

FACT SHEET 3

How a Coroner investigates a death



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Initial stage

- The initial stage of a coroner's investigation is assisted by the Victorian Institute of Forensic Medicine and includes:
 - receiving a report about the death from the police, a doctor/hospital, or another reporting organisation;
 - admitting the deceased person into the care of the Coroners Court;
 - contacting the senior next of kin to inform them about the coronial process and to obtain more information about the deceased, as well as the family's wishes with respect to the deceased's post-mortem examination (for more information, see Fact Sheet 9: My loved one's body and things); and
 - requesting information about the preliminary medical examination of the deceased.

The gathering of information stage

- An investigation may vary with the circumstances of the death but usually includes:
 - Gathering a range of information from police, family, friends, medical practitioners, witnesses, technical experts, and any other relevant persons to assist the coroner to form a picture about what happened and why. More often than not, a coroner is able to make a written finding into a death based on this information, without having to hold an inquest.
 - attending the scene of the death (if safe and appropriate to do so).
 - directing that an autopsy be performed on the deceased (for more information, see Fact Sheet 9: My loved one's body and things, including if you wish to object to an autopsy being performed).
 - requesting Victoria Police provide statements, reports, and information about the death; and
 - conducting research and considering potential recommendations.
- The Coroners Court will communicate with the senior next of kin throughout the investigation process.

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:
 - the identity of the deceased;
 - the cause of the death;
 - 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 copy of the inquest finding is published on the Coroners Court of Victoria website unless a coroner orders it not to be published.
- 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, public authority or organisation that may help prevent similar deaths.
- A public authority or organisation who receives a recommendation from a coroner must respond, in writing, within 3 months stating what action, if any, has or will be taken in relation to the recommendation(s).
- A coroner **must not** include in a finding any statement that a person is, or may be, guilty of an offence. However, a coroner may include a notification to the Director of Public Prosecutions that they believe a serious criminal offence may have been committed in connection with the death.
- Sometimes a coroner is **not** required to make a finding if an inquest into the death was not held, and the coroner decides that there is no public interest in making a finding.



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