Coroners Court of Victoria

Practice Handbook

A legal practitioner's guide to the coronial system in Victoria

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Acknowledgements

This publication has been supported by a General Grant from the Victoria Law Foundation – www.victorialawfoundation.org.au. The Coroners Court of Victoria greatly appreciates the Victorian Law Foundation's generous funding, without which this handbook would not have been possible.

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State Coroner Judge Jennifer Coate on behalf of the Coroners Court of Victoria would like to thank and acknowledge the following Steering Committee members who wholeheartedly contributed their time, knowledge and experience. This publication could not have been accomplished without their help.

- Iain West – *Deputy State Coroner*
- Adjunct Professor Ray Watterson – *La Trobe University*
- Jason Rosen – *Association for the Prevention of Medical Errors*
- Sergeant David Dimsey – *Police Coronial Support Unit*
- Charandev Singh – *Federation of Community Legal Centres*
- Sara Hinchey – *The Victorian Bar* (nominated by The Victorian Bar)
- Paul McClure – Doogue & O'Brien (nominated by the *Law Institute of Victoria*)
- Dominique Saunders – *Australian Health Practitioner Regulation Agency*
- Elizabeth Kennedy – *Epworth Health Care*
- Lara Wentworth – *Courts and Tribunals Unit, Department of Justice*
- Sarah Gebert – *Courts and Tribunals Unit, Department of Justice*
- Mark Regan – *Victoria Legal Aid*
- Emily Howie – *Human Rights Law Resource Centre*
- Christopher Howse – *Victorian Aboriginal Legal Services*
- Samantha Burchell – *Judicial College of Victoria*
- Judy Leitch – *Chief Executive Officer, Coroners Court of Victoria*
- Dheepna Benoit – *Associate to Judge Coate, Coroners Court of Victoria*
- Sheree Argento – *Publications Officer, Coroners Court of Victoria*

The writers would also like to thank Lorena Guidos, Stephen Kocaj, Scott Anderson, Madeleine Whiteaker and Toby Chandler for their contributions to this handbook.

Raymond Ryczkowski (legal project officer)

Martin Botros (legal policy officer)

Overview

This handbook aims to give legal practitioners greater access to the coronial system by providing detailed information about the jurisdiction. While the handbook has been directed primarily at the legal profession, considerable effort has been put into endeavouring to make the handbook accessible to all readers who have an interest in the jurisdiction.

Disclaimer

This practice handbook is a general guide and should be used as a source of general information only. While every effort has been made to ensure the information here is accurate and reflects the practices and procedures at the time of publication; the law, procedures, practices, contact details and other information may change. Any examples or references referred to in this handbook are solely for illustrative and explanatory purposes and do not in any way whatsoever imply definite and/or determined areas of law, conclusions, recommendations or suggested approaches or other final outcomes. The Coroners Court of Victoria accepts no responsibility for any loss, damage or injury, financial or otherwise, suffered by any person or organisation acting or relying on this handbook.

Published by the Coroners Court of Victoria

November 2011

For further information please contact:
Coroners Court of Victoria
Level 11, 222 Exhibition Street
Melbourne VIC 3000
Tel 1300 309 519

Authorised by Judge Jennifer Coate

Designed by The X Factor Design & Editing Pty Ltd

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About the Coroners Court of Victoria Practice Handbook

This handbook has been developed to guide legal practitioners through the coronial process.
It covers:

- important changes under the *Coroners Act 2008* (Vic)
- jurisdiction of the Coroners Court
- overview of the coronial jurisdiction
- the role of the coroner
- court structure and other key organisations
- reporting of deaths
- preliminary court processes
- medical examinations
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- interested parties
- role of the coroner's assistant
- directions hearings
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- findings, comments and recommendations
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- appeals to the Supreme Court.

The Victorian Parliamentary Law Reform Committee reviewed the *Coroners Act 1985* (Vic) and found there was a general lack of understanding of the true nature of inquisitorial proceedings.[1] Most legal practitioners are generally trained in, and have long experience in, the adversarial system. As a result, this *Coroners Court of Victoria Practice Handbook* ("the handbook") provides a general outline of the coronial process, including the inquisitorial practices and procedures of the Coroners Court ("the court") in conducting investigations and inquests.

The handbook may also help Victorians who are considering representing themselves in a coronial matter and it may be of assistance to health professionals. There is also a further publication titled *Information for Health Professionals* which outlines health professionals obligations. This can be found on the court's website at www.coronerscourt.vic.gov.au.

It is important to remember that aspects of this handbook may cause distress to people who have lost a loved one. Please be mindful of this when relying on, discussing or distributing the contents of this handbook with bereaved families and friends. A separate publication, *The Coroners Process: Information for family and friends*, which deals specifically with the questions and concerns of bereaved families and friends, is available free of charge from our website at www.coronerscourt.vic.gov.au or by calling the court on 1300 309 519.

The handbook incorporates the relevant provisions from:

- the Act
- the *Coroners Regulations 2009* (Vic) and
- the *Coroners Court Rules 2009* (Vic)

These are published in both hard copy and electronically. Hardcopies can be purchased from either Anstat Pty Ltd on (03) 9278 1144 or Information Victoria on 1300 366 356. An electronic copy of each of the Act, the Regulations and the Court Rules can be obtained from the Victorian Legislation and Parliamentary Documents website www.legislation.vic.gov.au. Copies can also be downloaded from the court's website www.coronerscourt.vic.gov.au.

1 Law Reform Committee, Parliament of Victoria, *Inquiry into the Review of the Coroners Act 1985 – Final Report* (2006), 589-592.

Background

In December 2004 the Victorian Parliament Law Reform Committee ("PLRC") received a reference to inquire into and report to Parliament on the effectiveness of the *Coroners Act 1985* and to consider whether this Act provided an appropriate legislative framework for:

- the independent investigation of deaths and fires in Victoria
- making recommendations to prevent deaths and fires in Victoria and to improve the safety of Victorians
- providing support for the families, friends and others associated with a deceased person who is subject to a coronial inquiry.

In particular, the PLRC was required to recommend any areas where the 1985 Act should be amended or modernised to better meet the needs of the community.[2]

The PLRC Report made 138 recommendations for legislative and operational reform, in particular, in relation to:

- the system for reporting deaths to a coroner
- reportable deaths
- death investigation
- a coroner's role in death and injury prevention
- the needs, rights and support of bereaved families and others in the coronial system.

The commencement of the new *Coroners Act 2008* (Vic) ("the Act") on 1 November 2009 represents one of the most significant reforms of the Victorian coronial system since its inception in 1865 and anticipates creating a new modern coronial system for all Victorians. The Act provides for the independent investigation of deaths and fires and aims to reduce the number of preventable deaths and fires across the State. See "1. Jurisdiction of the Coroners Court".

As a result of the new legislation, the State Coroners Office has been replaced with the Coroners Court of Victoria. The new Act establishes the court as Victoria's first inquisitorial court with a key focus on reducing preventable deaths (ss 109, 110). A Coronial Council has also been established to provide advice and make recommendations to the Attorney-General in relation to a number of matters (s 110) including:

- issues of importance to the coronial system in Victoria
- matters relating to the preventative role played by the court
- the way in which the coronial system engages with families and respects the cultural diversity of families
- any other matters relating to the coronial system that are referred to the Coronial Council by the Attorney-General.

With an aim of promoting a coronial system that is more transparent and accessible to the Victorian community, the requirements of the new Act recognise the serious and important contributions the coronial system makes to public health and safety and the administration of justice.

Key changes in the new Act include:

- In addition to making recommendations to "any Minister or public statutory authority" a coroner may make recommendations to any "entity" on any matter connected with a death or fire (s 72).
- Any public statutory authority or entity receiving a coroner's recommendations must now respond in writing within three months, indicating what action (if any) will be taken in relation to the recommendations (s 72).
- All findings, comments and recommendations made following an inquest and responses to recommendations must be published on the internet, unless otherwise ordered by a coroner (s 73). This is the first time in Victorian coronial history that a requirement to publish inquest findings has been enshrined in legislation.

For further information regarding these changes please refer to "*Coroners Act 2008* – What has changed?". This can be found on the court's website at www.coronerscourt.vic.gov.au

2 Law Reform Committee, Parliament of Victoria, *Inquiry into the Review of the Coroners Act 1985 – Final Report* (2006).

Coroners Act 1985 ("Transitional Provisions")

The title of the *Coroners Act 1985* was changed to the *Victorian Institute of Forensic Medicine Act 1985* by virtue of section 120 of the new Act on 1 November 2009.

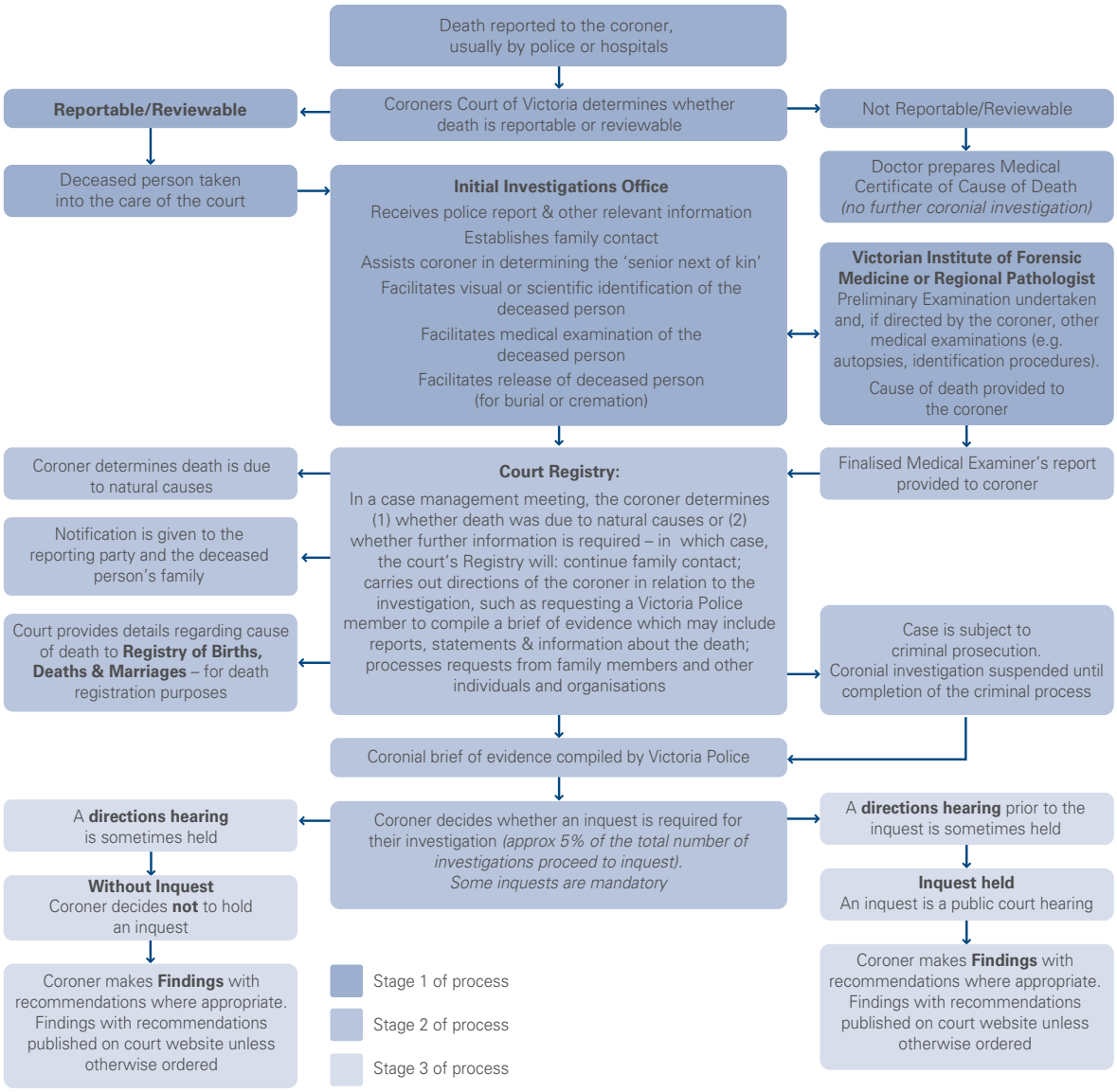
Schedule 1 to the new Act contains saving and transitional provisions. For example, clause 7 of the Schedule contains provisions relating to inquests that had commenced under the previous *Coroners Act 1985*.

Overview of the coronial process

The coronial system entails a number of steps from the time a death or fire is reported to the court until the time the investigation is complete.

Figure 1, below, provides an overview of the general coronial investigation under the Act.

Figure 1: overview of the coronial process




CORONERS
COURT

1. Jurisdiction of the Coroners Court

The Coroners Court of Victoria ("the court") is established by Division 1, Part 8 of the *Coroners Act 2008* ("the Act").

The Act makes it clear that the court is a "specialist inquisitorial court" (ss 1, 89).

The Attorney-General stated that the purpose of the inquisitorial Court is to ensure:

> that coroners operate independently of the executive and can effectively investigate deaths without the coronial system becoming too adversarial.[3]

1.1 Preamble to the Act

The Preamble provides:

> The coronial system of Victoria plays an important role in Victorian society. That role involves the independent investigation of deaths and fires for the purposes of finding the causes of those deaths and fires and to contribute to the reduction of the number of preventable deaths and fires and the promotion of public health and safety and the administration of justice.
>
> This role will be enhanced by creating a Coroners Court and setting out the role of the Coroners Court and the coronial system and the procedures for coronial investigations.[4]

1.2 Purposes of the Act

The purposes of the Act, outlined in Part 1, include:

- to require the reporting of certain deaths
- to provide for coroners to investigate deaths and fires in specified circumstances
- to contribute to the reduction of the number of preventable deaths and fires through a coroner's investigation of deaths and fires, and the making of findings and recommendations
- to establish the Coroners Court of Victoria as a "specialist inquisitorial court" and
- to establish the Coronial Council of Victoria.

1.3 Objectives of the Act

The Act contains a set of objectives (in Part 2) that seek to ensure the coronial system:

- avoids unnecessary duplication of inquiries and investigations and expedites the investigation of deaths and fires
- acknowledges the distress of families and their need for support following a death
- acknowledges the effect of unnecessarily lengthy or protracted investigations
- acknowledges and respects that different cultures have different beliefs and practices surrounding death
- acknowledges the need for families to be informed about the coronial process and the progress of an investigation
- acknowledges the need to balance the public interest in protecting a person's information and the public interest in the legitimate use of that information
- acknowledges the desirability of promoting public health and safety and the administration of justice
- promotes a fairer and more efficient coronial system.

1.4 Purpose of the coronial jurisdiction

In accordance with the Preamble to the Act, the role and purpose of the coronial jurisdiction includes:

- carrying out independent investigations into a range of deaths and fires defined by the Act[5]
- assisting families of the deceased person to understand what happened to their loved one
- giving the community an understanding of what happened
- examining the question of whether there were any shortcomings, gaps or failures in an organisation's system that contributed to a death or fire
- promoting public health and safety and the administration of justice
- setting the public mind at rest where there are unanswered questions about a reportable death.[6]

3 Rob Hulls, Attorney-General, Coroners Bill 2008 (Vic), *Second Reading Speech*, 9 October 2008, 4037.
4 *Coroners Act 2008* (Vic), Preamble.
5 See "4. Reporting of deaths", below, for further information.
6 *Domaszewicz v State Coroner* [2004] VSC 528, 28 (Ashley J).

1.5 A specialist and inquisitorial court

Parliament has created the court as a "specialist court" (s 1(d)).

The Act also clearly defines the court as an "inquisitorial court" (s 89(4)). As a result, coronial investigations and inquests (public inquiries) are not conducted in the same adversarial manner as criminal and civil trials. Rather, the primary objectives of coronial investigations and inquests are to determine the facts and circumstances relating to the death or fire and, where appropriate, to make recommendations to prevent similar deaths or fires.

Figure 2, below, provides a brief comparison of the adversarial and the coronial inquisitorial systems.

In this specialist inquisitorial coronial system, a Victorian coroner's role may include:

- conducting all parts of the investigation
- shaping and controlling the issues of the investigation
- having the ability to ask questions
- issuing warrants
- instructing police on enquires to be made
- requiring witnesses to answer questions even if the answers may be incriminating to the witness
- obtaining reports from experts
- discussing cases with investigators and witnesses.

1.6 Practising in the coronial jurisdiction

Legal practitioners practising in the Victorian coronial jurisdiction have a primary duty to the court. They must reconcile this primary duty with their other obligations, including those to a client, such as confidentiality and acting in the client's best interest.

As previously explained, there are many differences between inquisitorial and adversarial systems. Practice in an inquisitorial system requires awareness of these differences and a need to adopt appropriate measures to suit this type of forum. For example, practice in a coronial inquisitorial process involves a coroner steering the course of proceedings (such as determining the issues to be explored and the witnesses to be called). However, in the adversarial system this is generally the role of the respective parties. Although the Act permits submissions by interested parties that may, for example, suggest to a coroner a particular route of inquiry, a coroner makes the final decision.

The coronial jurisdiction does not determine legal rights or obligations. Rather, it makes, where possible, findings of facts related to a death or fire and, where appropriate, comments and recommendations. Consequently, the outcome of coronial proceedings does not depend on parties contesting legal arguments and providing

Figure 2: comparison of the adversarial and inquisitorial systems

Features of the adversarial system	Features of the coronial inquisitorial system (under the *Coroners Act 2008*)
Minimum intervention by the decision-maker	Unlimited intervention by a coroner to advance the inquiry
Parties define the issues	Coroner determines the relevant issues (s 64)
Parties define what evidence they will put before the judge	Coroner determines witnesses to be called, issues to be explored and evidence to be produced (ss 55, 64)
Not a search for what happened	An inquiry into what happened and, where appropriate, to make recommendations in order to contribute to the reduction of the number of preventable deaths and fires and the promotion of public health and safety and the administration of justice (Preamble)
Proceedings are formal	Inquest conducted with as little formality as the interests of justice permit (s 65)
Bound by rules of evidence	Coroner is not bound by rules of evidence (s 62)

contradicting evidence. Legal practice in this jurisdiction requires an appreciation of the court's distinctive nature, purposes and objectives.

The inherent nature of the coronial investigation encompasses sensitive aspects that can affect family members of a deceased person whose death is being investigated. For example, the evidence introduced into an investigation and/or inquest may be distressing for families, such as when they hear in court for the first time the replay of a call made to emergency services.

So too, some witnesses who are involved with a coronial inquiry find it inherently stressful. For instance, witnesses may have developed strong working relationships and emotional connections with the deceased person and their family, and will experience emotions such as grief and loss at the time of their death which is then exacerbated by their involvement in the inquest.

As a result, collaborative efforts by all parties involved in investigations and/or inquests need to be attuned to exercising an appropriate, courteous, sensitive and respectful manner in the proceedings.

The Victorian Charter of Human Rights

The *Charter of Human Rights and Responsibilities Act 2006* (Vic) ("the Charter") may be relevant to coronial investigations in a number of ways. Section 4(1)(j) of the Charter provides that "[f]or the purposes of the Charter a public authority…does not include…a court or tribunal except when it is acting in an administrative capacity"[7]. Accordingly, coroners acting in an administrative capacity must not act in a way that is incompatible with a human right. Furthermore, coroners acting judicially are bound to interpret statutory provisions in a way that are compatible with human rights.

For further reading, see *R v Momcilovic* [2010] VSCA 50.

7 The meaning of "administrative capacity" is primarily a question of statutory construction and is to be distinguished from judicial capacity.

2. The role of a coroner

The role of a coroner is to investigate certain deaths and fires to determine how and why they happened and to help prevent similar deaths and fires from occurring.

A coroner is not a medical examiner. Rather, a coroner is an investigator, fact-finder and analyst who relies on a range of experts such as medical and forensic scientists, engineers, chemists, mental health experts, and so on, depending on the circumstances surrounding the death being investigated.

If possible, a coroner investigating a death must find:

- the identity of the deceased person
- the cause of death
- the circumstances in which the death occurred and
- the particulars needed to register a death with the Registry of Births, Deaths and Marriages (s 67(1)).

However, a coroner is not required to make a finding with respect to the circumstances in which a death occurred if an inquest into the death was not held and:

- the deceased was not, immediately before they died, a person placed in custody or care and
- there is no public interest to be served in making a finding regarding those circumstances (s 67(2)).

A coroner investigating a fire must find, if possible, the cause and origin of the fire and the circumstances in which the fire occurred (s 68).

Consistent with their prevention role, a coroner looks for any inherent failures in systems that contributed to a death or fire and suggests measures that can be implemented to avoid a similar death or fire from occurring in the future.

2.1 Holding inquests

Coroners hold inquests only in a small number of cases. Approximately 5–6% of investigations lead to an inquest. See "11. Inquests", for further information.

2.2 Providing comments and recommendations

A coroner may comment on any matter connected with a death, including matters relating to public health and safety or the administration of justice (s 67(3)). A coroner may also make recommendations to any Minister, public statutory authority or entity on any matter connected with a death or fire that a coroner has investigated, including recommendations relating to public health and safety or the administration of justice (s 72(2)).

See "12. Findings, comments and recommendations", below, for further information.

2.3 No determination of liability or guilt

The task of a coroner is not to determine whether someone is entitled to a legal remedy, is liable to another or whether a person should face civil, criminal or disciplinary proceedings.[8]

Moreover, a coroner does not have the jurisdiction to commit a person for trial and must not produce a finding containing a statement that a person is or might be guilty of an offence (s 69(1)). A coroner's function also does not extend to gathering evidence in the preparation of possible criminal proceedings.

However, if a coroner believes an indictable offence may have been committed in connection with a death or fire, then they can refer a case to the Director of Public Prosecutions (s 49).

See "12. Findings, comments and recommendations" for further information.

2.4 Appointment of coroners

In Victoria there are currently nine full-time coroners, including the State Coroner and Deputy State Coroner.

As required under Division 1, Part 8 of the Act:

- the State Coroner is a judge of the County Court who is appointed by the Governor in Council on the recommendation of the Attorney-General made after consultation with the Chief Judge

8 See *R v Doogan* [2005] ACTSC 74, 12.

- the Deputy State Coroner is a magistrate who is appointed by the Governor in Council on the recommendation of the Attorney-General
- coroners are generally magistrates or acting magistrates
- acting coroners are generally Australian lawyers who have been practising for at least five years who are appointed full time for a 5 year term.

Regional coroners

Every magistrate in regional Victoria, once assigned by the State Coroner and Chief Magistrate pursuant to section 93 of the *Coroners Act 2008*[9], has the authority to hold the position of coroner and perform the functions of the court. They have the same investigative powers as metropolitan coroners. However, they perform their coronial duties along with their other work in the adversarial jurisdiction.

Regional coroners hold inquests, usually in their local Magistrates' Court.

Regional coroners enable families and interested parties to have investigations and inquests conducted in an area close to where the deceased person lived, and to investigate any systems issues at a local level.

9 All magistrates who held the office of coroner prior to 1 November 2009 continue to hold their appointment – see clause 16(1) of Schedule 1, *Coroners Act 2008*.

Judge Jennifer Coate,
State Coroner
(2007 to present)

3. Court structure and role of other key organisations

Court structure

The Coroners Court ("the court") comprises of several areas that assist a coroner in their investigation into a death or fire.

3.1 Initial Investigations Office

The Initial Investigations Office (IIO) is a 24 hour, 7 days a week service and takes the initial reports of deaths as well as assists in determining if a death is reportable to the coroner. See "4. Reporting of deaths".

The IIO performs a significant and critical role for families during what can be a very distressing time.

Staff at the IIO assist bereaved family and friends by:

- informing them about the coronial process and their rights
- facilitating viewings and visual identifications if required [10]
- providing them with information regarding medical examinations that may be required (see "6. Medical examinations" for further information)
- liaising with funeral directors (see "5.5. Release of the body" for further information)
- answering any questions they may have about the initial stages of the coroner's investigation
- providing counselling support (see "3.2. Family and Community Support Service" for further information).

Staff at the IIO also seek and provide information to police, funeral directors, treating medical experts and coroners during the initial stages of an investigation.

The IIO's role concludes when a deceased person is released from the court's care.

To speak to the IIO, please contact the court on 1300 309 519.

3.2 Family and Community Support Service

The Family and Community Support Service offers assistance to relatives and anyone else affected by the death and investigation. Such assistance includes:

- free short-term counselling
- support for individuals and families after exposure to a death occurring in traumatic circumstances
- assistance with understanding the court's processes
- providing letters of support; for example, letters to employers and schools.

To speak to the Family and Community Support Service, please contact the court on 1300 309 519.

3.3 Registry

The Registry provides critical administrative and non-judicial support to coroners during the investigation of a death or fire. Registrars are the primary source of information and contact for:

- legal practitioners
- the senior next of kin (or person appointed by the senior next of kin)
- bereaved families and friends
- "interested parties"
- the public
- health services
- health professionals
- Victoria Police
- Victorian Institute of Forensic Medicine
- Victorian Registry of Births, Deaths and Marriages
- government departments and agencies.

In regional Victoria the registrars of the local Magistrates' Courts also perform the duties of a coroner's registrar.

The involvement of the Registry usually begins when a deceased person is released from the court's care (i.e. for burial/cremation). This involvement continues until a coroner makes a finding. In some cases, Registry involvement may continue after a finding has been made and the investigation has been closed.

The Act sets out the following registrar functions:

- on behalf of a coroner, receive information about a death or fire that a coroner is investigating
- administer an oath to a person in relation to a death or fire that a coroner is investigating
- swear an affidavit relating to an investigation by a coroner

10 A family member or somebody who knew the deceased person well at the time of their death may be required to identify the person.

- perform other functions as prescribed by the rules or regulations (s 98). [11]

In addition, registrars:

- obtain medical records and other information on behalf of a coroner, for example, reports from the medical investigator
- process any directions made by a coroner and ensure that relevant people or organisations are advised of them, for example, requesting statements/expert opinions on behalf of a coroner
- list a case for hearing
- advise interested parties when matters are listed for hearing
- ensure any witnesses are issued with a summons to attend court
- act as the bench clerk in court, for example, by reading out witness statements.

Another crucial function performed by registrars is that of providing bereaved families with relevant information on the coronial process as well as status updates at key decision points in the coroner's investigation.

To speak to the Registry, please contact the court on 1300 309 519.

3.4 Coroners Prevention Unit

The Coroners Prevention Unit is a specialist service for coroners. It was created to strengthen their prevention role and to provide coroners with expert assistance by:

- reviewing a range of reportable and reviewable deaths
- collecting and analysing data relating to reportable and reviewable deaths
- assisting in developing prevention-focused coronial recommendations
- monitoring and evaluating the effectiveness of coronial recommendations.

The Coroners Prevention Unit comprises several distinct investigative teams that gather and provide expert information on particular types of deaths. Figure 3, below, outlines these teams and their particular roles.

For further information about the Coroners Prevention Unit, please contact the court on 1300 309 519.

3.5 Publications and Communications Officer

The primary responsibility of the Publication and Communications Officer is to facilitate effective communication with key organisations and to manage media enquiries on behalf of the court.

The Publications and Communications Officer also acts as an intermediary between the media and bereaved families. Among other responsibilities, the role involves:

- attending court hearings to assess media interest in an inquest and assist where required
- providing various forms of assistance to family members where inquests attract media attention

Figure 3: Coroners Prevention Unit's investigative teams and their roles

Investigation team	Role
Unintentional Death Investigation Team	Assists in the investigation and development of recommendations surrounding unintentionally caused deaths – for example, drowning, fires, electrocutions and transport-related fatalities.
Intentional Death Investigation Team	Assists in the investigation and development of recommendations surrounding intentionally caused deaths – for example, suicides and assaults.
Health and Medical Investigation Team	Assists in the investigation and development of recommendations surrounding deaths occurring during the provision of healthcare. They assist in identifying factors that may help improve patient safety and risk management in such settings.
Operational Team	Undertakes specific and targeted projects – for example, developing a surveillance database for retrospective and prospective data capture.

11 See, for example, *Coroners Court Rules 2009* (Vic), rule 66, whereby a registrar may issue a summons requiring a witness to attend the court to give oral evidence or produce any document or other material.

- monitoring news reporting of inquests for accuracy
- providing advice and assistance to the media for the purpose of accurate reporting (such as correct spelling of witness(es) names and of counsel representing interested parties)
- ensuring any order made by a coroner, including a direction to prohibit publication of some or all parts of an inquest, is clearly communicated to the media.

It is also the responsibility of the Publications and Communications Officer to ensure that coroners' findings, recommendations, rulings and suppression orders are published as soon as practicable on the court's website www.coronerscourt.vic.gov.au. See "12. Findings, comments and recommendations" for further information.

To speak to the Publications and Communications Officer, please contact the court on 1300 309 519.

Role of other key organisations

3.6 Victoria Police

The police play an important role in coronial investigations by, for example:

- notifying a coroner of a reportable or reviewable death
- notifying relevant authorities about the death and, where applicable, working alongside such authorities
- collecting information relating to an investigation
- documenting information around the death or fire
- assisting with the identification of the deceased person
- compiling the inquest brief at the direction of a coroner. See "7. Inquest briefs" for further information.

3.7 Police Coronial Support Unit

The court in Melbourne has a dedicated unit called the Police Coronial Support Unit (PCSU), formerly known as the State Coroners Assistant Unit. The PCSU is staffed by members of Victoria Police who assist coroners with their investigations into deaths and fires and provide support to other Victoria Police members who are investigating matters for a coroner. The PCSU may also attend scenes at the request of a coroner.

PCSU staff may attend court to assist coroners at inquests and can help bereaved families with the inquest process if required.

PCSU also provide training, assistance and guidance to regional police prosecutors assisting regional coroners.

See "9. The Coroner's Assistant" for more information on the role of the PCSU.

For further information on the PCSU, see "Useful contacts".

3.8 Victorian Institute of Forensic Medicine

The Victorian Institute of Forensic Medicine conducts medical examinations in relation to deaths on behalf of the court, pursuant to section 66 of the *Victorian Institute of Forensic Medicine Act 1985*, and provides a report to a coroner about the results of those investigations and examinations.

In addition to the services performed for the court, the Victorian Institute of Forensic Medicine also:

- manages the Donor Tissue Bank of Victoria
- provides DNA testing
- provides expert opinions.

For further information on the Victorian Institute of Forensic Medicine, see "Useful contacts".

3.9 Victorian Registry of Births, Deaths and Marriages

Some of the functions of the Victorian Registry of Births, Deaths and Marriages include:

- recording all deaths occurring in the State of Victoria
- providing death and interim death certificates (see "5.11. Death certificates" for further information)
- collecting and disseminating statistical information to authorised agencies.

For further information on the Victorian Registry of Births, Deaths and Marriages, see "Useful contacts".

4. Reporting of deaths

4.1 Obligations to report a death

The deaths which must be reported to a coroner are those that meet the definition of a "reportable" or "reviewable" death (see below). There is a legal requirement under the *Coroners Act 2008* ("the Act") to report such deaths (ss 10–13).

Classes of people who must report a death to a coroner include:

- a medical practitioner who is present at or after a reportable or reviewable death (ss 10, 13)
- a police or prison officer who attempted to take the deceased person into custody (s 11)
- the person who had care, control or custody of a person (s 11).[12]

In addition to those listed above, any person who reasonably believes a reportable or reviewable death has occurred and that the Coroners Court ("the court") has not been advised of that death, must report the death immediately (s 12(1)).[13]

A person who reports a death to a coroner must give the coroner any information or other assistance that the coroner requests for the purpose of their investigation (ss 32–33, 36). The nature of the assistance will depend on the circumstances of the death and may include information relating to events leading up to the death's investigation. For example, a registered medical practitioner who was responsible for a person's medical care immediately before that person's death or who was present at or after the death may be requested by a coroner to give a document (such as a medical deposition form) or to prepare a statement (s 33).

The immediate family of a person who has died may also report the death to a coroner if that person was discharged from an approved mental health service within three months before their death (s 12(2)).

Reportable deaths

The death of a person is a reportable death if:

- the body is in Victoria
- the death occurred in Victoria
- the cause of death occurred in Victoria or
- the person ordinarily resided in Victoria at the time of death (s 4);

and if one of the following criteria applies:

- the death appears to have been unexpected, unnatural or violent or to have resulted, directly or indirectly, from an accident or injury
- the death occurs during a medical procedure or following a medical procedure where the death is or may be causally related to the medical procedure, and a registered medical practitioner would not immediately before the procedure was undertaken have reasonably expected the death
- the death is of a person who immediately before death was placed in custody or care [14]
- the person was a patient within the meaning of the *Mental Health Act 1986* immediately before death
- the person was under the control, care or custody of the Secretary to the Department of Justice or a member of the police force
- the person was subject to a non-custodial supervision order under the *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997*
- the deceased person's identity is unknown
- a notice under section 37(1) of the *Births, Deaths and Marriages Registration Act 1996* has not been signed and is not likely to be signed
- the death occurs outside Victoria where the cause of death is not certified and is not likely to be certified by a person who is authorised to do so in that place
- the death is a death of a prescribed class of person that occurs in prescribed circumstances.[15]

The court must be advised of a reportable death in order for a coroner to investigate. However, whether or not a death is a reportable death, a coroner must discontinue the investigation if the death probably occurred more than 100 years before it was reported to a coroner (s 16).

12 See section 3 of the Act for the definition of "person placed in custody or care". The definition should be read in conjunction with regulation 7 of the *Coroners Regulations 2009* (Vic).
13 Reporting must comply with rules 22 and 23 of the *Coroners Court Rules 2009* (Vic).
14 See section 3 of the Act for the definition of "person placed in custody or care". The definition should be read in conjunction with regulation 7 of the *Coroners Regulations 2009* (Vic).
15 The *Coroners Regulations 2009* (Vic) do not currently contain any prescribed circumstances.

Reviewable deaths

A reviewable death is the death of a second or subsequent child of a parent. A child is anyone under 18 years old. The child must have either died in Victoria or lived in Victoria but died elsewhere.

However, a death of a child is not a reviewable death if:

- the death occurs in a hospital and
- the child was born at a hospital and had always been an in-patient of a hospital and
- the death is not a reportable death.

Who is considered a parent?

In addition to biological parents, parents can include:

- step-parents
- adoptive parents
- foster parents
- guardians
- anyone who has custody or daily care and control of the child
- anyone who has the same rights as a legal parent (s 3).

Why does the court investigate reviewable deaths?

In 2003, following the deaths of four children from one Victorian family within a five-year period, the then Victorian Premier requested a report on the adequacy of the system in place for dealing with multiple child deaths[16].

Accordingly, in 2004 powers were given to coroners to investigate reviewable deaths to:

- find the identity of the child who died
- find the cause of their death and, in some cases, the circumstances
- assess the family's health needs
- assess, with other agencies, the needs of living siblings or any risk to other children.

However, since 2004 it has been noted that many reviewable deaths have involved children who were born in intensive care units and were not expected to survive. These deaths are traumatic for the parents and are not a risk indicator for child protection concerns. Capturing these deaths within the coronial system was an unintended consequence of the system and caused additional grief for families. Therefore the new Act addresses this situation in section 5(2) by excluding a death that occurs in a hospital, if the child was born at a hospital and had always been an in-patient of a hospital.

What happens if a child's death is a reviewable death?

If a coroner has been notified of a reviewable death, then the coroner assesses whether they need to investigate further. The Victorian Institute of Forensic Medicine will perform its functions under the *Victorian Institute of Forensic Medicine Act 1985* if a death is referred by the coroner (s 18).

If a coroner refers a case to the Victorian Institute of Forensic Medicine to investigate, then the court's Family and Community Support Service will contact the family. The Paediatric Liaison Officer at the Victorian Institute of Forensic Medicine may also make contact to assess the family's health and support needs. This may then involve referrals to specialised health or support services or other agencies.

Who tells a coroner about a reviewable death?

Medical practitioners tell the court when they identify a reviewable death. Note, the vast majority of notifications are made by the Registrar of Births, Deaths and Marriages.

If any member of the community has grounds to believe that a reviewable death has not already been reported, then they must also notify the court of the death.

4.2 Still-births

Under the Act, the definition of "death" specifically excludes still-births. Under section 4 of the *Births, Deaths and Marriages Registration Act 1996*, a "still-born child" is defined as "a child of at least 20 weeks' gestation or, if it cannot be reliably established whether the period of gestation is more or less than 20 weeks, with a body mass of at least 400 grams at birth, that exhibits no sign of respiration or heartbeat, or other sign of life, after birth".

4.3 Deaths by natural causes

If the death of a person was unexpected, then it must be reported to a coroner. However, in some situations a medical investigator's[17] preliminary examination[18] may include an opinion that the death was due to natural causes (s 17). A coroner may then determine that, other than the fact that the death was unexpected, the death is not a reportable or reviewable death and further investigation is not necessary (s 17).

In these situations, the coroner will write a finding that determines the identity of the person who died, and the cause of their death. However, the

16 Victoria, *Parliamentary Debates*, Legislative Assembly, 6 May 2004, 1052–1054 (Rob Hulls, Attorney-General).
17 Section 3 of the *Coroners Act 2008* (Vic) defines medical investigator as "the Institute [the Victorian Institute of Forensic Medicine], a pathologist or a registered medical practitioner under the general supervision of a pathologist".
18 See "6.1 Preliminary Examinations" for further information.

coroner is not required to include in the finding the circumstances surrounding the death. See "12. Findings, comments and recommendations" for further information.

4.4 Fires

A coroner can investigate a fire regardless of whether or not a death has occurred.

A coroner must investigate a fire after receiving a request to investigate from the Country Fire Authority or the Metropolitan Fire and Emergency Services Board, unless the coroner determines that the investigation is not in the public interest (s 30).

Any person may also request a coroner to investigate a fire by completing a Form 16 ("Request to Investigate a Fire")[19] and sending it to the court. This form is available on the court's website at www.coronerscourt.vic.gov.au.

If a coroner refuses to investigate the fire, then they must provide written reasons to the person who made the request (ss 30–31).

A person who reports a fire to a coroner must give the coroner any information or other assistance that the coroner requests for the purpose of their investigation (ss 34–36). The nature of the assistance will depend on the circumstances of the fire.

A coroner must make a finding following an investigation into a fire. Their finding must state, if possible, the cause and origin of the fire and the circumstances in which it occurred. See "12. Findings, comments and recommendations" for more information.

See also "11. Inquests" for further information regarding inquests into fires.

4.5 Death as a result of a multi-fatality disaster

The task of a coroner immediately following a multi-fatality disaster is to ensure that a rigorous identification process occurs for those who have died. The Disaster Victim Identification process is an internationally agreed process undertaken by Victoria Police to assist a coroner to formally identify those who have died in a disaster, particularly where visual identification is compromised. This process requires that those who have died in a multiple-victim disaster be identified, in almost all cases, using medical and scientific evidence, unless a coroner otherwise directs.

The process of confirming the identity of those who have died, finding the causes of their death and investigating the circumstances is a complex and lengthy one. As a result, returning deceased people to families for funerals will often take longer than it would in other circumstances.

Depending on the nature and extent of the disaster, it may be weeks or months before certain information, such as death certificates, is available.

Further information about the Disaster Victim Identification process is available by contacting the court on 1300 309 519.

19 See rule 39(1) of the *Coroners Court Rules 2009* and sections 30 and 31 of the Act.

5. Preliminary court processes and family information

The Coroners Court ("the court") recognises that the death of a family member, friend or community member can be distressing and that distressed people may require referral for professional or other support. The court is also acutely aware that different cultures have different beliefs and practices surrounding death that should, where possible, be respected (s 8). The court endeavours to do its best to keep bereaved family members informed of the progress of the investigation and of any other appropriate details.

As part of the court's ongoing effort to keep loved ones of the deceased person informed about the coronial process, the publications listed below were introduced in November 2009 (to coincide with the commencement of new Act). These publications can be downloaded from the court's website www.coronerscourt.vic.gov.au or obtained by contacting the court on 1300 309 519.

Brochures and booklets produced by the court

- **What do I do now?** – explains what bereaved families and friends need to know immediately after the death of a deceased person is reported to a coroner
- **Family and Community Support Services** – details the counselling and support services provided by the court
- **Inquest** – provides information about an inquest, including why is an inquest held and what to expect at an inquest
- **Findings** – contains information about what a coroner must include in a finding, the difference between a finding with inquest and a finding without inquest
- **Reviewable Deaths** – contains information for families who have experienced the loss of a child where the death has been identified as a reviewable death
- **Disaster Victim Identification** – provides information for families of a deceased person who has died in a natural or non-natural disaster
- **Coroners Prevention Unit** – provides information about the role and function of the unit
- **Access to Documents** – provides information about how the public and interested parties may obtain access to coronial documents
- **The Coroners Process: Information for Family and Friends** – contains information about the various stages of the coronial process

The court offers copies of these publications to bereaved families at various points throughout the coronial process, as applicable.

5.1 Interpreting services

The court can arrange interpreting services to assist people from culturally diverse backgrounds to better access and understand the coronial process.

If an interpreter is required during an inquest, the court generally covers the cost.

5.2 Senior next of kin

The "senior next of kin" of a deceased person or their nominee is the court's main point of contact throughout a coroner's investigation.

In the first part of a coroner's investigation, the senior next of kin or nominee will be notified about any necessary medical examinations[20] and will also be provided with updates on the progress of the investigation and any medical examination reports provided to a coroner. The senior next of kin will be contacted before any medical examination reports are sent out and they can elect not to receive them if they wish.

Section 3 of the Act outlines the order of priority as to who is the senior next of kin in relation to a deceased person. The hierarchy is as follows:

- a spouse[21] or domestic partner[22]
- a son or daughter of or over the age of 18 years
- a parent[23]
- a sibling[24] of or over the age of 18 years
- a person named in the will as an executor
- a person who, immediately before the death, was a personal representative of the deceased person
- a person determined to be the senior next of kin (s 3(3)).

20 See the definition in section 3 of the Act.
21 See the definition in section 3 of the Act.
22 See the definition in section 3 of the Act.
23 See the definition in section 3 of the Act.
24 See the definition in section 3 of the Act.

Section 3(3) provides that a person is the senior next of kin if a coroner determines that the person should be taken to be the senior next of kin because of the closeness of the person's relationship with the deceased person immediately before their death.

If there is more than one person who claims to be the senior next of kin, then a coroner will make a decision as to who will be taken to be the senior next of kin.

If family members, who are not the senior next of kin, would like to be informed about the progress of an investigation, then those members should contact the court to register their interest.

5.3 Collection of information

When a death has been reported, the Initial Investigations Office (IIO) commences collecting information about the deceased person for the investigation.

Information that the IIO may receive as part of the investigation includes:

- the police report of death for a coroner[25]
- the police outline of the possible identity of the deceased person[26]
- a Statement of Identification form – if completed at a hospital or at the death scene
- families' concerns or issues surrounding the death, including concerns about the medical treatment or care of the person prior to their death
- medical records from:
  - the general practitioner
  - the hospital
  - the nursing home
  - any other treating doctor.

If a person dies in hospital, then the original medical records and hospital statements of identification are usually transported with the deceased person. A Medical Deposition form is also completed electronically by a registered medical practitioner and sent to the court.[27] This form requires information such as:

- the registered medical practitioner's details
- the deceased's personal details
- whether the deceased was, immediately before their death, an involuntary patient according to the *Mental Health Act 1986* (Vic) or whether they were in custody or care
- details of the relevant specialist treating units (specialties, such as anaesthetics and paediatrics)
- medical procedures performed on the deceased person (including imaging, internal examinations and surgical procedures).

5.4 Viewing and touching

Family members may request to view or touch the deceased person. In some circumstances, court staff may need to negotiate the type of viewing that can take place to ensure a coroner's ability to determine the identity, cause and circumstances of the death is not compromised.

Family members may also not be able to touch the deceased person if the death is subject to a police criminal investigation. This is to prevent any interference with any forensic evidence that may need to be collected. Touching may not be possible if health risks are involved. In these circumstances, a coroner will determine what is most appropriate for all parties involved.

5.5 Release of the body

Sections 47–48 of the Act relate to the release of the body, including the application for release of the body.

A coroner may order that a body under the control of a coroner be released if:

- the coroner is satisfied that it is no longer necessary for a coroner to have control of the body in order to exercise their functions under the Act or
- the coroner has determined that the death was not a reportable death or a reviewable death.

Application to coroner for release of the body

A person (such as the senior next of kin) may apply to a coroner for a body to be released to them. Generally, the deceased person will be released to a funeral director in accordance with the instructions provided by the senior next of kin or a person nominated by the senior next of kin.

However, if two or more people apply for release of the body, then:

- the court will request that each applicant complete a Form 25 ("Application for the Release of Body")[28] and
- the coroner must determine the person to whom the body is to be released on the basis of who has the better claim (s 48(2)).

The Application For The Release Of Body form is available on the court's website at www.coronerscourt.vic.gov.au.

A coroner must have regard to a number of legislative principles when determining who has the better claim (s 48(3)). The following common law principles may also be relied on in establishing the better claim.

25 Also referred to as a Victoria Police form 83.
26 The Initial Investigations Office requests the investigating officer to complete a Victoria Police form 47 if there are outstanding issues relating to identity or some other information was not provided.
27 Rule 23 of the *Coroners Court Rules 2009* requires a medical practitioner to confirm the report by giving a written report, in the form of a medical deposition, to the coroner as soon as practicable after making the report to the coroner.
28 See rule 48 of the *Coroners Court Rules 2009* and section 48 of the Act.

Deaths where there is an executor

At common law, the right to receive a deceased person's body for burial lies with the executor of the will of the deceased person.[29]

Deaths where there is no executor

In *Threlfall v Threlfall*[30] Byrne J provided the following guidance in relation to applying common law principles in determining disputes about the right to receive a deceased person's body for burial where there is no will:

- a coroner should first determine who has priority in terms of the entitlement to a grant of letters of administration of the estate of the intestate deceased person.[31]
- the deceased person's body should be released to that person unless it is demonstrated that this is not an appropriate course.
- the decision is one which must be made in a pragmatic way, having regard to the competing relationships of the claimants and to any social, cultural and practical considerations and, further, having regard to the requirement that the deceased person be buried or otherwise dealt with in accordance with law without unnecessary delay.

However, these are not inflexible rules so this order of precedence will yield to the circumstances of the case.[32]

5.6 Funeral arrangements

A funeral director[33] can be contacted as soon as a person has died. It is not necessary to wait for a coroner to release the deceased person from their care. However, it is recommended that bereaved families do not confirm a day or time for the funeral service until after they have received notification from the court about the time frames for the release of the deceased person.

5.7 Access to the scene

While they are conducting an investigation a coroner or the Chief Commissioner of Police may restrict access to the place where a death or fire occurred or to a place reasonably connected to the place where the death or fire occurred (ss 37–38).

In addition, the Chief Commissioner of Police may restrict access to the place where an incident occurred or to a place reasonably connected to the place where the incident occurred (s 37).

If access is restricted, then the coroner or the Chief Commissioner of Police will usually place a notice (in the prescribed form) stating that access is restricted. It is an offence for an unauthorised person to enter such a restricted place (ss 37–38).

5.8 Personal belongings

Personal possessions, such as valuables of the deceased person, are generally retained by the police at the place of death and, if appropriate, returned to the senior next of kin.

Occasionally, the police may retain some items for forensic examination. Otherwise, personal items such as clothing and jewellery are usually given to the funeral director to be returned.

5.9 Access to seized things

A person may apply to the court for access to, or release of, seized things by completing and returning to the court a Form 34 ("Application to Access or have Released Seized or Received Things").[34]

This form is available on the court's website at www.coronerscourt.vic.gov.au.

Sections 39–41 and 114 of the Act, as well as rules 56, 57, 58 and 59 of the *Coroners Court Rules 2009* (Vic) are relevant to seized things.

5.10 Provision of medical examination report

Unless otherwise ordered by a coroner, the senior next of kin of a deceased person is to be provided with any reports given to a coroner as a result of a medical examination performed on the deceased person (s 115(1)(a)).

These reports may include the preliminary examination report, the identification procedure report (if performed), and the autopsy report (if performed). As these reports are written by medical investigators for a coroner, the language used is technical and graphic and may be distressing for family members to read.

The court will notify in writing the senior next of kin when the medical examination report(s) are available and will give them the option not to receive the report(s) if they wish.

29 *Williams v Williams* [1882] 20 Ch D 659; *Doodeward v Spence* (1908) 6 CLR 406; *Smith v Tamworth City Council* (1997) 41 NSWLR 680.
30 [2009] VSC 283 (at paragraph 16).
31 The order is determined by establishing who would most likely get the grant of administration; *Estate of Slattery* (1909) 9 SR (NSW) 577. This is the person who would be entitled to the majority share of the deceased's estate; *Estate of Slattery* (1909) 9 SR (NSW) 577, 26 WN (NSW) 116; *Smith v Tamworth City Council* [1997] NSWSC 197, 59. The statutory order of precedence is set out in the *Administration and Probate Act 1958* (Vic).
32 *Threlfall v Threlfall* [2009] VSC 283 [para 9]: citing the following authorities: *Leeburn v Derndorfer* (2004) 14 VR 100 at 104, *Dow v Hoskins* [2003] VSC 206 at 37, *Jones v Dodd* (1999) 73 SASR 328, *Smith v Tamworth City Council* (1997) 41 NSWLR 680 at 693–4, and *Burnes v Richards*, Supreme Court of New South Wales, Cohen J, 6 October 1993 7 BPR 15104.
33 Although the court cannot recommend a particular funeral director, there is no obligation to use the funeral director who transported the deceased person to the court.
34 See rules 57(3) and 59(2) of the *Coroners Court Rules 2009* and section 114 of the Act.

5.11 Death certificates

A coroner provides the Registry of Births, Deaths and Marriages with various particulars (for example, name, sex, age, etc) so the death can be registered.

There are three forms of death certificate:

- a standard death certificate
- an interim death certificate and
- an abridged death certificate.

The coroner will usually wait for the medical investigator who has conducted the medical examination to provide a report to the coroner as to cause of death.

Standard death certificate

A standard death certificate is commonly required for financial and other official purposes as proof of the death. It usually contains the details of the deceased person's birth, marriage(s), child(ren), and cause of death.

The senior next of kin or the funeral director may order from the Registry of Births, Deaths and Marriages a standard death certificate. After all the particulars of the death have been registered, the Registry will post the certificate to either the senior next of kin or to a person the senior next of kin has nominated.

If a coroner is involved, then it may take several weeks for a death certificate to be issued. If the medical examination is complicated, it may take even longer.

Interim death certificate

If a coroner has not yet established the cause of death, then the Registry of Births, Deaths and Marriages can issue an interim death certificate. However, as an interim death certificate does not specify the cause of death, it may not be accepted for all official purposes.

It is advisable to confirm with the particular organisation whether they will accept an interim death certificate.

Abridged death certificate

An abridged death certificate contains only limited particulars of the deceased person; for instance it does not include details of the deceased person's birth, marriage(s), child(ren), and cause of death. These certificates are an alternative to a standard death certificate for those who do not wish to provide the full details to an organisation.

5.12 Exhumation

An exhumation is where a person's remains are retrieved from a place of burial, usually for the purposes of further examination (ss 43–46).

Occasionally, the State Coroner[35] may need to authorise an exhumation if he/she believes it is necessary for the investigation of a death and it is appropriate to do so.

Advising the senior next of kin

If the State Coroner intends to authorise an exhumation, then a notice of intention to exhume will be given to the senior next of kin (s 45).

The senior next of kin may make suggestions under section 45 of the Act as to how and whether a proposed exhumation should be conducted. These suggestions must be in writing and filed with a registrar within the time specified.[36]

The State Coroner will consider the suggestions made by the senior next of kin or any other person who provides written suggestions to the State Coroner about the proposed exhumation (s 45(4)).

If the State Coroner authorises an exhumation of a body, then a second notice regarding the authorisation will be provided to the people[37] who were notified of the State Coroner's intention to exhume the body (s 46).

However, this authorisation will not take effect until 48 hours after the senior next of kin has been notified, or any further period specified by the State Coroner, unless:

- the State Coroner directs the exhumation to be conducted immediately or
- the senior next of kin advises the State Coroner that they will not appeal to the Supreme Court against the authorisation (s 46).

When an exhumation takes place, the court will contact the senior next of kin and will provide them with all the information about the procedure and processes involved.

For further information, please contact the court on 1300 309 519 and ask to speak to the Initial Investigations Office.

Advising the cemeteries and land owners

The State Coroner will also give notice of an exhumation to the relevant cemetery trust if the person is interred in a public cemetery or to the owner of the relevant land if the person is not interred in a public cemetery (ss 45–46).

When notices are not required?

The State Coroner is not required to give notice of their intention to authorise an exhumation if:

- there are reasonable grounds to believe that giving such notice would result in the escape of an offender or accomplice, or the fabrication or destruction of evidence or

35 or their delegate.
36 *Coroners Court Rules 2009*, rule 45.
37 The senior next of kin, the cemetery trust responsible for the public cemetery and the owner of the land where the place of interment is located.

- the exhumation is urgent and should not be delayed or
- giving notice is impossible (s 45(5)).

Requesting an exhumation

Any person may apply to the State Coroner for an exhumation by completing a Form 20 ("Application for Exhumation").[38]

This form is available on the court's website at www.coronerscourt.vic.gov.au and can be posted or faxed to the court.

If the State Coroner refuses the application, then the State Coroner must ensure that the applicant is advised of the refusal without delay.

The Act includes appeal provisions relating to exhumations (see s 81).

38 See rule 44(1) of the *Coroners Court Rules 2009* and section 43 of the Act.

6. Medical examinations

A "medical examination" is defined as a:

- preliminary examination
- identification procedure
- autopsy (s 3 *Coroners Act 2008* (Vic) ("the Act")).

A preliminary examination or identification procedure may be performed concurrently with an autopsy (s 25(4)).

6.1 Preliminary examinations

Once the deceased person is taken to the Coroners Court (the court), a coroner may provide the body to a medical investigator to enable a preliminary examination to be performed on the body (s 23(2)). The purpose of a preliminary examination is to assist a coroner perform their functions in respect of the death (s 23(1)).

The medical investigator who examines the body will be a pathologist or a registered medical practitioner under the general supervision of a pathologist or the Victorian Institute of Forensic Medicine (s 3).

A preliminary examination is minimally invasive and may include any of the following procedures:

- a visual examination
- collecting and reviewing information about the person who has died, including personal and health information
- taking body fluids such as blood, urine, saliva and mucus – in some cases, a small incision may be needed to collect these samples for testing
- taking samples from the surface of the body for testing, including swabs from wounds and inner cheek, hair samples and samples from under fingernails and from the skin
- imaging the person who has died, for example, by computed tomography (CT scan), magnetic resonance imaging (MRI scan), x-rays, ultrasound and photography
- fingerprinting (s 3).

After the procedure the medical investigator must provide a report to a coroner in accordance with rule 30 of the *Coroners Court Rules 2009* (Vic) ("the Court Rules").

The Act does not include any notice or appeal provisions with respect to preliminary examinations (as it does in relation to autopsies, discussed below).

6.2 Identifications

One of the roles of a coroner is to determine the identity of the person who has died.

Visual identification is the most common way for the coroner to establish the identity. However, in some situations, the coroner may direct a medical investigator to perform certain procedures on the body, including the removal of tissue (s 24), for the purposes of identifying the deceased person.

These identification methods may include:

- fingerprinting
- examining dental records
- taking samples for DNA comparisons.

After the procedure, the medical investigator must provide a report to a coroner in accordance with rule 32 of the Court Rules.

The Act does not include any notice or appeal provisions with respect to identification procedures (as it does in relation to autopsies, discussed below).

6.3 Autopsies

An autopsy, sometimes called a post mortem, is a type of medical procedure performed by a medical investigator.

A medical investigator is usually a qualified doctor specialising in pathology (that is, the science that looks at the effects on the body of disease or injury).

What does an autopsy involve?

The medical investigator carries out an external and internal examination of the deceased person.

Techniques similar to those used in surgical operations are involved. The major organs of the body are examined and specimens are taken for detailed scientific and medical examination. Such an examination may include tests for:

- infection
- changes in body tissue and organs
- chemicals such as medications, drugs or poisons.

These tests are carried out on minute samples of blood or tissue that are taken from the deceased person's body.

Why is an autopsy necessary in some cases?

An autopsy may provide detailed information about a deceased person's health condition and may assist a coroner in understanding the various factors that may have contributed to the death.

An autopsy can be beneficial even in cases where the mechanism of death seems clear, for example, as a result of a car accident. In this instance, it may be unclear what caused the crash – driver error or an underlying medical condition. In such a situation an autopsy may provide further information. However, in a small percentage of cases an autopsy may not be able to ascertain the cause of death.

If a coroner believes that an autopsy will help the investigation,[39] then the court will contact the senior next of kin first and explain the process and answer any questions that they may have.

How does an autopsy come about?

Coroner's direction

Section 25(2) of the Act provides that a coroner must direct a medical investigator to perform an autopsy on a body under the control of the coroner if it is:

- necessary for the investigation of the death and
- is appropriate.

The coroner must take reasonable steps to notify the senior next of kin of the direction (s 26(1)).

Person's request for autopsy

Any person may ask a coroner to direct that an autopsy be performed if the coroner has control of the body (s 27). This request must be:

- communicated by telephone to the court after the deceased person has been transferred to the court and
- confirmed in writing after that call (rule 36 Court Rules).

This written communication must specify the reasons for making the request and be signed by the person making the request.

If the coroner refuses a request for an autopsy to be performed, then within 48 hours of receiving the coroner's written notice of their refusal, the person requesting the autopsy may appeal to the Supreme Court under Part 7 of the Act (s 79).

Objection by the senior next of kin to coroner's direction

Within 48 hours of receiving notice of a coroner's direction to perform an autopsy, the senior next of kin of the deceased person may ask the coroner to reconsider the direction (s 26(2)). The autopsy will not proceed during this time.

This request to the coroner must be:

- communicated by telephoning the court on 1300 309 519 and
- confirmed in writing to the Court no later than 24 hours after that call (rule 35 Court Rules).

The written communication must specify the reasons for making the request and be signed.

Objections to autopsies from senior next of kin have been lodged in the past for various reasons, for example, on the grounds of religious and cultural beliefs.

The coroner will take these reasons into account and, without delay, give written notice of their determination.

For further reading, see:

- *Mirjana v State Coroner of Victoria* (2006) VSC 211
- *Horvath v State Coroner of Victoria* [2004] VSC 452.

After receiving a senior next of kin's written request to reconsider the direction to perform an autopsy, a coroner may still decide the autopsy is necessary and appropriate. However, within 48 hours of being notified that their request for reconsideration has been refused, the senior next of kin can appeal to the Supreme Court under Part 7 of the Act against the coroner's direction to perform an autopsy (and any conditions that may have been imposed). The appeal must be made before the 48 hours has elapsed.

The senior next of kin should advise the court as soon as possible of any intention to appeal a coroner's decision to the Supreme Court.

6.4 Removal and retention of tissue

Section 28 of the Act relates to the removal of tissue and the preservation of tissue and material, where a coroner directs a medical investigator to undertake a medical examination.

In some cases a medical investigator may advise a coroner that a further detailed examination of a tissue[40] (for example, whole organs such as the brain or heart) or material is necessary to establish the medical cause of death. The examination of these organs may take several weeks, as the tissue may need to be "fixed" for a period of time in a preservative solution before it can be examined.[41]

The court will contact the senior next of kin when this occurs, to inform them why this has been done and to determine the family's wishes once the tissue examination is complete. The senior next of kin can elect to delay the release of the deceased

39 See section 25 of the *Coroners Act 2008*.
40 See *Coroners Court Rules 2009* (Vic), rule 37(1).
41 David Ranson, "Tissue and Organ Retention at Autopsy: What are the Benefits?" (2001) 8 *Journal of Law and Medicine* 368, 371.

person's body until the tissue has been re-united with the body.

6.5 Donations of tissue (and organs) after death

The definition of "tissue" in the Act has the same meaning as in the *Human Tissue Act 1982* (Vic).[42] "Tissue" includes an organ, or part, of a human body or substance extracted from the human body. The donation of tissues is dealt with in the *Human Tissue Act 1982*.

If any members of a deceased's family wish to consent to tissue donation, then the court can put them in contact with the Donor Tissue Bank of Victoria. Donations facilitated by the Donor Tissue Bank of Victoria include heart valves, skin, bone and corneas.

In some cases[43] families may wish to donate organs (for example, the deceased person's heart). These donations usually take place in a hospital.

In either situation, if a coroner has (or will soon have) jurisdiction to investigate a death under the Act, then tissues (including organs) cannot be removed for therapeutic, medical or scientific purposes unless a coroner provides consent or gives a direction that their consent is not required.[44]

For further information, please contact the court on 1300 309 519 and ask to speak to the Initial Investigations Office.

6.6 Posthumous retrieval of gametes

A coroner generally has no jurisdiction to order posthumous retrieval of gametes as it does not form part of their investigation. However, a coroner may, while they have control of the body, permit the procedure in certain circumstances[45].

For further reading, see:

- *AB v Attorney-General for the State of Victoria* [2005] VSC 180
- *Y v Austin Health* [2005] VSC 427
- *YZ v Infertility Treatment Authority* (General) [2005] VCAT 2655.

For more information on posthumous use of gametes, please contact the Victorian Assisted Reproductive Technology Authority (see "Useful contacts").

6.7 Family Health Information Service

As a result of the medical examination, a medical investigator may uncover a previously unknown condition that may have a genetic basis and significance for other family members. In such situations the Family Health Information Service (provided by the Victorian Institute of Forensic Medicine) may, with the consent of a coroner, refer the next of kin to a genetic health service or other medical specialists.

Before contacting a family, the Victorian Institute of Forensic Medicine will seek coronial advice on relevant information, including:

- the existence of surviving blood relatives of the deceased person
- any contested next of kin issues
- any criminal investigation into a case and implications for communicating health information with a family.

Further information about the Family Health Information Service is available by contacting the Victorian Institute of Forensic Medicine (see "Useful contacts").

42 See *Human Tissue Act 1982* (Vic), section 3(1).
43 Where the deceased person is a suitable candidate.
44 *Human Tissue Act 1982*, section 72.
45 Subject to evidence of written consent from the deceased person, a request from the deceased person's partner, and the availability of qualified and competent medical professionals to perform the removal and extraction. See the *Assisted Reproductive Treatment Act 2008* (Vic) for more information.

7. Inquest briefs

At the time a death is reported, a coroner may have very limited information. As a result, Victoria Police may be required to assist with an investigation into a death or fire, as required by the coroner. Such assistance will usually include preparing a brief of evidence (that is, an inquest brief) (s 115(7) *Coroners Act 2008* (Vic) ("the Act")).

The Act provides that the inquest brief should contain the following information, if available:

- a statement of identification by an appropriate person
- any reports given to a coroner as a result of a medical examination (for example, autopsy, toxicology reports)
- reports and statements that a coroner investigating the death or fire believes are relevant to an inquest
- other evidentiary material that a coroner investigating the death or fire believes is relevant to the inquest (s 115(7)).

The inquest brief may also include (although the Act does not specify these):

- initial documentation from the police officer by way of a summary of how the incident may have occurred (Victoria Police form 83)
- photographs
- medical notes / records
- protocols, procedures and policies
- maps and drawings
- videos
- opinions from experts
- the police investigator's summary of the incident following their detailed investigation for a coroner.

However, an inquest brief does not include any part of a medical file that a coroner considers to be *irrelevant* to the inquest (s 115(8)).

7.1 Preparation of the inquest brief

Generally, members of Victoria Police compile the inquest brief.

Depending on the type of investigation, specific members of Victoria Police are allocated the task of compiling an inquest brief. Figure 4, below, indicates which members of Victoria Police compile particular inquest briefs.

Figure 4: preparing an inquest brief

Type of inquest brief	Victoria Police member
General death, for example, suicide	Police members who attended the death
Drug overdose	Member of the Criminal Investigations Unit
Workplace death	Detective, Major Collision Investigations Unit or an appropriate qualified member
Fatal collision involving police	Major Collision Investigations Unit overseen by Ethical Standards Department
Marine incidents	Water Police
Aviation Incidents	A police member who attended the death
Fatal shooting or death in custody	Homicide Squad overseen by Ethical Standards Department
Homicide	Homicide Squad
Motor vehicle accident	Traffic Management Unit

7.2 Criminal proceedings

After any criminal trial relating to a death has been completed, Victoria Police will usually forward the criminal trial brief and outcome to the Coroners Court ("the court"). The information contained in the Victoria Police criminal trial brief may also include information such as an outline of the facts of the case. If a criminal proceeding has taken place and if the information included in the brief suffices, then a separate inquest brief is usually not required. It is very unusual for a coroner to undertake a further investigation where a criminal trial has resulted in a conviction.

7.3 Time frame for the inquest brief

The time it will take to prepare the inquest brief depends on the complexity and circumstances of the matter.

7.4 Access to the inquest brief

Generally, interested parties (as determined by a coroner under section 56 of the Act – see "8. Interested parties") will have a right to the brief (s 115(1)(b)). The court will provide an interested party with a copy of the inquest brief.

Interested parties to the proceedings, such as family members of the deceased person, may make submissions to a coroner that only partial disclosure of the inquest brief can be made to the other interested parties. This may be because particular material(s) or document(s) in the inquest brief may be of a sensitive nature (they may, for example, relate to the deceased person's personal health or educational reports).

Non-interested parties may apply for access to the inquest brief under section 115 of the Act. See "13. Access to documents" for further information.

Medical records

The deceased person's medical records in the possession of the court can be released only at the direction of a coroner.

If the records are voluminous in nature, then the relevant parts of a medical record (which a coroner has deemed to be relevant to the inquest[46]) may not be physically attached to the inquest brief. In such cases, arrangements may need to be made with the Registry in order to inspect and/or obtain copies of the medical record.

Exhibits

Unless otherwise ordered by a coroner, exhibits tendered at an inquest generally form part of the public inquiry, and may be accessed by interested parties, upon request. Depending on the nature of the exhibit, a coroner may also make an exhibit available for inspection to an interested party if the exhibit forms part of, but is not included in, the inquest brief. For example, a coroner may, if appropriate, make available for viewing exhibits such as a boat or plane.

If an interested party believes that a document is missing from the inquest brief, then they should contact the court.

A person may apply to the court for access to seized things by completing a Form 34 ("Application to access seized thing or to have seized thing released").

46 Note section 115(7) of the *Coroners Act 2008*.

8. Interested parties

Section 56 of the *Coroners Act 2008* (Vic) ("the Act") contains the statutory test for a coroner to decide whether to grant a person leave to appear as an interested party at an inquest. A person may be granted leave if the person has **sufficient interest** in the inquest, and it is **appropriate** for the person to be an interested party. This determination is entirely up to a coroner.

8.1 Sufficient interest

The Act does not define "sufficient interest". However, when taking into account the Preamble to the Act, the purposes of the Act, and the new preventative role; the classes of people likely to express interest in being granted interested party status may have been widened, compared to the old Act.[47]

A further implication of these new preventative features of the Act may also result in a greater number of people and/or organisations establishing that their involvement in an inquest would assist in a coroner's preventative role. However, despite a person or entity claiming to have sufficient interest in the subject matter of the inquest, the coroner may nonetheless consider that the inclusion of the applicant as an interested party is not "appropriate" for a range of reasons.[48]

See "8.2 Appropriateness" for further information.

Moreover, at all times a coroner needs to ensure that an inquest is conducted in a fair and efficient manner (s 9). As a result, a crucial consideration for a coroner will be to ensure evidence is thoroughly examined, but not in an unnecessarily protracted way.

Possible considerations in determining whether a person has sufficient interest

In the case of a senior next of kin, interested party status is not automatically given. Accordingly, like other interested parties, the senior next of kin will be required to make an application under section 56 of the Act. See "8.3. Application for leave to appear at an inquest as an interested party". Where such an application is made, it is unlikely that a coroner will refuse it.

In *Barci v Heffey*[49] – a case based on the former *Coroners Act 1985* – Beach J stated that whether a person has a sufficient interest is a question of fact based on the circumstances of the death. His Honour outlined several relationships that may give rise to a sufficient interest, such as:

- a person closely related to the deceased, such as a spouse, parent, child or de facto partner
- the employer of a person killed in the course of employment
- the teacher of a student killed on a school excursion
- the commanding officer of a soldier killed during a peace-time exercise
- any person who may have caused or contributed to the death
- any person who may reasonably anticipate that a coroner may make a finding adverse to their interests.

The Victorian Supreme Court granted the plaintiff "interested party" status to the applicant in *Barci v Heffey* as they were "so inextricably involved in the events which led to the death…as to qualify [them] as persons with a sufficient interest".[50]

However, ultimately the question of whether a person is an interested party is a question of fact.[51]

Public interest organisations may seek to demonstrate a sufficient interest by establishing their expertise in relevant areas and their ability to assist a coroner to make recommendations on matters of public health and safety and the administration of justice.

Examples of where Victorian coroners have granted "interested party" status to public interest organisations include:

- Villamanta Legal Service and the Office of the Public Advocate in the inquest into the fire and nine deaths at Kew Residential Services [52]
- the Council to Homeless Persons, the Tenants

47 "Ruling on Applications to be granted leave to participate as interested parties pursuant to S 56 *Coroners Act 2008* ('The Act')", Inquest into the Death of Tyler Cassidy, Her Honour Judge Coate, Coroners Court of Victoria (4 March 2010).
48 "Ruling on Applications to be granted leave to participate as interested parties pursuant to S 56 *Coroners Act 2008* ('The Act')", Inquest into the Death of Tyler Cassidy, Her Honour Judge Coate, Coroners Court of Victoria (4 March 2010).
49 [1995] SC Vic 4306 (Unreported, 10 February 1995) per Beach J.
50 *Barci v Heffey* (1995) VSC 13, 22.
51 *Barci v Heffey* (1995) VSC 13, 17.
52 Unreported, State Coroner's Office – Victoria, State Coroner Graeme Johnstone,17 October 1997

Union of Victoria and Public Interest Law Clearing House (Homeless Persons Legal Clinic) in the inquest into two deaths in a boarding house fire [53]
- Victoria Legal Aid and the Human Rights Law Resource Centre Inc in the inquest into the death of Tyler Cassidy.[54]

It will always be at a coroner's discretion as to whether such public interest organisations are granted interested party status. Where a party is granted interested party status, a coroner may nevertheless choose to limit the terms of that grant of leave.[55]

8.2 Appropriateness

At the time of producing this handbook, there is no guidance in legislation or at common law as to the matters a coroner should consider in relation to "appropriateness". Therefore the implication may be that a coroner is not limited as to what they consider appropriate in terms of determining whether someone should have the status of an interested party.

However, factors that a coroner may consider in determining appropriateness may include, but are not limited to, the following[56]:

- whether or not the applicant is to be represented by competent counsel and whether there is clarity around the specific role the applicant wishes to take and for what purpose
- where an applicant is seeking to assist a coroner by reason of the applicant's expertise or experience in a particular matter (that is to be examined at an inquest), a coroner may properly consider whether or not it would be more appropriate for that person to be a witness in the investigation rather than an interested party
- the totality of the applicant and what they offer – for example, whether it is appropriate to have more than one party representing the same or largely similar "public interest" issues.

8.3 Application for leave to appear at inquest as an interested party

To become an interested party, a person (including a bereaved family member) must complete a Form 31 ("Application for Leave to Appear as an Interested Party")[57] and send it to the Coroners Court ("the court").

This form is available on the court's website at www.coronerscourt.vic.gov.au.

The court will inform the person whether a coroner has granted their application. A coroner may determine such an application in open court, for example, during a directions hearing.

8.4 Rights of interested parties

The Act gives interested parties specific rights (s 66), outlined below.

Right to make submissions to a coroner

An interested party may make submissions specifying whom they consider to be a relevant witness. A coroner may consider that submission and determine whether the proposed witness or witnesses should be called (s 66(1)).

Right to representation

An interested party may appear or be represented by an Australian lawyer or, with the permission of a coroner, by any person, and may examine or cross-examine witnesses and make submissions (s 66(3)).

If the family of the deceased person seek legal representation, then it is important to note that, because the court is independent, the court is unable to provide assistance in seeking a lawyer. Moreover, the court will not pay any costs associated with engaging a private solicitor.

See "9. The Coroner's Assistant" for information about the role of Counsel Assisting.

The coroner's assistant will also ensure every effort is made to address matters that families raise.

Families should be made aware that:

- free legal advice (and sometimes representation) may be obtained from Victoria Legal Aid or a community legal centre
- the Public Interest Law Clearing House facilitates pro bono (that is, free) legal services to individuals and organisations in need
- the Law Institute of Victoria offers a referral service to help find a lawyer experienced in coronial matters.

Please see "Useful contacts" for contact details of these organisations.

Although the court's staff and the Coroner's Assistant do not provide legal advice, they are available to help answer any questions that bereaved family members and friends of the deceased person may have if they are not represented.

53 Unreported, State Coroner's Office - Victoria, Coroner White,13 October 2009.
54 "Ruling on Applications to be granted leave to participate as interested parties pursuant to S 56 *Coroners Act 2008* ('The Act')", Inquest into the Death of Tyler Cassidy, Her Honour Judge Coate, Coroners Court of Victoria (4 March 2010).
55 See *Annetts v McCann* (1990) 170 CLR 596.
56 "Ruling on Applications to be granted leave to participate as interested parties pursuant to S 56 *Coroners Act 2008* ('The Act')", Inquest into the Death of Tyler Cassidy, Her Honour Judge Coate, Coroners Court of Victoria (4 March 2010).
57 See rule 53(2) of the *Coroners Court Rules 2009* and section 56 of the Act.

Appeal against the findings of a coroner in respect to a death or fire

Both interested parties and persons with a sufficient interest have a right to appeal to the Trial Division of the Supreme Court against a coroner's findings in respect to a death or fire (s 83).

8.5 Others with "interest" in the inquest

Sometimes, people or organisations may have an interest in an investigation and/or inquest but have not been granted the status of an interested party or have elected not to make an application under section 56 of the Act to be an interested party. For example, a government department may express interest in an inquest involving a death resulting from a road accident. In these instances, such parties may wish to simply be "information recipients", primarily interested in a coroner's findings in order to be kept informed, rather than being an interested party to the investigation or inquest.

If such people or organisations require access to documents, then they must apply by completing and submitting the Application For Access To Coronial Documents / Inquest Transcript form[58] and specify the reasons for the requested information.[59]

See "13. Access to documents" for further information.

58 See Form 45, rule 67 of the *Coroners Court Rules 2009* and sections 115 and 63 of the Act.
59 Examples of information that is commonly requested include autopsy results and the findings.

9. The Coroner's Assistant

A coroner at an inquest may be assisted by:
- a member of the police force
- an Australian lawyer
- the Director of Public Prosecutions or
- another person appointed by a coroner (s 60 *Coroners Act 2008* (Vic) ("the Act")).

The Police Coronial Support Unit (PCSU), previously known as the State Coroners Assistant Unit, comprises Victoria Police members who are trained prosecutors. In the vast majority of inquests a member of the PCSU will assist a coroner. However, in investigations where Victoria Police may have, or appear to have, a conflict of interest,[60] or where a case is considered particularly complex, an independent lawyer may be appointed to assist a coroner (for example, Counsel Assisting).

For the purposes of this handbook and for the remainder of this chapter, the people performing the roles of a PCSU member and Counsel Assisting will be referred to as the "coroner's assistant".

9.1 Persons appointed as the coroner's assistant

A coroner's assistant can be appointed at any time during the investigation, although they are usually appointed once the brief of evidence has been compiled or the decision to hold an inquest has been made.[61]

To adequately undertake the professional and technical components of coroner's assistant role, the person should have:
- a clear understanding of the coronial jurisdiction and relevant legislation
- experience in legal practice, including court appearances
- a theoretical and practical knowledge of the differences between coronial investigations and other proceedings.

While it is preferable that the coroner's assistant has a level of expertise in the subject matter of an inquest, this is not always possible. This is because the nature and subject matter of coronial inquests differ greatly from one case to another. Depending on the complexities and expected workload involved in an inquest, the desired level of experience and qualifications for this role will vary from case to case.

9.2 Role of the coroner's assistant

Although the role of a coroner's assistant is not defined in the Act, the role is nevertheless fundamental to the inquest process. It entails providing support to a coroner in the search for the identity, cause and, sometimes, circumstances of the death – or the origin, cause and circumstances of the fire. For example, one of the tasks involved encompasses discovering, assembling, presenting and testing evidence at the inquest.

The role of a coroner's assistant is inherently flexible and will be adapted in the particular circumstances, according to the interests of justice and nature of the investigation. Generally, the role also requires conducting the examination-in-chief of all witnesses with as little formality and technicality as possible. Where necessary, this function may also extend to cross-examining and re-examining witnesses. The forensic examination of evidence by the coroner's assistant may be conducted with a view to identifying particular possibilities and testing the evidence to prove or disprove hypotheses.[62]

If the family of the deceased person is not legally represented, then it may be necessary for a coroner's assistant to engage in a more active role in explaining to the family all the processes involved; including the examination of witnesses, exploring issues and making submissions at the inquest on behalf of the family.

In closing submissions, a coroner's assistant is expected to present a balanced view of the evidence relevant to the matters that are the subject of the findings.[63] Further, their submission may also contain suggestions as to whether recommendations should be formulated, which

60 Such as a death in police presence, in police custody or in circumstances where Victoria Police's conduct associated with a death is likely to come under scrutiny.
61 Law Reform Committee, Parliament of Victoria, *Inquiry into the Review of the Coroners Act 1985 – Final Report* (2006), p 206.
62 See, for example, *R v Coroner for North Humberside*; ex parte Jamieson [1995] QB 1.
63 I Freckelton and D Ranson, *Death Investigation and the Coroner's Inquest* (2006) p 542.

may be open to a coroner, to improve public health and safety or the administration of justice.

9.3 Distinction between a coroner's assistant and the coroner

It is important to understand the distinction between the functions of the coroner's assistant, and the exclusive role of a coroner. Although the coroner's assistant retains professional independence,[64] they ultimately take instructions directly from a coroner and carry out the role subject to the direction of a coroner. As a result, the coroner's assistant may confer with a coroner before, during and after an inquest.[65]

A coroner is the principal investigator and decision-maker as to the facts and the law. A coroner also conducts, regulates and determines the procedural aspects of the investigation.[66] Among other things, the coroner's assistant supports these functions and thereby ensures an adequate inquiry is conducted and the relevant facts are fully and fairly investigated. In doing so, the coroner's assistant owes a duty to the Coroners Court and must comply with the duties of fairness and disclosure.[67]

9.4 Distinction between a coroner's assistant and counsel assisting in a Royal Commission

Little has been written about the distinction between a coroner's assistant and counsel assisting in a Royal Commission.

In terms of similarities that may be drawn between the two roles, both are often required to make decisions in planning the investigation.[68] Both roles also involve ensuring that:

- a full and adequate inquiry is conducted and
- all relevant evidence is brought to the attention of the judicial officer and appropriately tested.[69]

It may be that the role of counsel assisting in a Royal Commission differs from that of a coroner's assistant in that it involves more of a "managerial role in relation to investigations, the assembling of evidence and presentation" – a role that should be performed "fearlessly and independently".[70] In his report on Royal Commissions, Hall J found that "Commissioners conventionally encourage counsel assisting to act with a sense of independence for maintaining a certain detachment [sic] serves the overall interests of an effective inquiry".[71] Accordingly, counsel assisting are expected to act as tacticians and as overall coordinators of investigations, thereby enabling Royal Commissioners to remain independent of the day to day investigative work.[72]

Usually coroners will be more directive with their assistant, although it may vary depending on the nature of the inquiry.

9.5 Distinction between a coroner's assistant and a crown prosecutor

The Full Court of the ACT Supreme Court has stated that, in contrast to the role of a crown prosecutor, the role of a coroner's assistant should be guided by the overriding principle that their goal is the attainment of justice rather than a preconceived objective.[73] Moreover, the role of a coroner's assistant is to "actively pursue the truth and that will almost inevitably involve identifying particular possibilities or tentative conclusions and testing the evidence with a view to determining whether it can be confirmed or discounted".[74]

Furthermore, unlike in criminal trials, where the crown prosecutor strives to prove the guilt of the accused; the role of a coroner's assistant does not include setting agendas or leading evidence in a particularly persuasive manner. Lord Justice Scott Baker in the Princess Diana inquest highlighted that the assistant to the coroner "[does] not represent any individual, they have no axe to grind, they are independent of all the interested persons and impartial".[75]

The role of a coroner's assistant also differs to that of a crown prosecutor in an adversarial proceeding, in that the coroner's assistant's involvement in the proceedings commences at an earlier stage. A coroner's assistant is responsible for gathering the evidence and discussing the progress of the investigation with a coroner; for example, suggesting who should be called as a witness. As a result, the role of a coroner's assistant has been described as requiring the capability "of wearing a

64 C Dorries, *Coroners' Courts: A Guide to Law and Practice* (2nd ed, 2004) p 205.
65 I Freckelton and D Ranson, *Death Investigation and the Coroner's Inquest* (2006) p 564.
66 I Freckelton and D Ranson, *Death Investigation and the Coroner's Inquest* (2006) p 531.
67 G Hampel and E Brimer, *Hampel on Ethics and Etiquette for Advocates* (2001) p 11.
68 Keith Chapple SC, "Counsel at the permanent commissions of inquiry" (2005) 3 *Bar News: The Journal of the New South Wales Bar Association* 44.
69 Commonwealth of Australia, *Royal Commission into Aboriginal Deaths in Custody, National Report* (1998) Vol 5, 28.
70 Peter M Hall QC, *Investigating Corruption and Misconduct in Public Office: Commissions of Inquiry – Powers and Procedures* (2004) p 676.
71 Peter M Hall QC, *Investigating Corruption and Misconduct in Public Office: Commissions of Inquiry – Powers and Procedures* (2004) p 676.
72 Peter M Hall QC, *Investigating Corruption and Misconduct in Public Office: Commissions of Inquiry – Powers and Procedures* (2004) p 676. For more information on the role of Counsel Assisting in Royal Commissions, see the article by Justice Peter M Hall (listed in "Further Resources").
73 *R v Doogan* [2005] ACTSC 74, (Doogan) at 162.
74 *R v Doogan* [2005] ACTSC 74, (Doogan) at 162.
75 *Transcript of Proceedings, Inquest into the Death of Diana, Princess of Wales and Mr Dodi Al Fayed* (Royal Courts of Justice, London, Lord Justice Scott Baker, (2 October 2007) 25.

number of hats, not just a barrister fulfilling the traditional role of counsel".[76]

Another important difference between the two roles is evident in their opening addresses. In an adversarial proceeding, the crown prosecutor commences with an outline of the propositions of fact and law that they will seek to persuade the court to accept[77]; whereas in an inquest, a coroner's assistant's opening statement should detail the facts, as well as the issues and matters of inquiry.

76 Keith Chapple SC, "Counsel at the permanent commissions of inquiry" (2005) 3 *Bar News: The Journal of the New South Wales Bar Association* 46.
77 Australian Commission for Law Enforcement and Integrity, *Practice Notes July 2008*, 53–54.

10. Directions hearings

Generally, directions hearings may be held at any stage a coroner feels one is needed. For example, a directions hearing may help determine whether an inquest should take place. A directions hearing will usually take place for inquests that are expected to last for more than one day. If a coroner has decided to proceed with an inquest, then a directions hearing may be held to finalise as many matters as possible before the inquest commences.

Directions hearings provide the opportunity for all parties to make submissions to a coroner as to what issues they wish the coroner to consider. A directions hearing may be the only opportunity for parties to make submissions to a coroner as to which documents, witnesses, evidence and any other relevant information may be of assistance to the coroner. As a result, it is expected that interested parties are thoroughly prepared for directions hearings.

Directions hearings are also held to:

- ensure all available evidence, including witnesses are available to a coroner and to provide parties with adequate time to prepare for the inquest
- identify and confirm all interested parties
- estimate the length of time required for an inquest and nominate suitable dates
- ensure that the inquest is free from unnecessary adjournments and can be finalised as quickly as possible, avoiding unnecessarily lengthy or protracted coronial investigations that may exacerbate the distress of family, friends and others affected by a death (s 8)
- avoid unnecessary duplication of enquires and investigations and to expedite the investigation of deaths and fires[78]
- ensure a fair and efficient investigation[79].

10.1 Proceedings at a directions hearing

Generally, there is no public examination of the evidence surrounding the death of the deceased person at the directions hearing. Rather, at the hearing a coroner will address the resolution of preliminary issues such as:

- the disclosure of any possible conflicts of interest
- how the inquest is to be generally conducted
- the granting of leave to appear as interested parties (see "8.3. Application for leave to appear at inquest as an interested party" for further information)
- whether it is necessary for a coroner to visit the scene of the death and, if so, whether to invite interested parties along
- the identification of present and potential issues, including issues raised by the parties
- determining witnesses to be called, including expert witnesses, as well as determining witnesses' availability and whether witnesses will provide evidence orally or through other means (see "11.9. Witnesses" for further information)
- the elimination of unnecessary witnesses and issues
- exchanging and distributing of all documentary material and determining whether any documents need to be suppressed[80]
- foreshadowing applications for privilege in respect of self-incrimination in other proceedings[81]
- the need for expert reports and exploring areas of expertise
- whether to exclude any person or a class of people (s 52(2)(d))
- setting an appropriate timeframe for the inquest with a view to balancing the need for a thorough determination of all the relevant issues with the need for the matter to be expeditiously resolved
- enabling an assessment of an appropriate venue (if relevant) to hold the inquest.

The issues that are determined at a directions hearing will depend on the nature, type and complexity of the individual case.

10.2 Outcome of directions hearings

Although directions hearings are sometimes held to determine the scope of an inquest, a directions hearing may result in a determination by a coroner that there is no need for an inquest.

78 See section 7 of the *Coroners Act 2008* (Vic)
79 See section 9 of the *Coroners Act 2008* (Vic)
80 See "12. Findings, comments and recommendations", below, for further information.
81 See section 57 of the *Coroners Act 2008* (Vic)

Section 55 of the *Coroners Act 2008* ("the Act") confers specific powers that a coroner may exercise if they believe it is necessary for the purposes of an inquest, or if they consider that exercise of these powers may help to determine whether or not to hold an inquest (s 55(1)). For example, although a directions hearing does not normally include the taking of sworn evidence, a coroner may summon a witness and order the witness to answer questions for the purposes of determining whether or not to hold an inquest (s 55(1), (2)(a), (c)).

A coroner's use of these powers does not necessarily suggest that an inquest has commenced or will even take place.

10.3 Provision of information to a coroner

Unlike in the adversarial system, interested parties to an inquest do not have a right or power to subpoena material. As the coroner holding the inquest determines the relevant issues and witnesses for the purposes of the inquest (s 64), it is they who will ultimately decide what material is required. For example, an interested party who wishes to "subpoena" a document may request that a coroner direct production of the document.

If a coroner considers that a document or a prepared statement is required for the purposes of the investigation, then the coroner may require a person to:

- give the document to the coroner or
- prepare and give a statement addressing the matters specified by the coroner (s 42).

If a person does not comply, within the period specified by the coroner, with a coroner's request to give a document or prepare a statement, and has no lawful excuse, then penalties apply[82] (s 42).

A coroner exercising a power, or a member of the police force who is authorised, to enter premises under section 39 of the Act may direct a person at the premises to:

- produce a document located at the premises that is in the person's possession or control or
- operate equipment or access information from the equipment[83] (s 40(1)).

Any information that is produced in response to a request by a coroner will generally be circulated to all the interested parties, however there may be a number of reasons as to why that may not happen – for example, where a coroner accepts a public interest immunity submission or a legal professional privilege claim.

10.4 Duration of a directions hearing

A directions hearing will usually last for approximately one hour, unless a coroner requests that it be listed for a longer or shorter period.

10.5 Attendance at a directions hearing

A coroner will indicate which parties are to be notified of the directions hearing. The Coroners Court will send a letter to the parties indicating the time and place for, and general information about, the directions hearing.

82 20 penalty units.
83 See also the *Coroners Act 2008* (Vic), sections 39, 41.

11. Inquests

An inquest is a public inquiry held by the Coroners Court ("the court") in respect of a death, fire or multiple deaths and/or fires (ss 3, 52–54 *Coroners Act 2008* (Vic) ("the Act")). Other than where inquests are mandatory (see "11.2 Types of inquests"), a coroner has discretion to hold an inquest into any death or fire a coroner is investigating (ss 52(1), 53(1)).

Only a small number (approximately 5%) of investigations proceed to inquest.

11.1 Purpose of an inquest

The purpose of an inquest is to independently investigate a death or fire in order to establish the facts of what occurred, with a view to improving public health and safety by:

- providing the opportunity to explore issues of public importance and
- trying to discover what measures, if any, may be taken to prevent a similar death and/or fire from re-occurring.

In the words of the late Lord Chief Justice of England and Wales, Lord Lane:

> An inquest is a fact-finding investigation and not a method of apportioning guilt…the procedure and rules of evidence which are suitable for one are unsuitable for the other. In an inquest, it should never be forgotten that there are no parties, there is no indictment, there is no prosecution, there is no defence, there is no trial – simply an attempt to establish facts[84]

See "12. Findings, comments and recommendations" for further information relating to what a coroner endeavours to establish and determine with respect to an investigation of a death or fire.

11.2 Types of inquests

Inquests into deaths

The Act provides that an inquest must be held for certain deaths; otherwise it is at a coroner's discretion as to whether to hold an inquest (s 52(3)).

An inquest must be held if the death or the cause of death occurred in Victoria and if one of the following applies:

- a coroner suspects the death was the result of homicide
- the deceased was, immediately before death, a person placed in custody or care
- the identity of the deceased is unknown or
- the death occurred in prescribed circumstances (s 52).[85]

Inquests are not required if:

- a coroner believes the death probably occurred more than 50 years before it was reported to a coroner
- a person has been charged with an indictable offence in respect of the death being investigated
- an interstate coroner has investigated, is investigating or intends to investigate the death or
- the death occurred outside Australia (s 52(3)).

However, none of these circumstances limits the powers of a coroner to hold, adjourn or recommence an inquest (s 52(4)).

Inquests into a fire

A coroner may hold an inquest into any fire that a coroner is investigating (s 53). There is no requirement that a death must occur during a fire in order for a coroner to hold an inquest into that fire.[86]

Inquests into multiple deaths and fires

A coroner may hold an inquest that investigates:

- two or more deaths
- two or more fires
- a death or two or more deaths and a fire or two or more fires (s 54).

Examples of where a coroner may hold an inquest into multiple deaths may include deaths resulting from a major car accident or from a fatal incident in a public area.

Summary inquests

Summary inquests are inquests that a coroner conducts because they are required under the Act

84 Lord Chief Justice Lane in *R v South London Coroner, ex parte Thompson* [1982] 126 SJ 625.
85 The *Coroners Regulations 2009* (Vic) do not currently contain any prescribed circumstances.
86 See, for example, an inquest held into the *Macedon Ranges Fires* [2003] Coroners Court of Victoria 562/04 (Unreported, Coroner Johnstone, 27th March 2006).

to do so (s 52(2)), in situations where the coroner is satisfied that the death does not raise matters requiring the further examination of the evidence or issues connected to the death. For example, where an elderly person dies of natural causes while undergoing a prison sentence in circumstances where there is no suggestion that the person received anything other than appropriate care, such a form of inquest will usually be adopted.

At a summary inquest the coroner's assistant will read a summary of the circumstances as outlined in the police brief of evidence. No witnesses will be called. The coroner will generally accept the evidence based on information presented by the coroner's assistant, having considered the contents of the brief beforehand.

The bereaved family and those people who have expressed an interest in the investigation will receive notification indicating that a coroner has directed a summary inquest and when it will take place. Summary inquests are conducted in open court to allow any person to attend.

11.3 Requesting an inquest

Any person may request a coroner to hold an inquest into any death or fire that a coroner is investigating (ss 52, 53). The person must complete a Form 26 ("Request for Inquest into Death")[87] or a Form 27 ("Request for Inquest into Fire")[88] and provide reasons why they believe an inquest is necessary.

Both forms are available on the court's website at www.coronerscourt.vic.gov.au.

The coroner will consider the request and advise of their decision in writing (ss 52(6), 53(3)).

If a coroner decides not to hold an inquest, then the person who requested the inquest can appeal to the Supreme Court within three months of the coroner's decision.

11.4 Deciding whether to hold an inquest

Unlike under the former *Coroners Act 1985* ("the former Act"), a coroner, in determining whether or not to hold an inquest, does not need to believe an inquest is "desirable".

It would appear, since the introduction of the *Coroners Act 2008*, that a coroners discretion as to whether or not an inquest should be held should be framed firstly be consideration of the Preamble and purposes of the Act, together with sections 7, 8 and 9.

There are also common law principles that may assist a coroner in determining whether or not an inquest should be held. In *Domaszewicz v The State Coroner*[89] Ashley J said that it is "proper" to take into account the following factors:

- whether or not all the relevant public issues relating to the death have been canvassed by the criminal law judicial process
- the probative value to a coroner of any material not admitted to the criminal law judicial process
- the emotional burden that holding an inquest would place on relatives of the deceased person and other participants
- the efficient use of the resources available to the coronial service.

Further, while there is no closed or exhaustive list of considerations for coroners when deciding whether to take a matter to inquest, the following considerations contain some useful guidance:

- when there is such uncertainty or conflict of evidence on central issues being investigated to justify the use of the judicial forensic process
- when there is a likelihood that an inquest will assist in allaying public concerns about the administration of justice, health services or other public agencies
- when there is a likelihood that an inquest will uncover important systemic risks or gaps not previously known about.

11.5 Commencement of an inquest

An inquest generally commences upon the opening of the court in a particular investigation and the commencement of the evidence. However, a coroner may announce that a matter is going to inquest and then make directions as to the conduct of that inquest – thus it would most likely be considered that the inquest would start at that point.

If a coroner indicates that the formal or public part of a hearing commenced before 1 November 2009, then the relevant provisions under the former Act will apply.[90]

In contrast, the 2008 Act will apply if:

- a coroner has not formed a view, before the operation of the 2008 Act that there will be an inquest or
- a coroner has indicated that the inquest has not commenced.[91]

So, if a coroner has not, before 1 November 2009, formed the view that there will be an inquest, but has only conducted, or continues to conduct, part of the investigation after 1 November 2009, then

87 See rule 49(1) of the *Coroners Court Rules 2009* and section 52(5) of the Act.
88 See rule 49(2) of the *Coroners Court Rules 2009* and section 53(2) of the Act.
89 [2004] VSC 528, 250.
90 See *Coroners Act 2008*, Schedule 1, clause 7.
91 See *Coroners Act 2008*, Schedule 1, clause 7.

the 2008 Act will apply in relation to a decision to hold an inquest.[92]

Unless a coroner otherwise directs, notice of the inquest will be published in a daily newspaper or on the court's website at least 14 days before the inquest is to take place. This publication will include the date, time and place of the inquest (s 61).[93]

Inquests that are expected to last for more than one day will usually be preceded by a directions hearing. See "10. Directions hearings" for further information.

11.6 Duration of an inquest

The duration of an inquest will vary, depending on the complexity of the case and on the number of witnesses and submissions to be considered. Some inquests may last a few hours while others may take several days or weeks. Generally, a directions hearings will help determine approximate time frames for inquests.

11.7 Attendance at an inquest

Generally, anyone can attend an inquest. However, a coroner may exclude a person or class of people (for example, the media) from attending (s 55(2)(d)). This is considered to be a very unusual course as it is the very nature of an inquest for the hearing to be public.

11.8 Proceedings at an inquest

The Act provides that a coroner may conduct an inquest in any manner that they reasonably think fit (s 62). The coroner will decide the best way to conduct the inquest, determining the relevant evidence, issues and witnesses to be examined.

The coroner will try to avoid using unnecessarily complex language in order to ensure that the inquest is comprehensible to interested parties and family members who are present (s65).

Coroner's introduction

The coroner may choose to make some opening remarks about the inquest process and, if applicable, acknowledge the presence of family members.

In the opening, the coroner may:

- explain the functions of a coroner and the court, including explaining how the court endeavours to establish facts
- explain that it is not the court's role to apportion blame
- discuss the difference between the adversarial nature of other courts and the inquisitorial nature of the court
- provide bereaved families and other interested parties with an idea of what to expect during the course of the inquest, including the possibility, and reasons for, any adjournments that may occur
- indicate there may be evidence or materials that some may find distressing
- ask the family how they wish the deceased person to be referred to
- advise that people are able to leave whenever they wish.

Witness(es) sworn in

Similarly to other court proceedings, a witness enters the witness box and swears or affirms to tell the truth and is asked to provide their name, address and occupation by the registrar.

Witness(es) statement given

After the witness is sworn in:

- the witness' "statement" is read out either by the witness or by the coroner's registrar (Bench Clerk)[94]. It is good practice to establish beforehand whether or not a witness wishes to read out their statement or have the registrar read it out.
- the witness is asked to confirm that the statement is their own, and is provided with an opportunity to make any changes to it
- the statement is tendered and admitted as evidence.

If a witness becomes troubled at any stage while reading their own statement in court due to the sensitivity of the matters contained in the statement or because of other difficulties presented in it, then the witness may ask the coroner for the statement to be read by the registrar (Bench Clerk).

Questioning of witness(es)

The purpose of an inquest is to investigate the circumstances and cause of death, as opposed to a forum in which the allocation of blame is considered or determined; accordingly counsel should bear this in mind when questioning witnesses, as failure to do so may result in questions being disallowed. It should also be noted that counsel representing their client in an adversarial manner is usually neither helpful to the coroner or a grieving family.

Generally, the questioning of a witness will commence with questions from the coroner's assistant, followed by questions from lawyers representing the various interested parties. The coroner may also ask the witness a question at any stage. Questions presented to a witness will usually expand on what the witness has indicated in their statement.

If a witness has been called by the coroner to give evidence, then they should be made aware that they may be cross-examined.

If more evidence is needed to clarify an issue, then

92 See also *Helmer v The State Coroner of Victoria* [2011] VSC 25 (9 February 2011).
93 *Coroners Court Rules 2009*, rule 51.
94 Almost without exception, a witness will have already provided a written statement, letter or report to the coroner.

the coroner may request that other witnesses be called.

Unlike in adversarial proceedings, witnesses are usually permitted in the courtroom before or after their questioning and during the questioning of other witnesses, unless otherwise ordered by the coroner.

If the deceased's family is not represented by a lawyer, then the Coroner's Assistant may confirm whether the family has any questions they would like to ask the witness. The coroner will often give some latitude to questions from a family in circumstances where those questions may not be strictly relevant to a fact in issue.

Final submissions

Once all the witnesses have been heard, the interested parties may make submissions (orally or written) to the coroner.

The family may also be given the opportunity to provide a written or oral submission to the coroner. If the family is legally represented, then this submission can be put forward on their behalf by their legal practitioner.

Inquest finding

Once the coroner has heard all the relevant evidence they will usually adjourn to complete their finding. In very limited circumstances, they may give their finding on the same day. Most often the enquiry will be adjourned to a future date when the court will reconvene for the coroner to deliver the finding. See "12. Findings, comments and recommendations" for further information.

11.9 Witnesses

The coroner conducting the inquest determines the witnesses to be called (s 64).

Witnesses give evidence or produce material or information to the court. Witnesses help a coroner clarify the circumstances surrounding the death or fire (s 59).

A coroner may issue a summons to ensure a witness appears at the inquest (s 55).

If a coroner wishes to have someone appear as a witness, then that person will usually receive a summons in person. The summons will usually be delivered by a police officer acting on the coroner's behalf. The summons provides the details of the inquest, including where and when to attend.

If the witness fails to attend or produce any requested document or material, then the coroner may issue a warrant to arrest and order that person be brought to the court (s 59).

11.10 Expert witnesses

Why are expert witnesses engaged?

It may be necessary from time to time to seek the assistance of an expert to provide an independent opinion to a coroner in relation to specific questions the coroner may have about the circumstances surrounding the death. Such an expert may better inform a coroner when the coroner is making findings of fact, or comments and recommendations on matters of public health and safety and the administration of justice.

If a coroner requires the assistance of an expert, then the relevant professional colleges and associations may be asked to nominate the names of experts that match the coroner's request for assistance. The court then selects an expert based on a number of factors, including the expert's qualifications, availability, and timelines in the production of the report. A letter of engagement is then sent to the preferred expert witness, containing (among other things):

- the written direction from the coroner setting out the questions and/or issues that the expert witness is required to address in their report
- references to the expert's responsibilities, including when they must deliver the report to the court and
- the court's Code of Conduct for expert witnesses.

Can an interested party engage an expert witness?

Although the decision to engage an expert witness is ultimately up to the coroner (s 64), an interested party may make a submission to the coroner if they wish to call an expert witness. However, the coroner must be satisfied that an expert opinion would assist in resolving, clarifying, or informing the issues to be determined by the investigation.

If an interested party is permited by the coroner to call an expert witness, unless otherwise ordered, the interested party must pay any costs for that witness.

Is there a range of expert witnesses used?

Expert witnesses are wide-ranging and can include, but are not restricted to, people with medical, scientific, engineering, aeronautical, marine, mechanical, psychiatric or risk assessment expertise. The nature of the expertise sought will depend upon the nature of the facts in issue.

How long does it take an expert to produce an expert report?

The time it may take for a report to be produced for a coroner ultimately depends on the availability of the most suitable expert and the complexity of the matter.

11.11 Coroner not bound by rules of evidence

A coroner holding an inquest is not bound by the rules of evidence (s 62). The Act provides that Parts II, IIA and III of the *Evidence (Miscellaneous Provisions) Act 1958* (Vic) do not apply to the court (s 62). Unless otherwise provided in the Act, the *Evidence Act 2008* (Vic) also does not apply to the court (s 62).

A coroner's ability to examine evidence is not as limited as it may be in adversarial proceedings. This gives a coroner greater scope to receive information that may not be admissible in other proceedings and to have regard to its provenance when determining what weight should be given to the information. For example, evidence rules relating to the proof of documents generally do not apply to the court as they do in other proceedings. As a result, a coroner will usually be interested in any reliable evidence that may assist them in attempting to determine the matters required under the Act. A coroner will also be interested in any relevant information that may contribute to preventing future deaths and/or fires. This flexibility has been explained as a consequence of an inquest being a fact-finding exercise rather than a means of apportioning guilt – an inquiry rather than a trial.[95]

While a coroner is not bound by the rules of evidence, they are bound to act independently and according to evidence that is relevant and cogent. Coroners also need to exercise their powers and conduct their functions in a fair and efficient manner,[96] ensuring that the rules of natural justice are applied.[97] For example, a coroner must take great care to ensure that the nature of their conduct does not result in an apprehension of bias.[98] Further, a coroner must ensure that any person or entity that may potentially be the subject of adverse criticism is provided with the opportunity to be heard and fully understands the nature of any potential criticism.

Note that section 63 of the Act still provides for the recording of evidence, including oral evidence, provided at an inquest in accordance with the *Evidence (Miscellaneous Provisions) Act 1958*.

11.12 Evidence

It is often necessary for a coroner to obtain evidence or reports from a number of organisations to assist with the inquest. The nature of the evidence depends on the circumstances of the death.

Examples of the range of documents that may generally be available to a coroner as part of their investigation include:

- Australian Transport and Safety Bureau report (for aviation, marine and rail-related deaths)
- Chief Psychiatrist report (for a mental health-related death)
- Civil Aviation Services Australia report (for an aviation-related death)
- Justice Health report (for a Corrections-related death)
- Office of the Child Safety Commissioner report
- Office of the Corrections Services Review report (for a Corrections-related death)
- Office of Police Integrity report
- Root Cause Analysis report[99] (for a health service-related death)
- Victoria Police, Ethical Standards Department report
- Victoria Police, Major Collision Investigation Unit's report (for a motor vehicle-related death)
- WorkSafe report and investigator's file (for a workplace/industrial-related death)
- diagrams and photographs
- expert opinion / reports (for example, relating to overall management)
- mechanical expert report
- medical history (for a health service-related death).

Note that the evidence available to the interested parties will be subject to the principles of public interest immunity, in that some of the agencies that have compiled the above documents may seek to have the coroner not compel production of a report, or not order its dissemination.

Standard of proof at inquest

The civil standard of the balance of probabilities applies in coronial proceedings.[100] In determining whether a matter is proved to that standard, the court should consider the nature of the facts in issue[101] and give effect to the principles explained by Dixon CJ in *Briginshaw v Briginshaw*.[102]

This approach means that the more significant the issue, the more serious an allegation and the more inherently unlikely an occurrence, then the clearer and more persuasive the evidence must be for a coroner to be sufficiently satisfied that it has been proved to the civil standard.

The principles drawn from *Briginshaw v Briginshaw* do not create a new standard of proof, nor does it mean that coroners apply the criminal standard when the case involves allegations of criminal conduct. Instead, a coroner must consider the

95 *R v South London Coroner; ex parte Thompson* (1982) 126 SJ 625 per Lord Lane CJ,
96 *Coroners Act 2008*, section 9; *Harmsworth v State Coroner* [1989] VR 989 at 994; see also Freckelton I, "Inquest Law" in H Selby, *The Inquest Handbook* (1998) 13.
97 See, for example, *Annets v McCann* (1990) 170 CLR 596, 598.
98 *Annets v McCann* (1990) 170 CLR 596, 598.
99 Please note that these reports may not always be tendered as evidence (see *Health Services Act 1988* (Vic), section 139(4)).
100 Re State Coroner; ex parte Minister for Health (2009) 261 ALR 152 at [21].
101 *Anderson v Blashki* [1993] 2 VR 89 at 95.
102 (1938) 60 CLR 336 at 362–363.

seriousness of the matters alleged and may consider the consequences of an adverse finding for a particular witness.[103]

See, for example, *Secretary, Department of Health and Community Services v Gurvich*[104] where the Briginshaw test was applied to a coronial proceeding.[105]

11.13 Scope of a coroner's inquiry

In most cases the inquires that are made by a coroner will be clearly central to the cause of death and the circumstances of the death. While the coroner's investigation must be for the substantial purpose of making findings, in some instances there may be peripheral issues that the coroner must determine to be within or outside the scope of an inquest. Accordingly, a coroner is entitled to exercise judgment as to the inquiries that must be made to satisfy their obligations under sections 67 and 68 of the Act.

The scope of an inquiry is determined first and foremost by the Act. It is not conclusively determined by judicial decisions or dicta on other legislation. In *Lucas-Smith v Coroners Court of the Australian Capital Territory*[106] the scope of a coroner's inquiry and the issues that may be considered at an inquest were described as being limited. As there is no rule that can be applied to clearly delineate those limits, "common sense" should be applied. Chief Justice Higgins in this case also provided a helpful example of the limits, suggesting that factual questions related to cause will generally be within the scope of the inquest. However, it may be outside the scope of the inquest to consider policy questions, such as the appropriateness of resource allocations by government. As a result, a coronial inquiry is not an open-ended or roving commission of inquiry. A coronial inquiry is limited to the facts, matters and issues that are to be properly connected to the death. Accordingly, the evidence to be examined at an inquest must assist a coroner to make the findings required and any comments and/or recommendations (that may flow from these findings), as referred to in sections 67, 68 and 72 of the Act.

In *R v Doogan*[107] the Full Court of the Supreme Court of the Australian Capital Territory considered, among other things, the scope of a coroner's inquiry pursuant to the *Coroners Act 1997* (ACT). In the case it was stated that, while none of the suggested issues raised could be said to be irrelevant, some were nevertheless considered:

somewhat remote from the concept of the cause and origin of the fire, and any adequate investigation of them would involve not only substantial time and expense, but also delving into areas of public policy that are properly the prerogative of an elected government rather than a coroner or, indeed, any other judicial officer [108]

Furthermore, the Full Court stated that:

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

However, note that the above decision was based on the *Coroners Act* in the Australian Capital Territory, which contains neither a preamble nor objectives – unlike the Victorian Act.

In comparison to the Victorian and Australian Capital Territory's approach, the scope of a coroner's inquiry in the United Kingdom is very specific. For example, in the *Coroner's Rules 1984* (UK), rule 36 provides:[109]

(1) The proceedings and evidence at an inquest shall be directed solely to ascertaining the following matters, namely—
  (a) who the deceased was;
  (b) how, when and where the deceased came by his death;
  (c) the particulars for the time being required by the Registration Acts to be registered concerning the death.

(2) Neither a coroner nor the jury shall express any opinion on any other matters.

However as a result of *R (Middleton) v West Somerset Coroner*[110], the intended limits of rule 36 on the scope of the inquiry has to a large extent been circumnavigated, whereby Bingham LJ held that rule 36(1)(b) must be read broadly, that is, how the deceased person came by their death.

103 See also *Secretary to the Department of Health and Community Services v Gurvich* [1995] 2 VR 69 at 73–74 and *Hurley v Clements* [2009] QCA 167.
104 [1995] 2 VR 69, 73, per Southwell J.
105 I Freckelton and D Ranson, *Death Investigation and the Coroner's Inquest* (2006) 596.
106 [2009] ACTSC 40 ("Lucas-Smith").
107 [2005] ACTSC74, 12.
108 [2005] ACTSC74, 27.
109 Made pursuant to the *Coroners Act 1988* (UK). A very similar provision has been replicated in the new *Coroners and Justice Act 2009* (UK), section 5.
110 [2004] 2 All ER 465.

As illustrated above, the issue of the scope of a coronial inquiry is often one of some tension between various interested parties and sometimes between a coroner and an interested party. In addition to the case law listed above, there are a number of authorities across the nation that have addressed the issue of the scope of a coroner's inquiry[111]. Ultimately, however, the scope of each investigation must be decided on its facts and the authorities make it clear that there is not a universal test that is readily available to a coroner.

11.14 Relationship between coronial process and concurrent investigations and other proceedings

Coronial investigations are separate and distinct from criminal, civil and disciplinary actions, although there may be some overlap between them.[112] For example, coroners do not determine guilt as this is the role of the criminal courts. However, the court is required to notify the Director of Public Prosecutions if a coroner investigating the death or fire believes an indictable offence may have been committed in connection with the death or fire (s 49); but the coroner is prohibited from including in a finding (or comment) a statement that a person is, or may be, guilty of an offence (s 69(1)).

If a person has been charged with an indictable offence in respect of a death or fire that is being investigated by a coroner, then the Act provides that a coroner is not required to hold an inquest (s 52(3)(b)). However, this does not limit the powers of a coroner to hold, adjourn or recommence an inquest (s 52(4)).

If a coroner decides not to hold or discontinue an inquest because a person has been charged with an indictable offence, then the coroner will not be required to make findings if it would be inappropriate to do so.[113]

Criminal trials examine evidence with a view to determining guilt; whereas an inquest examines evidence for the purposes of finding the causes of deaths and fires and to contribute to the reduction in the number of preventable deaths and fires and the promotion of public health and safety and the administration of justice.[114]

While it would be uncommon for a coroner to open an inquest after a criminal trial that has resulted in the conviction of an accused person or persons, a coroner may do so in order to pursue an issue of public health or safety or the administration of justice that was not part of the criminal prosecution, but found to be connected to the death for a coroner's purposes.

11.15 Privilege in respect of self-incrimination

Figure 5, on the following page, provides an overview of the application of the section 57 privilege in respect of self-incrimination in other proceedings.

11.16 Legal protection of Australian lawyers, witnesses and interested parties at inquest

Section 75 of the Act provides for the legal protection of Australian lawyers, witnesses and interested parties at an inquest as follows:

- an Australian lawyer assisting a coroner at an inquest or representing a person at an inquest has the same protection and immunity as an Australian lawyer has appearing for a party in proceedings in the Supreme Court
- an interested party taking part in an inquest has the same protection as a party to proceedings in the Supreme Court
- a person summoned to attend an inquest or appearing before a coroner as a witness at an inquest has the same protection as a witness in proceedings in the Supreme Court.[115]

11.17 Contempt of court

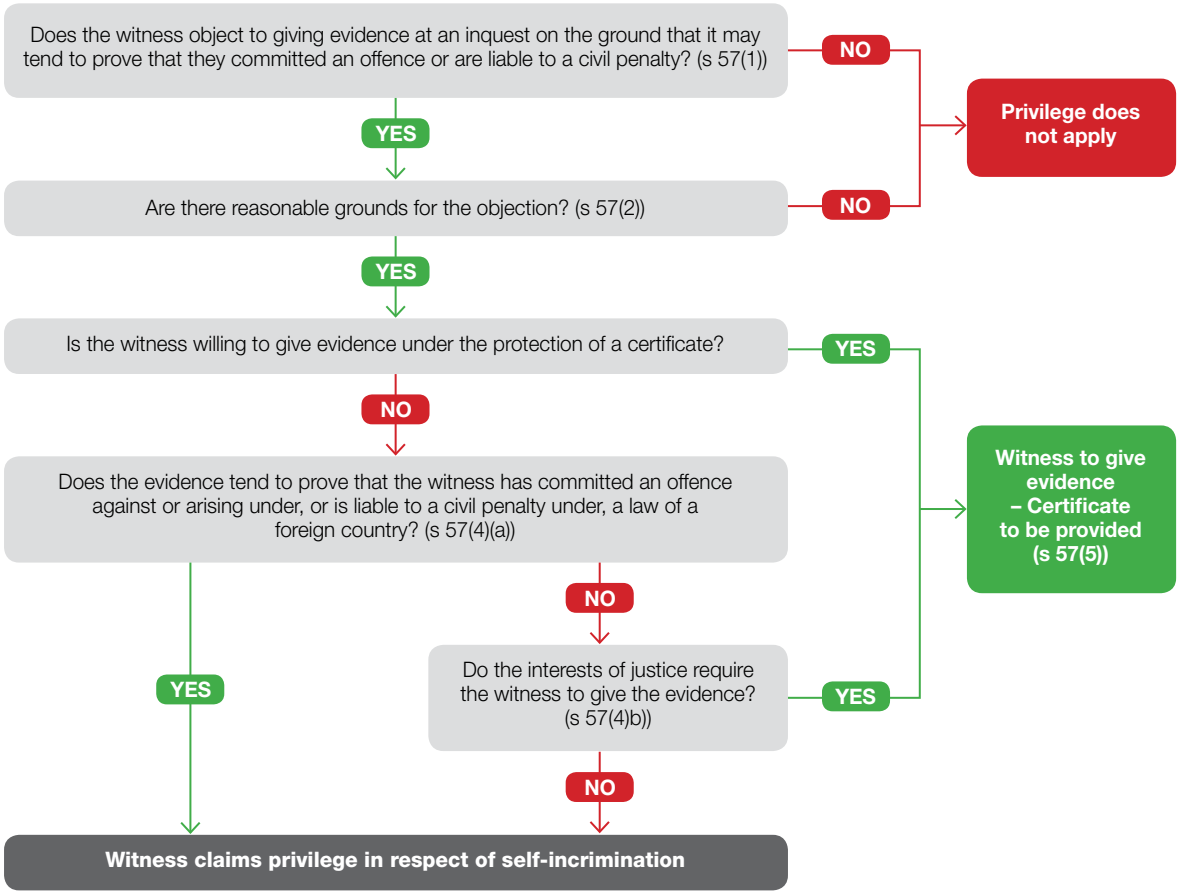
Section 103 of the Act relates to contempt of court. A person is guilty of contempt of court if they:

- wilfully fail to comply with a summons or order of a coroner
- insult an officer of the court while that officer is performing functions as an officer of the court
- insult, obstruct or hinder a person attending an inquest
- misbehave at, or interrupt, an inquest
- obstruct or hinder a person from complying with an order of a coroner or a summons to attend the court or
- do any other act that would, if the court were the Supreme Court, constitute contempt of that court.

If a coroner finds a person guilty of contempt of court, then the coroner may commit the person to prison for a term of up to 12 months or impose a fine of up to 120 penalty units[116] or, in the case of a corporation, impose a fine of up to 600 penalty units (s 103).

111 See *Harmsworth v State Coroner* [1989] VR 989; Grace v Saines [2004] VSC 229; *Commissioner of Police v Hallenstein* [1996] 2 VR 1; *Doomadgee & Anor v Deputy State Coroner Clements & Ors* [2005] QSC 357; *Thales Australia Limited v The Coroners Court of Victoria* [2011] VSC 133..
112 See I Freckelton and D Ranson, "Relationship of Inquests To Other Proceedings" in *Death Investigation and the Coroner's Inquest* (2006).
113 *Coroners Act 2008*, section 71.
114 Preamble to the *Coroners Act 2008*.
115 See also section 57 of the *Coroners Act 2008*.
116 As of 1 July 2010 one penalty unit is equivalent to $119.45.

Figure 5: privilege in respect of self-incrimination in other proceedings



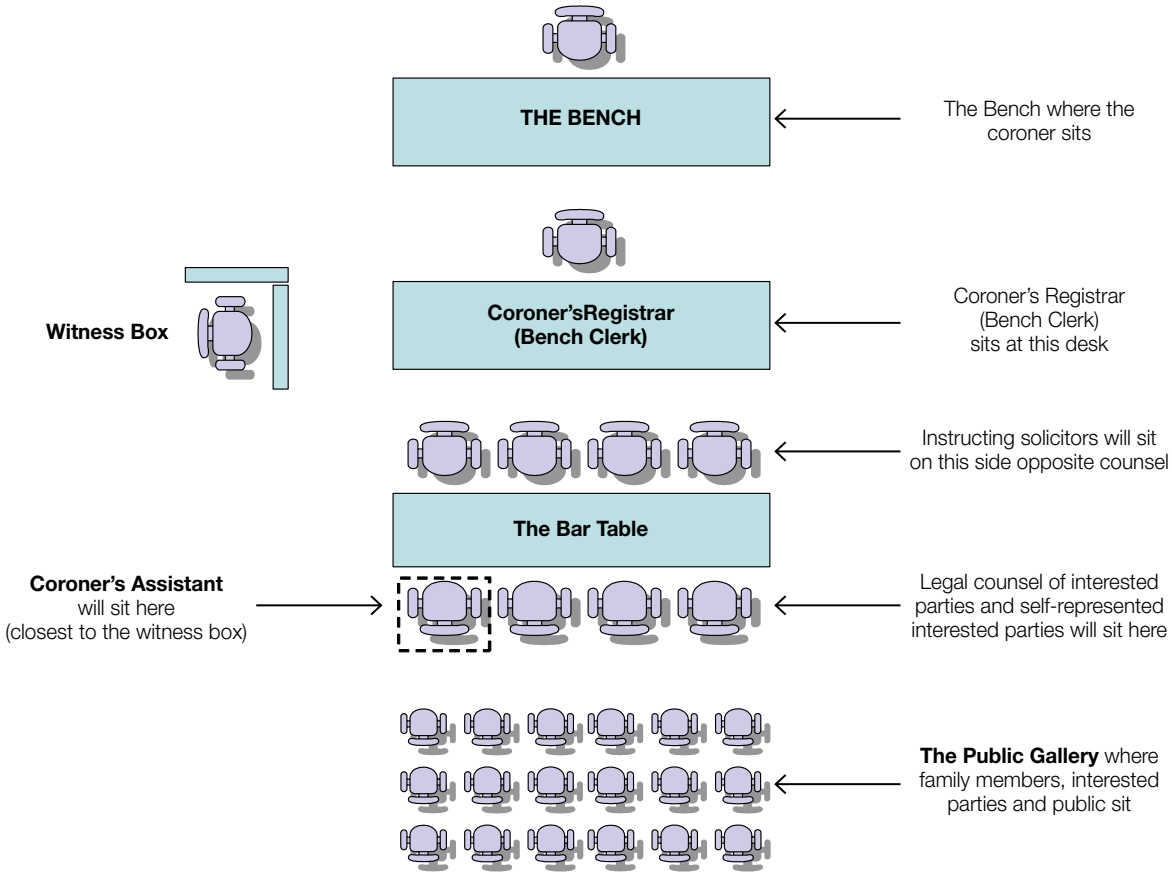
Please note that the above diagram is intended to be a general application of section 57 only and should be read in conjunction with section 128 of the *Evidence Act 2008* (Vic)

11.18 Courtroom setting

Figure 6, below, represents the general setting and layout of the courtroom at an inquest, indicating where the parties are generally positioned.

The setting may vary, depending on the circumstances of a case, such as the courtroom facility, number of interested parties to the inquest, or whether interpreters are required.

Figure 6: diagram of the courtroom setting



12. Findings, comments and recommendations

12.1 Findings

A finding is the formal ruling made by a coroner following an investigation into a death or fire. Except in certain circumstances, a finding is usually the final step in the investigation and is made whether an inquest is held or not.[117]

There are two types of findings: **"findings with inquest"** and **"findings without inquest"** (previously referred to as a "chambers finding"). The vast majority are findings without inquest that have been completed by a coroner based on all of the material gathered during the investigation without requiring a public hearing or inquest (as the coroner has decided that one is not required.[118])

The length of a finding can vary from a single page to numerous pages, depending on how complex the matter is.

Most findings take some time to prepare, particularly where an inquest has been held. In these circumstances, a coroner will usually adjourn the inquest until a later date to deliver their findings.

What information is included in a finding?

A finding with respect to a death will generally include the following information:

- the identity of the deceased person
- the cause of death
- the circumstances in which the death occurred (see below) and
- the particulars needed to register a death with the Registry of Births, Deaths and Marriages (ss 49(2), 67 *Coroners Act 2008* (Vic) ("the Act")).

A coroner is not required to make a finding with respect to the circumstances in which a death occurred if an inquest into the death was not held and the coroner finds that:

- the deceased person was not, immediately before they died, a person placed in custody or care and
- there is no public interest to be served in making a finding regarding those circumstances (see below for further information) (s 67(2)).

A coroner investigating a fire must find, if possible, the cause and origin of the fire and the circumstances in which the fire occurred (s 68).

What is in the public interest?

What is in the public interest has not been defined in the Act. As a result, there is little guidance as to what a coroner may consider in determining whether something is in the public interest. However, possible considerations may include, for example:

- the Preamble to the Act and the factors set out in section 8 of the Act
- whether a finding about the circumstances of a case will promote public health and safety
- whether a finding about the circumstances of the case will enhance the administration of justice
- other appropriate considerations relevant to a particular case.

When are findings not required?

A coroner is not required to make any findings in respect of a death they are investigating if:

- they have decided either not to hold an inquest or to discontinue an inquest, because a person has been charged with an indictable offence in respect of the death and
- based on this information, the coroner considers that making findings would be inappropriate in the circumstances (s 71).

Can a coroner determine guilt?

A coroner must not include in a finding or comment any statement that a person is, or may be, guilty of an offence. However, this does not prevent a coroner from including a comment that they have notified the Director of Public Prosecutions that a person is, or may be, guilty of an offence (s 69).

12.2 Comments in findings

In their findings, a coroner may comment on any matter connected with the death, including matters relating to public health and safety or the administration of justice (s 67(3)).

In *Commissioner of Police v Clements & Ors*,[119] it was considered that a coroner's comments must

117 Note that the court may re-open the investigation if it considers it appropriate. See *Coroners Act 2008*, section 77.
118 See "11.4. Deciding whether to hold an inquest".
119 [2006] 1 Qd R 210 at 217.

be connected with the particular death but can also be directed at wider issues, such as ways to prevent similar deaths from occurring in the future.[120] However, the power to make comments does not enlarge the scope of a coroner's jurisdiction.[121] See "11.13. Scope of a coroner's inquiry" for further information.

12.3 Recommendations in findings

In contrast to the former Act, coroners now have a greater scope to make recommendations since 1 November 2009. In addition to making recommendations to "any Minister or public statutory authority", under the 2008 Act a coroner may now make recommendations to any "entity" on any matter connected with a death or fire (s 72).

Recommendations should be connected to the death or fire but the 2008 Act does not otherwise limit the matters to which a coroner's recommendations may relate. However, it is clear that coronial recommendations are intended to contribute to reducing the number of preventable deaths and fires and promoting public health and safety and the administration of justice.[122] Accordingly, recommendations may for example include consideration of broader issues, such as:

- safety procedures and information provision
- staff training and communication
- any problems in patient management and emergency procedures (in health services-related deaths).

In *Conway v Jerram*[123] Barr AJ commented:

> The power of a coroner to make recommendations about matters of public health and safety seems apt to enable a coroner to consider matters outside the scope of what may be considered necessary to determine the manner and cause of death.

Can interested parties offer possible recommendations?

It is not the role of a coroner to apportion liability or guilt. Alternatively, a coroner plays a significant role in contributing to the reduction in the number of preventable deaths and fires and the promotion of public health and safety.[124] Therefore merely defending a "position", as is generally the case in the adversarial system, has no place at an inquest. Instead, a coroner relies on receiving information that may assist and maximise their preventative role. For this reason, interested parties and bereaved families may assist and strengthen the coroner's preventative role by offering possible recommendations in their final submissions to the coroner. However, this does not mean that such input will necessarily form part of the coroner's recommendations.

Who must respond to a coroner's recommendation(s)?

If a public statutory authority or entity receives recommendations made by a coroner, then it must provide a written response no later than three months after the date of receiving the recommendations. The written response by the public statutory authority or entity must specify a statement of action (if any) that has been, is being or will be taken in relation to the coroner's recommendations (s 72).

Figure 7 summarises the guidelines developed by the Coroners Court ("the court') to assist with responding to coroners' recommendations. They are suggested guidelines only. They contain the possible categories of responses to a coroner's recommendation and the suggested information that ought to be included in order for the public statutory authority or entity to fulfil their statutory obligations.

Are responses to recommendations published or distributed?

A copy of the public authority's or entity's response to a recommendation is now required to be published on the internet (s 72(5)(a)). A copy of the response must also be provided by the court to:

- any person who is considered by the court's Principal Registrar to have sufficient interest in the subject matter of the recommendations
- any person who has advised the court's Principal Registrar of an interest in the subject matter of the recommendations (s 72(5)(b)).

As previously discussed, these people may differ from those parties that have been granted status as interested parties; they may be people who simply have an interest in the subject matter of the inquest (i.e. information recipients). See "8.5. Others with 'interest' in the inquest" for further information.

120 *Commissioner of Police v Clements & Ors* [2006] 1 Qd R 210 at 217.
121 Doogan at [41]; see also Harmsworth at 996.
122 See the Preamble to the *Coroners Act 2008* and the provisions dealing with purposes (s (1)(c)), objectives (s 8(f)), findings (ss 67, 68), and reports and recommendations (ss 72, 73).
123 [2010] NSWSC 371 at 63.
124 Preamble to the *Coroners Act 2008*.

Figure 7: guidelines for responding to a coroner's recommendations

Category of a response to recommendations	Suggested information to be included in the response
A coroner's recommendation has or will be implemented	If the recommendation has been implemented, then the party should specify when this implementation took place and provide evidence demonstrating that the recommendation was implemented and what measures were taken to do so. Examples of this include amendments to existing legislation or regulations, development of new policy, procedures or standards, promotion of personal/community behaviour or change, new or additional training and education or new infrastructure or products.
An alternative to a coroner's recommendation has or will be implemented	If the recommendation will not implemented, then an explanation should be provided, along with what the alternative will be and the reasons for its implementation as an alternative to a coroner's recommendation.
Coroner's recommendation is under consideration	Outline the process by which the recommended intervention will be considered. Specify the time frame for making the decision.
There are unresolved issues with a coroner's recommendations that need to be addressed	Unresolved issues should be explained and a range of alternative solutions to such issues or interventions should be suggested.
A coroner's recommendation is unable to be implemented	Reasons for this and a range of alternative solutions to the issues should be provided.

12.4 Publication of findings, comments and recommendations

Unless a coroner orders otherwise, findings, comments and recommendations following an inquest will generally be published on the court's website www.coronerscourt.vic.gov.au (s 73(1)). While there is no requirement in the Act to publish a finding where there was no inquest,[125] a coroner may choose to order the publication of such a finding if they believe it is in the public interest. In coming to this decision the coroner will consider the principles enshrined in section 8 of the Act – in particular, the need to balance the public interest in protecting a living or deceased person's personal or health information with the public interest in the legitimate use of that information.

If findings without inquest do contain recommendations, then those findings will generally be published along with any response to those recommendations from the public statutory authority or entity. See "Are responses to recommendations published or distributed?", above, for further information.

Families who do not wish the finding to be published on the internet (for example, due to the nature of the death) may make a submission to the coroner that either part or all of the finding not be published. It will then be for the coroner to decide whether to grant this request.

12.5 Rulings and suppression orders

A coroner may direct that a suppression order and/or ruling be published on the court's website www.coronerscourt.vic.gov.au. This may occur where, for example, a coroner grants a witness immunity from self-incrimination. See "Restrictions on publication of reports", under "12.7 Access to findings", for further information.

12.6 Distribution of findings

A coroner determines who will receive a copy of their finding. For example, copies of findings may be sent to any person or organisation who the coroner believes may have an interest in the subject of the findings (for example, a health practitioner board that may be interested in the conduct of a nurse or doctor).

125 Findings without inquests generally do not contain recommendations.

Generally, the family of the deceased person and interested parties (as determined by the coroner) will also receive a copy of the finding.

See "Others with 'interest' in the inquest" in "8. Interested parties" for further information.

12.7 Access to findings

As previously mentioned, unless a coroner orders otherwise, findings following an inquest will be published on the court's website www.coronerscourt.vic.gov.au (s 73(1)).

To access those findings without inquest that have not been published on the website, please contact the court on 1300 309 519.

Restrictions on publication of reports

A coroner may choose to restrict publication of a document, material, or evidence provided as part of an investigation or inquest into a death or fire. This is generally referred to as a "suppression order". A coroner must order that a report about any documents, material or evidence provided to a coroner as part of an investigation or inquest into a death or fire is not to be published if the coroner reasonably believes that:

- publication would be likely to prejudice the fair trial of a person or
- publication would be contrary to the public interest (s 73).

Interested parties may, as part of their submission to a coroner, request such restrictions. An example of such a restriction may be a hospital's Root Cause Analysis report, which is usually considered by health services to be a sensitive document.[126]

12.8 Setting aside a finding and re-opening an investigation

Any person may apply to the court for an order that some or all of the findings of a coroner be set aside. An application can be made by completing a Form 43 ("Application to Set Aside Finding"),[127] which is available on the court's website at www.coronerscourt.vic.gov.au.

The court can set aside some or all of the findings and order that an investigation be re-opened if a coroner is satisfied that there are new facts and circumstances and it is appropriate to do so (s 77).

If a coroner refuses to re-open an investigation, then a person has the right to appeal to the Supreme Court within three months of that refusal (s 84).

Alternatively, a person with sufficient interest in the investigation or an interested party[128] has the right to appeal directly to the Supreme Court against the findings of a coroner within six months from the date of the finding (s 83).

See "14. Appeals to the Supreme Court" for further information.

126 The Root Cause Analysis (RCA) is a process analysis method, which can be used to identify the factors that cause adverse events. The RCA process is a critical feature of any safety management system because it enables answers to be found to the questions posed by high risk, high impact events: notably, what happened, why it occurred and what can be done to prevent it from happening again. (Courtesy of the State Government of Victoria, Department of Health, Victorian Government health information).

127 See rule 65(1) of the *Coroners Court Rules 2009* and section 77 of the Act.

128 As determined by the coroner pursuant to section 56 of the Act.

13. Access to documents

13.1 Types of documents

When a coroner investigates a death or fire, the Coroners Court ("the court") gathers a range of documents. The number of documents the court file may contain will depend on the complexity of the investigation.

Types of documents can include:

- police reports
- witness statements
- photographs
- expert reports
- medical examination reports.

Some of these documents will form part of the inquest brief (see "7. Inquest briefs" for further information).

13.2 Categories of access

A coroner must not release a document relating to the investigation except as permitted under the *Coroners Act 2008* (Vic) ("the Act") or any other law (s 115(6)).

Under section 115(2), a coroner may also release documents to:

- an interested party if the coroner is satisfied that party has a sufficient interest in the document [129]
- a statutory body if the coroner is satisfied that the release of the document is required to allow the statutory body to exercise a statutory function
- a member of the police force for law enforcement purposes
- a person who is conducting research if the coroner is satisfied that the research has been approved by an appropriate human research ethics committee
- any person if the coroner is satisfied that the release is in the public interest
- a person whom the coroner is satisfied has a sufficient interest in the document[130].

In deciding whether to provide access to documents to certain parties, a coroner may have regard to whether there is a reasonable possibility that the material will materially assist the party.[131] The coroner should also, as far as possible in the circumstances, have regard to the factors set out in section 8 of the Act.[132] In particular, the coroner may need to balance the public interest in protecting a living or deceased person's personal or health information with the public interest in the legitimate use of that information (s 8(e)).

The court may also contact the senior next of kin upon receipt of an access request to let them know that there is a request from a third party for a document and to ask whether they have any concerns regarding the release of the requested document(s). The coroner will then consider these concerns before deciding whether to release the document(s).

Figure 8 provides an overview of the range of documents that a coroner may release under section 115 of the Act.

13.3 Conditions that may be imposed on released documents

The Act contains provisions allowing a coroner to impose conditions on the release of any document(s) that has been released under the Act (s 115(3)). These conditions are generally imposed in order to prevent the unwanted dissemination of any document(s) or information that a coroner has released. The conditions generally relate to the use of those document(s).

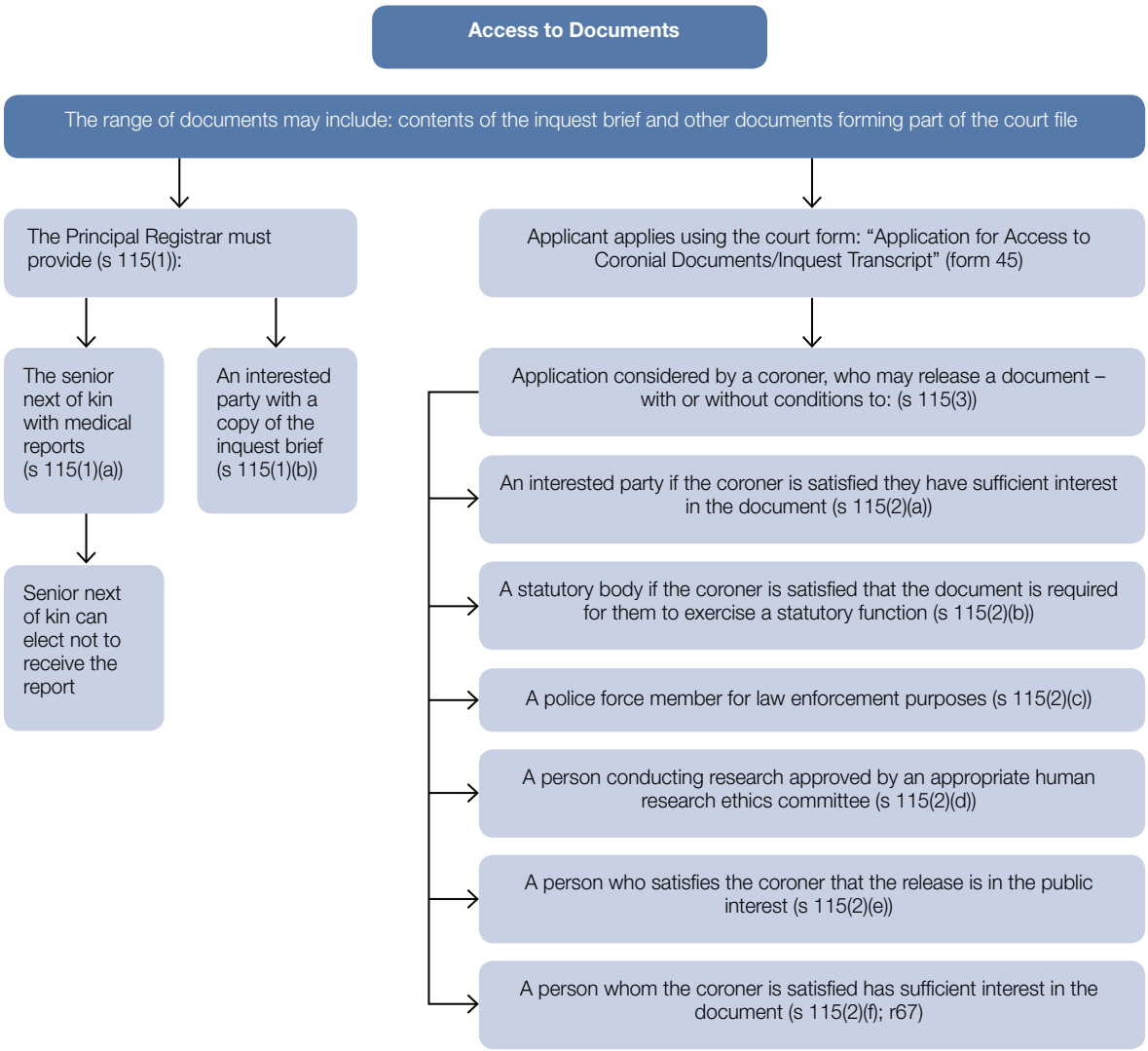
For example:

- an autopsy report may be released to a hospital on the condition that the document can be viewed only by the treating doctors or for the purpose of discovering how a patient died.
- a researcher may be required to sign a deed of confidentiality and destroy copies of the documents at the conclusion of their research project.

The Act imposes penalties (60 penalty units)[133] for breaching any conditions imposed on the release of a document (s 115(4)).

129 Note that an "interested party" in this section is as defined in section 3 of the Act (that is, a person granted leave under section 56 to appear at the inquest).
130 See rule 67 of the *Coroners Court Rules 2009* and section 115(2)(f) of the Act.
131 *Alister v R* (1984) 154 CLR 404, 414; *Smith v Western Australia* (2000) 98 FCR 359, 4.
132 See also *Coroners Bill 2008*, Explanatory Memorandum, clause 115.
133 As of 1 July 2010 one penalty unit is equivalent to $119.45.

Figure 8: documents available under section 115 of the Act



13.4 Applying for access

A person applying to a coroner for access to a document and/or transcript held by the coroner under section 115(2) must complete a Form 45 ("Application for Access to Coronial Documents / Inquest Transcript"),[134] and specify the materials sought and the reasons for requesting access.

This form is available on the court's website at www.coronerscourt.vic.gov.au.

For example, an organisation such as a hospital may have sufficient interest in obtaining a copy of an autopsy report for the purpose of conveying the cause of death to the clinical treating team (s 115(2)(f)).

How long will it take to receive the materials?

The time it will take to receive a released document and/or transcript will vary and depend on a range of matters, such as how recent the matter is, the volume of the material sought and/or whether any person is required to be put on notice about the request for the material.

Are there any fees?

The applicant may be required to pay processing charges in respect of their application. However, the court may waive or reduce these charges if appropriate.

At the time of publication of this handbook the standard fees are:

- no more than $1.00 per page for black and white copy
- no more than $2.00 per page for a colour copy.

See the court's website www.coronerscourt.vic.gov.au for updated information as these fees may vary.

134 See rule 67 of the *Coroners Court Rules 2009* and sections 115 and 63 of the Act.

Does freedom of information legislation apply to the court?

The *Freedom of Information Act 1982* (Vic) gives a person the right to access their personal and non-personal information held by government agencies.

However, the court is not subject to the provisions contained in section 6 of the *Freedom of Information Act*, relating to accessing documents held by the court.

14. Appeals to the Supreme Court

The *Coroners Act 2008* ("the Act") provides for appeals from the Coroners Court of Victoria to the Supreme Court of Victoria on a question of law.[135]

Part 7 of the Act contains appeal provisions in relation to:

- a coroner's determination that a death is not a reportable death
- a coroner's direction that an autopsy be performed
- a coroner's refusal to direct an autopsy following a request
- a determination of a coroner not to investigate a fire
- an authorisation of exhumation
- a refusal to authorise an exhumation following a request
- a coroner's determination not to hold an inquest following a request
- the findings of a coroner
- a refusal by a coroner to re-open an investigation
- an order to release a body.

For examples of decisions where a coroner's decision to order an autopsy has been overturned by the Supreme Court of Victoria, see:

- *Green v Johnstone* [1995] 2 VR 176
- *Horvath v State Coroner* [2004] VSC 452
- *Saunders v State Coroner of Victoria* [2005] VSC 460
- *Mapapalangi & Anor v State Coroner of Victoria* [2008] VSC 535

For examples of decisions where a coroner's decision to order an autopsy has been upheld in the Supreme Court of Victoria, see:

- *Magdziarz v Heffey* [1995] VSC 201
- *Resetar v State Coroner of Victoria* [2006] VSC 211

For an example of a decision in the Supreme Court of Victoria against a coroner's direction relating to the release of body, see *Threlfall v Threlfall* [2009] VSC 283.

A person can institute an appeal under Part 7 of the Act by filing a Notice of Appeal in the Trial Division of the Supreme Court.[136]

As soon as practicable after filing the notice, the appellant must deliver a copy of the Notice of Appeal to the coroner's Registrar or "other proper officer" of the Coroners Court.[137]

135 *Coroners Act 2008*, section 87.
136 *Supreme Court (General Civil Procedure) Rules 2005* (Vic), Order 58.34.
137 *Supreme Court (General Civil Procedure) Rules 2005* (Vic), Order 58.35.

List of court forms

The following forms, extracted from the *Coroners Court Rules 2009* (Vic), can be downloaded from the court's website www.coronerscourt.vic.gov.au:

Request to Investigate a Fire (Form 16)
Application for Exhumation (Form 20)
Application for the Release of Body (Form 25)
Request for Inquest into Death (Form 26)
Request for Inquest into Fire (Form 27)
Application for Leave to Appear as an Interested Party (Form 31)
Application to Access or have Released Seized or Received Things (Form 34)
Application to Set Aside Finding (Form 43)
Application for Access to Coronial Documents / Inquest Transcript (Form 45)

List of court brochures

The following brochures can be downloaded from the court's website www.coronerscourt.vic.gov.au or requested by contacting the court on 1300 309 519:

Family and Community Support Services
What do I do now?
Inquest
Findings
Reviewable deaths
Disaster Victim Identification
Coroners Prevention Unit
Access to documents
The Coroners Process: Information for family and friends

The court will offer the applicable brochures to bereaved families at various points throughout the coronial process.

Contacts within the court

The following areas of the court can answer the specific questions listed, as well as more general questions:

Initial Investigations Office *can answer questions relating to:*

- whether a death is a reportable or reviewable death
- lodging a request to the coroner to reconsider an autopsy direction
- when a deceased person will be released from the care of the court

Family and Community Support Service *can answer questions relating to:*

- counselling and letters of support for individuals and families

Registry *can answer questions relating to:*

- medical records in the court's possession
- statements that have been requested by a coroner
- things / samples seized, taken or received on behalf of a coroner
- exhumations
- leave to appear as an interested party
- inquest briefs
- direction hearings
- inquest hearings
- findings
- applications to set aside a finding
- access to coronial documents

Coroners Prevention Unit *can answer questions relating to:*

- responses to coronial recommendations

For all other questions our reception staff will be able to direct your queries to the appropriate area.

Useful contacts

Coroners Court of Victoria

Level 11, 222 Exhibition Street Melbourne VIC 3000
T 1300 309 519
F 1300 546 989
W www.coronerscourt.vic.gov.au

Donor Tissue Bank of Victoria
T (03) 9684 4444
W www.vifm.org

Federation of Community Legal Centres
T (03) 9652 1500
W www.communitylaw.org.au

Human Rights Law Resource Centre
T (03) 8636 4450
W www.hrlrc.org.au

Interpreter Service
(Translating and Interpreting Service)
T 131 450

Law Institute of Victoria
T (03) 9607 9311
W www.liv.asn.au

National Relay Service TTY Service
(for hearing impaired)
T 133 677
(Speak and listen) 1300 555 727
W www.relayservice.com.au

Police Coronial Support Unit (PCSU)
T (03) 9685 1131

Public Interest Law Clearing House
T (03) 8636 4400
W www.pilch.org.au

Public Records Office of Victoria
T (03) 9348 5600
W www.prov.vic.gov.au

Supreme Court of Victoria
T (03) 9603 6111

Victorian Aboriginal Legal Service
T (03) 9419 3888 / 1800 064 865
W www.vals.org.au

Victorian Assisted Reproductive
Technology Authority
T (03) 8601 5250
W www.varta.org.au

Victorian Court Information and
Welfare Network
T (03) 9603 7433 / 1800 681 614
W www.courtnetwork.com.au

Victorian Institute of Forensic Medicine
T (03) 9684 4444
W www.vifm.org

Victoria Legal Aid
T (03) 9269 0234 / 1800 677 402
W www.legalaid.vic.gov.au

Victorian Registry of Births, Deaths and
Marriages
T 1300 369 367
W www.bdm.vic.gov.au

Victims Support Agency
T 1800 819 817
W www.justice.vic.gov.au/victimsofcrime

Further resources

Articles/Books/Reports

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We acknowledge Dr Ian Freckelton S.C. who has provided the majority of the above listed further resources.

Coroners Court of Victoria

Level 11, 222 Exhibition Street Melbourne VIC 3000 [DX 212560]
T 1300 309 519
F 1300 546 989
www.coronerscourt.vic.gov.au