# Preparing for the hearing
# &
# learning how the death happened

Booklet 4

Help in coping:

When someone dies in a road accident

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In memory of Colin Rodgers. To all those who have died on Canberra's roads. For all those bereaved by a road accident in Canberra, and for those helping them.

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# FOREWORD

This booklet tells you what the ACT coronial system is and how it operates.

Most people, even lawyers, have no experience of the system until they suffer the personal loss of a family member whose death is reported to the coroner.

The booklet explains what happens, why and what you can ask for. Along with the other booklets in the kit, it is a most useful guide for bereaved people and those who wish to help them.

RON CAHILL
ACT CHIEF CORONER

# INTRODUCTION

## HOW CAN THIS BOOKLET HELP YOU?

This is likely to be your first experience of the coronial system and of a coronial hearing. You may know very little about how coronial procedures work, what is expected of you and what your entitlements are. You may feel overwhelmed by an unfamiliar system, and have many concerns and questions – and this at a time of great sorrow.

This booklet aims to help you develop an understanding of how the coronial system operates and your rights within this system. It gives you information on some of the procedures involved and how to go about preparing for the hearing.

Many of the procedures discussed in this booklet are underpinned by the *Coroners Act 1997* (ACT). This Act recognises that family members will be affected by the death and by the inquest into the death, and enables you to participate in some aspects of the coronial process, including the hearing.

### How to use this booklet

The booklet makes reference to relevant sections of the *Coroners Act 1997* (ACT). Word-for-word quotations from the Act are enclosed in ‘ ’ (inverted commas); otherwise, references to the Act are not the exact wording of the Act.

There is a *Glossary* at the end of the booklet, which provides definitions of terms you may not know.

### Other booklets

- For information about procedures that take place soon after the person’s death, and examination of the motor vehicle, > see *Booklet 1*.
- For information about the death certificate, motor vehicle insurance and Compulsory Third Party insurance, > see *Booklet 3*.
- Seek further information and assistance from the contacts listed in *Booklet 8*.
- For leads to published information, including how to access the Coroners Act, > see *Booklet 6*.
- > See the chart ‘Coronial & other procedures following a fatal road accident’ enclosed in this kit.

## UNDERSTANDING HOW THE ACCIDENT HAPPENED – WHY IS IT IMPORTANT?

Finding out *how* and *in what circumstances* the person died will not ‘bring the person back’ – tragically, nothing can. But it will help you to get some sense of *how* the accident happened and *how* the person died.

The process of finding out more – like the process of grieving more generally – will be painful, and it is natural to want to avoid it. Nevertheless, going through this painful process now can help you (and other family members) in the long

term to resolve your grief. Finding out more now can mean you won't be left, months or years down the track, wondering exactly what happened. Consider this advice to parents of a child who has been killed by a drunk driver:

'Try to develop enough of an understanding of how your child was killed so that you no longer have to puzzle about it. There are ways in which it will never make sense. Questions like why it happened to your child, why it happened to you, have no answer. But you can understand exactly what happened that led to the killing of your child: who was driving, from where to where, at what speed, with what sort of control of the car, where your child was, and so on.

You may feel driven to find out what happened, in full detail. This determination can be useful. It is important to know, so that you need not wonder in the future.

On the other hand, you may feel initially that you don't care about detail. All that matters is that your child was killed. Try to learn as much as you can, anyway. Later you may want to know, and then it may be harder to go back and find out what happened.

Do your best to dispel mysteries. Ask questions.'

*Excerpted from 'Will It Always Feel This Way? For the Parent Whose Child Has Been Killed by a Drunk Driver' by Robert S. Weiss. Published on the Internet by Mothers Against Drunk Drivers (USA) (http:www.madd.org)*

## PREPARING FOR THE HEARING

### Why is it important?

To try and find out how the accident happened, the best way is to prepare for the coronial hearing as best you can. In essence, the hearing is your one and only opportunity to ask questions of witnesses in order to clarify any questions you may want resolved. This may involve some hard work on your part now. But later on, after the hearing is over, it may be much harder for your questions to be clarified.

### How do I prepare? An overview

Preparing for the hearing might mean engaging a lawyer specialised in this area to assist you. If you can't afford a lawyer, or feel it's not necessary, you can still access some sources of free legal advice and information and read up on the subject.

There are many things you (and/or your lawyer, where relevant) will need to do if you want to derive the full benefit from the hearing. Much of this will need to be done ahead of time:

- ☐ **Request access to the coroner's brief.**

  If you don't request access well beforehand, you may be shown the brief by a police officer when you arrive at court for the hearing. This will not allow enough time for you to consider its contents. (If this happened, you could ask the coroner for time to review the brief before the hearing begins; however, this might require an **adjournment**, which should be avoided (and

which might not be considered to be justified); > see below.)

- ☐ **Carefully consider the brief to see what questions may emerge.**
  In some cases, only the investigating officer's statements (which include a summary of witnesses' statements) will be read out during the hearing; other elements of the brief may be merely tendered in evidence instead of being read out in full. If you haven't had ample time to examine the brief and listen to any taped statements beforehand, you won't be able to know the full details, including points that you might wish to have clarified.
- ☐ **Find out which witnesses the coroner intends to call and, if necessary, ask the coroner to call a witness.**
  You will need to know which witnesses will attend (and be available for examination and cross-examination), and which ones will not (this might include the police officer who examined the vehicle, for instance).

  If a witness's statement is read out and that witness is not there in person, you won't be able to ask questions – unless you ask the coroner to adjourn the hearing. It is better to find out beforehand which witnesses the coroner intends to call and, if necessary, request before the hearing that the coroner call a witness.
- ☐ **Take the opportunity offered during the hearing to ask questions and have your questions resolved.**

'Find out everything you can about the death . . . Ask questions – and remember, if a question is important enough to worry you, it's important enough to ask. Keep asking until you get an answer.'

*Excerpted from 'Death of an Infant Twin', Centering Corporation, Omaha, Nebraska*

### Avoiding possible disruption or frustration

An **adjournment** is a break in the hearing, of whatever length (a few minutes, hours, days, etc.). It is entirely up to the coroner to decide whether to adjourn the hearing or not.

An unplanned adjournment may cause a disruption to the court's schedule. While it is possible to request an adjournment, it is best to avoid it unless you consider an issue to be really important.

If, for example, the coroner does not adjourn the hearing so that you can ask questions of a particular witness that the coroner has not called, and you have unanswered questions, or if you are unsatisfied with the investigation or hearing for other reasons, it may be very difficult to do anything about it afterwards, despite various review mechanisms (> see also *Chapter 6)*.

It is much better to prepare ahead of time in order to avoid possible disruption to the court's schedule, or possible frustration on your part.

The following chapters in this booklet give you more information that you will need to know about how the coronial system operates and how to prepare for the hearing.

# 1 NOTIFICATIONS & TIME FRAMES

## 1 WHAT NOTIFICATIONS WILL I RECEIVE?

The Coroner's Office will generally write to you on three occasions:

- **soon after the death** – to notify you that the death has been reported to the coroner and is being investigated, and that the coroner will inform you later whether or not he or she intends to hold a hearing.
- **later on** – to inform you whether a hearing is to be held and, if so, when and where. You may also be contacted if the hearing has been postponed or adjourned.
- **after the hearing** – to send you the coroner's findings on the manner and cause of death.

## 2 WHO WILL BE NOTIFIED?

### Who will be notified as a matter of course?

During the initial investigation of a coronial matter, the police will inform the coroner of the name and address of the deceased person's nearest relative. All correspondence from the Coroner's Office relating to the deceased will be sent to that person at that address.

### Who may be notified if notification is requested?

#### Other family members

Other close relatives may also wish to be consulted and informed about the inquiry. It would be a courtesy on your part to inform them that, if they wish to receive separate relevant notifications, they should contact the Coroner's Office, in writing.

#### PARENTS LIVING SEPARATELY

Where the parents of a deceased person are living separately, the coroner will send correspondence to one of the parents only, unless the other parent writes to the Coroner's Office and asks to receive the information also.

#### SPOUSE

If not already identified as the nearest relative, any spouse may ask to be kept informed and to participate in the coronial process. 'Spouse' includes *married, de facto* and *same-sex partners* (section 3, Coroners Act).

## 3 WHAT TIME FRAMES WILL BE INVOLVED?

### The investigation

The person's death must be investigated by the police, and this will take time. For example, depending on what tests are conducted, the results of the post-mortem examination (> see *Booklet 1*) may not be available for approximately six to eight

weeks. Toxicology tests (to detect poisons or drugs) can take some months to complete. The police must also examine the scene of the accident and the motor vehicle(s) involved, and interview relevant witnesses.

The investigating police officer cannot give out much information about the results of the investigation; the information gathered by police investigators is, generally speaking, subject to restricted access until it has been presented to the coroner.

### If you have any concerns

At this stage, you can make inquiries but, as a general rule, do not expect to be given much specific information about the cause and circumstances of the death. You can contact:

- the **Coroner's Officer** – if you wish to know the provisional cause of death, possible time frame for medical tests that may be required and approximate date of the hearing
- the **investigating police officer** – to inquire about the mechanical examination of the vehicle, for example (> see *Booklet 1)*
- the **Coroner's Office** (Deputy Registrar of the Coroner's Court) – for information about the timing of the hearing or to indicate that you wish to receive notifications.

If a serious issue arose, you could ask to speak to the Registrar, counsel assisting the coroner, or the coroner.

### The hearing

As the time of the hearing approaches, you can begin to prepare for the hearing and request access to the coroner's brief (> see *Chapter 5).*

Generally speaking, do not expect a hearing to be held until three months or more after the death.

## 4 WILL A HEARING BE HELD?

### In what circumstances will a hearing be held?

Once the initial investigation is complete, the coroner decides whether or not a hearing will be held.

A coroner may decide not to hold a hearing if satisfied that the circumstances of the death have been made clear (subsection 14(1), Coroners Act). This is called 'dispensing with' a hearing.

In some circumstances there is a legal requirement to hold a hearing. This applies if the person died in custody, or died during or as a result of the administration of an anaesthetic (subsection 14(2), Coroners Act).

In the case of a motor vehicle accident, current practice in the ACT is that a hearing will be held (however, if the accident took place outside of the ACT, > see *Chapter 2).*

## Notification – if a hearing is to be held

If a hearing is to be held, the coroner sets the time and place of a hearing (section 35, Coroners Act). The Coroner's Office will send the details of the time, date and place of the hearing to a member of the immediate family. You will usually receive *two to four weeks' notice*, sometimes more.

This does not mean that *all* family members will be notified; you may wish to advise other family members (> see above, *Who will be notified?*).

The Coroner's Office will also send these details to anyone who has informed the coroner that they would like to give evidence at the hearing or be represented by a lawyer at the hearing. If you are represented by a lawyer, he or she will be kept informed. The coroner must also, where practicable, publish notice of the hearing in a daily newspaper at least two weeks before the hearing (section 38, Coroners Act).

### NEXT STEPS

Now is the time to begin preparing for the hearing; read the next chapters to find out more.

## Notification – if the coroner intends to dispense with a hearing

You do not need to read this section unless you have received notice that the coroner does not intend to hold a hearing; this is unlikely in the case of a motor vehicle accident that took place in the ACT.

### NOTIFICATION OF IMMEDIATE FAMILY

If the coroner decides to dispense with a hearing, he or she must notify a member of the immediate family (and the Chief Coroner) of this decision, in writing, stating the reasons and giving the cause of death (section 14, Coroners Act).

### REQUESTING A HEARING

If the coroner intends to dispense with a hearing but you want one, you may ask for a review of the decision. You must write to the Chief Coroner and explain your reasons (section 64, Coroners Act). (Any person with a sufficient interest in the inquest into the death may do this.)

If your request is refused, you may apply to the ACT Supreme Court within 30 days of the refusal (section 90, Coroners Act). If the Supreme Court considers it would be in the interests of justice, it may order a coroner to hold a hearing (section 91, Coroners Act).

(The ACT Attorney-General may also apply to the Supreme Court for a review of a coroner's decision not to hold a hearing. In this case, if the Supreme Court considers it would be in the public interest or the interests of justice, it may order a coroner to hold a hearing – section 92, Coroners Act).

Before deciding whether to request a hearing, you may wish to look at the coroner's brief (> see *Chapter 5)* and consider what, if any, questions or concerns you want addressed. In rare circumstances, it may be possible to deal with these in a meeting with the coroner or Registrar, without the need for a hearing.

# 2 THE CORONIAL INQUEST OR INVESTIGATION

## 1 WHICH DEATHS MUST BE INVESTIGATED?

The coronial system is responsible for investigating the circumstances of **'reportable' deaths** (section 13, Coroners Act) – those where a person:

- is killed
- is found drowned
- dies a sudden death the cause of which is unknown
- dies under suspicious circumstances
- dies during or within 72 hours after, or as a result of, an operation or invasive procedure (medical or diagnostic)
- dies, and a medical practitioner has not given a certificate as to the cause of death
- dies, not having been attended by a medical practitioner in the previous three months
- dies after an accident to which the cause of death appears to be related
- dies, or is suspected to have died, in circumstances that the Attorney-General believes should be investigated
- dies in custody (e.g. mental hospital, child welfare institution, prison or lock-up, or otherwise in police custody).

These deaths all come *within the coroner's jurisdiction* (as does the investigation of fires and, in certain circumstances, disasters). All 'reportable' deaths must be reported to a coroner (section 77, Coroners Act).

### What if the accident happened outside the ACT?

If the accident took place outside of the ACT and the person was brought to a hospital in the ACT and died in the ACT, here is what generally happens.

The death is reported to the ACT coroner, who takes control of the person's body and may authorise a post-mortem.

Assuming the accident took place in NSW: the matter will be referred to the NSW State Coroner and then to the local NSW coroner in the vicinity of the accident. NSW police investigate the accident.

The local NSW coroner sends a dispensation to the ACT coroner, who dispenses with a hearing in the ACT and closes the file. The ACT Coroner's Office will inform the next of kin that the matter has been reported to a NSW coroner.

It is up to the relevant NSW coroner whether to hold a hearing. You should follow up the matter with the NSW coroner and seek more information about NSW coronial law and practice (> see *Booklet 6)*. You may be able to obtain assistance from counsellors at Glebe Coroner's Court in Sydney.

This being said, the ACT coroner may investigate the death of a person if the person was ordinarily resident in the ACT and the death was a 'reportable' death (> see above) (subsection 13(2), Coroners Act). You may request the ACT coroner to hold a hearing into the matter (> see *Will a hearing be held?* in *Chapter 1)*; whether or not you are successful would depend on the circumstances involved. Conversely, if you have reasons to think that an inquest should be held in NSW rather than in the ACT, speak to the Coroner's Office as soon as possible.

### What if criminal charges are laid?

The Coroner's Court is not a criminal court. If it becomes apparent that criminal charges may be involved, the matter goes *outside the coroner's jurisdiction.*

Section 58 of the Coroners Act provides that if, at any time during an inquest, it appears to the coroner that a person may have committed a serious criminal offence, the coroner must inform the Director of Public Prosecutions (DPP). The coroner must not proceed further with the inquest for the time being; the DPP then decides whether to prosecute the person concerned.

It may also happen that the DPP or police informs the coroner that a person is to be charged (or has already been charged) in relation to the death being investigated; in this case also the coroner must not proceed further with the inquest.

After any criminal proceedings are finalised, the matter returns to the coroner, who may make a *finding* concerning the person's death.

## Interim finding and death certificate

The circumstances described above will involve delays. However, the coroner may make an *interim finding* on any matter connected with the inquest into the death (section 53, Coroners Act). This would allow the family to obtain a death certificate *with* cause of death (> see also *Booklets 3* and *8)*. If you wish to ask the coroner to make an interim finding on the cause of death, contact the Coroner's Office.

## Assistance to families of victims

If criminal charges are laid against a person, families of victims may seek assistance from the Australian Federal Police Victims' Liaison Officers but are not eligible to claim criminal injuries compensation (section 9, *Criminal Injuries Compensation Act 1983 (ACT)).* (However, these families – as well as those where criminal charges are not involved – may in certain circumstances be able to claim compensation to relatives under the Compulsory Third Party insurance scheme; > see also *Booklets 3* and *8*.)

## 2 WHO IS INVOLVED?

### Coroner's Court

#### Coroner

The coroner is responsible for holding an inquest (investigation) into 'reportable' deaths (> see above, *Which deaths must be investigated?*). The coroner must find out, if possible, the manner and cause of death, when and where the death occurred and the identity of the deceased (section 52, Coroners Act). In the ACT, magistrates (of the ACT Magistrates Court) are also coroners (of the ACT Coroner's Court) (section 5, Coroners Act).

#### Chief Coroner

The Chief Magistrate is also the Chief Coroner (section 6, Coroners Act). 'The Chief Coroner is responsible for ensuring the orderly and expeditious discharge of the business' of the Coroner's Court and makes arrangements as to which coroner is to deal with a particular case (section 7, Coroners Act).

#### Court administration

The Coroner's Court is given administrative support by staff who fall under the administrative responsibility of the ACT Attorney-General and his or her department (the ACT Department of Justice and Community Safety).

##### REGISTRAR

The Registrar is the administrative head of the Coroner's Court and also of the Magistrates Court (section 11, Coroners Act).

##### CORONER'S OFFICE

The **Deputy Registrar** of the Coroner's Court is an administrative officer who assists coroners in handling correspondence and inquiries, keeping coronial records, preparing summonses for witnesses, etc. You can contact the Deputy Registrar about the administrative aspects of a particular coronial matter – for example, whether a coronial hearing will be held and, if so, when and where – and to request access to the **coroner's brief** (> see below).

### Police

#### Police investigation on behalf of the coroner

Police officers carry out the investigation on behalf of the coroner. (The coronial responsibilities of police also include reporting deaths to a coroner, notifying relatives of a death and obtaining official identification of the deceased, as discussed in *Booklet 1*).

The coroner can direct police to carry out additional investigations if the coroner considers this to be necessary (section 63, Coroners Act).

Specialist sections of the police may be involved in the investigation. In the case of a road accident, the Accident Investigation Team usually carries out the investigation.

When the police have finished their investigations, they pass their file of information on to the Coroner's Officer.

## Coroner's Officer

The Coroner's Officer is a police officer and is the link between the coroner and the police. The Coroner's Officer reports to the coroner and is notified of all deaths reported to the coroner.

He or she performs the following tasks:

- attends all post-mortem examinations (as does the investigating police officer) and liaises with pathologists and others in relation to the post-mortem
- attends the release of the deceased's body from the morgue
- coordinates the investigation on behalf of the coroner and is primarily responsible for ensuring the brief of evidence has been prepared
- serves summonses on witnesses (after the police have drawn up a list of proposed witnesses and the coroner, in consultation with the Coroner's Officer, has decided which witnesses to call)
- consults with the coroner in the setting of a date for a hearing
- where requested, explains procedures to families.

#### CORONER'S BRIEF

Once the Coroner's Officer receives the file of evidence from the police, he or she passes on one copy to the coroner and another copy to counsel assisting the coroner. The information that is to be presented at the hearing is called the 'coroner's brief' or 'inquest brief'.

You can request access to the brief of evidence. If access is approved by the coroner, the Coroner's Officer will provide a copy to you (or your lawyer). > See *Chapter 5* for further details.

## Office of the Director of Public Prosecutions

The coroner may appoint a legal practitioner to assist him or her (section 39, Coroners Act). This person will be from the ACT Office of the Director of Public Prosecutions, one of whose functions is to assist a coroner in the conduct of inquests and inquiries. The role of the DPP officer is to:

- review the evidence

  Where necessary, he or she could instruct the Coroner's Officer to obtain further evidence.
- assist the coroner at the hearing.

  In this capacity the person is referred to as **'counsel assisting the coroner'** (or simply 'counsel assisting') (> see also *Chapter 3).*

# 3 WHAT IS A CORONIAL HEARING?

## 1 WHAT IS A CORONIAL HEARING?

A coronial hearing is a public hearing before a coroner to decide the circumstances of a death. The coroner hears the evidence about the death and then makes *findings* about the cause and circumstances of the death and related matters.

### Purpose of the hearing

The purpose of the hearing is not to find out whether someone is guilty or at fault, or to award compensation, as happens in criminal or civil courts. The coroner is said to have an 'inquisitorial' role. This means that a coronial hearing is designed to inquire into the circumstances of the death and establish facts; it is not a trial.

As part of this inquisitorial role, the coroner may compel a witness to answer a question (or compel a witness, where summoned, to give evidence or produce a specified document or thing). But, because the coronial hearing is not a trial, evidence presented before the coroner cannot, on its own, be used to prove someone is guilty of an offence nor to prove someone was negligent. Similarly, the coroner's findings will not determine any findings made by other courts.

If, in the course of hearing evidence, it appeared to the coroner that a case existed against a person for a serious criminal offence, the coroner must adjourn the hearing and inform the DPP. It would then be up to the DPP to decide whether to prosecute the person concerned (section 58, Coroners Act; > see also *Chapter 2)*, and, if the case proceeded to court, the other court would consider the evidence afresh.

### Importance of the hearing

The hearing provides an opportunity for the evidence collected in the investigation to be tested by questioning *(examination and cross-examination)* (> see below). This is why it can be important to be present (and/or represented) and to prepare beforehand; > see *Introduction* and *Chapter 5*.

What comes out during the hearing may be important for other possible proceedings in other courts (outside the jurisdiction of the Coroner's Court). However, as stated above, the coroner's findings will not determine any findings made by other courts, which would consider the evidence afresh.

## 2 SOME POWERS OF THE CORONER

### Granting leave to appear

A coroner may grant leave to a person 'to appear in person at a hearing or to be represented by a legal practitioner and, at the hearing, to examine and cross-examine witnesses on matters relevant to the inquest . . .' (section 42, Coroners

Act). This applies to:

- persons who, in the coroner's opinion, have a sufficient interest in the subject of the inquest (members of the immediate family of the deceased are generally considered to have sufficient interest (> see also *Chapter 4)*);
- persons who have been summoned to give evidence.

### Witnesses and documents

It is the coroner's responsibility to decide which witnesses to call and in what order (generally speaking, this is decided before the hearing).

The coroner has powers to summon witnesses to appear at the hearing to give evidence or produce documents, and to force them to appear before the coroner (sections 43, 44, 45, Coroners Act).

### Adjournment

The coroner may adjourn a hearing (section 36, Coroners Act). This means the hearing temporarily stops, for whatever length of time may be involved. A person may ask the coroner to adjourn the hearing, but the decision is at the coroner's discretion.

## 3 What happens during the hearing?

### Proceedings are usually in public

The court room and the hearing itself are open to the public. The evidence heard by the coroner may be reported by the media. However, the coroner may close the court and hear evidence in private, and order that evidence not be disclosed or published (this is called a **'suppression order'**) (section 40, Coroners Act) – but these powers are not often used.

A hearing may expose family members to disturbing information and perhaps embarrassing publicity. If you have any concerns, you may wish to discuss these with a lawyer or the coroner.

The proceedings are recorded by the court (the typed up version is known as the **'transcript'**).

### Presenting of evidence & examination of witnesses

#### Witnesses

All witnesses who have been called to give evidence do so before the coroner. Witnesses may be required to take an oath or affirmation (section 48, Coroners Act). Sometimes witnesses must wait outside or leave the court so that they are not influenced by the evidence given by another witness.

The investigating officer's statement, giving a summary of witnesses' statements, is read out. Sometimes other witnesses' statements are merely tendered in evidence (and not read out). Taped witnesses' statements that have not been transcribed will also be tendered in evidence (and not played).

#### The coroner

During the hearing, the coroner hears the evidence and may question witnesses.

### Counsel assisting the coroner

Counsel assisting the coroner (also called 'counsel assisting') presents the evidence and takes the witnesses through their statements (**'examines'** witnesses).

Counsel assisting is a legal practitioner (usually an officer of the DPP) who represents the public interest in the hearing (unlike any other legal practitioners who may have been granted leave to appear at the hearing to represent the particular interest of a person).

## Participation by those with a sufficient interest

### Cross-examination of witnesses

After each witness has been questioned by counsel assisting, he or she may be questioned further about their evidence by any interested party or a lawyer acting for the party.

### Submissions

After the evidence has been heard, the people appearing or represented may:

- make *submissions* to the coroner about the *finding* they consider appropriate
- ask the coroner to make *recommendations* about matters raised in the evidence.

One of the roles of the coronial system is to prevent similar deaths in the future. If you believe your family member's death resulted from inadequacies in practices, policies or laws, you may want the coroner to draw attention to these problems.

At the end of a hearing, the coroner can make formal recommendations to the relevant authorities. If you think recommendations should be made, these should be suggested before or during the course of the hearing.

## At the end of the hearing

The coroner:

- must, if possible, make *findings*, concerning the identity of the deceased, when and where the death occurred, and the manner and cause of death (section 52, Coroners Act)
- may make *comments* on any matter connected with the death (section 52, Coroners Act)
- may *report*, and make *recommendations,* to the Attorney-General on any matter connected with the inquest (section 57, Coroners Act).

Any of these would be presented in writing after the hearing and may also be mentioned during the hearing.

## How long does the hearing last?

A coronial hearing may take a few hours, a few weeks or even months to complete. Its duration depends on the number and types of questions to be answered, the number of witnesses called and other factors such as the perseverance of those who are interested in the outcome and the extent of public unrest.

In the case of a motor vehicle accident, the hearing can be fairly short – sometimes only an hour or two (> see also *Timing* in *Chapter 5)*.

# 4 PARTICIPATION IN THE HEARING

## 1 WHO CAN PARTICIPATE?

### Persons with a sufficient interest

The coroner may allow relatives and others with a **'sufficient interest'** in the inquest (as well as those who have been summoned to give evidence) to participate in the hearing (section 42, Coroners Act). This is called being granted **'leave to appear'**.

### Coroner's discretion

Family members are generally considered to have a sufficient interest, but the coroner has a broad discretion to decide which individual or group has 'sufficient interest' in the subject matter of an inquest. No individual or group has a right to participate at a hearing; this is a decision for the coroner's discretion, and he or she does not have to give reasons for refusing this permission.

## 2 LEAVE TO APPEAR

You may choose to:

- **appear in person**; or
- **be represented by a legal practitioner** (solicitor or barrister).

You (or your lawyer) may:

- **question witnesses during the hearing**; and
- **make submissions to the coroner.**

## 3 REQUESTING LEAVE TO APPEAR

### Formal participation

#### Appearing in person

If you would like to participate in this way in the hearing, it is best to notify the Coroner's Office of your wishes, even if you are the next-of-kin, preferably in advance of the hearing. You can also ask what other persons have sought leave to appear at the hearing (> see below). And you should prepare for the hearing; > see *Chapter 5*.

#### Legal representation

If you don't feel confident of your ability to represent your interests or those of your family (or of the deceased) at a hearing, you may wish to be represented by a lawyer.

##### WHO ELSE MAY BE LEGALLY REPRESENTED?

At a coronial hearing concerning a traffic accident death, and depending on circumstances, there could be three or more parties represented (e.g. drivers

involved or persons injured or their insurers). At a hearing concerning a work-related death, the workers' compensation authority, the employer and trade union representative may participate. Any government department or agency that believes it has an interest in the outcome may participate for some or all of the hearing.

#### WHEN SHOULD I BE REPRESENTED BY A LAWYER?

In such circumstances, you may find it desirable to be represented, especially if a third-party claim (> see also *Booklet 3)* or possible charges may be involved. You may find yourself at a disadvantage if you are not represented.

It may therefore be a good idea to be represented by a lawyer experienced in inquests if there is going to be a later claim for compensation or if you suspect that another person or organisation will be trying hard to lay the blame on your deceased family member (> see also *If you are legally represented* in *Chapter 5)*. You will need to weigh up the cost.

## Informal participation

If you haven't notified the coroner beforehand, you could attend the hearing and ask the coroner if you may be allowed to 'appear' at the hearing. If this is refused, you can still sit in on the hearing. You can bring a relative or friend for support.

The coroner may explain the procedures involved and ask if there are any questions. As a close relative of the person whose death is the subject of the hearing, you can generally ask the coroner for assistance on anything you don't understand. Don't be afraid to speak up.

You can question witnesses – but if you intend to play a very active role, it is probably best to request 'leave to appear' ahead of time.

# 5 PREPARING FOR THE HEARING

## 1 IF YOU ARE LEGALLY REPRESENTED

### What preparation should you expect of a lawyer?

If you are legally represented by a lawyer, here are some of the things you should expect the lawyer to do, well before the hearing:

- ☐ inquire about the progress of the investigation and whether a **hearing** is likely to be held and, if so, **when** and **for how long**
- ☐ notify the Coroner's Office of the intention to attend the hearing and request **leave to appear** (in writing)
- ☐ request access to the **coroner's brief** of evidence (preferably in writing)
- ☐ **when access to the brief is granted:**
  - see what **evidence** is in the brief (by perusing the brief at the court or obtaining a copy of it) and assess the case

    What appear to be the key issues? How do the pieces of the puzzle fit together? What points need to be clarified?
  - **documents**

    What documents are or will be available?

    Should the coroner be asked to subpoena other documents?
  - **witnesses' statements**

    What statements are or will be available? What form are statements in? (fully transcribed? or taped on cassette and summarised?)
  - **witnesses to be called**

    Will written witnesses' statements be sufficient?

    If not, which witnesses does the coroner intend to call to attend the hearing (to be available for examination and cross-examination)?

    Should the coroner be asked to call any witnesses?

    If a witness will not be in the ACT, does the coroner intend to call the witness to attend, or use teleconferencing?

    In what order will the witnesses be called?
  - **expert opinion**
  - Is the full post-mortem report available? If not, when will it be available?

    Is it advisable to consult with a pathologist on the meaning and implications of the post-mortem report?
  - Are the **police mechanical examination reports** (on vehicles involved in the accident) available? If not, when will they be available?

    Are the reports adequate to answer any questions that may have arisen during the perusal of the evidence?

Does the coroner intend to call the person who examined the vehicles as a witness? Is a further mechanical examination advisable? (> see *Booklet 1*)

- ☐ if advisable, seek a conference with counsel assisting or the coroner to discuss the case and canvas possible options. (In complicated cases, this may even involve preliminary hearings.)

Make sure that the lawyer has previous coronial experience and expertise, that he/she is aware of the matters of concern to you and that you agree on the approach to be taken and the fee to be charged. It is probably a good idea for you to spend time perusing the brief with your lawyer before the hearing.

### What is the point of having a lawyer?

'. . . Police and experts inquiring into the causes and manner of death are applying their experience and research to develop and test hypotheses by identifying the relevant facts. The coronial system relies upon them to pose the right questions.

However, it does not rely on them alone. The lawyers are expected to know coronial law and practice and to master sufficient of the technical expertise to be able to lead and test evidence and then make submissions about its weight to the coroner . . . the competent advocate can help the coroner by highlighting shortcomings in the evidence and forcing a reassessment of the evidence.'

*Hugh Selby, editor, The Inquest Handbook, 1998, p. xxii*

## 2 IF YOU ARE NOT LEGALLY REPRESENTED

The importance of preparing for the hearing is discussed in the *Introduction*. Preparation ahead of time on your part will help to ensure a smooth and uninterrupted hearing, without the need for an adjournment (break in the hearing).

### How to prepare: An overview

You can prepare for the hearing by doing what a lawyer with expertise in coronial cases would do (> refer to the points above). As well, here is a checklist of things to do if you are intending to represent yourself.

### Before the hearing: A checklist

- ☐ Preferably in writing and soon after you receive notification of the hearing date:
  - Notify your intention to attend and request leave to appear (> see *Chapter 4*).
  - Request access to the coroner's brief (> see below, *Coroner's brief*).
- ☐ Make sure you have ample time to read the brief (and listen to taped statements, where relevant).

It is important to read the brief very carefully before the hearing. Make sure that the brief contains answers to all your questions and all matters have been fully explored.

- ☐ Find out which **witnesses** the coroner intends to call and, if considered necessary, ask the coroner to call other witnesses (> see below, *Witnesses).*
- ☐ Find out what **other parties** (if any) will be represented at the hearing.
- ☐ Raise any **concerns** you may have (> see below, *If you have any concerns*).
- ☐ **Learn** more about coronial matters (> see *Booklet 6*).
- ☐ **Familiarise yourself with the court and coronial hearings.**

  It may be a good idea to do a 'dry run' well ahead of time to familiarise yourself with the surroundings and with coronial proceedings. Visit the court building. Sit in on a coronial hearing. (Call the Coroner's Office to find out when there is a hearing scheduled that you can attend as a member of the public.)
- ☐ Write out any **questions** you want to ask witnesses or matters you would like to raise with the coroner.

### During the hearing: Some tips on court procedures

- ☐ Arrive at the ACT Magistrates Court building early enough to allow yourself time to find the right court room. Check the court list or ask at the information desk (both are near the entrance of the building).
- ☐ If you have young children, you will need to make your own arrangements for child care. Children should not disrupt the court proceedings.

#### WHO SITS WHERE?

- The coroner will sit at the front of the court room (the Bench). Those familiar with court procedures address the coroner as 'Your Worship'. If you address the coroner, you may call the coroner 'Sir' or 'Madam', as the case may be, or 'Your Worship'.
- Witnesses will give their evidence at the witness box, which is located near the side of the Bench.
- Counsel assisting (usually from the DPP's office) will sit at the Bar table (in front of the Bench). If you are not legally represented, introduce yourself to counsel assisting.
- Any legal representatives of parties with a sufficient interest will also sit at the Bar table.
- If you are not legally represented, the coroner may invite family representatives to sit at the Bar table. If not, and if you cannot hear what is being said, convey your concerns to the coroner and ask to sit at the Bar table.
- Other persons sit at the back. This may include other people involved in the accident and their family or friends.

### Timing

Court sittings are from 10.00 a.m. to about 11.15 a.m; 11.30 a.m. to 1.00 p.m.; and 2.00 p.m. to 4.00 p.m.

The number of witnesses called generally determines the expected length of the hearing and therefore the scheduling of the sitting. If few witnesses are called, the hearing would generally be listed for either of the morning sittings. If more witnesses are called, the hearing would generally be listed for the mid-morning or afternoon sitting (or all day in some cases). **In the case of a motor vehicle accident, many coronial hearings would be expected to finish within the one sitting** (> see also *How long does the hearing last?* in *Chapter 3).*

## Coroner's brief

### What is the coroner's brief?

The coroner's brief is the file of information about the death, collected by the police on behalf of the coroner, that will be presented at the hearing. It may include:

- **police report on mechanical examination of vehicle(s)** (including tachygraph reading and weight of heavy vehicles, if relevant)
- **police report/statements** concerning the accident and the scene of the accident
- **doctor's statement pronouncing life extinct**
- **pathologist's post-mortem report**, including **toxicology report** (concerning alcohol or drugs) (restricted access; > see below)
- **other witnesses' statements** (including witnesses of the accident, drivers, any other expert witnesses) (Statements of some witnesses may be recorded on cassette. Sometimes these statements are transcribed; sometimes they are not, and the investigating police officer makes a written summary of them; > see below.)
- **sketch plan of accident scene**
- **photographs** (restricted access; > see below).

> See also below, *What can I request?* and *When and how should I request access?*, and *Other information not usually in the coroner's brief.*

### Access to the coroner's brief

Section 51 of the Coroners Act provides that:

> **'A Coroner may make available to any person with sufficient interest in an inquest or inquiry–**
>
> **(a) any document or thing that is produced at, or the Coroner intends to consider in relation to, an inquest or inquiry; and**
>
> **(b) any evidence relevant to the inquest or inquiry to which the Coroner intends to have regard.'**

The exception is when the investigation must remain confidential. This is a matter for the coroner to decide.

#### WHO CAN REQUEST ACCESS?

Any person (and/or their legal representative) with a 'sufficient interest' in the inquest may request access to the coroner's brief. This includes the immediate family and may also include other persons or entities.

#### WHAT CAN I REQUEST?

For the purposes of requesting access to the coroner's brief, all items in the list mentioned above would be considered to be evidence, statements, documents or things. This would include taped witness statements that have not been transcribed.

### Taped witnesses' statements

Not all witnesses' statements are transcribed, as noted above and in *Chapter 3*. The investigating police officer may make a written summary of witnesses' statements, which is read out during the hearing. In this case, the taped statements may be tendered in evidence (and not played). Nor are transcribed witnesses' statements necessarily read out during the hearing; these, too, may be merely tendered in evidence.

Taped witnesses' statements are the best evidence, because they are first hand and not summarised. If you want to have access to the best evidence, then you should ask to listen to the tapes before the hearing.

### Restricted access

Your access to some sensitive elements of the brief may be restricted:

- **photographs**: The coroner would be very reluctant to make photos available to the immediate family, as these may be distressing. (However, if you are represented by a lawyer, he or she may view all the photos.)
- **post-mortem report**: The coroner is also reluctant to make the post-mortem report available directly to the immediate family. The Coroner's Office prefers that you nominate a doctor to whom the report will be sent (> see also immediately below).

#### WHEN AND HOW SHOULD I REQUEST ACCESS?

It is best to make your request early on. Telephone the Coroner's Office. Ask what elements are in the brief and in what format (e.g. transcribed or taped statements).

Indicate that you wish to receive the brief (and listen to taped statements, where relevant) well ahead of the hearing. (If you were to receive the brief only a day or two before the hearing, or the day of the hearing, this would not allow enough time for you to read it (and listen to tapes, where relevant) and consider its contents.)

**Follow up by putting your request in writing to the Coroner's Office:**

- **taped witness statements**: Indicate that you wish to have either the *transcribed* witness statements or, if these are not available, *copies of the cassettes* of witness statements.

- **post-mortem report**: Give the name and address of the doctor to whom you wish the Coroner's Office to send the report. Ask that the report be sent well ahead of the hearing so that you will have time to discuss it with your doctor before the hearing. Then contact your doctor.

  NOTE: The post-mortem report describes each stage of the post-mortem and gives the medical cause of death as found by the pathologist (> see also *Booklet 1*). It will probably contain unfamiliar medical terms and may contain graphic detail. It is a good idea to ask your doctor to interpret the report for you. This is an opportunity to learn about the precise manner of death.

Call the Deputy Registrar or the Coroner's Officer if you have any questions or concerns.

#### WHEN WILL I GET A COPY OF THE CORONER'S BRIEF?

**If you live in the ACT:** When the brief is ready, the Coroner's Officer will call you to arrange a time to deliver a copy of it to you. This is usually about *one week* before the hearing.

**If you live interstate:** A copy of the brief will be posted to you. If time is running short, the Deputy Registrar would call you and ask you to come in and read the brief before the hearing.

## Your statement to police

If you made a statement to the investigating police and that statement is transcribed or summarised in writing, you should normally be asked to check the accuracy of the statement and sign it. If necessary, you can contact the investigating police officer to follow up on this.

## Witnesses

### Finding out which witnesses will appear

You may contact the Coroner's Officer to find out which witnesses the coroner intends to call (to be present at the hearing and available for examination and cross-examination).

### Asking the coroner to call a witness

If considered necessary, you may ask the coroner to call a witness (a person with sufficient interest may ask the coroner to request a person to give evidence – section 50, Coroners Act).

If statements have not already been provided by that witness, the coroner may require the police investigators to obtain them. The coroner will then decide whether to call the witness to appear at the hearing.

You may do this either before the hearing (if, for example, you are informed that the coroner does not intend to call a particular witness but you believe that witness should be made available for examination and cross-examination) or during the hearing. However, it is best to do this in advance of the hearing so as not to disrupt the hearing.

## If you have any concerns

### Court administration

If you have any problems, concerns or complaints concerning court administrative procedures, contact the Coroner's Office in the first instance. If your concern is not addressed or resolved, contact the Registrar. Complaints concerning court administration (but *not* actions or decisions of a coroner) may also be made to the Ombudsman's Office.

### Conduct of police

You may make a complaint to the Ombudsman's Office concerning police conduct and procedures. An example of wrong conduct may be gross delay or failure to investigate a matter thoroughly. Call the Ombudsman's Office and ask for the police complaints section (> see also *Booklet 8)*.

### The inquest (investigation)

Generally speaking, you may raise any matters of concern by writing to the coroner before the hearing. If you become aware of other relevant information, make sure that you send a copy of the information to the coroner well before the hearing date.

If you are dissatisfied with the investigation, discuss your concerns with the Coroner's Officer or the investigating police officer in charge of the investigation. If you are still not satisfied, contact counsel assisting, the Registrar or the coroner to whom the death was reported, or contact the Chief Coroner (who is also the Chief Magistrate).

## Other information not usually in the coroner's brief

Most of the materials listed below are not routinely part of the coroner's brief (> see above, *Coroner's brief)*. If you wish to obtain them, contact the Coroner's Office in the first instance. Some items may be available through the Coroner's Officer; if not, contact the relevant organisation directly (> see *Booklet 8* for contact information and other details).

If your request is refused, you could consider using **freedom of information** procedures (> see *Booklet 8)* or asking the coroner to issue a **summons** to obtain them. > See also *Informal follow-up* in *Chapter 6*.

- ☐ **police traffic accident report** (a form with details about place and date of accident, driver(s) and vehicle(s) involved) – not usually in coroner's brief; to request from the police; supplied as a matter of routine **R**
- ☐ **investigating officer's notes/request for mechanical examination of vehicle(s)** – not in coroner's brief; to request from the police **R**
- ☐ **site history of crashes** at location of crash; **engineer's report** on site of crash (report on inspection of site to assess factors possibly contributing to crash – e.g. road geometry, signs, line markings) – not usually in coroner's brief; to request from ACT Department of Urban Services **R**

- **items that you may wish to request if the person was alive for some time after the accident, or if response times or actions are of concern:**
  - **police records**: **computer records**, including incident details, time at which police were contacted); **radio tapes** (or transcript) (kept for **six months**) – not in coroner's brief; to request from police **T**
  - **ambulance records**:
    - **case sheets** (including record of time at which ambulance was dispatched and clinical data relating to the case): kept for at least 10 years; not usually in coroner's brief; if not, to request from ACT Ambulance Service **R**
    - **communications data** (including radio tapes, time at which ambulance was contacted and computer records): kept for about **6 weeks** but may be kept longer if coronial inquest; not usually in coroner's brief; if not, would need to be subpoenaed **T, S**
  - **hospital medical records**: e.g. notes of triage sister at hospital, hospital treatment notes. Treatment notes usually reviewed by pathologist prior to post-mortem examination and then returned to hospital unless of particular relevance. If required again (e.g. if a question arose during the coronial hearing), they may need to be subpoenaed **S**
  - **fire brigade records**:
    - **incident report** (incident detail sheet (including time (of notification, arrival, departure), address, personnel, vehicles, damage, etc.) and comments sheet (summary of incident, actions (including in relation to other agencies), outcomes): kept for at least 7 years; not usually in coroner's brief; to request from ACT Fire Brigade **R**

      NOTE: If relevant, police may obtain fire brigade records and get statements from fire brigade officers – e.g. concerning observations of scene of accident (whether vehicle's ignition or lights on, etc.) – but not routinely. Nor are observations by fire brigade officers of scene of accident necessarily included in incident report.
    - **communications tapes** (voice information transmitted by radio): kept for about **6 months** (may be saved for future reference if requested); not usually in coroner's brief; if not, would need to be subpoenaed **T, S**

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**NOTES**:

**R** Supplied upon **request**

**S** **Subpoena** – Some items might be subpoenaed by the coroner if a question arose during the coronial hearing/would need to be subpoenaed

**T** **Time-sensitive** – **Some materials may be kept for limited periods of time only**; if you wish to have access to these items, request them very soon after the accident (or request that they be preserved for the time being) – **do not delay**.

# 6 AFTER THE HEARING

At the end of a hearing, the coroner will make a finding as to the circumstances of the death and may make recommendations to the relevant authorities. As far as the case is concerned, this is the end of the coronial process. However, you may wish to follow up matters arising from the hearing.

## 1 REQUESTS FOR COURT RECORDS

### How long are court records kept?

Although most coronial records are kept forever, the *Magistrates Court Act 1930* (ACT) provides that transcripts need be kept for only seven years.

### Who can have access to court records?

As a general rule, court records relating to the coroner's inquest into the person's death can be made available to persons who, in the opinion of the coroner, have 'sufficient interest' in the cause of death. Relatives are usually seen as having 'sufficient interest'.

### Findings

The coroner must make a copy of his or her findings available to a member of the immediate family (or their representative), if so requested (section 54, Coroners Act). Generally the Coroner's Office will send the findings to you (and to other family members who have asked to be kept informed) without your needing to ask.

### Recommendations

If the coroner has made any recommendations in relation to the death, these would be contained in the findings. They would also be contained in the annual report by the Chief Coroner to the ACT Attorney-General, published in the annual report of the Attorney-General.

If recommendations have been made, you may want to follow these up directly with the relevant government departments, Ministers or other agencies, to see if they have been acted upon. You can write a letter to the relevant department or to the Minister who is responsible for that department.

### Coroner's brief

If you have not already requested a copy of the coroner's brief (> see *Chapter 5)*, you may do so now. Contact the Coroner's Office.

### Post-mortem report

The post-mortem report is not automatically sent to relatives. The Coroner's Office prefers that you nominate a doctor to whom the report will be sent. If you would like a copy, and if you did not already request it before the hearing, you (or

your doctor) should make a request in writing to the Coroner's Office. Copies will normally be supplied free of charge if requested by relatives. > See also *Chapter 5*.

### Audio tape or transcript of proceedings

In certain circumstances, you may want a record of what was said in court. The cheapest, quickest and most convenient record is a copy of the audio tape of the proceedings. Much more expensive is a typed transcript; a fee is charged per page.

Your application should be made to the Coroner's Office. Not everybody is entitled to receive the audio tape or transcript. The Registrar or coroner must be satisfied that you have good reasons for applying (section 49, Coroners Act).

## 2 Death certificate

The coroner will inform the ACT Registrar-General of the findings so that the cause of death can be entered in the ACT Register of Deaths.

If you have already applied for a death certificate, the ACT Births, Deaths and Marriages Office will shortly send you the death certificate with cause of death; you do not need to re-apply. (If you haven't already applied, > see *Booklet 8*.)

## 3 Dissatisfaction with the result of the hearing

If you are not satisfied with the result or outcome of the inquest or hearing, it may be possible, in very rare cases, for another inquest or hearing to be held. You would need to seek legal advice before proceeding with this.

If a coroner concludes a hearing or you wish the finding to be altered, you may apply to the Chief Coroner to ask the coroner to reconsider the decision and to alter the finding that was made (section 64, Coroners Act).

If not satisfied with that, you can appeal to the Supreme Court (sections 90 and 91, Coroners Act).

In certain circumstances, the Chief Coroner may arrange for the holding of a fresh inquest into the death (section 68, Coroners Act).

In rare cases, the Supreme Court may order that an inquest be quashed and a new inquest be held (section 93, Coroners Act).

## 4 Informal follow-up

Some bereaved people have found it helpful to speak to:

- **witnesses** of the accident. Keep in mind that the accident may have been traumatic for these persons, too. Some may be cooperative and welcome the opportunity to share their experiences with you. Others may be reluctant to speak with you, considering that the case is closed.
- **police officers** who were present at the scene or who investigated the death

- **ambulance superintendent** (about patient care at scene of accident)
- **fire brigade superintendent** (about road rescue operations, if fire brigade attended scene of accident – for example, to release persons trapped in or by vehicle).

You may also find it helpful to revisit:

- the scene of the accident. It can be helpful to 'walk through' the accident and try and reconstruct what happened, using the knowledge you now have about the circumstances of the accident.
- the hospital, if the person died there.

It may be best to do these things accompanied by another family member or friend, or a counsellor, rather than by yourself.

## 5 SOME FINAL THOUGHTS

Here are some final thoughts from Mothers Against Drunk Drivers:

'You have learned enough when you are no longer tormented by questions about how it happened.

Questions like, "Why did it have to happen?" or "Why did it happen to us?" are unanswerable. It is natural to ask these questions, but they do not have answers. You should not feel frustrated because you cannot get answers to them.

If you, yourself, were part of the cause, really part of the cause, you should recognise this. But don't exaggerate your role. If you exaggerate your role, then, quite apart from making yourself feel unbearably guilty, you will add to your own confusion. Just try, as dispassionately as you can, to understand how it happened.

If you find that no matter how much you learn, the question of how it happened continues to torment you, then try to think through an explanation that you can accept and live with.

If you haven't learned enough to really know what happened, you may have to make guesses. Go ahead and make the guesses. And if they strike you as the best guesses that can be made, then take them as your explanation. If you learn more, you can always reconsider. But until you learn more, put confidence in your best guesses.'

*Excerpted from 'Will It Always Feel This Way? For the Parent Whose Child Has Been Killed by a Drunk Driver' by Robert S. Weiss. Published on the Internet by Mothers Against Drunk Drivers (USA)*

# GLOSSARY

**appear**: come formally before a court.

**autopsy**: the examination of the body after death to find out the medical cause of death. Usually this involves looking at the organs as well as the surface of the body. Samples of tissue are usually taken for testing and sometimes organs are removed for further examination. The autopsy is also called a post-mortem examination.

**coroner**: the person who inquires into deaths that are sudden, unexpected or where the cause is unknown. If a hearing is held, the coroner is in control of the hearing. This means the coroner decides who can give information, in what form that information can be presented, and generally how the hearing will be conducted.

**coroner's brief or file**: information collected by the police will be contained in a file (e.g. statements from witnesses including experts, medical reports, other information gathered). After the police have finished their investigation they pass on their file to the coroner. The 'coroner's brief', or 'inquest brief', refers to those elements of the file that are to be presented at the hearing. The terms 'brief' and 'file' are often used interchangeably.

**Coroner's Court**: A single coroner constitutes the court in relation to the death the subject of the inquest.

**Coroner's Office**: the registry and administrative support provided to the Coroner's Court and headed up by the **Deputy Registrar** of the Coroner's Court.

**Coroner's Officer**: the police officer who reports to and assists the coroner in all cases where a death is reported to the coroner. Plays an important role as the link between the coroner, the police and the community.

**counsel**: a legal practitioner who directs a case or represents an interest in court.

**counsel assisting (counsel assisting the coroner)**: the legal practitioner who represents the public interest and assists the coroner at the hearing by presenting evidence and questioning witnesses.

**cross-examination**: After a witness has given evidence, their evidence may be tested by other parties. Their evidence is tested when the other parties ask the witness questions and sometimes even make suggestions about the truth of the witness's statement. This questioning of the witness' evidence is called cross-examination.

**deceased**: dead; the dead person(s).

**Director of Public Prosecutions (DPP)**: Officers from the Office of the DPP play an important role in coronial inquests by assisting the coroner in reviewing the evidence, making recommendations to the coroner, preparing the case for hearing and acting as counsel assisting the coroner at the hearing.

**evidence**: all the information that the coroner considers when inquiring into the cause and circumstances of the death. Evidence will include the statements and information gathered by the police, the medical reports presented and any other information that is presented at the hearing.

**examination-in-chief**: This is when counsel assisting the coroner asks questions about a statement. If you are giving evidence it is your opportunity to present your information in your own words to the coroner.

**findings**: The coroner must, if possible, make findings concerning the identity of the deceased, when and where the death occurred, and the manner and cause of death.

**forensic medicine**: application of medical science to the law.

**forensic medical centre** > see **morgue**.

**hearing**: A coronial hearing is a public hearing before a coroner to decide the circumstances of a death. The coroner hears the evidence about the death and then makes findings about the cause and circumstances of the death and related matters.

**inquest**: (a) the investigation held by the coroner into the cause and circumstances of the death; (b) the hearing held by the coroner. (This booklet uses 'inquest' in its broad sense to designate the coroner's investigation, which begins soon after the person's death. It uses 'hearing' (not 'inquest') to designate the formal coronial hearing. This is in order to reflect the terminology used in the *Coroners Act 1997*.)

**interested party** > see **person with a sufficient interest**.

**jurisdiction**: the limits of the inquiry. For example, the coroner does not have a jurisdiction that intrudes into criminal issues or civil issues of damages.

**legal representation**: the legal practitioner who acts on behalf of or represents the interests of a client in a court; the fact of being legally represented by a legal practitioner.

**morgue**: the place where the deceased's body is taken and kept until the coroner gives permission for burial or cremation, and where an autopsy authorised by the coroner may be carried out.

**party**: person concerned in a legal proceeding or transaction.

**pathologist**: a specialist doctor who carries out the medical examination to find out the medical cause of death.

**person with a sufficient interest**: a person or entity (such as a company, government department, trade union, etc.) with a sufficient interest in the matter being investigated by the coroner who is granted leave to appear at the hearing.

**post-mortem examination** > see **autopsy**.

**produce a document (or thing)**: formally present or exhibit a document or object as evidence.

**recommendations**: After the coroner makes findings about the cause of death, they sometimes add recommendations for reform to prevent future deaths.

**statement**: declaration setting out facts, particulars, spoken or in writing.

**submissions**: the suggestions – both in writing and spoken to the coroner – about the findings and recommendations that the submitting party thinks the coroner should make.

**summon(s)/subpoena**: call to appear before a court or produce a document in a court. The coroner may subpoena or serve a summons on a witness or a document.

**toxicology**: the science of poisons, their detection, etc. Tests may be required to detect the presence of poisons (e.g. alcohol, drugs). The results of these tests are contained in the toxicology report.

**transcribe**: put spoken words, recorded on audio tape, into writing (a time-consuming and therefore expensive process).

**transcript**: a written copy of everything that was said during the hearing into the death. It is a record of the hearing. It is made from the audio tapes that record everything said by anyone in the court room.

**witnesses**: people who give evidence. Witnesses provide information about the facts of the case; expert witnesses may provide other types of information and opinion. The coroner may call a witness to attend the hearing to give evidence in person.