The Coroners Process

Information for family and friends

Coroners Court of Victoria

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This booklet is 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 meant to be used instead of legal advice. In case of a disagreement, we strongly suggest you ask for help from a lawyer or one of the agencies listed in the booklet. While we have taken care to make sure the information in this booklet is correct, we cannot take responsibility for any mistakes or any information that has been left out.

Interpreting services

INTERPRETER SERVICES 13 14 50

English

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

The interpreting and translation services are organised between the service and the Court. The Court covers the cost of the services.

Arabic - عربي

بإمكان المحكمة ترتيب خدمات الترجمة الفورية لمساعدة الأشخاص من خلفيات ثقافية ولغوية متنوعة للوصول بشكل أفضل وفهم لإجراءات الطب الشرعي.

يتم تنظيم خدمتي الترجمة الفورية والخطية بين مزود الخدمة والمحكمة. تغطي المحكمة تكلفة الخدمتين.

Cantonese - 粵语

法庭可安排口譯服務，幫助改善多元文化及語言背景人士使用和理解驗屍程序。

由服務提供方和法庭安排口譯和筆譯服務。法庭負擔服務費用。

Dari - دری

محکمه می تواند خدمات ترجمانی شفاهی را ترتیب دهد تا به اشخاص دارای سوابق متفاوت کلتوری و لسانی کمک کند که به پروسه تحقیقات دسترسی و درک بهتری داشته باشند.

خدمات ترجمانی شفاهی و تحریری فیمابین آن خدمات و محکمه سازمان دهی می شوند. محکمه مصارف آن خدمات را تقبل می کند.

Greek - Ελληνικά

Το δικαστήριο μπορεί να κανονίσει υπηρεσίες διερμηνείας για να βοηθήσει άτομα ποικίλης πολιτισμικής και γλωσσικής καταγωγής να έχουν καλύτερη πρόσβαση και κατανόηση της διαδικασίας της ιατροδικαστικής ανάκρισης (coronial).

Οι υπηρεσίες διερμηνείας και μετάφρασης οργανώνονται μεταξύ παρόχου τέτοιων υπηρεσιών και του δικαστηρίου. Το κόστος των υπηρεσιών καλύπτεται από το δικαστήριο.

Hindi - ihndl

न्यायालय दुभाषिया सेवाओं की व्यवस्था कर सकता है ताकि सांस्कृतिक एवं भाषाई तौर पर विविध पृष्ठभूमियों से सम्बन्धित लोगों को कोरोनियल प्रक्रिया तक बेहतर तरीके से पहुँच प्राप्त करने और इसे समझने में मदद मिल सके।

दुभाषिया और अनुवाद सेवाएँ सेवा और न्यायालय के बीच आयोजित की जाती हैं। न्यायालय सेवाओं के खर्च का भार उठाता है।

Indonesian - Bahasa Indonesia

Pengadilan dapat menyediakan layanan juru-bahasa untuk membantu orang-orang dari latar belakang budaya dan bahasa yang beragam untuk lebih memahami mendapat akses lebih baik atas proses koroner.

Layanan juru-bahasa dan penerjemah akan diurus oleh penyedia juru bahasa dan penerjemah serta pengadilan. Pengadilan akan menanggung biaya layanan tersebut.

Italian - Italiano

Il tribunale può offrire servizi d'interpretariato per aiutare le persone con retroterra culturalmente e linguisticamente differenti ad avere un migliore accesso e una migliore comprensione del procedimento davanti al Coroner.

I servizi di traduzione e interpretariato sono organizzati tra il servizio e il tribunale. Il tribunale copre i costi dei servizi.

Japanese - 日本語

検視審問過程へのアクセスとその理解をより容易にするため、裁判所は多様な文化的・言語的背景をお持ちの方々を対象に、通訳サービスの手配を行うことができます。

通訳・翻訳サービスの手配は、サービス提供者と裁判所の間で行われます。サービス利用料は、裁判所が負担します。

Mandarin - 普通话

法庭能安排翻译服务，帮助有多元文化和语言背景的人更好地使用并了解法医鉴定流程。

法庭联系翻译服务机构，安排翻译服务。法庭承担翻译服务费用。

Persian - فارسی

دادگاه می تواند ترتیب خدمات ترجمه شفاهی بدهد تا به افرادی که دارای پیشینه فرهنگی و زبانی متفاوت هستند کمک کند که به روند کار پزشکی قانونی دسترسی بهتری داشته باشند و آن را بهتر بفهمند.

خدمات ترجمه شفاهی و کتبی بین این سرویس و دادگاه سازماندهی می شود. هزینه این خدمات را دادگاه می پردازد.

Punjabi - ਪੰਜਾਬੀ

ਵੱਖ-ਵੱਖ ਸਭਿਆਚਾਰਕ ਅਤੇ ਭਾਸ਼ਾਈ ਪਿਛੋਕੜਾਂ ਵਾਲੇ ਲੋਕਾਂ ਨੂੰ ਕੋਰੋਨਰ ਨਾਲ ਸਬੰਧਿਤ ਕਾਰਵਾਈ ਨੂੰ ਚੰਗੀ ਤਰ੍ਹਾਂ ਸਮਝਣ ਅਤੇ ਪ੍ਰਾਪਤ ਕਰਨ ਵਿੱਚ ਮੱਦਦ ਕਰਨ ਲਈ ਅਦਾਲਤ ਦੋਭਾਸ਼ੀਆ ਸੇਵਾਵਾਂ ਦਾ ਪ੍ਰਬੰਧ ਕਰ ਸਕਦੀ ਹੈ।

ਦੋਭਾਸ਼ੀਆ ਅਤੇ ਅਨੁਵਾਦ ਸੇਵਾਵਾਂ ਅਦਾਲਤ ਅਤੇ ਸੇਵਾ ਦੇ ਵਿਚਕਾਰ ਆਯੋਜਿਤ ਕੀਤੀਆਂ ਜਾਦੀਆਂ ਹਨ।ਅਦਾਲਤ ਸੇਵਾਵਾਂ ਦਾ ਖਰਚਾ ਦਿੰਦੀ ਹੈ।

Spanish - Español

El juzgado puede organizar los servicios de un intérprete para ayudar a personas de origen cultural y lingüísticamente diverso a que accedan y comprendan mejor el proceso forense.

Los servicios de interpretación y traducción se organizan entre el proveedor de servicios y el juzgado. El juzgado corre con los gastos de este servicio.

Tagalog

Maaaring magsaayos ang korte ng mga serbisyo ng pag-iinterprete upang tulungan ang mga taong mula sa iba't ibang mga kultura at wika, para mas madali nilang magamit at maintindihan ang pamamaraan ng pagdinig sa korte ng usapin ukol sa naging dahilan ng kamatayan ng isang tao.

Ang pag-iinterprete at pagsasalinwikang pasulat ay isasaayos sa pagitan ng serbisyo ng pagsasalinwika at ng korte. Ang korte ang magbabayad ng mga serbisyo ng pagsasalinwika.

Turkish - Türkçe

Mahkeme, farklı kültür ve dillerden bireylerin, sorgu hâkimlerinin yürüttüğü sürece daha kolay erişmelerine ve bu süreci daha iyi anlamalarına yardımcı olmak amacıyla tercümanlık hizmeti sağlanmasını ayarlayabilir.

Sözlü ve yazılı tercüme hizmetleri, hizmet sağlayıcısı ile mahkeme arasında ayarlanır. Mahkeme, bu hizmetlerin ücretini karşılar.

Vietnamese - Tiếng Việt

Toà có thể thu xếp dịch vụ thông dịch để giúp những người có nguồn gốc văn hoá và ngôn ngữ đa dạng có thể tiếp cận và hiểu được thủ tục điều tra cái chết dễ dàng hơn.

Dịch vụ thông dịch và phiên dịch là do toà sắp xếp với dịch vụ. Toà trả chi phi cho dịch vụ này.

Contents

Introduction

The death of a partner, child, friend, family member or colleague is one of the most difficult and painful experiences we can go through.

When a death happens suddenly, unexpectedly, or in traumatic circumstances, it can be overwhelming.

We have created this booklet to help you understand the coronial process. It includes information about the support that is available to families and friends when a loved one's death is being investigated by the Coroners Court of Victoria.

We know that most people will have had little or no contact with the Court.

This situation often means people have a limited understanding of what we do and why we need to do the work that we do.

This can be distressing and frustrating for families and friends who are looking for an explanation of how and why their loved one died.

We hope this booklet answers many of your questions and gives you some understanding of our processes.

In all our investigations, we try to find out what happened and why, and how we can stop further deaths from happening in similar situations.

Your participation and understanding of what we do is an important part of this process. We will try at all times to give you information where it is possible and appropriate.

AIMS OF THE *CORONERS ACT 2008*

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

The Act's introduction says that the coronial system of Victoria plays an important role in Victorian society. That role includes the independent investigation of deaths and fires to find the causes of those deaths and fires. The role also includes helping to reduce the number of deaths and fires that could have been prevented; promoting public health and safety; and administering justice.

Most importantly, the law promotes and protects the need to recognise the impact that a death, and the following coronial investigation, can have on the family and friends of a loved one. The Act states clearly that processes should:

- avoid repeating investigations when they are not needed
- recognise families' distress and their need for support after a death
- understand the effect of investigations that are unnecessarily long or drawn out
- recognise that different cultures have different beliefs and practices around death
- accept that family members affected by a death that is being investigated should be given information about the investigation and its progress, if it is appropriate
- recognise that there is a need to balance the public interest in protecting a living or deceased person's personal or health information, with the appropriate use of that information
- understand that it is important to promote public health and safety and to administer justice for a fairer and more effective coronial system.

Why a coroner investigates

PURPOSE OF A CORONIAL INVESTIGATION

The role of a coroner is to investigate certain deaths and fires to work out how and why they happened, so that similar deaths and fires can be prevented. 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 happened and, in some cases, the circumstances around it
- the details needed to register a death with the Registry of Births, Deaths and Marriages, Victoria

The *Coroners Act 2008* says that coroners must investigate all deaths that are 'reportable' or 'reviewable' deaths (We explain what this means on **page 11**).

There does not have to be anything suspicious about a death for a coroner to investigate it. Many investigations are about people who have died due to natural causes.

Coroners may comment and make recommendations about public health or safety, or about how justice should be administered to help stop similar deaths from happening (There is more information about this on **page 43**).

REPORTABLE DEATHS

Coroners must investigate a particular type of death called 'reportable deaths'. Someone must tell the Court about a reportable death so that a coroner can investigate.

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

What is a reportable death?

A death is reportable if at least one of the following is true:

- the body is in Victoria
- the death happened in Victoria
- the cause of the death happened in Victoria
- the person usually lived in Victoria at the time of death.

And if at least one of the following is also true:

- the death seems to have been unexpected, unnatural or violent, or to have been caused, directly or indirectly, from an accident or injury
- the death happened during a medical procedure or after a medical procedure where the death is, or can be, related to the medical procedure. And a registered medical practitioner would not, before the procedure was done, have expected the death to happen
- the identity of the person is not known
- a medical practitioner has not signed, and is not likely to sign, a death certificate certifying the cause of death
- a death has happened at a place outside Victoria and the cause of death is not certified and is not likely to be certified
- the person was placed in 'custody or care' just before their death. (We explain what this means on **page 14**.)
- the person was a patient under the *Mental Health Act 2014* just before their 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 under a non-custodial supervision order under section 26 or 38ZH of the Crimes *(Mental Impairment and Unfitness to be Tried) Act 1997*.

Coroners do not investigate the stillborn death of a child.

Who tells the coroner about a reportable death?

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

The Registry of Births, Deaths and Marriages Victoria may report a death to the Court if they think it is a reportable death.

A member of the community must also let the Court know about a reportable death, if they believe that the death has not already been reported.

REVIEWABLE DEATHS

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

What is a reviewable death?

A reviewable death is when two or more children from the same parents have died. A child is anyone under 18 years of age. As with reportable deaths, the child must have a connection to Victoria before a death is reviewable.

The deaths of children who lived their whole lives in hospital are not reviewable deaths, unless a coroner decides that they are.

Who is considered a parent?

As well as the biological parents, parents can include:

- step-parents
- parents who adopt
- foster parents
- guardians
- anyone who has custody or daily care and control of a 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 who has died and to work out the cause of death. The coroner can also refer a reviewable death to the Victorian Institute of Forensic Medicine (VIFM) so that they can check the health and safety of a living brother or sister of the deceased child and the health of the parent. VIFM can make sure that a family is referred to suitable health, bereavement and support services. The Court and VIFM are always sensitive to the grief and trauma that a family experiences when there have been deaths of multiple children.

Who tells the coroner about a reviewable death?

Medical practitioners and the Registry of Births, Deaths and Marriages Victoria must tell the Court when they come across a reviewable death.

A member of the community, including the police, must also let the Court know about a reviewable death, if they 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, they will work out if they need to investigate further.

VIFM provides forensic and scientific services to the Court. VIFM will help the Court investigate the death and will check the health and safety of living brothers and sisters, as well as the health of the parents if the coroner asks them to.

If a coroner refers the matter to VIFM to check the health and safety of brothers, sisters and parents, a staff member will contact the family to let them know. The Family Health Nurse may then get in touch to check the family's health and support needs. VIFM may refer families to specialised health or support services, or to other agencies, if needed.

FIRES

A coroner can investigate a fire whether or not there has been a death.

A coroner must investigate a fire if they receive a request to investigate from the Country Fire Authority or Metropolitan Fire and Emergency Services Board. However, the coroner may decide that the investigation is not in the public interest.

Any person can ask a coroner to investigate a fire. You can make a request by contacting the Court and filling in Form 16 — *Request to investigate a fire*. You will need to provide details of the fire and the reasons why the coroner should investigate. You can find a copy of the form from the Court website at **www.coronerscourt.vic.gov.au** or by contacting the Court on 1300 309 519.

If the coroner is not going to investigate the fire, they must give their reasons in writing to the person who made the request.

After investigating a fire, a coroner must make a finding that includes, if possible, the cause and origin of the fire, as well as the circumstances of how it happened.

DEATHS DUE TO NATURAL CAUSES

The death of a person may be reported to the Court because the death was unexpected and needs a coroner to investigate further.

In some situations, a forensic pathologist may examine the person and give a report to the coroner with the opinion that the death was due to natural causes.

A coroner may then decide that, apart from the death being unexpected, it does not fit any other category of a reportable or reviewable death, and that they do not need to investigate further.

In these situations, the coroner will write a finding that includes the identity of the person who died and what caused their death, but not the circumstances around the death.

In these situations, an inquest (public hearing) is not needed.

If the medical examination has found information that may affect other living relatives, staff from VIFM may contact you to talk about this health information.

DEATHS IN CUSTODY OR CARE

The death of a person who is in custody or care is a reportable death that a coroner must investigate.

If a person dies in custody or care, the Court must hold an inquest. This is unless the coroner decides the death was due to natural causes. In this case, there will not be an inquest. However, the coroner will publish their finding into the death on the Court's website.

A person is in custody or care if they are:

- a person for whom the Secretary to the Department of Human Services has parental responsibility under the *Children, Youth and Families Act 2005*
- a child placed into emergency care under the *Children, Youth and Families Act 2005*
- in the legal custody of the Secretary to the Department of Health and Human Services under section 483 of the *Children, Youth and Families Act 2005*
- under the control, care or custody of the Department of Health and Human Services
- in the legal custody of the Secretary to the Department of Justice or the Chief Commissioner of Police
- in the custody of a member of the police force

- in the custody of a protective services officer
- held in a treatment centre under the *Severe Substance Dependence Treatment Act 2010*
- a patient in a mental health service covered by the *Mental Health Act 2014*
- a person who a member of the police force or a prison officer is trying to take into custody
- a person who is dying from injuries caused by a member of the police force or a prison officer who tried to take the person into custody
- in Victoria and dying from an injury that happened while in the custody of the State
- held in detention in Victoria by an authorised person under the law of the Commonwealth or another jurisdiction
- in Victoria and an authorised person is trying to take them into custody
- in Victoria and dying from injuries caused by an authorised person who tried to take them into custody
- dying from an injury that happened while:
  - in the care, control or custody of an authorised person
  - in detention in Victoria under the law of the Commonwealth or another jurisdiction.

RESPONSIBILITY TO REPORT

Some deaths are reported to the coroner because they are reportable or reviewable deaths and legally must be reported under the *Coroners Act 2008*.

People who must report

People who must let the coroner know about a reportable or reviewable death include:

- a medical practitioner who was present at or after the death
- a police or prison officer who was trying to take the person who died into custody
- a responsible person, under the *Coroners Act 2008*, who had care or custody of a person who died
- a medical practitioner who was present at or after the death of a child, which may be a reviewable death.

General responsibility to report and provide help to a coroner

Anyone who thinks a reportable or reviewable death has happened and the Court has not been told about it, must report the death as soon as possible.

The close family of a person who has died can also report the death to the coroner if the person was discharged from a mental health service within three months of the death.

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

It may be appropriate to ask for legal advice about reporting responsibilities, as there are some complex legal issues in this area. Advice about who must report is also available by contacting Coronial Admissions and Enquiries (CA&E) on **1300 309 519**.

Differences between investigations and inquests

Coroners investigate all deaths and fires (where appropriate) that are reported to the Court, whether the matter goes ahead to an inquest (public hearing) or not.

Investigations usually include gathering a range of information for the coroner. In the early stages of an investigation, the coroner may ask the police to provide a coronial brief. This means the police may take statements from family and friends of the deceased person. The coroner may collect statements from medical practitioners and technical experts and any others to help with the coronial investigation (see **page 48** for more information). This helps 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 an inquest and call people to court to provide evidence. This is called a finding without inquest (see **page 41** for more information).

Inquests are public hearings and are held for only a small number of deaths and fires reported to the Court (see **page 36** for more information).

A coroner will usually only decide to hold an inquest if the circumstances around the death or fire are unclear, or if the circumstances mean there must be an inquest under the Coroners Act 2008 (for example such as a death in custody). Sometimes, a coroner may also decide to hold an inquest if there are issues of public health and safety that need to be considered.

Coronial Support Services staff can help you with further information about how to ask a coroner to investigate a death or fire, or how to apply for a coroner to hold an inquest into a death or fire.

Who takes part in an investigation?

CORONERS

The role of a coroner is to investigate particular deaths and fires. Their investigations are to find out:

- the identity of the person who died
- what caused the death or fire
- in some cases, the circumstances around the death or fire.

Coroners also hold inquests (public hearings) and may recommend ways to help stop similar deaths and fires from happening 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 practised law for at least five years.

CORONIAL ADMISSIONS AND ENQUIRIES

Coronial admissions and enquiries (CA&E) organises the first stage of the coroner's investigation, including receiving reports of deaths and accepting people into the care of the coronial jurisdiction. This office is open 24 hours a day.

CA&E also starts the process of asking for information that the coroner may need for their investigation, such as medical records.

CA&E staff organise any medical, scientific and forensic investigations to help the coroner work out the identity of the person who died and the medical cause of their death.

Pathologists from the VIFM (see **page 22** for more information) run the medical, scientific and forensic examinations. They provide medical and scientific expertise to coroners to help with the medical parts of their investigations.

Staff from CA&E can help with information about:

- viewing a person who has died
- how a person is identified
- any medical examinations that may be needed, including the preliminary examination and an autopsy
- the release of the person's body for the funeral
- any questions families have about the first stages of the coroner's investigation
- referring families to counselling and support services.

THE POLICE

The police play an important role in coronial process by conducting the first part of the coronial investigation. As such, they may be at the scene of the death on behalf of the coroner.

It is normal for the police to prepare a report of death for the coroner. Later police will often be asked by the coroner to get statements from the family and witnesses as part of the coronial investigation.

Just because the police are collecting statements from family and witnesses does not necessarily mean the death is suspicious or is the result of a crime.

The Court has a unit called the Police Coronial Support Unit (PCSU), which include police staff. Members of the PCSU can go to the scene of a death or fire for the coroner. They can also provide coronial briefs for the coroner and support other police officers who are investigating for the coroner. PCSU staff go to court to help coroners at some inquests and can also help families with the inquest process (see **page 46** for more information).

CORONERS SUPPORT SERVICE

The Coroners Support Service provides legal and administrative support to coroners after CA&E completes the first stage of the investigation and the person's body is released for the funeral.

The Coroners Support Service is made up of coroners' registrars, Court administration officers and family liaison officers. These staff members are the main source of information and contact for the next of kin, families, interested parties, the public, police, health service providers and many other departments and agencies.

Coroners Support Service staff process coroners' directions and orders and make sure that the right people or organisations complete them. This can include asking for further statements for the coroner, organising medical expert opinions, or listing a case for a hearing in open court.

They also speak to Victoria Police, the VIFM, hospitals, doctors and other government departments or agencies to make sure that any information the coroner needs is given to them as soon as possible.

Providing information and updates to families through letters and phone calls is also an important part of what the Coroners Support Service does. They send letters and emails to family members at key points during a coroner's investigation. These letters and emails include updates about the cause of death, how the coroner is going to run the investigation and if any further medical investigations are needed.

Registrars communicate with families. They help coroners with the coronial investigation by providing administrative support, organising court hearings including inquests, directions hearings, mention hearings and the delivery of findings. They also go to court hearings when needed.

Court administration officers help the coroners and registrars with general administration, maintaining records and registers, and going to court hearings as needed.

Family liaison officers help coroners with investigations where families and witnesses need extra support during the coronial process. This includes passing on to families sensitive information from coroners and other stakeholders, helping families understand information in a coronial brief and providing support during court proceedings.

Family liaison officers also help families and witnesses by giving them referral information and advice for counselling and support agencies which can help with grief and loss.

The **Aboriginal Engagement Unit** supports Aboriginal and Torres Strait Islander families and friends, by providing cultural supports and ensuring Sorry Business requirements are intertwined into the coronial process. They advise coroners on the cultural and spiritual needs of Aboriginal families and their loved ones.

The **Multifaith and Multicultural Advisory Committee** advise coroners and staff on the cultural issues facing families from multifaith and multicultural communities in Victoria. This ensures families broader cultural and traditional needs are integrated into the coronial process.

LEGAL SERVICES

Legal Services is a division of the court that assists coroners with their investigations.

Solicitors help coroners with coronial investigations by analysing evidence, drafting legal documents and communications for the Court, and preparing matters for inquests. They instruct counsel at court hearings and sometimes appear as counsel assisting the coroner.

In-House Solicitor Service is made up of lawyers who help coroners in investigations where the relevant circumstances involved the police, or where the behaviour of police may be examined.

This includes deaths that:

- happened in front of police
- are because of a police shooting or pursuit
- happened while the person was in police custody
- happened when police tried to take the person into custody.

In these situations, these lawyers make sure the coronial investigations stay independent and that there are no conflicts of interest. These lawyers also instruct at court hearings and sometimes appear as counsel assisting the coroner, and provide coroners and the Court with legal advice on complex areas of coronial law.

CORONERS PREVENTION UNIT

The Coroners Prevention Unit (CPU) is made up of a range of different specialist teams of case investigators that help coroners investigate deaths. The specialists include physicians, nurses, psychologists, social workers and lawyers. The CPU also looks for ways to improve public health and safety by developing recommendations that can be put in place to stop similar deaths from happening in the future.

VICTORIAN INSTITUTE OF FORENSIC MEDICINE

The VIFM is in the same building as the Coroners Court of Victoria, in the Coronial Services Centre at 65 Kavanagh Street, Southbank.

VIFM provides a team of medical specialists and forensic scientists to help with death investigations in Victoria. They also provide expert opinions in forensic pathology, clinical forensic medicine and forensic science, both nationally and internationally.

VIFM manages any medical or scientific examinations that a coroner needs to help identify the person who has died and, if possible, the medical cause of their death. They also provide health service follow-ups when the medical investigation shows that there may be health issues for other living relatives.

VIFM staff also operate the CA&E office and the Donor Tissue Bank of Victoria.

Exhumations

An exhumation is where a person's remains are retrieved from where they are buried. This is usually done for further examination.

Occasionally, the State Coroner may need to authorise an exhumation if they believe it is needed for the investigation of a death and that it is right to do so.

ADVISING SENIOR NEXT OF KIN

If the State Coroner is going to order an exhumation, the Court will usually let the senior next of know However, in some cases, the State Coroner does not have to let the senior next of kin know about an exhumation.

The senior next of kin will be told that they are allowed to offer suggestions as to how and if the exhumation should be done.

The exhumation will not be ordered until 48 hours after the senior next of kin has been informed.

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

You may want to get legal advice before lodging an appeal.

ADVISING CEMETERIES AND LAND OWNERS

If the person's remains are in a public cemetery, the State Coroner must let the cemetery trust know that they plan to authorise an exhumation. If the person is not in a public cemetery, the State Coroner must let the owner of the land know that they plan to authorise and exhumation.

The State Coroner must consider suggestions about the exhumation from the senior next of kin or any other person who provides written notice.

The suggestions must be in writing and filed with the Court by a time that is set by the coroner. The Court will include this information in the notice about the planned exhumation.

WHEN THE CORONER DOES NOT HAVE TO GIVE NOTICE

The State Coroner does not have to give notice that they plan to exhume if they believe that giving notice would cause:

- the escape of an offender or accomplice
- the making of, or destruction of, evidence.

The coroner also does not have to give notice that they plan to exhume if:

- the exhumation is urgent and should not be delayed
- giving notice is not possible.

REQUESTING AN EXHUMATION

Anyone can apply to the State Coroner for an exhumation.

You can apply by completing Form 20 – *Application for Exhumation*. You can find a copy of the form from 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.

You can also email the form to **courtadmin@coronerscourt.vic.gov.au**

If the State Coroner refuses the application, you will be told as soon as possible.

Family information

In most cases, if a person died in Melbourne, staff from CA&E will take them into the care of the coronial jurisdiction at the Coronial Services Centre located at 65 Kavanagh Street, Southbank.

If a person died in regional Victoria, staff from the Court or CA&E will let families know where they are being cared for. This may be at a regional hospital or at Southbank.

All people under the care of the coronial jurisdiction are cared for in a respectful way.

Where possible, CA&E staff will try to respect a family's religious or cultural requests throughout the coronial process.

If you want to make a religious or cultural request, please contact the CA&E office on **1300 309 519** as soon as possible.

IDENTIFICATION

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

This can include a visual or medical and scientific process. If the coroner needs a visual identification, you or someone close to 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 ways to identify a person include:

- fingerprinting
- looking at dental records
- using blood, tissue or saliva to check for DNA comparisons.

The coroner will decide which is the most appropriate way to identify the person and CA&E staff will let you know what identification process will be used.

You can contact CA&E on **1300 309 519** for more information about the identification process.

VIEWING AND TOUCHING

CA&E staff will help anyone who wants to see or touch a loved one who has died. This is called a 'viewing'.

CA&E and the Court know that viewings are an important part of the grieving process for many people and will work with you to organise this. In some situations, it may be better for the viewing to be at the funeral home. However, families can tell CA&E staff if they would like a viewing while the person is still in the care of the coronial jurisdiction.

In some situations, CA&E may need to talk to you about the type of viewing that can take place to make sure the viewing will not affect the coroner's ability to work out the identity the cause and circumstances of the death.

It may not be possible to touch a loved one, if their death is under criminal investigation by police. This is so that any forensic evidence that needs to be collected is not affected. You may also not be able to touch a person if there are health risks involved. In these situations, the coroner will decide what is most appropriate for everyone 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.

The CA&E will let them know about any medical procedures that are needed. The Court will also give them updates on how the investigation is going and about any medical examination reports given to the coroner. The Court will send a form to request the medical examination report to the senior next of kin. If the senior next of kin would like a copy of the report, they will need to complete and return the form.

The senior next of kin is worked out by following the order of priority below:

- if the person, just before their death, had a spouse or domestic partner – **the spouse or domestic partner will be the senior next of kin**
- if the person, just before death, did not have a spouse or domestic partner, or if the spouse or domestic partner is not available – **a son or daughter 18 years or older will be the senior next of kin**
- if a spouse, domestic partner, son or daughter is not available – **a parent will be the senior next of kin**
- if a spouse, domestic partner, son, daughter or parent is not available – **a sibling who is18 years or older will be senior next of kin**
- if a spouse, domestic partner, son, daughter, parent, or sibling is not available – **a person named in the will as an executor will be senior next of kin**
- if a spouse, domestic partner, son, daughter, parent, sibling or executor is not available – **a person who, just before the death, was a personal representative of the deceased will be senior next of kin**
- if a spouse, domestic partner, son, daughter, parent, sibling, executor or personal representative is not available – **a person the coroner decides had a close relationship with the person just before their death will be senior next of kin.**

The coroner will decide who will be senior next of kin if there is more than one person who wants to be the senior next of kin. In some circumstances, the Court may refer the people who wish to be made senior next of kin, to a lawyer for free legal advice.

If you are not the senior next of kin and want to receive certain documents, you will need to fill in Form 45 – *Access to Coronial Documents*. This form is available on our website at **www.coronerscourt.vic.gov.au/forms-resources/request-coronial-documents**

FUNERAL ARRANGEMENTS

You can contact a funeral director as soon as a person has died. You don't need to wait for the coroner to release the person from the care of the Court.

Families do not have to use the funeral director who transferred the person into the care of the coronial jurisdiction. The Court cannot recommend a funeral director.

When will my loved one be released?

The coroner can release a person if they believe the death was not a reportable or reviewable death or they no longer need to keep the person for their investigation.

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

To let the Court know which funeral director you have chosen, an 'Application for Release of a Deceased Person' form will need to be filled out. A funeral director usually fills this out for the family and sends it to the Court. Once the coroner has the form, they can authorise the release.

The coroner's order must say who the person is being released to, and it may include terms or conditions if the coroner thinks that is necessary.

In cases where two or more people apply for the release of a person, the coroner will decide who the person will be released to. In certain circumstances the Court may refer one or more applicants to a lawyer for free legal advice.

You can call **1300 309 519** and ask to speak to CA&E for more information about the release process.

ACCESS TO WHERE THE DEATH HAPPENED

Public place

Anyone can access a public place where a death happened, as long as the investigation at the scene is finished. Police or the coroner sometimes restrict access to the place, or a place where they think a death has happened, while they are investigating.

It is an offence for an unauthorised person to go into a place where access has been restricted by the police or coroner.

You can contact the Court on **1300 309 519** for information about going to a scene with restricted access.

Private premises

If the death happened on private premises or property, the person wanting to visit would need the permission of the owner.

Police or the coroner may restrict access to the place, or a place where they think a death has happened, while they are investigating.

It is an offence for an unauthorised person to go into a place of death where access has been restricted by the police or coroner.

You can contact the Court on **1300 309 519** for information about going to private premises with restricted access.

Personal belongings

The police usually keep personal belongings of the person who has died – such as jewellery, clothing and other valuables – which may be found at the place of death. They then return them to the senior next of kin once the investigation is finished.

You can call **1300 309 519** for information about personal belongings.

If you wish to apply for property to be released during a coronial investigation, you can do so by completing a Form 34 - *Application to Access Seized Things or to Have Seized Things Released.* Your application will then be considered by the coroner and a written response will be provided. You can find the Form 34 on the Court's website at **www.coronerscourt.vic.gov.au** or by contacting the Court on **1300 509 519**.

DEATH CERTIFICATES

How do I get a death certificate?

Death certificates are issued by the Registry of Births, Deaths and Marriages Victoria (BDM). There is a fee for death certificates, which may be included as part of the funeral costs. In most cases, you won't need to apply directly for a death certificate - the funeral director will usually do it for you.

BDM will issue the death certificate to the person who the funeral director listed as the informant. If you were not the one making the funeral arrangements, you may be eligible to apply directly to BDM for a copy of the death certificate.

BDM offers different types of certificates depending on your needs and whether the coroner has determined cause of death.

Death Certificate – without cause of death

This legal certificate does not include sensitive information about your loved one, such as the cause of death, burial information, or registration date. This certificate can be issued if the coroner has not yet established the cause of death and it can be used with organisations which do not require you to provide the cause of your loved one's

death. It is always best to check with the organisation you are dealing with to see if they will accept the death certificate without case of death.

Death certificate – with cause of death

This legal certificate includes all details about your loved one, including sensitive information such as the cause of death, burial information, and registration date. This certificate can be provided to any organisation that asks you to prove the death of your loved one has occurred.

Note: the coroner must have determined cause of death before BDM can issue this certificate.

Interim death certificate

Interim death certificates are used if you need to repatriate your loved one to their own country. This can be issued if the coroner has not yet established the cause of death.

Medical processes

PRELIMINARY EXAMINATIONS

Once a person's death has been reported, a doctor or pathologist will examine them to provide information to the coroner. This preliminary examination is minimally invasive and will be done at the VIFM in the Coronial Services Centre at 65 Kavanagh Street, Southbank, or at a regional hospital.

A preliminary examination includes one or more of the procedures below:

- a visual examination
- collecting and reviewing information about the person who has died, including personal and health information
- taking bodily fluid 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 of the person who has died for testing. This includes swabs from wounds and the inner cheek, hair samples, as well as samples from under fingernails and from the skin
- imaging of the person, such as computed tomography (CT scans), magnetic resonance imaging (MRI scan), x-rays, ultrasound and photography
- fingerprinting.

The pathologist uses this information to recommend to the coroner if more medical investigations, such as an autopsy, are needed to help confirm the cause of death.

The coroner then looks at the pathologist's recommendation and decides if further medical investigations are necessary.

Staff from CA&E can answer any questions you have about the preliminary examination.

AUTOPSY

What is an autopsy?

An autopsy – sometimes called a post-mortem examination – is a medical procedure that a forensic pathologist carries out.

A forensic pathologist is a qualified doctor who specialises in pathology, which is the science that looks at the effects that disease or damage has on the body.

What does it involve?

If the coroner asks for an autopsy to be done, a forensic 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 kept for that reason.

Who decides if there will be an autopsy?

The coroner decides if an autopsy should be done 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 ask for an autopsy to be done if they think that it will help the investigation into a person's death and the circumstances around the death.

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

If a coroner asks for an autopsy, CA&E staff will contact the senior next of kin to explain the process, answer any questions, and let them know that they have the right to object to the autopsy (see **Objecting to an autopsy** for more information).

You can call **1300 309 519** and ask to speak to CA&E staff for more information about autopsies.

Where will the autopsy take place?

VIFM will usually do the autopsy at the Coronial Services Centre, 65 Kavanagh Street, Southbank.

If the death happened in regional Victoria, the autopsy may be done in a regional hospital. Some people will be transferred to Melbourne for the autopsy, depending on the circumstances surrounding the death, such as suspected homicide. All child deaths and incidents involving major trauma are handled in Melbourne.

If an autopsy is needed, CA&E staff will let families know where their loved one will be taken.

REQUESTING AN AUTOPSY

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

If the coroner says no, you can apply to the Supreme Court for an order that an autopsy be performed.

You must make the application to the Supreme Court within 48 hours of receiving the coroner's written reason for refusing the autopsy. If you are in this situation, you can speak to CA&E who may be able, through a coroner's direction, to arrange for a barrister to speak to you and give you advice for no charge. Or you can seek your own 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 done.

If the objection to an autopsy is for religious, cultural or other reasons, the senior next of kin will need to put their objection in writing, including their reasons for objecting, and send it to the coroner, addressed to CA&E. You can do this by email or fax.

You must send your written objection within 48 hours of a coroner ordering that an autopsy be done. The autopsy will not go ahead during this time.

The coroner will take these concerns into account and CA&E staff will let you know the coroner's decision.

If the coroner decides an autopsy should still be done, the senior next of kin can apply to the Supreme Court for an order stopping it from happening.

You will need to do this within 48 hours of being told that the coroner has refused your objection. If you are in this situation, you can speak to CA&E who may be able, through a coroner's direction, to arrange for a barrister to speak to you and give you advice for no charge. Or you can seek your own legal advice and help before making a Supreme Court application.

In some situations, the coroner may ask for an autopsy without letting the senior next of kin know.

RETAINING ORGANS

Sometimes, a pathologist will recommend that whole organs, such as the brain, heart or larger portions of tissue, be kept for medical tests to help the investigation.

CA&E staff will contact the senior next of kin to talk about this and the coroner will need to agree before it happens.

CA&E staff will also need to speak to the senior next of kin about their wishes for what happens to the organs when the testing and examination has been completed.

You can contact CA&E on **1300 309 519** for more information about retaining organs.

TISSUE DONATION

Staff from CA&E can organise the Donor Tissue Bank of Victoria to contact family about tissue donation. Tissue donation is not a part of the coronial process. However, a coroner will need to give permission before a donation happens to make sure that it does not affect their investigation.

Receiving a tissue transplant from a person who has just died can help many ill or injured people, including burns victims. 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).

VIFM manages the Donor Tissue Bank of Victoria.

You can contact VIFM on **(03) 9684 4444** and ask to speak to the Donor Tissue Bank of Victoria for more information about tissue donation.

Court processes

INQUESTS

An inquest is a court hearing into a death. A coroner hears an inquest, which is usually open to the public. Some inquests may be held online. While every reportable death will have an investigation, inquests or public hearings are only needed in a small number of investigations.

An inquest is not like other court cases. It is an inquisitorial rather than an adversarial process. This means an inquest is not a trial, with a prosecutor and a defendant, but an inquiry that tries to find out why the death or fire happened.

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

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

After the coroner has heard all the evidence, they will write a finding. A finding may include recommendations to a government minister, public statutory authority or other organisation, to help stop similar deaths or fires from happening in the future (see **page 41** for more information).

Why is an inquest held?

A coroner holds an inquest because they think there is an issue of public interest and they need more information to answer all the questions about the death or fire.

In some situations, a coroner also has to hold an inquest under the *Coroners Act 2008*. For example, there must be an inquest if a person died while they were in police custody, unless the coroner decides the death was due to natural causes (see **page 14** for more information).

A coroner also has to hold an inquest if the death is a suspected homicide or the identity of the person who died is not known.

A coroner, however, does not have to hold an inquest if:

- the death probably occurred more than 50 years before it was reported to the coroner
- a person has been charged with a criminal offence to do with the death
- a coroner in another state has investigated, is investigating or plans to investigate the death
- the death happened outside of Australia.

What happens if there is no inquest?

Coroners investigate all deaths reported to the Court, whether or not an inquest is held.

An inquest will only be held if it has to be under law or if the coroner decides an inquest is necessary.

If the coroner does not have to hold an inquest, they may instead make a finding about a death without an inquest (see **page 41** for more information). This is sometimes called a 'chambers finding'.

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

Who can ask for an inquest?

Any person can ask that a coroner hold an inquest into a death or fire reported to the Court. To do this, you need to complete Form 26 – *Request for Inquest into Death* — or Form 27 – *Request for Inquest into Fire* — and give the reasons why you believe an inquest is needed. You can find copies of the forms from the Court website at **www.coronerscourt.vic.gov.au** or by contacting the Court on **1300 309 519**.

Before asking for an inquest, speak to Coroners Support Service staff to talk about the investigation. The coroner needs time to gather all the evidence before deciding if an inquest is needed. The coroner will think about all requests. If a coroner decides not to hold an inquest, they must give written reasons.

If the coroner decides not to hold an inquest, you can appeal to the Supreme Court within three months of their decision (see **page 44** for more information).

At the inquest

Coroners try to make inquests less formal than other court proceedings. The coroner will try not to use complex language. The coroner wants family members and those interested in the case to understand what is happening.

It can be hard to hear details about the death of a loved one or friend in a public courtroom. Coroners understand if family members and friends need to leave the courtroom, so they do not have to hear or see evidence the coroner is examining. Court staff are there to help and answer any questions you have.

Who can come?

Usually, anyone can come to an inquest. Sometimes, a coroner will decide to stop the public, or specific people, from going, but this is unusual.

A coroner may also stop the evidence or part of the evidence from being published.

While anyone can go to the inquest, only people that a coroner has given permission to can be an 'interested party'. (We explain what this means on **page 40**.)

Who are witnesses?

Witnesses are people who give evidence or give material or information to the Court. They help the coroner understand the circumstances of the death or fire and give evidence of any knowledge they have about the death or fire.

A coroner may issue a summons to make sure a witness appears at the inquest. A summons is a legal document that orders someone to come to the Court. If the witness does not attend or give any document or material the coroner has asked for, the coroner may issue a warrant to arrest that person and bring them to court.

If the coroner wants a person to appear as a witness, a police officer acting for the coroner will give them the summons in person. The summons tells witnesses when and where to go.

The Coroner sometimes orders that a summons be posted to a witness instead of having it served personally.

Do you need a lawyer?

Families can choose to have a lawyer represent them at an inquest. The Court cannot help you choose a lawyer. The person helping the coroner, usually a member of the PCSU or a lawyer (see **page 21** and **46** for more information), can help you to understand and take part in the inquest if you decide not to get a lawyer. The coroner can also guide you during the inquest.

Court Network

Network is a group of trained volunteers who support families and friends that have to go to court hearings. They can also give you information and refer you to other support organisations. If you want to meet a Network volunteer at your court hearing, please contact the Court on **1300 309 519** or call Network on **1800 681 614**.

What happens during an inquest?

The coroner will decide the best way to run the inquest. Unlike what happens in other courts, the coroner decides what information and issues to look at, and who they want 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, will then ask the witness questions.

Interested parties can also give statements, documents or other related items to the coroner.

After all the evidence is given, those involved in the inquest may give the coroner submissions that explain their position on the evidence and the things they want the coroner to think about.

These submissions may be spoken out loud in court or written. 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 surrounding a 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 make a finding (see **page 41** for more information). In some hearings, the coroner may give the finding on the same day that the inquest ends. With other more complex issues, it may take the coroner longer to prepare the finding. Court staff will let you know when the coroner is ready to give the finding.

Directions and mention hearings

Directions and mention hearings are smaller hearings that help the coroner to identify issues related to their investigation. They may be held online or in the courtroom. A directions or mention hearing gives a coroner the chance:

- to hear from the people involved and to find out what their opinion of the issues in the case are
- to talk about any issues that may affect the coroner's decision on whether there needs to be an inquest
- to work out how long an inquest may run for and who the witnesses would be
- to raise any other related issues with the those involved.

INTERESTED PARTIES

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

In coronial proceedings, an interested party is a person, organisation or group who has information about the death or fire being investigated or who may be affected by the coroner's finding.

To be an interested party for an inquest, a person or organisation must be able to show the coroner that they have enough interest in the issue.

Interested parties include:

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

To be an interested party in an inquest, you need to complete Form 31 – *Application for Leave to Appear as an Interested Party* — and give it to the Court. The coroner may go through these applications in court as part of a directions and mention hearing (see **page 40** for more information).

The senior next of kin does not need to fill out an application form.

You can find a copy of the form from 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 get information about an investigation by completing Form 45 – *Access to Coronial Documents/Inquest Transcript* (see **page 49** for more information).

Rights of an interested party

Interested parties have the right to:

- appear in the Court or be represented by a lawyer or, with the coroner's permission, by another person
- make a submission to the coroner that lists who they believe are relevant witnesses
- examine or cross examine witnesses and make submissions
- be given a copy of the coronial inquest brief, unless the coroner decides not to.
- have a document given to them if the coroner believes they have enough interest in the document
- the same protection as a party in a Supreme Court proceeding
- appeal to the Supreme Court against the coroner's findings about a death or fire.

Restrictions on an interested party

Interested parties may only be able to appear in the part of the inquest that relates to their interest. Parties who only have a financial interest in the outcome of an inquest may not be able to be an interested party for that inquest.

FINDINGS

A finding is the formal document that a coroner prepares after an investigation into a death or fire and is usually the last 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 a number of pages, depending on the complexity of the investigation.

Inquest findings

The coroner delivers a finding made after an inquest. This is called an 'inquest finding'. A copy of an inquest finding is published on the Court website — **www.coronerscourt.vic.gov.au** — unless a coroner orders it not to be published,

Finding without inquest

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

Most coronial investigations end with findings without inquests. In some circumstances, a coroner can direct findings be published on the Court's website.

If the coroner is going to make a finding without an inquest, the senior next of kin will be told.

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
- what caused the death
- in some cases, the circumstances of the death.

A coroner does not have to work out the circumstances of the death if there was no inquest; the person who died was not held in 'custody or care' just before their death; and if there is no public interest in working them out.

The coroner can comment on any issue connected with the death, including public health and safety or the administration of justice. The coroner may also make recommendations to any government minister, public statutory authority or other organisation that can help to stop similar deaths from happening in the future (see **page 43** for more information).

The coroner cannot make a comment or statement in any finding that a person is guilty or may be guilty of a crime.

However, if a coroner thinks a crime may have been committed, they will ask the Principal Registrar to let the Office of Public Prosecutions (OPP) know. A coroner may include a comment that they have passed information on to the OPP, in their finding.

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

A coroner must also make a finding after an investigation into a fire. A coroner must find, if possible, the cause and source of the fire and the circumstances surrounding the fire.

How do you register concerns regarding medical treatment or care?

Some families may have concerns regarding the medical treatment or care their loved one received. For more information and to access the *Concerns of Care* form, please refer to the publication *Which organisation is most appropriate for your concerns?* which is located in the Forms & Resources section on the court's website **www.coronerscourt.vic.gov.au**.

Who can receive a finding?

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

Copies of the finding may also be given to any person or organisation that the coroner has decided is an interested party or has enough interest in the matter.

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

RECOMMENDATIONS

Under the *Coroners Act 2008*, a coroner can make recommendations as part of their finding after an investigation into a death or fire.

A coroner can make recommendations to any government minister, public statutory authority or other organisation that can help stop similar deaths from happening in the future.

Any public statutory authority or other organisation receiving a recommendation from a coroner must reply, in writing, within three months of receiving the recommendation. This reply must include what action, if any, they have taken or will take.

The Court will publish all coroners' recommendations and replies on the Court website at **www.coronerscourt.vic.gov.au**.

LEGAL REPRESENTATION

Families attending an inquest at the Court can choose to have a lawyer represent them. However, the Court cannot help a family choose a lawyer.

If families want legal representation, they will usually have to pay for a private solicitor. There are contact details for Victoria Legal Aid and Victorian Aboriginal Legal Services at the end of this publication, which may be able to provide advice and assistance.

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

You can get free legal advice (and sometimes representation) from Victoria Legal Aid, the Victorian Bar or a community legal centre.

However, if families decide not to ask a lawyer to represent them, the person helping the coroner, as well as the coroner's guidance and support, can help you understand and take part in the inquest.

Help given to the coroner at an inquest

In most inquests, a member of the police helps the investigating coroner. This person is called the coroner's assistant and can examine and cross examine witnesses.

In some cases, the coroner may ask a lawyer from the Court's in-house legal counsel or a barrister for help. This person is called counsel assisting the coroner.

A coroner may also ask for help from experts to understand and explain complex issues during an inquest. These people are called expert witnesses and can include people with medical, scientific or engineering expertise.

Can a coroner's investigation be reopened?

Yes. Anyone can apply to the Court asking that a coroner reopen an investigation. Coroners can reopen investigations if they think that there are new facts and circumstances, and that it is right to do.

You can apply to reopen an investigation by filling in Form 43 – *Application to Set Aside Finding*. You can find a copy of the form 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 done. If you want to object to an autopsy for religious, cultural or other reasons, you need to put your objection in writing outlining your reasons and address it to the Court.

You must make your written objection within 48 hours of a coroner ordering that an autopsy be done. The autopsy will not go ahead during this time.

The coroner will consider your concerns and the CA&E staff will let you know the coroner's decision.

If the coroner decides an autopsy should still be done, you can apply to the Supreme Court for an order to stop it from going ahead.

You need to do this within 48 hours of being told the coroner has refused your objection.

If you are in this situation you can speak to CA&E who may be able, through a coroner's direction, to arrange for a barrister to speak to you and give you advice for no charge.

In some situations, the coroner may direct an autopsy to be done without letting the senior next of kin know.

Appealing a refusal for an inquest

After receiving a request for an inquest, a coroner must let you know their decision in writing.

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

Appealing a refusal to set aside a finding and reopen an investigation

If the coroner refuses to reopen an investigation, you have the right to appeal to the Supreme Court within three months of this decision.

Appealing against coroner's findings

A person with enough 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.

You may want to get legal advice before lodging an appeal.

Appealing against an exhumation

An exhumation is where a person's remains are taken from where they are buried. This is usually done for further examination (see **page 24** for more information).

Occasionally, the State Coroner may need to authorise an exhumation if they believe it is needed for the investigation of a death and it is right to do so.

The senior next of kin can appeal against an exhumation to the Supreme Court. The appeal must be made within 48 hours after you receive notice that the State Coroner has authorised an exhumation.

You may want to get legal advice before lodging an appeal.

In certain cases, the State Coroner does not have to let the senior next of kin know they are going to exhume.

Appealing against a coroner's decision not to exhume

Anyone can apply to the State Coroner for an exhumation by filling out Form 20 –*Application for Exhumation*. You can find the form on the Court website at **www.coronerscourt.vic.gov.au** or obtain one by contacting the Court on **1300 309 519**.

If the State Coroner refuses to authorise an exhumation, you can make an appeal to the Supreme Court.

You must make the appeal within three months of the State Coroner's refusal. You may wish to get legal advice before lodging an appeal.

COURTROOM BEHAVIOUR

If you are going to attend a hearing, make sure you allow plenty of time to get to Court.

Please check with Court staff about where the hearing will be held.

Every court has its own rules, but people going to an inquest should know:

- visitors to the Court will need to comply with the Court's security arrangements. This may involve going through a metal detector when you enter
- visitors must follow the instructions of the Court staff while on Court grounds
- tape recorders and cameras are not allowed in any Court building without specific approval – there are special rules for the media
- radio receivers or transmitters, including mobile phones, must be switched off in any courtroom
- food or drink must not be taken into any courtroom
- visitors can enter and leave the Court at any time, unless there is a sign on the door of the courtroom saying that you cannot
- visitors must not move around or speak in the courtroom when a witness is taking an oath or affirmation
- lawyers and counsel helping the coroner will bow to the coroner when they enter or leave the courtroom. This is to show that they are taking part in an official court proceeding. Visitors do not need to bow; however, it is considered respectful to do so.

Visitors should check with Court staff or the coroner's assistant if they have any questions about how to behave in court.

IN THE COURTROOM

When the inquest begins, the lawyers representing family members or other interested parties introduce themselves and say who they are representing. 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 agrees to tell the truth. The witness is asked to give their name, address and occupation. Sometimes, a witness does not want to have their address read out in court and the coroner may agree to this.
- **The witness statement may be read out** – Whether or not it is read out, a statement 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** – These expand on what they have said in their statement. The other lawyers can also ask the witness questions. The coroner's assistant or counsel assisting the coroner can then ask more questions to clear up any issues. If a lawyer is not representing the family, the coroner's assistant or counsel assisting the coroner will check if they have any questions they would like the witnesses to be asked.

If the coroner has allowed interested parties to appear at the inquest, they can ask questions. The coroner can also ask questions.

- **Final submissions 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 out loud. 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 believes 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 made on the same day, but in other more complex investigations, the finding may take weeks or months.

The inquest finding, and any recommendations and responses, will be published on the Court website at **www.coronerscourt.vic.gov.au**, unless the coroner orders that this does not happen.

Access to documents

CORONIAL DOCUMENTS

When a coroner investigates a death or fire, documents are prepared and may be made available. These can include:

- medical examiners' reports
- toxicology reports
- witness statements
- transcripts from an inquest
- coronial briefs
- coronial findings.

CORONIAL BRIEFS

Police prepare coronial briefs for most coronial investigations. The brief contains all the material that the coroner will examine. Usually, the coroner decides who gets a copy of the coronial brief and when. The number and type of documents in a brief of evidence will depend on the complexity of the investigation.

Documents can include:

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

CORONIAL FINDINGS

At the end of the investigation, the coroner writes a finding. A finding includes the identity of the person who has died; the cause of the death or fire; in some situations, the circumstances of the death or fire; and any comments or recommendations that can help stop similar deaths from happening.

Unless a coroner orders them not to be, most inquest findings are available on the Court website at **www.coronerscourt.vic.gov.au**.

APPLYING FOR ACCESS

If you want to access documents, you must complete Form 45 – *Application for access to Coronial Documents/ Inquest Transcript*. You can find the form on the Court website at **www.coronerscourt.vic.gov.au** or obtain one by contacting the Court on **1300 309 519**.

You can post, fax or email the form back to the Court.

The coroner will decide if access is appropriate for each case and Court staff will let the person know in writing if the coroner approves the application.

A coroner may release documents to:

- the senior next of kin
- a statutory body for a statutory function
- a member of the police force for law enforcement
- researchers carrying out 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 enough interest.

The coroner may put conditions on the release of a document. A penalty may be applied if these conditions are broken.

If the investigation was completed before 1 June 1986, you should 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 happening, or if the person who has applied does not have enough interest in the investigation.

Are there any fees?

You may have to pay for copies of documents. The Court may waive or reduce these charges where appropriate. You can find a copy of the Court's standard fees on the Court website at **www.coronerscourt.vic.gov.au**.

If you want the fees waived or reduced, contact the Court on **1300 309 519**.

Does freedom of information legislation apply?

Documents collected for a coronial investigation do not come under freedom of information applications.

Feedback

REGISTERING FEEDBACK

The Court welcomes feedback about our service and the coronial process, as well as on the information in this booklet.

Please go to **www.coronerscourt.vic.gov.au** to lodge your feedback online or contact the Court on **1300 309 519**. Written feedback can be sent to Coroners Court of Victoria, 65 Kavanagh Street, Southbank 3006.

Feedback can be anonymous, but if you would like the Court to respond to your feedback, you should include your contact details.

THE CORONERS COURT OF VICTORIA

The Coroners Court of Victoria is committed to enabling the community to provide feedback on its services and processes. The Court understands the impact coronial investigations can have on family and friends who have lost a loved one. We value community feedback and use it to continually improve our services and the experiences of people who come into contact with the Court.

Notes

Helpful contacts

BUSINESS HOURS UNLESS STATED

Aboriginal Advancement League

(03) 9480 7777

Amber Community (road incident support and education)

1300 367 797

Compassionate Friends

(03) 9888 4944 (24 hours)
1300 064 068 (24 hours)

Coronial Admissions and Enquiries

1300 309 519

Court Network (Court Process Support)

1800 571 239

Donor Tissue Bank of Victoria

(03) 9684 4444

Federation of Community Legal Centres Victoria

(03) 9652 1501

Interpreter Service

13 14 50

GriefLine

1300 845 745 (6am – Midnight)

Grief Australia (formerly Australian Centre for Grief and Bereavement)

(03) 9265 2100

Lifeline

13 11 14 (24 hours)

Local Aboriginal Community Controlled Health Organisation (ACCO)

(03) 9411 9411

https://www.vaccho.org.au/

Mercy Grief Services

1300 369 019

(For people in the Western Metropolitan Region)

National Relay Service TTY

13 36 77 (for hearing impaired)

1300 555 727 (speak and listen)

0423 677 767 (SMS relay number)

Registry of Births, Deaths and Marriages

1300 369 367 (8am – 2pm)

Road Trauma Support Services

1300 367 797

Red Nose Australia

1300 308 307 (24 hours)

State Trustees

1300 138 672

SuicideLine Victoria

1300 651 251 (24 hours)

Support After Suicide

1800 943 415

StandBy Suicide After Support

1300 727 247 (6am to 10 pm, 7 days a week)

Victims of Crime Helpline

1800 819 817 (8am – 11pm)

Victoria Legal Aid

1300 792 387

Victorian Aboriginal Health Service (VAHS)

(03) 9419 3000 (Fitzroy)

(03) 9403 3300 (Preston)

(03) 8592 3920 (Epping)

Victorian Aboriginal Legal Services

1800 064 865

Coroners Court
of Victoria

65 Kavanagh Street, Southbank VIC 3006

T 1300 309 519 **F** 1300 546 989

www.coronerscourt.vic.gov.au