The Coroners Court in ACT

FACT SHEET 3

How a Coroner investigates a death

THIRRILI

Initial stage

- Once a report of a death is received by the Coroner's Office, usually from the police, a doctor or a hospital, the deceased person is taken into the care of the Coroner's Office and a coroner will be begin an inquest.

The gathering of information stage

- An investigation may vary with the circumstances of the death but usually includes:
  - gathering information including from police, family, friends, medical practitioners (obtaining copies of medical records), witnesses, technical experts, and any other relevant persons;
  - attending the scene of the death (if safe and appropriate to do so);
  - directing that a post-mortem examination be performed on the deceased (for more information, see Fact Sheet 9: My loved one's body info sheet), including if you wish to object to a post-mortem examination being performed); and
  - appointing an investigator to make inquiries and prepare a report on certain issues.

Making a finding

- A coronial finding is the formal document that a coroner writes after an investigation of a death, and it is usually the last step in the investigation.

- A finding usually includes:
  - that the person has died (if it is a suspected death);
  - the identity of the deceased;
  - the cause of the death;
  - when and where the death occurred;
  - the circumstances of the death; and
  - comments or recommendations made by the coroner aimed at preventing similar deaths.

- There are two kinds of findings:
  - a 'finding without an inquest', which is where a coroner makes a finding on the available information without a public hearing. Most coronial investigations end with a finding without an inquest; and
  - an 'inquest finding', which is where a coroner delivers a finding after a public hearing is held.

- A coroner **may**:
  - comment on any matter connected with a death, including matters relating to public health and safety or the administration of justice; and/or
  - make recommendations to any Minister, the Attorney General, public authority or organisation about the risks to public safety.
- If an inquest is held into a death in care or death in custody, the findings must include a comment about the quality of care, treatment and supervision of the deceased that, in the opinion of the coroner, contributed to the cause of death.