# 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).[[1]](#footnote-1) 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/)[[2]](#footnote-2)
* [Births, Deaths and Marriages](http://www.justice.tas.gov.au/bdm)[[3]](#footnote-3)
* [Chief Forensic Psychiatrist](http://www.dhhs.tas.gov.au/mentalhealth/chief_psychiatrist)[[4]](#footnote-4)
* [Child Protection Services](http://www.dhhs.tas.gov.au/children/child_protection_services)[[5]](#footnote-5)
* [Corrective Services](http://www.justice.tas.gov.au/correctiveservices)[[6]](#footnote-6)
* [Department of Health and Human Services](http://www.dhhs.tas.gov.au/)[[7]](#footnote-7)
* [Forensic Science Service Tasmania](http://www.police.tas.gov.au/useful-links/forensic-science-service-tasmania-fsst/)[[8]](#footnote-8)
* hospitals, including:
  + [Royal Hobart Hospital](http://www.dhhs.tas.gov.au/hospital/royal-hobart-hospital)[[9]](#footnote-9)
  + [Launceston General Hospital](http://www.dhhs.tas.gov.au/service_information/services_files/launceston_general_hospital)[[10]](#footnote-10)
  + [Mersey Community Hospital](http://www.dhhs.tas.gov.au/hospital/mersey-community-hospital)[[11]](#footnote-11)
  + [North West Regional Hospital](http://www.dhhs.tas.gov.au/tho/nw/north_west_regional_hospital)[[12]](#footnote-12)
* [Marine and Safety Tasmania](http://www.mast.tas.gov.au/)[[13]](#footnote-13)
* mortuary ambulance contractors
* [Motor Accidents Insurance Board](http://www.maib.tas.gov.au/)[[14]](#footnote-14)
* residential aged care facilities
* [Safe at Home Tasmania](http://www.safeathome.tas.gov.au/)[[15]](#footnote-15)
* [Tasmanian Health Service](http://www.dhhs.tas.gov.au/tho)[[16]](#footnote-16)
* [WorkSafe Tasmania](http://worksafe.tas.gov.au/)[[17]](#footnote-17)

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)[[18]](#footnote-18)
* Attorney-General
* [Australian Aged Care Quality Agency](https://www.aacqa.gov.au/)[[19]](#footnote-19)
* [Australian Defence Force](http://www.defence.gov.au/)[[20]](#footnote-20)
* [Australian Federal Police](https://www.afp.gov.au/)[[21]](#footnote-21)
* [Australian Maritime Safety Authority](https://www.amsa.gov.au/)[[22]](#footnote-22)
* [Australian Transport Safety Bureau](https://www.atsb.gov.au/)[[23]](#footnote-23)
* [Civil Aviation Safety Authority](https://www.casa.gov.au/)[[24]](#footnote-24)
* [Department of Premier and Cabinet](http://www.dpac.tas.gov.au/)[[25]](#footnote-25)
* [Department of Justice](http://www.justice.tas.gov.au/)[[26]](#footnote-26)
* [Director of Public Prosecutions](http://www.crownlaw.tas.gov.au/dpp/about_us)[[27]](#footnote-27)
* [Forensic Mental Health Services](http://www.dhhs.tas.gov.au/service_information/services_files/mental_health_services/forensic_mental_health_service)[[28]](#footnote-28)
* health care professionals
* [Mineral Resources Tasmania](http://www.mrt.tas.gov.au/portal/home)[[29]](#footnote-29)
* port corporations
* radiation health physicists
* shipping companies
* specialist recovery services
* [Tasmania Fire Service](https://www.fire.tas.gov.au/)[[30]](#footnote-30)
* transport inspectors
* [Transport Tasmania](http://www.transport.tas.gov.au/)[[31]](#footnote-31)
* [Unions Tasmania](http://unionstas.com.au/index.php/en/)[[32]](#footnote-32)

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)[[33]](#footnote-33)

The [Tasmanian Emergency Management Plan](http://www.ses.tas.gov.au/assets/files/Plans/State/Tasmanian%20Emergency%20Management%20Plan%20-%20Issue%208.pdf)[[34]](#footnote-34)

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.[[35]](#footnote-35)

## 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).[[36]](#footnote-36)



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).[[37]](#footnote-37)

### 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/)[[38]](#footnote-38) and on how to [apply for a death certificate](http://www.justice.tas.gov.au/bdm/deaths/applyforcertificate)[[39]](#footnote-39) 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).[[40]](#footnote-40) 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).[[41]](#footnote-41)

*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.[[42]](#footnote-42) 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.[[43]](#footnote-43)

#### 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.’* [[44]](#footnote-44)

### 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*.’[[45]](#footnote-45)

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,_Lucille_2016_TASCD_96.pdf)[[46]](#footnote-46)

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,_Judah_2015_TASCD_286_docx.pdf)[[47]](#footnote-47)

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,_Jayden_Craig_2015_TASCD_373.pdf)[[48]](#footnote-48)

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)[[49]](#footnote-49)

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,_Barbara.pdf)[[50]](#footnote-50)

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,_Aidan_Andrew_2016_TASCD_091.pdf)[[51]](#footnote-51)

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)[[52]](#footnote-52)

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_298,299,300,301,302,303.pdf)[[53]](#footnote-53)

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**:[[54]](#footnote-54)

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,_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). [[55]](#footnote-55) 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).[[56]](#footnote-56) 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)).

1. http://www.magistratescourt.tas.gov.au/about\_us/publications [↑](#footnote-ref-1)
2. http://agedcaretas.org.au/ [↑](#footnote-ref-2)
3. http://www.justice.tas.gov.au/bdm [↑](#footnote-ref-3)
4. http://www.dhhs.tas.gov.au/mentalhealth/chief\_psychiatrist [↑](#footnote-ref-4)
5. http://www.dhhs.tas.gov.au/children/child\_protection\_services [↑](#footnote-ref-5)
6. http://www.justice.tas.gov.au/correctiveservices [↑](#footnote-ref-6)
7. http://www.dhhs.tas.gov.au/ [↑](#footnote-ref-7)
8. http://www.police.tas.gov.au/useful-links/forensic-science-service-tasmania-fsst/ [↑](#footnote-ref-8)
9. http://www.dhhs.tas.gov.au/hospital/royal-hobart-hospital [↑](#footnote-ref-9)
10. http://www.dhhs.tas.gov.au/service\_information/services\_files/launceston\_general\_hospital [↑](#footnote-ref-10)
11. http://www.dhhs.tas.gov.au/hospital/mersey-community-hospital [↑](#footnote-ref-11)
12. http://www.dhhs.tas.gov.au/tho/nw/north\_west\_regional\_hospital [↑](#footnote-ref-12)
13. http://www.mast.tas.gov.au/ [↑](#footnote-ref-13)
14. http://www.maib.tas.gov.au/ [↑](#footnote-ref-14)
15. http://www.safeathome.tas.gov.au/ [↑](#footnote-ref-15)
16. http://www.dhhs.tas.gov.au/tho [↑](#footnote-ref-16)
17. http://worksafe.tas.gov.au/ [↑](#footnote-ref-17)
18. http://www.dhhs.tas.gov.au/ambulance [↑](#footnote-ref-18)
19. https://www.aacqa.gov.au/ [↑](#footnote-ref-19)
20. http://www.defence.gov.au/ [↑](#footnote-ref-20)
21. https://www.afp.gov.au/ [↑](#footnote-ref-21)
22. https://www.amsa.gov.au/ [↑](#footnote-ref-22)
23. https://www.atsb.gov.au/ [↑](#footnote-ref-23)
24. https://www.casa.gov.au/ [↑](#footnote-ref-24)
25. http://www.dpac.tas.gov.au/ [↑](#footnote-ref-25)
26. http://www.justice.tas.gov.au/ [↑](#footnote-ref-26)
27. http://www.crownlaw.tas.gov.au/dpp/about\_us [↑](#footnote-ref-27)
28. http://www.dhhs.tas.gov.au/service\_information/services\_files/mental\_health\_services/forensic\_mental\_ health\_service [↑](#footnote-ref-28)
29. http://www.mrt.tas.gov.au/portal/home [↑](#footnote-ref-29)
30. https://www.fire.tas.gov.au/ [↑](#footnote-ref-30)
31. http://www.transport.tas.gov.au/ [↑](#footnote-ref-31)
32. http://unionstas.com.au/index.php/en/ [↑](#footnote-ref-32)
33. http://www.ses.tas.gov.au/h/em [↑](#footnote-ref-33)
34. http://www.ses.tas.gov.au/assets/files/Plans/State/Tasmanian%20Emergency%20Management%20Plan%20-%20Issue%208.pdf [↑](#footnote-ref-34)
35. http://www.anzpaa.org.au/nifs/resources/disaster-victim-identification [↑](#footnote-ref-35)
36. http://www.magistratescourt.tas.gov.au/about\_us/coroners/coronial\_findings [↑](#footnote-ref-36)
37. http://www.magistratescourt.tas.gov.au/about\_us/publications [↑](#footnote-ref-37)
38. http://www.service.tas.gov.au/about/shops/ [↑](#footnote-ref-38)
39. http://www.justice.tas.gov.au/bdm/deaths/applyforcertificate [↑](#footnote-ref-39)
40. http://www.magistratescourt.tas.gov.au/about\_us/coroners/coronial\_findings [↑](#footnote-ref-40)
41. http://www.magistratescourt.tas.gov.au/forms [↑](#footnote-ref-41)
42. http://www.supremecourt.tas.gov.au/practice\_and\_procedure/forms/sc\_forms\_1-20 [↑](#footnote-ref-42)
43. http://www.supremecourt.tas.gov.au/practice\_and\_procedure/fees [↑](#footnote-ref-43)
44. Abernethy, J., Baker, B., Dillon, H. & Roberts, H., *Waller’s Coronial Law and Practice in New South Wales* (LexisNexis Butterworths, 4th ed, 2010 preface xviii). [↑](#footnote-ref-44)
45. Freckelton, I., & Ranson, D., *Death Investigation and the Coroner’s Inquest* (Oxford University Press, 2006), p 548. [↑](#footnote-ref-45)
46. *Inquest into the death of Lucille Gaye Butterworth* 2016 TASCD 096. [↑](#footnote-ref-46)
47. *Inquest into the death of Judah Mattathyahu* 2015 TASCD 286. [↑](#footnote-ref-47)
48. *Inquest into the death of Jayden Craig Field* 2015 TASCD 373. [↑](#footnote-ref-48)
49. *Inquest into the death of Jasmine Rose Pearce* 2015 TASCD 75. [↑](#footnote-ref-49)
50. *Inquest into the death of Barbara Westcott* 2016 TASCD 286. [↑](#footnote-ref-50)
51. *Inquest into the death of Aidan Andrew Dawson* 2016 TASCD 091. [↑](#footnote-ref-51)
52. *Inquest into the death of John Ernest Mansell* 2016 TASCD 001. [↑](#footnote-ref-52)
53. *Inquest into Youth Suicide* 2015 TASCD 298-303. [↑](#footnote-ref-53)
54. Dillon, H. & Hadley, M., *The Australasian Coroner’s Manual,* (The Federation Press, 2015). [↑](#footnote-ref-54)
55. http://www.magistratescourt.tas.gov.au/about\_us/coroners/coronial\_findings [↑](#footnote-ref-55)
56. http://www.magistratescourt.tas.gov.au/about\_us/coroners/coronial\_findings [↑](#footnote-ref-56)