon=;pdfauthverid=;prompt=;rec=;rtfauthverid=;term=;webauthverid=) s 3 - Interpretation

There is a list on the Magistrates Court web site of common [legal words](http://www.magistratescourt.tas.gov.au/glossary)[[143]](#footnote-143)

## Bibliography

**Legislation:**

*Births, Deaths and Marriages Registration Act 1997* (ACT)

*Births, Deaths and Marriages Registration Act 1995* (NSW)

*Births, Deaths and Marriages Registration Act 1996* (NT)

*Births, Deaths and Marriages Registration Act 2003* (Qld)

*Births, Deaths and Marriages Registration Act 1996* (SA)

*Births, Deaths and Marriages Registration Act 1999* (Tas)

*Births, Deaths and Marriages Registration Act 1996* (Vic)

*Births, Deaths and Marriages Registration Act 1998* (WA)

*Births, Deaths and Marriages Registration Regulation 1998* (ACT)

*Births, Deaths and Marriages Registration Regulation 2011* (NSW)

*Births, Deaths and Marriages Registration Regulations 1998* (NT)

*Births, Deaths and Marriages Registration Regulation 2003* (Qld)

*Births, Deaths and Marriages Registration Regulations 2011* (SA)

*Burial and Cremation Act 2002* (Tas)

*Burial and Cremation Regulations 2015* (Tas)

*Coroners Act 1997* (ACT)

*Coroners Act 2009* (NSW)

*Coroners Act 1993* (NT)

*Coroners Act 2003* (Qld)

*Coroners Act 2003* (SA)

*Coroners Act 1995* (Tas)

*Coroners Act 2008* (Vic)

*Coroners Act 1996* (WA)

*Coroners Rules 2006* (Tas)

*Coroners (fees, expenses and allowances) Regulations 2016* (Tas)

*Corrections Regulations 2008* (Tas)

*Human Tissue Act 1985* (Tas)

*Magistrates Court Act 1987* (Tas)

*Obstetric and Paediatric Mortality and Morbidity Act 1994* (Tas)

*Promissory Oaths Act 2015* (Tas)

*Supreme Court Civil Procedure Act 1932* (Tas)

*Supreme Court Rules 2000* (Tas)

**Case Law:**

*Annetts and Anor v McCann and Ors.* (1990) 170 CLR 596

*Attorney General (NSW) v Maksimovich* (1985) 4 NSWLR 300

*Baff v New South Wales Commissioner of Police* [2013] NSWSC 1205

*Barci v Heffey* [1995] VSC 13

*Bilbao v Farquhar* [1974] 1 NSWLR 377 at 388

*Briginshaw v Briginshaw* (1938) 60 CLR 336 at 362

*Campbell v The* *Queen* (1981) WAR 286

*Chief Commissioner of Police v Hallenstein* [1996] 2 VR 1

Claremont Petroleum NL v Cummings (1992) 110 ALR 239

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102. http://www.humanservices.gov.au/customer/subjects/what-to-do-following-a-death [↑](#footnote-ref-102)
103. http://www.maib.tas.gov.au/benefits-and-claims/ [↑](#footnote-ref-103)
104. http://www.maib.tas.gov.au/benefits-and-claims/benefits-available/funeral-death-benefits/ [↑](#footnote-ref-104)
105. http://www.hobartlegal.org.au/ [↑](#footnote-ref-105)
106. http://www.lclc.net.au/ [↑](#footnote-ref-106)
107. http://www.nwclc.org.au/ [↑](#footnote-ref-107)
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111. http://lst.org.au/about/contact-us/ [↑](#footnote-ref-111)
112. http://lst.org.au/public-info/pro-bono-clearing-house/ [↑](#footnote-ref-112)
113. http://www.legalaid.tas.gov.au/ [↑](#footnote-ref-113)
114. http://www.magistratescourt.tas.gov.au/forms [↑](#footnote-ref-114)
115. http://www.justice.tas.gov.au/victims/about/contact [↑](#footnote-ref-115)
116. http://www.safeathome.tas.gov.au/services/legal#courtsupportandliaison [↑](#footnote-ref-116)
117. http://www.salvationarmy.org.au/find-help/court-and-prison-services/ [↑](#footnote-ref-117)
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121. http://www.dhhs.tas.gov.au/service\_information/disability/disability\_services [↑](#footnote-ref-121)
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123. http://www.afda.org.au/ [↑](#footnote-ref-123)
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125. http://www.healthcomplaints.tas.gov.au/ [↑](#footnote-ref-125)
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127. http://www.thelaw.tas.gov.au/tocview/index.w3p;cond=;doc\_id=85%2B%2B2000%2BGS9% 40EN%2B20160906000000;histon=;pdfauthverid=;prompt=;rec=;rtfauthverid=;term=;webauthverid= [↑](#footnote-ref-127)
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129. http://www.ombudsman.tas.gov.au/ [↑](#footnote-ref-129)
130. http://www.afda.org.au [↑](#footnote-ref-130)
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134. http://www.justice.tas.gov.au/bdm/deaths/applyforcertificate [↑](#footnote-ref-134)
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137. http://www.magistratescourt.tas.gov.au/forms [↑](#footnote-ref-137)
138. http://www.magistratescourt.tas.gov.au/ [↑](#footnote-ref-138)
139. http://www.magistratescourt.tas.gov.au/about\_us/coroners [↑](#footnote-ref-139)
140. http://www.magistratescourt.tas.gov.au/fees [↑](#footnote-ref-140)
141. http://www.magistratescourt.tas.gov.au/forms [↑](#footnote-ref-141)
142. http://www.supremecourt.tas.gov.au/practice\_and\_procedure/forms/sc\_forms\_1-20 [↑](#footnote-ref-142)
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