Coroners Court of Victoria

# The Coroners Process

## Information for family and friends

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This booklet is written to help the family and friends of any person whose death is reported to the court.

DISCLAIMER

This booklet is a general guide and is not intended as a substitute for legal advice. In case of a dispute, a person is strongly urged to seek the assistance of a lawyer or one of the agencies listed in the booklet. While care has been taken to ensure the accuracy of the material contained in this publication, no responsibility can be taken for any errors or omissions.

# Interpreting services

**English**

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

The interpreting and translation services are made by prior arrangement between the service and the court, the cost of which is covered by the court.

**عربي – Arabic**

بإستطاعة المحكمة أن ترتب خدمات الترجمة الشفوية لمساعدة الأشخاص الذين يتحدرون من أصول ثقافية متنوعة ليتمكنوا من الحصول على وفهم إجراءات التحقيق في اسباب الوفيات بشكل أفضل.

يتم تقديم خدمة الترجمة الشفوية والكتابية بالتنسيق المسبق بين الخدمة والمحكمة، وستغطي المحكمة مصاريف الخدمة.

**ភាសាខ្មែរ – Cambodian**

តុលាការអាចរៀបចំកិច្ចបំរើបកប្រែភាសាដើម្បីជួយដល់អ្នកដែលមានសាវតារបួធម៌ផ្សេងៗគ្នា ដើម្បីឲ្យមានលទ្ធភាពទទួលការជ្រួតជ្រាបហើយដឹងយល់កាន់តែច្បាស់អំពីជំណើរការស៊ើបអង្កេតសពន្លូវមូលហេតុលើការស្លាប់។

កិច្ចបំរើបកប្រែភាសាសរសេរ និងភាសានិយាយអាចធ្វើឡើងដោយមានការរៀបចំទុកជាមុន រវាងកិច្ចបំរើ និងតុលាការ ហើយការចំណាយ នឹងបានចេញថ្លៃដោយតុលាការ។

**简体中文 – Chinese Simplified**

法院可以安排口译服务，协助来自不同文化背景的人更好地介入和了解验尸流程。

口译和笔译服务由服务机构和法院事先安排，费用由法院承担。

**Hrvatski – Croatian**

Da bi se osobama koje dolaze iz različitih kulturoloških sredina osigurao bolji pristup i lakše razumijevanje istražnog mrtvozorničkog postupka, sud im može organizirati pomoć tumača.

Usluge prevođenja i tumačenja pružaju se na osnovu prethodnog dogovora između jezične službe i suda, a ove troškove snosi sud.

**Ελληνικά – Greek**

Το δικαστήριο μπορεί να κανονίσει υπηρεσίες διερμηνείας για να βοηθήσει άτομα με διαφορετική πολιτιστική καταγωγή να έχουν πρόσβαση και να κατανοήσουν την ιατροδικαστική διαδικασία.

Οι υπηρεσίες διερμηνείας και μετάφρασης κανονίζονται από πριν μεταξύ της υπηρεσίας και του δικαστηρίου, το κόστος καλύπτεται από το δικαστήριο.

**हिन्दी – Hindi**

सांस्कृतिकता की विविध पृष्ठभूमि के लोग कोरोनरी (मृत्यु-जाँच) प्रक्रिया का बेहतर इस्तेमाल कर सकें और उसे समझ सकें, इसके लिए अदालत दुभाषिए की सेवा का आयोजन कर सकती है।

दुभाषिए और अनुवाद की सेवाओं के लिए अदालत को सेवा प्रदाता के साथ पहले से इंतजाम करना होता है और इसका खर्च अदालत वहन करती है।

**Italiano – Italian**

Il tribunale può organizzare la partecipazione di un interprete per aiutare chi non parla l'inglese a meglio capire e accedere alle procedure del medico legale.

I servizi di traduzione e interpretariato vengono organizzati anticipatamente dal fornitore del servizio e il tribunale, a spese del tribunale.

**Македонски – Macedonian**

Судот може да обезбеди преведување за луѓето кои потекнуваат од различни културни средини, за да имаат подобар пристап и за да можат полесно да го разберат процесот на судско вештачење.

Услугите за преведување претходно се договараат меѓу понудувачот на услуги и судот, а трошоците за нив ги сноси судот.

**Wersja polska – Polish**

Sąd może zorganizować usługi tłumaczy dla osób różnego pochodzenia kulturowego w celu lepszego zrozumienia procedury urzędu kornera.

Usługi tłumaczy organizowane są z wyprzedzeniem przez sąd i biuro tłumaczy, a ich koszt jest pokrywany przez sąd.

**Русский – Russian**

Суд может предоставить переводчиков в помощь людям различного этнического происхождения для обеспечения большей доступности и лучшего понимания коронерского процесса.

Услуги по устному и письменному переводу предоставляются по предварительной договоренности между переводческой службой и судом, причем услуги переводчика оплачивает суд.

**Српски – Serbian**

Суд може да ангажује тумача да помогне особама различитог културног порекла како би имале бољи приступ и лакше разумеле судско-медицински поступак.

Услуге тумача и преводилаца су обезбеђене ранијим договором између службе тумача и преводилаца и суда, а трошкове сноси суд.

**Soomaali – Somali**

Maxkamada ayaa abaabuli karta adeega turjumida si ay u caawinto dadka dhaqan iyo luqad ahaan kala jaadjaadka ah si ay u helaan si fiicana ugu fahmaan habka baarista sababta dhimashada.

Adeegyada turjumaada qoraalka iyo afcelinta horay ayaa loo sii samaystaa qorshe wuxuuna ka dhexeeya adeega iyo maxkamada, kharajkana waxaa bixinaya maxkamadda.

**Español – Spanish**

El tribunal puede organizar servicios de interpretación para que las personas provenientes de distintas culturas puedan acceder al proceso forense y comprenderlo mejor.

Los servicios de interpretación y traducción se acuerdan previamente entre el servicio y el tribunal. El costo de dichos servicios lo cubre el tribunal.

**Türkçe – Turkish**

Mahkeme, farklı kültürel kökene sahip kişilerin şüpheli ölüm olaylarıyla ilgili soruşturma sürecinden daha iyi yararlanabilme ve bu süreci daha iyi anlayabilmelerinde yardımcı olmak için sözlü tercümanlık hizmeti sağlayabilir.

Sözlü ve yazılı tercümanlık hizmetleri servis ile mahkeme arasında önceden kararlaştırılarak sağlanmakta ve masraflar mahkeme tarafından karşılanmaktadır.

**Tiếng Việt – Vietnamese**

Tòa án có thể sắp xếp các dịch vụ thông ngôn để hỗ trợ những người có nguồn gốc văn hóa khác nhau có thể tiếp cận và hiểu rõ hơn về quy trình điều tra một vụ chết bất thường.

Các dịch vụ thông ngôn và phiên dịch được thực hiện nhờ sự sắp xếp trước giữa dịch vụ và tòa án. Chi phí dịch vụ sẽ do tòa án chi trả.

# Contents

# Introduction

## State Coroner's Message

The death of a partner, child, friend, family member or colleague is likely to be the most difficult and painful experience any one of us can go through.

When a death occurs suddenly, unexpectedly, or in traumatic circumstances it can have an overwhelming impact.

This booklet has been designed to assist in understanding the coronial process and to provide information about support available to families and friends whose loved one's death is being investigated by the Coroners Court of Victoria.

We understand most people will have little or no contact with the court until the death of a loved one is investigated by our jurisdiction.

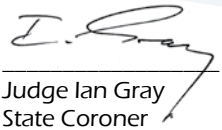
We recognise this unique situation often results in people having a limited understanding of our functions or why it is necessary for us to carry out the work that we do.

This can be distressing, frightening and frustrating for families and friends who are seeking an explanation as to how and why their loved one died.

We hope this booklet provides answers to many of your important questions and enables you to gain some understanding of our processes.

We aim in all our investigations to determine, as best we can, what happened and why, and how we may prevent further deaths occurring in similar circumstances.

Your involvement and understanding of what we do is a crucial part of this process and we will seek at all times to provide you with information where it is possible and appropriate.



Judge Ian Gray
State Coroner


CORONERS
COURT

## Objectives of the *Coroners Act 2008*

The *Coroners Act 2008*, came into effect on 1 November 2009.

The preamble in the Act states the coronial system of Victoria plays an important role in Victorian society. That role involves the independent investigation of deaths and fires, for the purpose 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.

Most importantly, the legislation has enshrined the need for recognition of the impact a death, and subsequent coronial investigation, can have on the family and friends of a loved one. The Act provides clear objectives to encourage practices where possible which:

- avoid unnecessary duplication of investigations
- acknowledge the distress of families and the need for support following a death
- acknowledge the effect of unnecessarily lengthy or protracted investigations
- acknowledge that different cultures have different beliefs and practices surrounding death
- acknowledge that family members affected by a death being investigated should, where appropriate, be kept informed of the particulars and progress of the investigation
- acknowledge that there is a 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
- acknowledge the desirability of promoting public health and safety and the administration of justice promote a fairer and more efficient coronial system.

# Why a coroner investigates

## Purpose of coronial investigation

The role of coroners is to investigate certain deaths and fires to determine how and why they happened in order to help prevent similar deaths and fires from occurring. It is their role to find out, if possible:

- the identity of the person who has died
- the cause of the death or fire
- how the death or fire occurred and, in some cases, the circumstances surrounding it
- the particulars needed to register a death with the Registry of Births, Deaths and Marriages.

The *Coroners Act 2008* requires coroners to investigate all deaths defined as being 'reportable' or 'reviewable' deaths (see pages 11 to 13).

There does not have to be anything suspicious about the death for a coroner to be involved. Many investigations involve people who may have died due to natural causes.

Coroners may comment and make recommendations about public health or safety or the administration of justice to help prevent similar deaths from occurring (see page 46).

## Reportable deaths

Coroners are required to investigate a particular category of death called 'reportable deaths'. The court must be advised of a reportable death in order for a coroner to investigate.

Coroners do not have the power to investigate a death that is more than 100 years old.

## What is a reportable death?

A death is considered reportable if:

- the body is in Victoria; or
- the death occurred in Victoria; or
- the cause of the death occurred in Victoria; or
- the person ordinarily resided in Victoria at the time of death; and
- the death appears to have been unexpected, unnatural or violent or to have resulted, directly or indirectly, from an accident or injury; or
- the death occurred 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 to occur; or
- the identity of the person was not known; or
- a medical practitioner has not signed, and is not likely to sign, a death certificate certifying the cause of death; or
- a death has occurred at a place outside Victoria and the cause of death is not certified and is unlikely to be certified; or
- the person, immediately before their death was a person placed in 'custody or care' (see pages 15-16); or
- a person immediately before their death was a patient within the meaning of the *Mental Health Act 1986*; or
- the person was under the control, care or custody of the Secretary to the Department of Justice or a member of the police force; or
- the person was subject to a non-custodial supervision order under section 26 of the Crimes *(Mental Impairment and Unfitness to be Tried) Act 1997*.

## Who tells the coroner about a reportable death?

Usually medical practitioners or the police report deaths to the coroner.

A member of the community must also notify the court of a reportable death if they have grounds to believe that the death has not already been reported.

## Reviewable deaths

Coroners must also investigate a category of deaths called 'reviewable deaths'.

### What is a reviewable death?

A reviewable death is the death of a second or subsequent child of a parent, with some exceptions. A child is anyone under 18 years of age. The child will have died in Victoria, the cause of death occurred in Victoria or the child lived in Victoria but died elsewhere.

Coroners do not investigate children who are stillborn. Children who lived their entire lives in hospital are also not considered reviewable deaths, unless otherwise determined by a coroner.

### Who is considered a parent?

Along with the 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 powers, responsibilities and authority that parents legally have.

### Why is it important for reviewable deaths to be investigated?

Reviewable deaths are investigated to find the identity of the child and to determine the cause of death. The coroner may also refer a reviewable death to the Victorian Institute of Forensic Medicine (VIFM) so that they can assess the health and safety of a living sibling of the deceased child and the health of the parent. VIFM can ensure that a family is referred to appropriate health, bereavement and support services. The court and VIFM are always sensitive to the grief and trauma being experienced by a family in which there has been multiple child deaths

### Who tells the coroner about a reviewable death?

Medical practitioners and the Registrar of Births, Deaths and Marriages must tell the court when they identify a reviewable death.

A member of the community, including the police, must also notify the court of a reviewable death if they have grounds to believe that the death has not already been reported.

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

Once the coroner has been notified of a reviewable death, he or she will assess whether they need to investigate further.

VIFM provides forensic and scientific services to the court. VIFM will assist the court in the investigation of the death and will assess the health and safety of living siblings and the health of the parents if requested by the coroner.

If a coroner refers the matter to VIFM to assess the health and safety of siblings and parents, staff from the Coronial Admissions and Enquiries area will contact the family to let them know. The Paediatric Liaison Officer at VIFM may then get in touch to assess the family's health and support needs. VIFM may refer families to specialised health or support services, or other agencies, if needed.

## 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 Metropolitan Fire and Emergency Services Board, unless the coroner determines that the investigation is not in the public interest.

Any person can also request a coroner to investigate a fire. A request can be made by contacting the court and completing a Request to Investigate a Fire form, including details of the fire and reasons why the coroner should investigate. A copy of the form is available on the court website at www.coronerscourt.vic.gov.au or by contacting the court on 1300 309 519.

If the coroner refuses to investigate the fire, he or she must give written reasons to the person who made the request.

A coroner must make a finding following an investigation into a fire stating, if possible, the cause and origin of the fire and the circumstances in which it occurred.

## Deaths due to natural causes

The death of a person may be reported to the court because the death was unexpected, requiring a coroner to investigate further.

In some situations, a medical investigator may conduct an examination and provide a report to the coroner that includes an opinion that the death was due to natural causes.

A coroner may then determine that, other than the fact that the death was unexpected, it does not fit any other category of a reportable or reviewable death and further investigation is not necessary.

In these situations, the coroner will write a finding that determines the identity of the person who died, their cause of death, but not the circumstances surrounding the death.

In these situations, a public inquest is not required.

In circumstances where the medical investigation has uncovered information which may have implications for other living relatives, staff from VIFM may contact you to discuss this health information in further detail.

## Deaths in custody or care

The death of a person who has been placed in custody or care is one of the categories of a reportable death that must be investigated by a coroner.

If a person dies in custody or care, an inquest must be held.

A person is considered to be in custody or care if the person is:

- in the custody or under the guardianship of the Secretary to the Department of Human Services under the Children, Youth and Families Act 2005; or
- a child taken into safe custody under the Children, Youth and Families Act 2005; or
- deemed to be in the legal custody of the Secretary to the Department of Human Services under section 483 of the Children, Youth and Families Act 2005; or
- under the control, care or custody of the Secretary to the Department of Human Services; or
- in the legal custody of the Secretary to the Department of Justice or the Chief Commissioner of Police; or
- in the custody of a member of the police force; or
- in the custody of a protective services officer appointed under Part VIA of the Police Regulation Act 1958; or
- admitted or committed to an assessment centre or treatment centre under the Alcoholics and Drug-dependent Persons Act 1968; or

- a patient in an approved mental health service within the meaning of the Mental Health Act 1986; or
- a person who a member of the police force or prison officer is attempting to take into custody or who is dying from injuries sustained when a member of the police force or prison officer attempted to take the person into custody; or
- in Victoria and is dying from an injury incurred while in the custody of the State; or
- held in detention in Victoria by an authorised person under the law of the Commonwealth or another jurisdiction; or
- in Victoria who an authorised person is attempting to take into custody or who is dying from injuries sustained when an authorised person attempted to take the person into custody; or
- who is dying from an injury incurred while –
  (i) in the care, control or custody of an authorised person; and
  (ii) in detention in Victoria under the law of the Commonwealth or another jurisdiction.

## Obligation to report

Some deaths are reported to the coroner because they meet the definition of a reportable or reviewable death and there is a legal requirement under the *Coroners Act 2008* to report them.

### People who must report

People who must advise the coroner of a reportable or reviewable death include:

- a medical practitioner who was present at or after the death
- a police or prison officer who was attempting to take a person who died into custody
- a responsible person, as defined in the *Coroners Act 2008*, who had care or custody of a person
- a medical practitioner who was present at or after the death of a child that may constitute a reviewable death.

### General obligation to report and provide assistance to a coroner

Anyone who thinks a reportable or reviewable death has occurred and the court has not been advised must report the death without delay.

The immediate family of a person who has died may also report the death to the coroner if the person was discharged from an approved mental health service within three months of the death occurring.

A person who reports a reportable or reviewable death must give the coroner any information or other assistance that the coroner requests for the investigation.

It may be appropriate to seek legal advice about reporting obligations as there are some complex legal issues in this area. Advice about obligations to report is also available by contacting Coronial Admissions and Enquiries on 1300 309 519 .

### Differences between investigations and inquests

Coroners investigate all deaths and fires reported to the court, regardless of whether the matter proceeds to an inquest.

Investigations usually involve the gathering of a range of information from police, family, friends, medical practitioners, witnesses, technical experts and any others (see page 53) to help the coroner form a picture about what happened and why. Often the coroner is able to make a written finding based on this information, without having to hold a public hearing and call people to court to provide oral evidence. This is called a finding without inquest (see page 45).

Inquests are public hearings and held in only a small number of matters reported to the court. (see page 39)

A coroner will usually only decide to hold an inquest if the circumstances surrounding the death or fire are unclear, or if the circumstances of the death or fire require a mandatory inquest under the *Coroners Act 2008* (such as a death in custody) or if there are broader issues of public health and safety that need to be examined.

Coronial Support Services staff can assist with providing further information about the processes for requesting a coroner investigate a death or fire, or making an application for a coroner to conduct an inquest into a death or fire.

## Coroners

The role of coroners is to investigate certain deaths and fires to find out the identity of the person who died, the cause of the death or fire and, in some situations, the circumstances surrounding the death or fire.

Coroners also hold inquests in some cases and may recommend ways to help prevent similar deaths and fires in the future.

In Victoria, the State Coroner must be a judge of the County Court and the Deputy State Coroner must be a magistrate.

All coroners are magistrates or lawyers who have been practising for at least five years.

## Coronial Admissions and Enquiries

The Coronial Admissions and Enquiries (CA&E) is a 24-hour office that coordinates the initial phase of the coroner's investigation including receiving reports of deaths and admitting people into the care of the coronial jurisdiction.

The CA&E also begins the initial process of requesting information that the coroner may need, such as medical records, to help in their investigation.

Importantly, CA&E staff also manage the coordination of any medical scientific and forensic investigations to help the coroner establish the identify of the person who died and the medical cause of their death, if possible.

The medical scientific and forensic examinations are conducted by pathologists from the Victorian Institute of Forensic Medicine (VIFIM) (see page 22) who provide medical and scientific expertise to coroners to assist with the medical aspects of their investigations.

Staff from the CA&E can assist with information regarding:

- viewings
- the identification process
- any medical examinations that may be required including the preliminary examination and/or an autopsy
- the release of the person for the funeral
- any questions families may have in relation to the initial stages of the coroner's investigation
- referral to external counselling and support services.

## Coroners Support Service

The Coroners Support Service provides legal and administrative support to coroners after the initial phase of the investigation is completed by the CA&E and the person is released for the funeral.

The Coroners Support Service consists of coroners' registrars, solicitors, court administration officers and family liaison officers who are the primary source of information and contact with the senior next of kin, families, interested parties, the public, police, health service providers and many other departments and agencies.

Coroners Support Service staff process a coroner's directions and orders and ensure that relevant people or organisations complete them. This may include seeking further statements on behalf of the coroner, or organising medical expert opinions, or listing a case for hearing in open court.

They also regularly speak to Victoria Police, the Victorian Institute of Forensic Medicine (VIFM), hospitals, doctors and other government departments or agencies to ensure that any information required by the coroner is provided as soon as possible.

Providing information and updates to families through letters and phone calls is also a crucial function of the Coroners Support Service. Letters are sent to family members at key points during a coroner's investigation. These letters provide updates regarding the cause of death, how the coroner intends to investigate and whether any further medical investigations are required.

**Solicitors** assist coroners with the coronial investigation by drafting legal documents and correspondence on behalf of the court, attending court hearings when required and communicating directly with families.

**Registrars** assist coroners with the coronial investigation by providing administration support, coordinating court hearings including inquests, direction hearings, mention hearings and the delivery of findings. They also attend court hearings when required and communicate directly with families.

**Court administration officers** assist the coroners by undertaking general administration, maintaining various records and registers and attending court hearings when required.

**Family liaison officers** assist coroners with investigations where families and witnesses require additional support during the coronial process. This includes delivering sensitive information on behalf of coroners and other stakeholders, helping families understand information contained within a coronial brief of evidence and providing support during court proceedings when needed.

Family liaison officers may also assist families and witnesses by providing referral information and advice for external counselling and support agencies who can assist with your grief and loss experience during this difficult time.

## In-House Solicitor Service

The In-House Solicitor Service comprises lawyers who assist coroners in investigations where the conduct of police will or may come under scrutiny. This includes matters such as deaths occurring in police presence, or as a result of a police shooting or pursuit or while the person was in police custody, or was attempting to be taken into police custody at the time of their death. In these circumstances, the In-House Solicitor Service ensures the independence of coronial investigations is maintained and that no conflict of interest issues arise.

The In-House Solicitor Service also provide legal advice to coroners on matters where a death has complex legal or medical issues and will also attend court as the Counsel Assisting the Coroner (see page 51) in court hearings.

## Coroners Prevention Unit

The Coroners Prevention Unit (CPU) is a specialist service comprising a team of investigators and health clinicians. The CPU assists coroners fulfil their prevention role and contribute to a reduction in preventable deaths.

To achieve this, the CPU:

- review a range of reportable deaths to identify opportunities to improve public health and safety
- examine data, literature, and regulatory and policy frameworks relevant to the deaths under review
- liaise with key stakeholders to assess the need for, and the facilitators and barriers to, preventive intervention
- provide coroners with information to support the investigation, particularly the formulation of evidence-based and feasible recommendations
- receive and publish responses to coroners' recommendations.

## Role of the police

The police play an important role in coronial investigations into deaths and fires by helping to gather information on behalf of the coroner.

The court has a dedicated unit called the Police Coronial Support Unit (PCSU), which is staffed by members of Victoria Police.

PCSU can attend scenes at the request of the coroner, provide inquest briefs for the coroner and support other Victoria Police members who are investigating matters for the coroner.

PCSU staff usually attend court to assist coroners at most inquests and can also help families with the inquest process if required (see page 51).

## Victorian Institute of Forensic Medicine

The Victorian Institute of Forensic Medicine (VIFM) is co-located with the Coroners Court of Victoria at the State Coronial Services Centre at 65 Kavanagh Street, Southbank.

VIFM provides a 'Medico-Legal Death Investigation' service involving a team of consultant medical specialists and forensic scientists who assist with death investigations in Victoria and provide expert opinions in the fields of forensic pathology, clinical forensic medicine and forensic science both nationally and internationally.

VIFM is responsible for managing any medical scientific examinations that may need to be undertaken to help a coroner to identify the person who died and, if possible, their medical cause of the death. They also provide important health service follow-ups in circumstances where the medical investigation uncovers information that may have implications for other living relatives.

VIFM staff are also responsible for operating the Coronial Admissions and Enquiries office and the Tissue Donor Bank of Victoria.

# Exhumations

An exhumation is where a person's remains are retrieved from a place of burial, usually for the purpose of further examination.

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

### Advising senior next of kin

If the State Coroner intends to do this, a notice of intention to exhume must be given to the senior next of kin.

In the notice, the senior next of kin will be advised that they can provide suggestions as to how and whether the proposed exhumation should be conducted.

The authorisation will not take effect until 48 hours after the senior next of kin has been notified.

The senior next of kin can appeal to the Supreme Court against the authorisation. The appeal must be made within 48 hours of receiving a notice of the State Coroner's authorisation of the exhumation.

It may be appropriate to seek legal advice before lodging an appeal.


exhume

### Advising cemeteries and land owners

The State Coroner must also give notice of their intention to authorise an exhumation to the cemetery trust if the person is interred in a public cemetery or to the owner of the land if the person is not interred in a public cemetery.

The State Coroner must take into account the suggestions made by the senior next of kin or any other person who provides written notice about the proposed exhumation.

The suggestions must be in writing and filed with the court by a time specified by the State Coroner. The court will advise relevant parties of this time in the notice of intention to exhume.

### When notice is not required

The State Coroner is not required to give notice if there are reasonable grounds to believe that giving such a notice would result in:

- the escape of an offender or accomplice; or
- the fabrication or destruction of evidence; or
- the exhumation is urgent and should not be delayed; or where
- giving notice is impossible.

### Requesting an exhumation

Any person may apply to the State Coroner for an exhumation to be authorised.

An application can be made by completing an Application for Exhumation form. A copy of the form is available on the court website at www.coronerscourt.vic.gov.au or by contacting the court on 1300 309 519.

The form can be posted or faxed back to the court.

If the State Coroner refuses the application, the person making the application will be advised without delay.

# Family information

In most cases, if a person died in Melbourne, he or she will be taken into the care of the coronial jurisdiction by staff from Coronial Admissions and Enquiries (CA&E) at the State Coronial Services Centre located at 65 Kavanagh Street, Southbank.

If a person died in regional Victoria, staff from the court or the CA&E will advise where he or she is being cared for. This may be at a regional hospital or at Southbank.

All people taken into the care of the coronial jurisdiction are cared for in a respectful manner.

CA&E staff are aware that some people may wish to make requests regarding the coronial process on religious and cultural grounds and these will attempt to be facilitated where possible.

If a person wishes to make a request on these grounds they can assist staff at the CA&E by contacting the office on 1300 309 519 and raising these matters as soon as possible.

## Identification

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

This may involve a visual or medical and scientific process. In circumstances where a visual identification is required, you may be asked to identify your loved one.

To identify a loved one you must be a family member or somebody who knew them well at the time of their death. CA&E staff will support the person making the identification through this process.

Medical and scientific methods of identification may include:

- fingerprinting
- examining dental records
- the removal of blood, tissue or saliva for DNA comparisons.

The coroner will determine the most appropriate method of identification and CA&E staff will inform you of the identification process that will be required for your loved one

Further information about the identification process is available by contacting the CA&E on 1300 309 519.

## Viewing and touching

CA&E staff will assist anyone who wishes to see or touch a loved one. This is called a 'viewing'.

The CA&E and the court understand viewings are an important part of the grieving process for many people and will work with families to facilitate this. In some circumstances it may be better for the viewing to take place at the funeral home, however, families can assist the CA&E by advising staff if they would like a viewing while the person is still in the care of the coronial jurisdiction.

In some circumstances, the CA&E may need to negotiate the type of viewing that can take place to ensure the coroner's ability to determine the identity, cause and circumstances of the death is not compromised.

It may not be possible to touch a loved one if their death is subject to a police criminal investigation so as not to interfere with any forensic evidence that may need to be collected. It also may not be possible where health risks are involved. In these circumstances, the coroner will determine what is most appropriate for all parties involved.

## Senior next of kin

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

They will be notified about any medical procedures required and will also be provided with updates on the progress of the investigation and any medical examination reports provided to the coroner. The senior next of kin will be contacted prior to any medical examination reports being sent and can elect not to receive them if they wish.

The senior next of kin is usually determined by the following order of priority:

- if the person, immediately before death had a spouse or domestic partner — **the spouse or domestic partner;** or
- if the person immediately before death did not have a spouse or domestic partner or if the spouse or domestic partner is not available — **a son or daughter of, or over the age of 18 years;** or
- if a spouse, domestic partner, son or daughter is not available — **a parent**
- if a spouse, domestic partner, son, daughter or parent is not available — **a sibling who is of, or over the age of 18 years;** or
- if a spouse, domestic partner, son, daughter, parent, or sibling is not available —
- **a person named in the will as an executor;** or

- if a spouse, domestic partner, son, daughter, parent, sibling or executor is not available — a person who, immediately before the death, was a personal representative of the deceased; or
- if a spouse, domestic partner, son, daughter, parent, sibling, executor or personal representative is not available — a person determined by a coroner to be taken as the senior next of kin because of the closeness of the person's relationship with the deceased person immediately before his or her death.

The coroner will make a decision if there is more than one person wanting to be the senior next of kin.

If a person is not the senior next of kin and would like to be informed about the progress of an investigation, they should contact the court for further information on 1300 309 519.

## Funeral arrangements

A funeral director can be contacted as soon as a person has died, without waiting for the coroner to release the person from the care of the court.

Families are not obliged to use the funeral director who transferred the person into the care of the coronial jurisdiction. The court cannot recommend a particular funeral director. Funeral directors are listed in the Yellow Pages.

### When will my loved one be released?

The coroner can release a person if he or she is satisfied the death was not a reportable or reviewable death and/or it is no longer necessary to keep the person for the purpose of their investigation.

As soon as the identification and any other medical procedures (such as an autopsy if one is required) are completed, the person will be released to the senior next of kin's chosen funeral director.

This is done by completing a Release Authority form. These are usually completed by a funeral director on behalf of the family and sent to the court. After receiving the form, the coroner can then authorise the release.

The coroner's order must specify who the person is being released to, and it may contain terms or conditions the coroner considers necessary.

In cases where two or more people apply for the release of a person, the coroner will determine who has the better claim.

Further information about the release process is available by contacting 1300 309 519 and asking to speak to Coronial Admissions and Enquiries.

## Access to the scene

### Public place

Anyone may access a public place where a death has occurred, providing the investigation at the scene is complete. Police and/or the coroner sometimes restrict access to the place or a place where they reasonably believe a death has occurred, while they are conducting an investigation.

It is an offence for an unauthorised person to enter a place of death with restricted access.

Contact the court on 1300 309 519 for information regarding attending a scene with restricted access.

### Private premises

If the death occurred in private premises, the person wishing to visit would need the permission of the owner of those premises.

Police and/or the coroner may restrict access to the place or a place where they reasonably believe a death has occurred while they are conducting an investigation.

It is an offence for an unauthorised person to enter a place of death with restricted access.

Contact the court on 1300 309 519 for information regarding attending a private premises with restricted access.

## Personal belongings

Personal belongings of the person who has died — such as jewellery, clothing and other valuables — are generally retained by the police at the place of death and then later returned to the senior next of kin.

Occasionally, the police may keep some items for forensic examination.

Otherwise, personal items are given to the funeral director to be returned.

Call1300 309 519 and ask to speak to Coronial Admissions and Enquiries for information about personal belongings.

# Death certificates

## How do I get a death certificate?

The coroner provides the Registrar of Births, Deaths and Marriages with information about the cause of death so the death can be registered and a death certificate issued.

## Standard death certificate

A person, or their chosen funeral director, can order a standard death certificate. Many funeral directors order the death certificate as part of their service. It may be helpful to ask the funeral director if they intend to make the order as part of their service. The Registry of Births, Deaths and Marriages will post the certificate to either the person making the order or to someone they have nominated after all the particulars of the death have been registered.

A standard death certificate is commonly required for financial and other official purposes as proof of the death.

A person can contact the Registry of Births, Deaths and Marriages on 1300 369 367 for further information. It may take several weeks or sometimes more for a death certificate to be issued where the coroner is involved.

This may be because the coroner is waiting for medical or scientific information before being able to find the medical cause of death. Sometimes no medical cause of death can be established.

## Interim death certificate

In matters where the coroner has not yet established the cause of death, 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.

The court and CA&E can also provide an interim death certificate confirming that a death has occurred. This interim certificate is not accepted by all financial and/or legal institutions for official purposes.

It is always best to check with the organisation as to whether they will accept an interim death certificate.

## Preliminary examinations

Once a person's death has been reported, a doctor or pathologist will examine him or her to provide information to the coroner. This preliminary examination is minimally invasive and will take place at the Victorian Institute of Forensic Medicine at the State Coronial Services Centre at 65 Kavanagh Street, Southbank, or at a regional hospital location.

A preliminary examination may include one or more of the following procedures:

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

The pathologist uses this information to make a recommendation to the coroner about whether further medical investigations, such as an autopsy, are required to help establish the cause of death.

The coroner then considers the pathologist's recommendation and decides whether further medical investigations are required for their investigation.

Staff from Coronial Admissions and Enquiries can answer any questions about the preliminary examination.

# Autopsy

## What is an autopsy?

An autopsy — sometimes called a post-mortem examination — is a type of medical procedure performed by a pathologist.

A pathologist is a qualified doctor specialising in pathology, which is the science that looks at the effects on the body of disease or damage.

## What does it involve?

If the coroner directs an autopsy be performed, a pathologist will carry out an external and internal examination of the body. The person's body is treated with respect at all times.

Techniques similar to those used in surgical operations are involved. The major organs of the body are examined and specimens are taken for more detailed examination.

These may include tests for:

- infection (microbiology)
- changes in body tissue and organs (histology)
- chemicals, for example medication, drugs or poisons (toxicology and pharmacology).

These tests are carried out on samples of blood or tissue that are taken from the person's body and retained for that purpose.

## Who makes the decision for an autopsy?

The coroner makes the decision that an autopsy should be conducted after considering the wishes of the senior next of kin and any information provided by police, pathologists or other scientists.

### Why are autopsies necessary in some cases?

The coroner will direct that an autopsy be performed if he or she is satisfied that it will assist in the investigation into a person's death and/or the circumstances surrounding the death.

An autopsy can provide detailed information about the person's health condition and give an understanding of the various factors that may have contributed to their death. Sometimes, even after an autopsy, the cause of the person's death may not be able to be ascertained.

If a coroner directs an autopsy, Coronial Admissions and Enquiries (CA&E) staff will contact the senior next of kin to explain the process, answer any questions, and advise of the right to object to the autopsy (see page 36).

Further information about autopsies can be obtained by calling 1300 309 519 and asking to speak to staff at CA&E.

### Where will the autopsy take place?

The autopsy will usually be conducted by the Victorian Institute of Forensic Medicine (VIFM) at the State Coronial Services Centre located at 65 Kavanagh Street, Southbank.

If the death occurred in a regional area, the autopsy may be conducted in a regional hospital. A proportion of people however, will always be transferred to Melbourne for the autopsy depending on the circumstances surrounding the death, including homicides, all child deaths and incidents involving major trauma.

Should an autopsy be required, CA&E staff will advise families where the person will be taken.

## Requesting an autopsy

Anyone can write a letter to the coroner, addressed to the court, asking for an autopsy to be performed.

If the coroner refuses, the person can apply to the Supreme Court for an order that an autopsy must be performed.

An application must be made to the Supreme Court within 48 hours of receiving the coroner's written reason for refusal.

It may be appropriate to seek legal advice before applying to the Supreme Court.

## Objecting to an autopsy

The senior next of kin has the right to object to an autopsy being performed.

If an objection to an autopsy is intended for religious, cultural or other reasons, the senior next of kin will need to put their objection in writing to the coroner and addressed to Coronial Admissions and Enquiries (CA&E ) stating their reasons. This can be by email or fax.

The written objection must be made within 48 hours of a coroner ordering that an autopsy be performed. The autopsy will not go ahead during this time.

The coroner will take these concerns into account and CA&E staff will advise of the coroner's decision.

If, after receiving an objection, the coroner decides an autopsy should still be performed the senior next of kin can apply to the Supreme Court for an order preventing it.

This will be required within 48 hours of being notified that the objection has been refused.

It may be appropriate to seek legal advice and assistance before making a Supreme Court application.

## Organ retention

Occasionally, a pathologist will recommend as part of the autopsy, that it is necessary to retain whole organs such as the brain or heart, or larger portions of tissue for medical tests to help further investigate a death.

Coronial Admissions and Enquiries staff will contact the senior next of kin to discuss this and the coroner will need to authorise the retention before it happens.

CA&E staff will also need to speak to the senior next of kin about their wishes concerning what happens to the organs when the testing and examination is complete.

For further information about organ retention contact Coronial Admissions and Enquiries on 1300 309 519.

## Tissue donation

Staff from Coronial Admissions and Enquiries can facilitate contact with the Donor Tissue Bank of Victoria for families who would like to consider consenting to tissue donation.

Tissue donation is not part of the coronial process, however a coroner will need to give permission before any donation occurs to ensure that it does not interfere with their investigation.

Many ill or injured people, including burn victims, can be helped by receiving a tissue transplant from a person who has just died. Tissue donation is different from organ donation. Organ donation usually takes place in a hospital.

Types of tissue collected for transplantation include heart valves, skin, bone and corneas (a part of the eye).

The Victorian Institute of Forensic Medicine (VIFM) manages the Donor Tissue Bank of Victoria.

More detailed information about tissue donation is available by contacting VIFM on (03) 9684 4444 and asking to speak to the Donor Tissue Bank of Victoria.

# Court processes

## Inquests

An inquest is a court hearing into a single death, multiple deaths and/or a fire. It is heard by a coroner and is generally open to the public. Inquests are only held in a small number of investigations.

An inquest is unlike other court cases. It is an inquisitorial process rather than adversarial. In other words, an inquest is not a trial, with a prosecutor and a defendant, but an inquiry led by a coroner that seeks to find out why the death or fire occurred.

Coroners have more flexibility than other jurisdictions with the type of evidence they can accept. Coroners do not decide if someone is legally liable for a death.

The coroner's role is to identify the person who has died and to find out how their death occurred including the cause and circumstances, in some cases.

After the coroner has heard all the evidence, he or she will write a finding. A finding may include recommendations to a Minister, public statutory authority or entity to help prevent similar deaths or fires (see page 45-46).

### Why is an inquest held?

An inquest is held because the coroner believes there is some issue of public importance, or he or she needs more information to answer all the questions about the death or fire.

In some situations, inquests are mandatory under the *Coroners Act 2008*. For example, there must be an inquest if a person died while they were in police custody (see pages 15-16).

An inquest is also mandatory if the death is a suspected homicide or the identity of the person who died is not known.

A coroner, however, is not required to hold an inquest if:

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

### What happens if there is no inquest?

Coroners investigate all deaths reported to the court, regardless of whether an inquest is conducted.

An inquest will only be held if it is mandatory or if the coroner decides an inquest is necessary.

If it is not mandatory to hold an inquest, the coroner may instead make a finding about a death without an inquest (see page 45). This is sometimes referred to as a 'chambers finding'.

If you have questions about a decision by a coroner not to conduct an inquest, or about a finding, contact the court on 1300 309 519.

### Who can request an inquest?

Any person may request that a coroner hold an inquest into a death or fire reported to the court. This is done by completing a Request for Inquest into Death form or a Request for Inquest into Fire form and providing reasons why an inquest is necessary. Copies of the forms are available on the court website at www.coronerscourt.vic.gov.au or by contacting the court on 1300 309 519.

Before requesting an inquest, speak to Coroners Support Service staff to discuss the status of the investigation. The coroner needs time to gather all relevant evidence before deciding whether an inquest is appropriate. The coroner will consider all requests. If the coroner decides not to grant a request for inquest they must give written reasons.

If the coroner decides not to hold an inquest, the person can appeal to the Supreme Court within three months of this decision (see page 48).

### At the inquest

Coroners try to make inquests less formal than other court proceedings. The coroner will try to avoid using unnecessarily complex language. The coroner wants family members and interested parties to understand what is happening in the proceeding.

It can be hard to hear details about the death of a loved one or friend in a public courtroom. Coroners will understand if family members and/or friends wish to leave the courtroom so as not to hear or see some evidence the coroner is examining that they may find distressing. Court staff are there to help and answer any questions.

## Who can come?

Generally, anyone can come to an inquest. Sometimes a coroner will decide to exclude the public, or specific people, from attending, however this would be unusual.

A coroner may also restrict publication of the evidence, or part of the evidence.

While anyone can attend, only people granted permission by a coroner can appear as an 'interested party' (see page 43).

## Who are witnesses?

Witnesses are people who have to give evidence or produce material or information to the court. They help the coroner clarify the circumstances and may give evidence of any relevant knowledge they have in regard to the death or fire.

A coroner may issue a summons to ensure a witness appears at the inquest. If the witness fails to attend or produce any document or material, the coroner may issue a warrant to arrest and order that person to be brought to court.

If the coroner wishes a person to appear as a witness, they will receive the summons in person, usually from a police officer acting on the coroner's behalf. The summons tells witnesses where and when to attend.

## Do you need a lawyer?

Families can choose to be legally represented at an inquest. The court cannot help choose a lawyer because it is independent. The person assisting the coroner, usually a police member or a lawyer (see page 21-22 & 51), can help a person understand and participate in the inquest if they decide not to seek legal representation. The coroner can also provide guidance during the inquest.

## What happens during an inquest?

The coroner will decide the best way to conduct the inquest. Unlike in other courts, because it is a coronial investigation the coroner decides what information and issues to examine, and who to hear from.

During the inquest, the coroner will call witnesses to give evidence. The coroner, coroner's assistant, counsel assisting the coroner, or a lawyer representing an interested party, may then ask the witness questions.

Interested parties may also give statements, documents or other relevant items to the coroner.

After all the evidence is given, the coroner may receive submissions which restate the position of all parties on the evidence and the matters they wish the coroner to take into consideration.

These may be spoken aloud in court or given in writing. The coroner usually hears submissions either on the last day of the hearing or on another set date.

## How long does an inquest go for?

It varies. The length of an inquest depends on how complex the circumstances of the death or fire are and how many witnesses and submissions there are. Some inquests may last a few hours, while others may take weeks or months.

## After the inquest

At the end of the inquest, the coroner must complete a finding (see page 45). In some hearings, the coroner may deliver the finding on the same day. In other more complex matters, the finding may take much longer for the coroner to prepare. Court staff will advise when the coroner is ready to deliver the finding.

## Directions hearing

Directions hearings are smaller hearings intended to assist the coroner to identify issues relevant to their inquiry. The purpose of a directions hearing is to hear from the parties involved, to discuss any issues that will be raised at inquest, to estimate how long the inquest will run for, or for the coroner to determine whether there is a need to proceed to inquest.

Generally, a directions hearing is held if it is believed the inquest will take two days or longer. In these circumstances the hearing is conducted to determine the scope of the inquest, to confirm the list of witnesses required to give evidence and to ascertain the relevant 'interested parties'.

Family members and interested parties can also raise issues before and during the inquest and the coroner may consider those issues.

## Interested parties

An interested party is not just a person who happens to be interested in a death or fire reported to the court.

In coronial proceedings, the term 'interested party' is used to define, people, organisations or entities who have relevant information regarding the death or fire being investigated or who may be affected by the written finding made by the coroner.

To be an 'interested party' for the purpose of an inquest a person or organisation must be able to demonstrate to the investigating coroner that they have sufficient interest in the matter and that it is appropriate that they be an interested party.

Interested parties may include:

- family members of the deceased
- employers
- a doctor who treated the person who has died
- anyone who has relevant information
- a person who, in a coroner's opinion, may be involved in some way with the death or fire.

To become an interested party in an inquest a person must complete an Application for Leave to Appear as an Interested Party form and submit it to the court. The court will write back advising whether the coroner has granted the application. Sometimes the coroner may wish to determine such applications in court as part of a direction hearing (see page 42).

The senior next of kin is not required to fill out an application form.

A copy of the form is available on the court website at www.coronerscourt.vic.gov.au or by contacting the court on 1300 309 519.

If a person is not an interested party, they may still be able to access information about an investigation by completing an Access to Coronial Documents/Inquest Transcript form (see page 53).

### Rights of an interested party

Interested parties have the right to:

- appear or be represented by a lawyer or, with the permission of the coroner, by any other person
- make a submission to the coroner specifying who they consider to be relevant witnesses
- examine or cross examine witnesses and make submissions
- be provided with a copy of the inquest brief, unless otherwise ordered by the coroner
- have a document released to them if the coroner is satisfied that they have a sufficient interest in the document
- the same protection as a party to a proceeding in the Supreme Court
- appeal to the Supreme Court against the findings of a court in respect to a death or fire.

### Limitations on an interested party

Interested parties may be restricted to appearing in the part of the inquest that relates to their interest only and parties who only have a financial interest in the outcome may not be considered an interested party for the purpose of an inquest.

# Findings

A finding is the formal document prepared by a coroner following an investigation into a death or fire and is generally the final step in the investigation.

The coroner is the only person who can make a finding.

The length of a finding can vary from a single page to numerous pages depending on the complexity of the investigation.

### Inquest Findings

A finding made following an inquest is delivered in court by the coroner. This is called an 'inquest finding'. A copy of inquest findings, unless otherwise ordered by a coroner, are published on the court website www.coronerscourt.vic.gov.au

### Finding without inquest

A 'finding without inquest' is where the coroner makes a finding on the material available without a public hearing in court.

If a finding without inquest is to be completed the senior next of kin will be informed.

Most coronical investigations are finalised with findings without inquests. Only findings without inquests that contain recommendations made by a coroner are published on the court website, unless the coroner orders otherwise (see page 46).

### What does a coroner have to find after investigating a death?

In the case of a death a coroner must find, if possible, the identity of the person who died, the cause of death, and in some situations, the circumstances.

A coroner does not have to determine circumstances if there was no inquest, the person who died was not held 'in custody or care' immediately before their death and there is no public interest in doing so.

The coroner may comment on any matter connected with the death including public health and safety or the administration of justice and may also make recommendations to any Minister, public statutory authority or entity that may help to prevent similar deaths (see page 46).

The coroner cannot make a comment or statement in any finding that a person has committed or is guilty of an offence. However, if a coroner believes an indictable offence may have been committed, the coroner will ask the Principal Registrar to notify the Department of Public Prosecutions. A coroner may include a comment about any such notification in the finding.

### What does a coroner have to find after investigating a fire?

A coroner must also make a finding following an investigation into a fire. A coroner must find, if possible, the cause and origin of the fire and circumstances in which the fire occurred.

### Who can receive a finding?

The coroner determines who will receive a copy of the finding. The senior next of kin usually receives a copy of the finding.

Copies of the finding may also be supplied to any person or organisation that the coroner has determined is an interested party or has a sufficient interest.

Unless the coroner otherwise orders, all inquest findings and coroners' recommendations will be published on the court website at www.coronerscourt.vic.gov.au

## Recommendations

The *Coroners Act 2008* allows a coroner to make recommendations as part of their finding following an investigation into a death or fire.

Recommendations by a coroner can be made to any Minister, public statutory authority or entity that may help prevent similar deaths.

Any public statutory authority or entity receiving a recommendation from a coroner must respond, in writing, within three months stating what action, if any, has or will be taken.

The court will publish all coroners' recommendations and the subsequent responses on the court website at www.coronerscourt.vic.gov.au

## Legal representation

Families attending an inquest of the court can choose to be legally represented.

The court cannot help choose a lawyer because it is independent.

If families want legal representation, they will usually have to pay for a private solicitor.

The Law Institute of Victoria has a referral service to help people find a lawyer experienced in coronial matters.

Free legal advice (and sometimes representation) can be obtained from Victoria Legal Aid or a community legal centre.

However, if families decide not to seek legal representation, the person assisting the coroner, along with the guidance and support of the coroner, can help them understand and participate in the inquest.

If families do not intend to seek legal representation at an inquest, they should let the court know so that assistance with information about the inquest process can be provided.

### Assistance provided to the coroner at inquest

In most inquests, assistance is provided to the investigating coroner by a police member who attends the hearing. This person is called the Coroner's Assistant and can examine and cross examine witnesses.

In some circumstances the coroner may need to seek assistance from a lawyer from the court's in-house legal counsel or a barrister to perform this function, and this person is called Counsel Assisting the Coroner.

A coroner may also seek assistance from experts to clarify and explain complex matters during an inquest. These people are called Expert Witnesses and can include, but are not restricted to, people with medical, scientific or engineering expertise.

### Can a coroner's investigation be reopened?

Yes. Any person may apply to the court requesting that a coroner reopen an investigation. The coroner can reopen the investigation if he or she is satisfied that there are new facts and circumstances and it is appropriate to do so.

An application to reopen can be made by completing an Application to Set Aside Findings form. A copy of the form is available on the court website at www.coronerscourt.vic.gov.au or by contacting the court on 1300 309 519.

## Appeals and objections

### Objecting to an autopsy

The senior next of kin has the right to object to an autopsy being performed. If a person intends to object to an autopsy for religious, cultural or other reasons, they will need to put their objection in writing addressed to the court, stating the reasons.

The written objection must be made within 48 hours of a coroner ordering that an autopsy be performed. The autopsy will not go ahead during this time.

The coroner will take the concerns into account and court staff will notify the person of the coroner's decision.

If, after receiving the objection, the coroner decides an autopsy should still be performed the person can apply to the Supreme Court for an order preventing it.

The person will need to do this within 48 hours of being notified that their objection has been refused.

### Appealing a refusal to grant an inquest

After receiving a request for an inquest, a coroner must advise of their decision in writing.

If the coroner decides not to hold an inquest, the person can appeal to the Supreme Court within three months of this decision.

### Appealing a refusal to reopen 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 an Application to Set Aside Findings form. A copy of the form is available on the court website at www.coronerscourt.vic.gov.au or by contacting the court on 1300 309 519.

The coroner can reopen the investigation if he or she is satisfied that there are new facts and circumstances and if it is appropriate to do so.

If the coroner refuses to reopen an investigation, a person has the right to appeal to the Supreme Court within three months.

### Appealing to have a finding set aside

A person with sufficient interest in the investigation or an interested party has the right to appeal to the Supreme Court against the findings of a coroner within six months of the date of the finding.

The person may wish to obtain legal advice before lodging an appeal.

### Appealing against an order for exhumation

An exhumation is where a person's remains are retrieved from a place of burial, usually for the purpose of further examination (see page 23).

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

The senior next of kin can appeal to the Supreme Court against the authorisation. The appeal must be made within 48 hours after the person receives notice of the State Coroner's authorisation of the exhumation.

The person may wish to obtain legal advice before lodging an appeal.

### Appealing against a coroner's decision not to authorise an exhumation

Any person may apply to the State Coroner for an exhumation to be authorised by completing an Application for Exhumation form. The form is available on the court website at www.coronerscourt.vic.gov.au or by contacting the court on 1300 309 519.

If the State Coroner refuses to authorise an exhumation, the person who applied may appeal against that refusal to the Supreme Court.

The appeal must be made within three months of the refusal by the State Coroner.

The person may wish to obtain legal advice before lodging an appeal.

## Courtroom etiquette

The first step in attending an inquest is to allow plenty of time to get to court.

Please check with court staff about the location of the inquest.

Every court has its own rules but generally people attending should know:

- visitors to the court will be required to comply with the court's security arrangements. This may involve passing through a metal detector upon entry
- visitors must obey the instructions of the court staff while on court premises
- tape recorders and cameras are not permitted in any court building without specific approval. Special rules apply to the media
- radio receivers or transmitters, including mobile phones, must be switched off when in any courtroom
- food or drink must not be taken into any courtroom
- unless there is a sign on the door of the courtroom stating otherwise, visitors can enter and leave the court at any time
- visitors are requested not to move around or speak in the courtroom when a witness is taking an oath or affirmation
- lawyers and counsel assisting the coroner will bow to the coroner upon entering or leaving the courtroom. This is to acknowledge that they are taking part in an official court proceeding. Visitors are not required to bow, however it is generally considered respectful to do so.

Visitors should check with court staff or the coroner's assistant if they have any questions about courtroom etiquette or appropriate behaviour.

## In the courtroom

When the inquest begins, the lawyers representing family members or other interested parties introduce themselves and identify who they represent. The coroner's assistant or counsel assisting the coroner will then call the witnesses one by one to give evidence. The procedure is:

- **witnesses are sworn in**. The witness goes into the witness box and swears an oath or affirms to tell the truth. The witness is asked to give their name, address, and occupation. Sometimes a witness does not wish to have their address read out in court and the coroner may agree to this
- **the witness statement will be read out.** This is a written statement that the witness will already have given to police. The witness will be asked to confirm that it is their statement and then given a chance to make any changes to it. The statement then becomes part of the evidence that can be referred to later
- **the coroner's assistant or counsel assisting the coroner can then ask the witness questions** which expand on what they have said in their statement. The other lawyers also have the opportunity to ask the witness questions. The coroner's assistant or counsel assisting the coroner can then ask more questions to clarify any matters. If the family is not represented by a lawyer, the coroner's assistant or counsel assisting the coroner will check whether they have any questions they would like asked of the witnesses. The coroner can also ask questions
- **final statements are heard.** Once all the witnesses have been heard, the lawyers may make submissions to the coroner, summing up their client's position. These can be made by written submissions or said in court aloud. If the family is not represented the coroner may ask them if there is anything they want to say
- **a finding is completed**. Once the coroner is satisfied that all the relevant evidence has been heard, they will usually postpone (adjourn) the matter so that they can complete their finding. Sometimes the finding is handed down on the same day, but in other more complex investigations, the finding may take weeks or months.

Unless otherwise ordered by the coroner, the inquest finding and any recommendations and responses will be published on the court website at www.coronerscourt.vic.gov.au

# Access to documents

## Coronial documents

When a coroner investigates a death or fire, the court gathers a range of documents. At the end of the investigation the coroner writes a finding. A finding details the identity of the person who has died, the cause of the death or fire, in certain situations the circumstances of the death or fire, and any comments or recommendations that may help prevent similar deaths.

A number of findings are available on the court website at www.coronerscourt.vic.gov.au unless otherwise ordered by a coroner.

Usually, other documents available to appropriate parties will be described as a 'brief of evidence'.

## Brief of evidence

A brief of evidence is prepared by police for most coronial investigations and contains all the relevant material that will be examined by the coroner. If the coroner determines that the investigation needs to proceed to an inquest, the brief of evidence is sometimes refered to as the inquest brief. Generally the coroner decides who and when a person gets a copy of the brief of evidence. The number and type of documents in a brief of evidence will depend on how complex the investigation is.

Documents can include:

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

## Applying for access

Generally, a person needs to be an interested party in an investigation to gain access to documents in a brief of evidence. To become an interested party, a person must write to the court and explain their interest in the case (see page 43), and list the documents they require.

The senior next of kin is usually automatically included as an interested party. Unless the coroner decides otherwise, all interested parties receive a copy of the brief of evidence prepared for an inquest. The senior next of kin also receives any medical examination reports, unless they do not wish to.

A coroner may also release documents to:

- a statutory body for a statutory function
- a member of the police force for law enforcement
- researchers for research approved by an ethics committee
- anyone who can satisfy the coroner that it is in the public interest
- a person the coroner is satisfied has sufficient interest.

### How do I apply?

If a person is not the senior next of kin or an interested party recognised by the court, they can apply for access to documents by completing the Access to Coronial Documents/ Inquest Transcript form. The form is available on the court website at www.coronerscourt.vic.gov.au or by contacting the court on 1300 309 519.

The form can be posted, faxed or emailed back to the court.

Court staff will let the person know in writing if the coroner grants the application.

### Who decides whether to approve my application?

If the investigation was completed after 1 June 1986, a coroner will decide whether to approve the application.

The coroner may impose conditions on the release of a document. A penalty may apply if these conditions are broken.

If the investigation was completed before 1 June 1986, contact the Public Records Office of Victoria on 1800 657 452.

### Can my application be refused?

Yes. A coroner may refuse an application to release documents for a range of reasons, such as if a criminal prosecution related to the coronial investigation is in progress, or if the person who has applied does not have sufficient interest.

### How long will it take to receive the documents?

This varies depending on how recent the matter is. The court may also contact the senior next of kin first to let them know a request has been received and ask if they have any concerns about releasing the information. The coroner will consider these concerns before deciding whether to release the documents.

### Are there any fees?

A person may have to pay for copies of documents. The court may waive or reduce these charges if it is appropriate. A copy of the court's standard fees is available on the court website at www.coronerscourt.vic.gov.au

If a person would like the fees waived or reduced they should contact the court on 1300 309 519.

### Does Freedom of Information legislation apply?

Documents collected for the purpose of an inquest are not subject to Freedom of Information applications.

# Feedback

## Registering feedback

The court welcomes feedback about its service and views on the coronial process.

The court also welcomes feedback about the written information provided in this booklet.

A Feedback form is available from the court website at www.coronerscourt.vic.gov.au or by contacting the court on 1300 309 519.

The form can be filled out anonymously and posted, faxed or emailed back to the court.

If a person would like the court to respond to their feedback, they should include their contact details, so the feedback can be referred to the appropriate person.

# Notes

# Helpful contacts

## Business hours unless stated

| | |
|---|---|
| Bereavement Counselling and Support Service | (03) 9265 2111 |
| Compassionate Friends | (03) 9888 4944<br>1800 641 091 |
| Coronial Admissions and Enquiries | 1300 309 519 |
| Donor Tissue Bank of Victoria | (03) 9684 4444 |
| Federation of Community Legal Services Victoria | (03) 9652 1500 |
| Industrial Deaths Support and Advocacy | (03) 9654 3353 |
| Interpreter Service | 13 14 50 |
| Law Institute of Victoria | (03) 9607 9550 |
| LifeLine | 13 11 14 (24 hours) |
| Mercy Western Grief Services | (03) 9364 9838 |
| National Relay Service TTY Service | 13 36 77 (for hearing impaired)<br>1300 555 727 (Speak and Listen) |
| Registry of Births, Deaths and Marriages | 1300 369 367 |
| Road Trauma Support Team | 1300 367 797 (24 hour service) |
| SIDS and Kids Victoria | 1800 240 400 |
| State Trustees | (03) 9667 6319<br>1300 138 672 (country areas) |
| Suicide Helpline | 1300 651 251 (24 hour service) |
| Support After Suicide | (03) 9427 9899 |
| Victims Support Agency | 1800 819 817 |
| Victoria Legal Aid | (03) 9269 0234 |
| Victorian Aboriginal Legal Services | (03) 9419 3888<br>1800 064 864 (24 hours) |
| Victorian Court Information and Welfare Network | (03) 9603 7433<br>1800 681 614 (24 hours) |
| Victorian Institute of Forensic Medicine | (03) 9684 4444 |

**Coroners Court of Victoria**
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