Guidance on whether to request an inquest

Coroners Court of Victoria

It is a common misunderstanding that every death reported to a coroner is the subject of an inquest (public hearing). Inquests are only *a part* of some coronial investigations and only account for less than 1% of deaths reported to the coroner each year.

The *Coroners Act 2008* provides that, unless the death probably occurred more than 50 years before it was reported to the coroner, coroners must hold an inquest into the death if:

- the death or cause of death occurred in Victoria; and
- the coroner suspects that the death was due to homicide; or
- the deceased was, immediately before their death, a person placed in custody or care (unless the death was due to natural causes); or
- the deceased's identity is unknown.

It is important to note that, regardless of whether a public hearing is held, a coroner must conduct a coronial investigation into:

- all reportable and reviewable deaths and make findings, if possible, as to:
  - the identity of the deceased;
  - the medical cause of death; and
  - where appropriate, the circumstances in which the death occurred; and
- where appropriate, a fire and make findings, if possible, as to:
  - the cause and origin of the fire; and
  - the circumstances in which the fire occurred.

As a result of their investigation, the coroner may also comment on or make recommendations in relation to any matter connected with a death or fire, including matters relating to public health and safety or the administration of justice.[1] The power to comment or make recommendations is incidental to the obligation to make findings. As such, coroners are not allowed to conduct an inquest for the sole or dominant purpose of making comment or recommendations.[2]

In any matter where it is not mandatory to hold an inquest, the decision whether to hold an inquest is at the discretion of the coroner handling the investigation.

[1] Sections 67(3) and 72(2) of the *Coroners Act 2008.*

[2] *Thales Australia Limited v The Coroners Court & Ors* [2011] VSC 133 at [67].

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A coroner should not allow an inquest to be used for improper purpose. An inquest is not an opportunity to:

- investigate possible criminal conduct and compile a brief of evidence in preparation for a future criminal trial;
- gather or test evidence solely in preparation for a civil claim;
- use the inquest as a 'political platform' to advance a cause or to make damaging or 'baseless allegations' not relevant to the coronial function; or
- for family members to perpetuate a family dispute.

While none of the following factors are determinative of the matter, a coroner may consider the following factors in deciding whether to hold an inquest:

a. whether the medical cause of death cannot be established without holding an inquest (e.g. uncertainty or conflicting expert opinions about the cause of death);

b. whether the circumstances in which the death occurred cannot be established without holding an inquest;

c. whether there is such uncertainty or conflict of evidence as to justify the use of the judicial forensic process;

d. the efficient use of the resources available to a coroner, including whether there have been any other similar inquiries and investigations by other investigative authorities, official bodies or statutory authorities;

e. whether all the relevant public issues relating to the death have been canvassed by the criminal law judicial process;

f. whether an inquest is likely to assist in maintaining public confidence in the administration of justice, health services or other public agencies;

g. whether an inquest is likely to uncover systemic defects or risks not already known;

h. whether an inquest is likely to provide additional information that has not already been disclosed within the evidence available to the coroner during their investigation;

i. that a death, when grouped with other deaths that have occurred in similar circumstances, indicates that there may be an unexpected increase in danger in a location, area, family, industry or activity;

j. that there has been an incident involving multiple deaths;

k. that it is not possible to exclude the involvement of a third party in procuring the death or in failing to prevent it;

l. that an inquest will provide the opportunity to compel a witness to give evidence, using section 57 of the Act;

m. whether an inquest may help to prevent similar deaths;

n. whether restorative and/or preventative measures have been implemented in response to a death;

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o. whether previous inquests have dealt with similar deaths and made recommendations for reform that have not been adopted;

p. whether drawing attention to the death may highlight the risk of similar deaths (either increase or decrease);

q. the emotional burden that holding an inquest would place on the relatives and other participants;

r. whether a coroner is considering making an adverse comment against a person or institution;

s. any other matter the coroner considers relevant.

Note: The matters contained in this document are general in nature and do not constitute legal advice. Persons who are considering whether to request that an inquest be held are encouraged to obtain independent legal advice regarding the circumstances of their case.

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