24 July 2026

Tasmania Law Reform Institute
By email: Law.Reform@utas.edu.au

This submission discusses investigations and inquests into sudden, unexpected and/or violent deaths. Readers might find the content of this submission distressing.

Dear Professor Prichard

Re: Review of the *Coroners Act 1995* (Tas)

Thank you for the opportunity to provide feedback on the review of the *Coroners Act 1995* (Tas) (*Coroners Act*). I commend the Tasmania Law Reform Institute (TLRI) for its thorough analysis of the key issues, which has supported my appreciation of, and commentary on, the areas in need of reform.

As Interim Commissioner for Children and Young People, my feedback necessarily focuses on the relevance and impact of Tasmania's coronial system on children and young people, and their families. Accordingly, this submission is not intended to be exhaustive and instead considers several key topics from two broad perspectives – investigations and inquiries into child deaths, and participation of bereaved children and young people in coronial matters – with reform recommendations included at the end.

While the unexpected, unnatural or violent death of any person can have a profound impact on the deceased's family and community, the death of a child or young person can be uniquely destabilising,[1] as it 'shatters core beliefs and assumptions about the world and the expectations about how life should unfold'.[2] The Coroner's Court plays a crucial role in investigating and conducting inquiries into reportable deaths of children and young people. In addition to providing loved ones with answers as to the cause(s) of death, the coroner's work serves important education and prevention functions to help mitigate the risk of similar tragedies in the future.

[1] Peter J Fleming et al, 'Investigating Sudden Unexpected Deaths in Infancy and Childhood and Caring for Bereaved Families: An Integrated Multiagency Approach' (2004) 328 *BMJ* 331.
[2] The Compassionate Friends, *The Grief of Parents When a Child Dies*.

+61 (03) 6166 1366
childcomm@childcomm.tas.gov.au
www.childcomm.tas.gov.au
Level 1, 119 Macquarie Street, Hobart, Tas., 7000
GPO Box 708, Hobart, Tas., 7001

Role of the Commissioner for Children and Young People

The statutory role of the Commissioner for Children and Young People (Commissioner) is to provide independent, child-centred feedback and advice on law reform relevant to Tasmanian children and young people, and to assist in ensuring Tasmania satisfies its national and international child rights obligations. In performing these and other functions, the Commissioner is required to:

- adhere to the principle that the wellbeing and best interests of children and young people are paramount;
- observe any relevant provisions of the United Nations Convention on the Rights of the Child (UNCRC); and
- give special regard to the needs of children and young people who are vulnerable or disadvantaged.

My perspective on the matters raised in the Issues Paper is informed by a child rights framework. Pursuant to article 6(1) of the UNCRC, children have an 'inherent right to life' – a right also referred to in the International Covenant on Civil and Political Rights (ICCPR). Expert commentary on the ICCPR notes that the 'inherent right to life' is not to be viewed narrowly and includes 'entitlement of individuals to be free from acts and omissions that are intended or may be expected to cause their unnatural or premature death'.[3]

In addition, states parties to the UNCRC are required to undertake all appropriate legislative, administrative, and other measures to implement the UNCRC rights (article 4). More specifically, they must ensure, to the maximum extent possible, children's survival and development (article 6(2), UNCRC), and must protect children from all forms of violence, abuse, neglect and maltreatment (article 19(1), UNCRC). Needless to say, these rights and obligations are directly relevant to the coroner's functions.

Together with the right to life and the right to protection against all forms of abuse, neglect and maltreatment, a child's right to participate in decisions that affect them, in article 12 of the UNCRC, is also highly relevant to the way coronial investigations and inquiries are conducted, as will be argued throughout this submission. Moreover, with a view to upholding the right to participate, any reforms to the coronial system contemplated by the Tasmanian Government should be informed by the voices of children and young people themselves, including through targeted consultation with those who have lived experience of the Coroner's Court.

Recognising families in the Coroners Act

The unexpected death of a child or young person is among the most horrific experiences any family can face. However, apart from provisions that relate to senior next of kin,[4] and the fact that close family members are generally considered to be 'interested persons',[5]

[3] Human Rights Committee, *General Comment No 36: Article 6 – Right to Life*, 124th sess, UN Doc CCPR/C/GC/36 (3 September 2019).
[4] *Coroners Act 1995* (Tas) s.3A.
[5] Ibid s.52; Magistrates Court of Tasmania (Coronial Division), *Tasmanian Coronial Practice Handbook* (2016).

there is no explicit acknowledgement of bereaved families in the *Coroners Act*. This stands in contrast to several other jurisdictions, including the ACT, Victoria and Queensland.[6]

In particular, it is worth considering the 'objects' provision in the *Coroners Act 1997* (ACT), which places family and friends of the deceased person at the centre of the coronial process.[7] Where there is an inquest into a person's death, the objects of the ACT's legislation must be carried out in a way which recognises that:

- the family and friends of the deceased person have an interest in having all reasonable questions about the circumstances of the person's death answered;
- the death of a person, and an inquest into the person's death, has a significant impact on the person's family and friends;
- where appropriate, members of the immediate family of the deceased person should be given the earliest opportunity to participate in, and be kept informed of the particulars and progress of, the inquest into the person's death; and
- different cultures have different beliefs and practices about death that should, where possible, be respected.

Similar recognition of the impact of coronial processes on families and their unique needs as participants in proceedings is found in the *Coroners Act 2008* (Vic) which, in addition to the factors mentioned in the ACT statute, also acknowledges that family members 'may require referral for professional support or other support' and that 'unnecessarily lengthy or protracted coronial investigations may exacerbate the distress of family, friends and others affected by the death'.[8]

In practice, recognising the unique needs of families in coronial matters also requires consideration of bereaved children and young people who tend to be 'the forgotten mourners'.[9] While children grieve differently depending on their age, cognitive development and relationship with the deceased,[10] children impacted by a loved one's death need to be properly recognised in Tasmania's coronial system and their unique needs taken into account.

Reportable deaths of children and young people

As the Issues Paper suggests, the definition of 'reportable death' in the *Coroners Act* may need to be reviewed and revised. This section focuses on two aspects of this definition that are highly relevant to children and young people – deaths of a 'person held in care' and deaths of a 'person held in custody'.

[6] *Coroners Act 1997* (ACT); *Coroners Act 2008* (Vic); *Coroners Act 2003* (Qld).
[7] *Coroners Act 1997* (ACT) s.3BA.
[8] *Coroners Act 2008* (Vic) s.8(b).
[9] The Compassionate Friends (n 2).
[10] Alexandra Wray, 'Exploring the Experiences of Support with Parentally Bereaved Children and Their Surviving Parents Using Constructivist Grounded Theory' (PhD Thesis, Hull York Medical School, 2023).

Deaths of children and young people in care

The legislative definition of 'reportable death' includes the death of a person who immediately before passing was held in care,[11] where 'person held in care' is defined as:

- a child, within the meaning of the *Children, Young Persons and Their Families Act 1997* (CYPTF Act), in the custody or under the guardianship of the Secretary within the meaning of that Act; and
- a person detained or liable to be detained in an approved hospital within the meaning of the *Mental Health Act 2013* or in a secure mental health unit or another place while in the custody of the controlling authority of a secure mental health unit, within the meaning of that Act.

Firstly, regarding children 'in the custody or under the guardianship of the Secretary', while it is essential that the death of any such child be treated as a 'reportable death', consideration should be given to whether this definition is sufficiently broad. For instance, it does not seem to include the death of a child under a supervision order,[12] since such an order does not affect the custody or guardianship of a child, nor does it appear to include the death of a child where a restraint order has been issued instead of an 'assessment order' or a 'care and protection order'.[13] However, in a number of these cases, a child will have been formally assessed as being 'at risk', as defined in the CYPTF Act.[14]

In my view, an approach similar to s.24 of the *Coroners Act 2009* (NSW) should be considered.[15] That is, the *Coroners Act* should be revised so that a 'reportable death' includes:

- the death of any child (or the sibling of any child) who has been assessed as being 'at risk', as defined in the CYPTF Act, within three years of their passing; and
- the death of any child that may be due to abuse or neglect, or that occurs in suspicious circumstances.

While the former would cover the death of a child (or their sibling) after a formal assessment had determined the child to be 'at risk', the latter would likely cover situations where such an assessment did not occur, but where concerns about a child's welfare had been raised. This would include situations where, prior to their death, one or more reports about a child had been made to the Strong Families, Safe Kids Advice and Referral Line (ARL) and where, under the recently redesigned ARL system, a family had been referred to a Family Referral Hub. This would also likely cover situations where a deceased child had been the subject of an assessment order or interim assessment order under the CYPTF Act.

---

[11] *Coroners Act 1995* (Tas) s.3 (definition of 'reportable death') para (a)(ix).
[12] *Children, Young Persons and Their Families Act 1997* (Tas) s.42A.
[13] Ibid ss.23 and 43.
[14] Ibid ss.42A and 43.
[15] Section 24 of the *Coroners Act 2009* (NSW) does not provide a definition of 'reportable death', which is instead found in s.6, but it gives a senior coroner jurisdiction to hold an inquest into specified child deaths.

Where the meaning of 'person held in care' is expanded to cover the above situations, the coroner would be required to conduct an inquest under s.24(1)(b) of the *Coroners Act* and, pursuant to s.28(5), their report would have to comment on the care, supervision or treatment of the deceased person while they were 'held in care', providing valuable insight to inform future preventative measures. Alternatively, if the two situations above were incorporated as new categories of 'reportable death', separate from paragraph (a)(ix), an inquest would not be mandatory but could be conducted pursuant to the coroner's discretion in s.24(2).

While I note that the Department for Education, Children and Young People (DECYP) has an Adverse Outcomes Review (AOR) policy which applies to an event resulting in death that has occurred in any DECYP portfolio,[16] a DECYP review in and of itself is insufficient in the above circumstances, as the department does not have the investigative powers of the coroner.

Mindful of how crucial it is to conduct an inquiry when a child has died while in out-of-home care, I am also cognisant of the fact that children and young people leaving care are widely recognised as a highly vulnerable group.[17] Where adequate transitional supports are lacking, children and young people leaving care arrangements may experience a range of adverse outcomes, including death. For this reason, consideration should also be given to extending the definition of 'reportable death' to cover young people who die within 12 months of leaving out-of-home care. This would support critical learnings about the adequacy of transitional supports for care leavers in Tasmania, should a child or young person tragically lose their life in these circumstances.

Secondly, regarding people detained under the *Mental Health Act 2013* (Tas), as the Issues Paper notes, the scope of the definition of 'person held in care' may be inadequate as it does not cover a person who died while subject to an involuntary mental health order in a community setting. I note the changes to the management and support of people with mental health conditions in Tasmania, with people increasingly treated within community settings,[18] including through the expansion of the Youth Mental Health Hospital in the Home program.[19]

Where a person is subject to an involuntary order in the community, they are still subject to a significant exercise of state power and, as such, I consider that the death of any such person should be treated as a 'reportable death'. Notably, this aligns with the approach taken in the ACT,[20] where 'death in care' includes the death of a person while subject to an order under the *Mental Health Act 2015* (ACT), which is defined to include a 'community care order'.[21]

---

[16] DECYP, *Adverse Outcomes Review Policy* (September 2024).
[17] Sarah Butterworth, Philip Mendes and Catherine Flynn, 'Young People Leaving Out-of-home Care in Victoria, Australia: An Exploration of Factors Influencing Positive Transitions' (2020) 3(2) *Education for Critical Social Work Practice Over the Decades* 1.
[18] Department of Health (Tas), *Towards Tasmania's Next Mental Health Strategy – Developing the Next Steps for Rethink and Beyond* (Discussion Paper, 2026).
[19] Tasmanian Government, *Delivering Greater Mental Health Services for Younger Tasmanians* (Update, 22 June 2026).
[20] *Coroners Act 1997* (ACT) s.3BB.
[21] *Mental Health Act 2015* (ACT) Dictionary (definition of 'mental health order').

Ensuring that involuntary community-based orders fall within the definition of 'reportable death' is especially important to support learnings about the effectiveness of community-based interventions and to identify areas in need of reform, such as whether further support is needed to ensure people under such orders are consistently taking any prescribed medication.[22]

Deaths of children and young people in custody

As with the definition of 'person held in care', there appears to be a gap in the definition of 'person held in custody' which would mean that, in certain circumstances, the death of a child or young person subject to a youth justice detention order would not amount to a reportable death that occurred 'in custody'.

I note that the definition of 'person held in custody' includes people who are in specific physical locations, including 'in a detention centre' or 'in a building or part of a building at a police station used for the confinement of persons under arrest or otherwise lawfully detained in custody'. It also includes people in the custody or control of certain persons, including but not limited to a 'police officer' or 'correctional officer' or 'person who has custody under the order of a court for the purposes of taking the person to or from a court'. A 'correctional officer' means an officer appointed pursuant to s.5 of the *Corrections Act 1997* (Tas), which are persons appointed or employed for the purposes of that Act. Notably, this does not include youth justice workers appointed under s.166A of the *Youth Justice Act 1997* (Tas).

Further, the definition does not seem to cover a situation where a child under a youth justice detention order is being transported either by a youth justice worker or security contractor to a dental or medical appointment, as routinely occurs.[23] Tasmania's Custodial Inspector recently reported highly concerning treatment of children being transported by security personnel for these and other purposes without the presence of a youth justice worker. While the death of a child in these circumstances may be a 'reportable death' where it is 'unexpected, unnatural or violent', such a death should be investigated as a reportable death that occurred 'in custody', as this would trigger a mandatory coronial inquiry,[24] and would require the coroner's report to comment on the care, supervision or treatment of the deceased child or young person while 'held in custody'.[25]

With this in mind, consideration should be given to approaches in other jurisdictions. Queensland, for example, includes within its definition of 'custody' the detention of a person, whether or not by a police officer, under the authority of a court order.[26] Similarly, in Western Australia, the definition covers any person detained under the *Young Offenders Act 1994* (WA).[27] Notably, this wording does not rely on the person in whose custody the detainee is at any particular time or the type of building in which the detainee is situated.

---

[22] Royal Commission into Victoria's Mental Health System, *Final Report Volume 3: Promoting Inclusion and Addressing Inequities* (Final Report, February 2021) p 386.
[23] Office of the Custodial Inspector (Tas), *Security Contractor Transport of Young People in Custody: Safeguarding Review 2025* (Report, 2025).
[24] *Coroners Act 1995* (Tas) s.24(1)(b).
[25] Ibid s.28(5).
[26] *Coroners Act 2003* (Qld) s.10(2).
[27] *Coroners Act 1996* (WA) s.3 (definition of 'person held in care').

Moreover, as discussed above in relation to care leavers, children and young people leaving youth justice detention are also highly vulnerable.[28] Indeed, research shows that for people transitioning out of custodial environments, 'post-release, risk of death from drug overdose and suicide is high and morbidity is greatly elevated compared with the general population'.[29] As such, in my view, the definition of 'reportable death' should also cover children and young people who die within 12 months of exiting youth justice detention.

Finally, I also note the concerns raised in the Issues Paper regarding conflicts of interest that may arise where police are involved in investigating a reportable death that occurred when a person was in the custody or control of a police officer. In my view, policies and procedures relevant to these situations should be reviewed and revised, noting the memorandum of understanding in Queensland, which outlines 'operational arrangements for the investigation of police related deaths'.[30] In addition, consideration should be given to amending the *Coroners Act* to authorise the coroner to give a police officer directions concerning investigations to be carried out for the purposes of a coronial investigation or inquiry into any such death or suspected death, similar to the approach in Victoria and the Northern Territory.[31]

Supporting bereaved families, including children and young people

Communication with, and information provided to, families of the deceased person

Poor communication has been identified as a key cause of increased distress for families involved in coronial matters, including where parents have lost a child.[32] Indeed, if coronial staff are perceived to communicate without compassion or empathy, or do not discuss the circumstances of a child's death effectively with parents, it can make it harder for parents to cope with the trauma, understand what happened, and grieve in a healthy way.[33]

Further, as reviews of the coronial systems in Victoria and Western Australia have found,[34] where appropriate information is not provided in a timely manner, families often have a poor understanding of the coronial process and their associated rights. Clear and accessible communication is not only important at the start of the coronial process, but throughout any investigation or inquiry, particularly for lengthy matters.[35]

Clear, timely and ongoing communication is obviously important for parents of deceased children, but it is just as important for children and young people who have lost a loved one. It is essential that bereaved children are treated as 'interested persons' in their own right

---

[28] Kate van Dooren et al, 'Complex Health-related Needs Among Young, Soon-to-be-released Prisoners' (2013) 1(1) *Health and Justice* 1.
[29] Ibid.
[30] Issues Paper, 156.
[31] *Coroners Act 2008* (Vic) s.15A; *Coroners Act 1993* (NT) s.25.
[32] Belinda Carpenter, Gordon Tait and Steph Jowett, 'Managing Families' Expectations in the Coronial Jurisdiction: Barriers to Enacting an Ethic of Care' (2022) *Journal of Law and Medicine* 29(4) 1040.
[33] Emily Cooper et al, 'Needs and Experiences of Families After a Sudden Unexplained Death in Childhood: A Qualitative Study' (2025) 9(1) *BMJ Paediatrics Open* 1.
[34] Carpenter, Tait and Jowett (n 32) citing the 2006 review by the Law Reform Committee in Victoria and the 2012 review by the Law Reform Commission of Western Australia.
[35] Carpenter, Tait and Jowett (n 32).

and provided with age-appropriate and accessible resources to allow them to understand and participate in coronial processes to the extent that they wish to do so or are required to do so.[36] As research by Dr Alexandra Wray has shown, bereaved children appreciate and benefit from being informed about what is happening and having choice about their involvement in post-death processes.[37]

With this in mind, I note that in 2022 the Coronial Council of Victoria considered the need for improved communication with families involved in coronial matters and found that any communication or interaction with bereaved relatives should be 'family-focused, trauma-informed and culturally safe'.[38] The Council recommended development of improved, user-friendly information materials that outline the fundamental features of coronial processes, issues relevant to specific types of deaths, the full range of ways that family members can participate in proceedings and how family members can raise a question or concern.[39] They also recommended informal face-to-face (or online) discussion sessions with family members early in the coronial process, and the use of online portals or apps that allow family members to access up-to-date information throughout the investigation or inquiry.[40]

While the *Tasmanian Coronial Practice Handbook* (Coronial Handbook) provides extensive information to interested persons about coronial processes and procedures, it is prohibitively lengthy, text heavy and complex. It should be borne in mind that when loved ones are grieving, they can find it challenging to take in new information[41] and that, in terms of environmental context, a significant proportion of Tasmanians of working age are functionally illiterate.[42] In my view, the simpler approach taken on the coroner's website is preferable, which provides easy navigation and succinct dot-point summaries on various topics. However, much more can be done to provide child-friendly materials in a variety of formats and links to specific resources for bereaved children and young people noting, for example, the approach taken on the Coroner's Court website in Victoria.[43]

Viewing and touching the deceased person's body

In Tasmania's coronial system, where a person agrees to identify the deceased person at the mortuary, they are generally not allowed to touch the body and it is only in 'special cases' where the coroner's office might authorise a viewing before the body is released from the mortuary.[44] As such, family viewings of the deceased person typically occur later, once the body has been released to the funeral home.[45] However, there may be a considerable delay before this occurs and, as the Issues Paper notes, viewings at the funeral home can be too

---

[36] Coronial Council of Victoria, *Review into Improving the Experience of Bereaved Families with the Coronial Process* (Final Report, March 2022).
[37] Wray (n 10).
[38] Coronial Council of Victoria (n 36).
[39] Ibid.
[40] Ibid. As the Issues Paper notes, Victoria is now developing an online portal.
[41] Jessica Jacobson, Lorna Templeton and Alexandra Murray, '"I Just Felt We Were Shadows": Scope and Limits of Participation by Bereaved Families in Coroners' Inquests in England and Wales' (2026) 48(1) *Journal of Social Welfare and Family Law* 30.
[42] Lisa Denny et al, *A Roadmap to a Literate Tasmania* (Report, February 2021).
[43] Coroners Court of Victoria, *Resources for Grieving Children*.
[44] Magistrates Court of Tasmania (Coronial Division) (n 5).
[45] Ibid.

expensive for some families, meaning a mortuary viewing may be the only opportunity they have to see their loved one.

As the Issues Paper highlights, Tasmania's approach differs from other Australian jurisdictions, which have implemented measures to support earlier access to the deceased person's body as a general rule rather than the exception, while maintaining the integrity of the coronial investigation. Notably, this approach has been recommended by various expert panels, including the Law Reform Committee in Victoria,[46] and the Law Reform Commission of Western Australia.[47]

It is important to recognise that a bereaved person may wish to see the deceased person's body for a variety of reasons – they may feel they ought to, they may want to say 'goodbye', they may wish to check that the body is being properly cared for, or they may wish to wash and dress the body (including where this is part of their cultural or spiritual practice).[48] Notably, parents who lose a child can experience significant distress where they are unable to spend time alone with the deceased or touch and care for them. As Pat explained after her child died in a motor vehicle accident in the UK:

> *'I was suddenly an outsider and not able to do things for my son … It felt as if he was somebody else's property and I had to ask permission to go and see him'.*[49]

For surviving children, viewing their loved one's body can also help them to accept the finality of death.[50] A therapeutic viewing can give them a chance to say 'goodbye' and begin to process their grief.[51] However, a compassionate and trauma-informed approach must be taken to prepare children for what to expect,[52] to make the viewing space as child-friendly as possible in the circumstances, and to ensure appropriate support persons are available.[53]

With these considerations in mind, I suggest that therapeutic mortuary viewings should be generally permitted in Tasmania, where appropriate. In my view, the approach in Queensland strikes the right balance by generally permitting families to view, touch and hold the body at the mortuary, unless 'the death is suspicious or the condition of the body could place the family at risk of emotional distress or trauma'.[54]

---

[46] Parliament of Victoria Law Reform Committee, *Coroners Act 1985* (Parliamentary Paper No. 229, September 2006).
[47] Law Reform Commission of Western Australia, *Review of Coronial Practice in Western Australia* (Final Report No. 100, 2012).
[48] Alison Chapple and Sue Ziebland, 'Viewing the Body After Bereavement Due to a Traumatic Death: Qualitative Study in the UK' (2010) *BMJ* 340.
[49] Ibid.
[50] Wray (n 10).
[51] Jane Mowll, *Report on a Best Practice Bereavement Model for the Coroners Court of Victoria* (Report prepared for the Coronial Council of Victoria, 2021) cited in Coronial Council of Victoria (n 36); Wray (n 10).
[52] Chapple and Ziebland (n 48).
[53] Wray (n 10).
[54] *State Coroner's Guidelines* (Qld) cited in the Issues Paper, 130.

Autopsies and considerations related to family wishes and cultural or spiritual practices

As the Issues Paper notes, conducting post-mortem examinations and autopsies as part of the coronial process can 'exacerbate the trauma experienced by bereaved relatives', particularly where there is a clear preference against internal examinations, including for religious or cultural reasons.[55] For example, in *Paterson v Coroner King* [2019] WASC 25, the mother of a 14-year-old girl who died by suicide objected to an invasive post-mortem examination on the basis of the family's Aboriginal culture and their spiritual belief that if an autopsy was conducted, the girl's spirit would suffer eternal torment.[56] While Acting Justice Strk noted that a family's wishes do not always outweigh the public interest in conducting an autopsy, in this case the cultural and spiritual beliefs of the family prevailed.[57]

Absent relevant spiritual or cultural beliefs, however, the prospect of an autopsy can still be terribly distressing for a family, including where a child has died and certain procedures, such as organ removal, seem unrelated to coronial purposes.[58] For example, the mother of a child who died after being struck by a motor vehicle was deeply distressed when advised that her child's brain would need to be removed to determine the cause of death. The mother explained how this impacted the family, saying:

> *'We know how she died. A car ran into her. So it's either burying a body without her brain or burying her in two weeks'.*[59]

As this mother's comments highlight, lengthy delays caused by autopsies can also mean that families cannot begin to mourn properly or hold a funeral.[60]

The Issues Paper notes that in Tasmania senior next of kin may apply for an order that an autopsy not be performed, providing 'an opportunity for consideration of cultural and religious beliefs and practices at this key stage of the coronial process'. However, there is no explicit acknowledgement in the *Coroners Act* of a family's spiritual beliefs or cultural traditions and little opportunity for a family member, other than senior next of kin, to raise concerns.

In contrast, Queensland's legislation recognises that particular coronial procedures, such as autopsies, are potentially distressing to families and, whenever practicable, the coroner is required to consider:[61]

- that in some cases a deceased person's family may be distressed by the making of this type of order, for example, because of cultural traditions or spiritual beliefs; and

---

[55] Issues Paper, 71 citing the Coronial Council of Victoria, *Review into the Appropriate and Responsive Care of Deaths in Multifaith and Multicultural Communities by the Coroners Court of Victoria and Related Entities Involved in Coronial Processes* (Final Report, Fifth Reference, July 2020).
[56] *Paterson v Coroner King* [2019] WASC 25 cited in Coronial Council of Victoria (n 36).
[57] Coronial Council of Victoria (n 36).
[58] Parliament of Victoria Law Reform Committee (n 46).
[59] Ibid.
[60] Coronial Council of Victoria, *Review of Reportable Deaths in Victoria* (Final Report, April 2020).
[61] *Coroners Act 2003* (Qld) s.19(5).

- any concerns raised by a family member, or another person with a sufficient interest, in relation to the type of examination to be conducted during the autopsy.

In my view, Tasmania should consider adopting a similar approach to Queensland. Further, the *Coroners Act* should also require that the least invasive procedures be used during post-mortem examination,[62] and should outline a range of alternative procedures, such as imaging techniques, that may be used during a 'preliminary examination'.[63]

Children and young people's experiences of traumatic loss

Doubtless, intense emotion and trauma are closely associated with deaths investigated in the coronial jurisdiction, as such deaths are typically sudden, unexpected and/or violent.[64] While this trauma can be experienced by all family members, I wish to focus here on the experience of bereaved children.

Children bereaved of a loved one face a 'tornado of emotions',[65] and the way children process grief varies according to their age, cognitive development and relationship with the deceased.[66] Where a child loses a close family member, especially a parent, they will often experience anxiety (including anxiety about losing a surviving parent), difficulty concentrating and engaging with school, and physical manifestations of stress, such as headaches, stomach aches and sore muscles.[67]

Of course, where a child or young person witnesses a traumatic death, they may also experience post-traumatic stress disorder (PTSD),[68] as highlighted by Wood J in Her Honour's sentencing decision after Darren Mark Wake pleaded guilty to murdering his ex-wife, Rachel Wake, mother of Ms Romany Wake.[69] Wood J noted, among other things, that the deceased's daughter had been diagnosed with PTSD, struggled to regulate her emotions and experienced severe anxiety attacks. These sorts of issues require appropriate, trauma-informed support and therapy to address long-term mental health challenges and risks.[70]

Detrimental impacts of traumatic loss are not only experienced by children who witness a loved one's death. Where bereaved children do not receive appropriate and ongoing support, particularly where a sudden, unexpected and/or violent death of a loved one is the subject of a coronial investigation or inquiry, they often fail to understand their grief and may engage in masking behaviours where they act like everything is okay.[71] Risk of masking behaviours can increase where a child wants to fit in with their friends at school or where

---

[62] *Coroners Act 2009* (NSW) s.88(1)-(2).
[63] *Coroners Act 2009* (NSW) s.88A; *Coroners Act 2003* (Qld) s.11AA; *Coroners Act 2008* (Vic) s.23.
[64] Ian Freckelton, 'Minimising the Counter-therapeutic Effects of Coronial Investigations: In Search of Balance' (2016) 16(3) *QUT Law Review* 4; Carpenter, Tait and Jowett (n 32).
[65] Wray (n 10).
[66] Ibid.
[67] Atle Dyregrov, *Grief in Children: A Handbook for Adults* (Jessica Kingsley Publishers, 2nd ed, 2008).
[68] Ibid.
[69] *State of Tasmania v Darren Mark Wake* [2024] TASSC (Wood J).
[70] Ann-Sofie Bergman, Ulf Axberg and Elizabeth Hanson, 'When a Parent Dies – A Systematic Review of the Effects of Support Programs for Parentally Bereaved Children and Their Caregivers' (2017) 16(39) *BMC Palliative Care* 1.
[71] Wray (n 10).

they are concerned about upsetting or putting further stress on a surviving parent.[72] Further, research shows that children bereaved of a parent can feel pressure to grow up more quickly, often taking on extra responsibility around the house and putting their parent's needs before their own – as Toby, an older child, explained:[73]

> *'I think that's where it came from, is my desperation for us not to just crumble and fall down, and under the weight of everything that we had to do, and instead just get on with it, and, and get going, but it does feel like a lot of responsibility'.*

Unfortunately, when children engage in masking behaviour and 'just get on with it', adults can wrongly conclude that they no longer need support or that they do not require the same level of support that was provided in the immediate aftermath of their loved one's death.[74]

Support for affected families, including children and young people

The discussion above regarding children's experiences of, and responses to, traumatic loss is highly relevant to the coronial jurisdiction. Bereaved children and young people involved in a coronial matter require a compassionate, trauma-informed and child-friendly approach to be embedded in the coronial process from start to finish.

Together with measures discussed earlier, including child-friendly materials on coronial processes, ready access to resources which support children to process their grief, and early access to family discussion sessions with coronial staff, children and young people also require access to tailored, therapeutic supports and counselling.

Importantly, as the Issues Paper notes, Tasmanian families can receive support from a Coronial Liaison Officer and referrals to external grief counsellors. However, Tasmanians involved in coronial matters, including children and young people, would likely benefit from a bespoke model of care co-designed by coronial staff, allied health professionals, bereavement specialists, relevant community sector organisations and people with lived experience of the Tasmanian Coroner's Court, including children and young people.

In developing a coronial model of care, co-designers should be informed by new and innovative approaches in other jurisdictions, including but not limited to the 'stepped care' model in Victoria, which provides 'appropriate levels of support to bereaved families according to expressed need or choice'.[75] Notably, Victoria's approach also includes dedicated Family Liaison Officers who are the primary contact point and source of information for families, a Coroners Support Service which provides crucial updates to families, Aboriginal cultural support, and referral pathways to counselling and bereavement services.[76]

---

[72] Ibid.
[73] Ibid.
[74] Ibid.
[75] Coronial Council of Victoria (n 36).
[76] Coroners Court of Victoria, *The Court.*

Conducting coronial investigations and inquiries

Impact of delays on families and improving efficiencies in the coronial system

Significant delays in coronial investigations and inquiries have been said to have a 'toxic effect' on bereaved families as they unnaturally suspend the grieving process,[77] seeming to freeze bereaved loved ones in time.[78] In addition, prolonged anticipation of an inquest can cause significant anxiety, especially where someone expects to be called as a witness.[79]

The impact of delays may be acutely felt by children and young people. For example, where a parent dies when a child is 12 years of age, a delay of four or five years in resolving the matter would mean that most of the child's teenage years would have passed. The child has not only had to navigate adolescence without their parent, but also without conclusive answers as to why their parent's life was cut short. Further, where the child or young person is a witness in coronial proceedings, they will have to revisit details of their parent's death many years later, a process that has been described as 'total agony'.[80]

The impacts of delay on children and young people are, of course, highly relevant to the pending inquest into the Hillcrest Primary School tragedy. While the reasons for delay in this case include the finalisation of criminal proceedings,[81] it is important to be mindful that almost five years have passed since this incident.

In my view, while delay may be unavoidable in some cases, every effort should be made to progress matters as quickly as possible, without compromising the coroner's fact-finding mandate, including through streamlining coronial processes and ensuring the Coroner's Court is adequately resourced, as the Issues Paper suggests.

Legislation should explicitly permit a mandatory inquest to be conducted through an abridged approach, noting that inquests on the papers already occur in the Tasmanian Coroner's Court.[82] As the Issues Paper suggests, 'statutory recognition of an abridged inquest process may better support the needs of family members in non-complex cases where there is no dispute over facts'. However, an abridged hearing should not be permitted in certain circumstances, including where a death has occurred in care or custody.[83]

Secondly, legislation should authorise the coroner to compel a person to provide an affidavit or other information necessary for an *investigation* since, if a person refuses a request to provide information, the coroner's only recourse is to hold an *inquest* and obtain the information compulsorily. Consideration should be given to the approach in Queensland, where a coroner conducting an investigation may require a person to provide information, a

---

[77] Alison Wertheimer as cited in Freckelton (n 64).
[78] Lindsay McCabe, *Report into Restorative Justice and Coronial Hearings* (Report prepared for Victims Support ACT, 2024).
[79] Alison Wertheimer as cited in Freckelton (n 64).
[80] Parliament of Victoria Law Reform Committee (n 46). This report details the experience of Mr and Mrs Kaufmann who waited more than three and a half years after their son died in a police shooting until the coroner's findings were handed down.
[81] Sandy Powell, 'Hillcrest Jumping Castle Inquest Hoped to Begin this Year Now Criminal Case has Concluded', *ABC News* (online, 15 April 2026).
[82] Issues Paper, 173.
[83] *Coroners Act 1997* (ACT) s.34A(2).

document or anything else relevant to the investigation, unless they have a reasonable excuse.[84]

Thirdly, a triage model, like the one adopted in Queensland, should be considered for Tasmania, including the appointment of a registrar, noting that an enhanced triage approach has also been recommended for Victoria.[85] As mentioned in the Issues Paper, the Queensland model 'seeks to proactively manage natural cause death to reduce the strain on limited coronial, pathologist and police resources, as well as reduce distress for family members.'

Finally, consideration should be given to the 'dual track' approach discussed in the Issues Paper, where matters are allocated either to a 'general track' or 'complex track'.[86] Those in the general track do not require intensive case management, but family members are given access to counselling and other supports with restorative justice conferences conducted to give loved ones the opportunity to discuss how the death has impacted them and to express any grievances.[87] In contrast, the complex track requires intensive case management involving a multi-disciplinary team, including psychologists, counsellors and lawyers (among others), led by the coroner.[88]

Inquests into family violence deaths

I note that the circumstances in which a coroner may or must hold an inquest into a death vary slightly across Australian jurisdictions. In Tasmania, the coroner *must* hold an inquest where, among other things, the death is a suspected homicide, the death occurred in care or custody (or escaping custody), the death occurred during an attempt to detain a person, or the identity of the deceased is unknown.[89] Similar to other jurisdictions, the coroner also *may* conduct an inquiry into a death which they have jurisdiction to investigate if 'desirable to do so'.[90]

However, unlike other jurisdictions, there is an additional situation in the uncommenced s.24(1)(eb) of the *Coroners Act* that would require the coroner to conduct an inquest where they suspect family violence has materially contributed to a person's death.[91] As this provision relies on the definition of 'family violence' in the *Family Violence Act 2004* (Tas),[92] its application would generally be limited to conduct committed against a person's spouse or partner.[93]

In my view, there is dire need to better understand the circumstances surrounding deaths that result from family violence in Tasmania to prevent such tragedies in the future. However,

---

[84] *Coroners Act 2003* (Qld) s.16.
[85] Coronial Council of Victoria (n 60).
[86] Freckelton (n 64).
[87] Ibid.
[88] Ibid.
[89] *Coroners Act 1995* (Tas) s.24(1). This provision also requires an inquest into a workplace death as Tasmania does not have industrial manslaughter laws.
[90] *Coroners Act 1995* (Tas) s.24(2).
[91] *Justice and Related Legislation (Miscellaneous Amendments) Act 2024* (Tas) s.6 amending s.24 of the Principal Act.
[92] Ibid s.5 amending s.3 of the Principal Act.
[93] *Family Violence Act 2007* (Tas) s.7.

these insights are just as important where a child has died as a result of violence in their home, as when an adult has died in circumstances of family violence. With this in mind, and noting the coroner's discretion to conduct an inquest pursuant to s.24(2) of the *Coroners Act*, as an alternative to commencing s.24(1)(eb) consideration should be given to establishing a Family Violence Death Review mechanism in Tasmania, which relies on a broader understanding of 'family violence' than that provided by the *Family Violence Act 2004* (Tas). A similar approach has been adopted in other jurisdictions, including Victoria, NSW and Queensland, with the aim of identifying risk factors and reducing family violence-related deaths.[94] Regrettably, Tasmania remains the only Australian jurisdiction without a systematic domestic and family death review process, as observed in the Australian Domestic and Family Violence Death Review Data Report, *Filicides in a Domestic and Family Violence Context 2010–2018*.[95]

In any case, before s.24(1)(eb) and associated amendments are commenced, consultation should occur with the Chief Coroner to further discuss key issues relevant to commencement, including resource implications for the Coroner's Court and potential negative impacts on surviving family members where there are delays or unwanted publicity related to an inquest.[96] Further, if s.24(1)(eb) is commenced, consideration should be given to incorporating a provision, similar to that found in s.26A(2) of the *Coroners Act*, to allow senior next of kin to submit a written request that an inquest into a family violence death not be conducted.

Inquest proceedings – reducing unnecessary formality

The Coronial Handbook outlines how inquest proceedings are conducted and the various formalities that are followed. It specifies that court is a formal place and recommends compliance with various protocols including a dress code, bowing towards the coroner when entering or exiting the court room, addressing the coroner as 'Your Honour' and not talking in the back of the court room.[97] The Coronial Handbook also outlines the 'very formal' set up of the court, the elevated positioning of the coroner at the bench, the requirement to go through a security check and a metal detector, and the positioning of the witness box.[98]

While a certain level of formality is appropriate to show proper respect to the deceased person and to support the serious fact-finding objectives of an inquest,[99] as the Issues Paper notes, formalities may also have 'antitherapeutic impacts on bereaved family members'.[100] Indeed, participants in coronial proceedings have described feeling 'isolated, confused and culturally unsafe'.[101] Families have said they were 'particularly disturbed by the judicial

---

[94] *Coroners Act 2008* (Vic) Part 8, Div 1C; *Coroners Act 2009* (NSW) Ch 9A; *Coroners Act 2003* (Qld) Part 4A.
[95] Holly Blackmore and Freya McLachlan, *Filicides in a Domestic and Family Violence Context* (Australian Domestic and Family Violence Death Review Network Data Report, 1st ed, 2024).
[96] Adam Holmes, 'Coroner Questions "Jari's Law" and Finds No Evidence Melissa Oates Deliberately Hit Jari Wise with Car', *ABC News* (online, 13 May 2024).
[97] Magistrates Court of Tasmania (Coronial Division) (n 5).
[98] Ibid.
[99] Stephanie Dartnall, Jane Goodman-Delahunty and Judith Gullifer, 'An Opportunity to Be Heard: Family Experiences of Coronial Investigations into Missing People and Views on Best Practice' (2019) 10 *Frontiers in Psychology* 1.
[100] Issues Paper, 59.
[101] Coronial Council of Victoria (n 36).

atmosphere, media activity, the invasion of privacy, and giving evidence'.[102] These impacts may be particularly pronounced for children and young people. As a family in Victorian coronial proceedings described:[103]

> *'It was run just like a criminal trial and that was horrifying for us. It was like, we were sitting in the room, there was nothing we could do by that point. We were just parties, we were just sitting ducks really. We just had to wait and see. It was shocking to see the process unfold, which was nothing like we expected'.*

In Tasmania, legislation allows the coroner to conduct an inquest in any manner they reasonably think fit.[104] Noting the inquisitorial rather than adversarial nature of the coronial jurisdiction, in my view there is scope to implement a more therapeutic and restorative approach to the physical layout and design of the Coroner's Court and to procedural aspects of hearings, paying particular attention to the needs of children and young people.

Firstly, the physical environment in which coronial proceedings are conducted needs to be reconsidered. Research in the UK, which describes the coronial court set-up in very similar terms to those in Tasmania's Coronial Handbook, showed participants were 'taken aback by the formality of the courtroom layout, and found it daunting'.[105] As one bereaved family member explained:

> *'I thought it would be less formal than what it was, but it was a very court-type arrangement… It's one of the most intimidating things I think I've done, and equally one of the most devastating things I've had to do… It was one of those old brick buildings with massive, great big rooms, with high ceilings. I think the coroner - he certainly was up on a big, I think it was a wooden desk'.*

The need for a more therapeutic and family-friendly setting has been recognised and actioned in some other jurisdictions. For example, the design and layout of the Forensic Medicine and Coroners Court Complex (FMCCC) in NSW stands in stark contrast to the set-up of court rooms used for coronial inquests in Tasmania. The FMCCC was designed with the intent to 'create an environment that would be sensitive to the experience of visitors in stressful situations' and to 'help families and staff who work in demanding and often emotionally challenging situations'.[106] Similarly, the Victorian Coroner's Court has dedicated family rooms which can be adapted for alternative uses, such as providing a quiet space with facilities for refreshments. Availability of these spaces was particularly useful for families during the inquest into the deaths of 50 residents at St Basil's Home for the Aged in 2020.[107]

---

[102] Lucy Biddle, 'Public Hazards or Private Tragedies? An Exploratory Study of the Effect of Coroners' Procedures on Those Bereaved by Suicide' (2003) 56(5) *Social Science and Medicine* 1033.
[103] Coronial Council of Victoria (n 36).
[104] *Coroners Act 1995* (Tas) s.51.
[105] Jessica Jacobson, Lorna Templeton and Alexandra Murray, '"I Just Felt We Were Shadows": Scope and Limits of Participation by Bereaved Families in Coroners' Inquests in England and Wales' (2026) 48(1) *Journal of Social Welfare and Family Law* 30.
[106] Cox, *Forensic Medicine and Coroners Court Complex – Lidcombe, NSW.*
[107] Coronial Council of Victoria (n 36).

In my view, there is a pressing need to re-design the physical environment in which coronial proceedings are conducted in Tasmania to provide a more therapeutic and family-friendly set-up (with safe spaces for different cultural groups),[108] and to explore ways to maximise the use of technology (including online hearing access) to support participation of families with children, people with a disability and those living in regional and remote areas.

Secondly, consideration should be given to removing any unnecessary procedural formalities. While certain formalities are important, such as taking an oath or affirmation before giving evidence, more alienating formalities could be dispensed with.

As one bereaved woman recounted about her experience in the UK:[109]

> *'I didn't realise it was going to be set out like a court … and that you stand up and you sit down … It's all got a bit of pomp and ceremony about it, hasn't it, and you don't really feel like it, do you?'*

And, as a woman who attended proceedings about her daughter's death expressed:[110]

> *'All this nonsense: "My learned friends", and the way they address people. It's so antiquated, pompous and full of ceremony … I shouldn't have to stand up when that man walks in a room when he won't even look me in the eye to discuss my daughter'.*[111]

Importantly, dispensing with unnecessary formalities and technical language wherever possible is crucial to ensuring that children and young people can better understand and engage with the coronial process.

Inquest proceedings – children and young people giving evidence

Like adults, children and young people may be required to participate as witnesses in coronial proceedings. This may occur in a range of contexts, such as where the child or young person witnessed the death (or the circumstances surrounding the death), or the death was of a family member in a family violence incident, a classmate at school, a fellow detainee in youth justice detention or a child living in an out-of-home care arrangement. I note that the coroner may summon any such witness and compel them to answer questions where they believe it is reasonably necessary for the purposes of an inquest.[112]

Firstly, in relation to child witnesses, while special measures are available in certain proceedings pursuant to the *Evidence (Children and Special Witnesses) Act 2001* (Tas) (ECSW Act), it seems this legislation only applies to adversarial proceedings and, as such, does not appear to cover proceedings in the Coroner's Court.[113] However, the principles in

---

[108] Ibid.
[109] Jacobson, Templeton and Murray (n 41).
[110] Ibid.
[111] Ibid.
[112] *Coroners Act 1995* (Tas) s.53.
[113] While s.3A of the ECSW Act outlines principles that apply to child witnesses in 'any proceeding', this term is not defined and provisions related to special measures available under the ECSW Act use terminology relevant to adversarial proceedings, such as 'trial', 'judge' and 'prosecutor'.

relation to child witnesses, in s.3A of the ECSW Act, are just as relevant to children giving evidence in the Coroner's Court, particularly the requirements to treat the child with dignity, respect and compassion, and to limit the distress or trauma likely to be experienced by the child.

As such, noting that coronial proceedings are similar to commissions of inquiry, insofar as they are inquisitorial rather than adversarial, it may be appropriate to adopt a similar provision to s.23B(c) of the *Commissions of Inquiry Act 1995* (Tas), which allows a commission of inquiry to identify a person as potentially vulnerable and apply any special evidentiary procedures or measures that may be appropriate, including but not limited to measures under the ECSW Act, whether or not the pre-requisites under that Act for those measures are met.

Secondly, the Issues Paper raises some concerns about the scope of the protection against self-incrimination in s.54 of the *Coroners Act*, which provides that '[a] statement or disclosure made by any witness in the course of giving evidence before a coroner at an inquest is not admissible in evidence against that witness in any civil or criminal proceeding in any court other than a prosecution for perjury in the giving of that evidence'. Under s.53(1)(c) a coroner may order a witness to answer questions, and under s.53(4) a person must not disobey such an order without a reasonable excuse. While there is some protection in s.54, as outlined above, the legislation does not explicitly refer to a person's right to refuse to answer a question on the grounds of self-incrimination. Further, the immunity in s.54 only relates to 'direct use' of a statement in criminal or civil proceedings and does not cover 'derivative use' where a witness' statement is used as a basis for obtaining other evidence.

This approach differs from most other jurisdictions,[114] where legislation explicitly refers to a person's right to object to answering a question on the grounds of self-incrimination. If a witness does object, the coroner must then determine if there are reasonable grounds for the objection and may still compel a witness to answer in certain circumstances, such as where it is in the 'public interest' or the 'interests of justice' to do so (and where the evidence would not tend to incriminate the person under a foreign law). In such cases, where a witness is compelled to answer a question that may incriminate them, they are provided with a certificate which specifies the purposes for which this evidence cannot be used. In NSW, the evidence to which a certificate relates cannot be used against the person '[i]n any proceeding in a NSW court within the meaning of the *Evidence Act 1995* or before any person or body authorised by a law of the State, or by consent of parties, to hear, receive and examine evidence'.[115]

My chief concern here, particularly regarding the absence of a prohibition on derivative use, centres on the potential criminalisation of children and young people, including where a child or young person is a witness in proceedings concerning the death of a former detainee in youth justice detention. For example, if a fellow detainee has died by suicide, counsel assisting may wish to ask if the deceased had approached the witness in detention seeking access to contraband drugs with which to overdose. With no clear right in the *Coroners Act* to invoke the privilege against self-incrimination and no prohibition on derivative use, the

[114] *Coroners Act 2009* (NSW) s.61; *Coroners Act 1997* (ACT) s.51B; *Coroners Act 2003* (Qld) ss.16(5)-(6) and 39; *Coroners Act 2003* (SA) s.23A; *Coroners Act 1996* (WA) s.47; *Coroners Act 1993* (NT) s.38.
[115] *Coroners Act 2009* (NSW) s.61(7).

Coroners Act does not appear to provide sufficient protection to witnesses in these circumstances.

In my view, the legislation should clearly acknowledge that a witness may rely on the privilege against self-incrimination, subject to limited exceptions, and should ensure that where the privilege is abrogated the witness is protected against both direct and derivative use of that evidence in any proceeding in a court or before any person or body authorised by a law of Tasmania, or by consent of parties, to hear, receive and examine evidence.

Therapeutic and restorative justice approaches

In addition to reducing formalities, as discussed earlier, consideration should be given to adopting therapeutic measures and restorative justice approaches that promote the participation of bereaved families, including children and young people, in coronial proceedings. Research has highlighted a range of therapeutic and restorative measures that may be useful in coronial matters, including but not limited to:[116]

- ensuring case management conferences provide sufficient opportunity for family members, including children and young people, to participate;
- allowing families to display a photo of the deceased person and/or to provide an 'impact statement' or other tribute; and
- referring families to restorative justice conferences where it would be beneficial.

Case management conferences

Case management conferences provide an important opportunity to help parties, including family members, prepare for an inquest. Research shows that families consider pre-inquest communication to be 'crucial to reduce unnecessary distress and facilitate family voice'.[117] Notably, the Issues Paper describes these conferences as a two-way process, where both the coroner and interested parties seek and provide information.

In my view, consideration should be given to the extent to which this two-way process facilitates the participation of children and young people, and appropriate reform measures should be implemented following consultation with people with lived experience. I note, for example, that during research by Darntall et al, one participant with lived experience recommended separate pre-inquest conferences for young people, with counsellors in attendance to help them understand the process and ask any questions.[118] This approach would be particularly beneficial for inquests related to mass casualty events where children and young people are significantly affected. Alternatively, child-friendly family conferences with counsel assisting could be helpful in the lead-up to an inquest.[119]

[116] Dartnall, Goodman-Delahunty and Gullifer (n 99).
[117] Ibid.
[118] Ibid.
[119] Ibid.

Photos, impact statements and other tributes

Jacobson et al have highlighted that coronial proceedings should centre on the 'personhood of the deceased'.[120] In my view, the Coroner's Court should explore ways to better promote this aim, including by developing guidelines to support bereaved persons, including children and young people, to create a photo display, write an impact statement or develop a creative tribute to share at the inquest. While it is important that these measures do not impact on the objectivity and impartiality of the coroner,[121] I believe the approach in the *Coroner's Protocol on Family Statements (NSW)* strikes an appropriate balance.

This protocol allows a family statement to be provided and acknowledges that such a statement can offer 'valuable insight into the life of the deceased and their significance to loved ones'.[122] Given that a family statement may involve music, a short video, photographs, poems or other artwork,[123] this is a key way that children and young people may be involved in coronial proceedings. However, the NSW protocol also provides clear guidance on types of content that are not permitted – this includes:

- any new evidence relevant to the inquest;
- allegations of criminal or civil liability against an organisation or person;
- critical or insulting comments, including defamatory statements, about any organisation or person, including medical staff, police or other family members; and
- other statements attributing blame.

Further, the protocol requires draft family statements to be provided to counsel assisting two days before delivery.

Notably, family statements and photos can help personalise the coronial process and promote participation. As one mother explained:[124]

> *'We put together a document of what [my son] was like. It gave us an opportunity to say what he was like. I believe that was read out [at the inquest], as well, which was really great, because we felt that we had a voice'.*

Restorative justice conferences

The Issues Paper rightly highlights the potential for restorative justice mechanisms to support participation and improve the experience of bereaved families involved in coronial

---

120 Jacobson, Templeton and Murray (n 41).
121 Caxton Legal Centre (Coronial Assistance Legal Service), *Coronial Investigation in Queensland: (Counter)- Therapeutic Effects* (November 2019).
122 Local Court of New South Wales, *State Coroner's Protocol on Family Statements* (Protocol, Commences 8 September 2025).
123 Ibid.
124 Jacobson, Templeton and Murray (n 41).

matters. The approaches being trialled or implemented in other jurisdictions are well worth considering for Tasmania,[125] particularly Victoria's Referral Out program.

I note that the aim of the Referral Out program is to help meet families' justice needs that have not been addressed through the coronial process. It allows families to have a facilitated discussion with a person or organisation involved in their loved one's death through an independent restorative justice service. The program also brings together people affected by the death who would not otherwise be involved in the coronial process.[126]

For example, following a coronial investigation into the death of their sons in a motor vehicle accident, Rosalie Dows and Roslyn Hall were very dissatisfied with the Victorian coroner's findings. The Coronial Council of Victoria notes they 'felt let down by the process and wanted answers and information that were not provided'.[127] The two mothers were referred to Open Circle to participate in a restorative dialogue.[128] Noting that one of the deceased had a history of schizophrenia, the restorative process allowed these women to talk about their loss and shared their concerns about Victoria's mental health system.[129] After the restorative dialogue, the two women made a submission to the Royal Commission into Victoria's Mental Health System.[130] This moving example shows the potential power of restorative mechanisms which, in this case, ultimately facilitated lived experience input into the overhaul of Victoria's mental health system.

Prevention and education functions of the Coroner's Court

Publishing findings and recommendations, and promoting accountability

Making and publishing findings and recommendations is, of course, at the very heart of the coroner's mandate in Tasmania.[131] As the Issues Paper notes, the coronial process is 'fundamentally connected with improving public safety and reducing fatalities', and recommendations should aim to improve processes, policies and legislation with a view to preventing avoidable deaths. In my view, legislative and procedural changes are required to more effectively support these objectives.

Firstly, I see merit in more clearly articulating and emphasising the prevention functions of the Coroner's Court in legislation. The approaches in the ACT,[132] Queensland[133] and New Zealand[134] deserve particular attention.

---

[125] In addition to the Referral Out program, Victoria also has a Hospital Pilot program. In the ACT, there is a coronial restorative reform pilot, and the Galambany Circle Sentencing Court in the ACT has been used, on occasion, for coronial matters.
[126] Coronial Council of Victoria (n 36).
[127] Ibid.
[128] Ibid.
[129] Ibid.
[130] Ibid.
[131] *Coroners Act 1995* (Tas) s.28.
[132] *Coroners Act 1997* (ACT) s.3BA(1)(d).
[133] *Coroners Act 2003* (Qld) s.3(d).
[134] *Coroners Act 2006* (NZ) s.3(1).

Secondly, similar to the approach in the ACT,[135] it may be helpful to require the coroner's published findings to explicitly state if a matter of public safety arose in connection with an investigation or inquiry and, where this is the case, to provide comment on the matter or matters that arose.

Thirdly, noting that s.28(5) of the *Coroners Act* requires the coroner to report on the 'care, supervision or treatment' of a person who died in care or custody, it is curious that s.30 does not require the coroner to provide such a report to the Attorney-General. While this may be done in practice, I suggest the statutory approach in Queensland should be considered.[136]

Finally, and perhaps most importantly, I consider it unacceptable that neither policy nor legislation requires the government to respond to coronial recommendations that relate to it. Among other things, it is worth considering the associated lack of accountability, the inability to 'effectively measure the trends and impact of recommendations',[137] and the frustration that bereaved families can experience when, for all intents and purposes, it seems the coroner's recommendations can simply be ignored.[138] Indeed, as Moore has argued, 'when coroners' recommendations are not implemented, this has counter-therapeutic outcomes for the community who deserve remedial action, and for families who hoped for change'.[139]

While I note that jurisdictions like NSW[140] and Queensland[141] have processes established in policy, I see merit in the clearer, legislative mandate adopted in Victoria.[142] Under the *Coroners Act 2008* (Vic), if a public statutory authority or entity receives recommendations made by the coroner that relate to them, they must provide a written response within three months.[143] This response must 'specify a statement of action (if any) that has, is or will be taken in relation to the recommendations' and this must be published on the coroner's website.[144]

Expert commentary on Victoria's approach has suggested that it represents 'a significant and innovative step in coronial law by bringing the judicial, public health and regulatory systems into much closer contact'.[145] While Victoria's legislation does not mandate compliance with recommendations, the requirement to publish an entity's response is an important accountability mechanism that may indirectly support compliance.[146]

---

135 *Coroners Act 1997* (ACT) s.52(4).
136 *Coroners Act 2003* (Qld) s.47(1)-(2).
137 Legislative Council Select Committee on the Coronial Jurisdiction in NSW, *Coronial Jurisdiction in New South Wales* (Final Report, April 2022).
138 Parliament of Victoria Law Reform Committee (n 46).
139 Jennifer Moore, 'The Impact of Therapeutic Jurisprudence on the New Zealand Coronial Jurisdiction' in Warren J Brookbanks (ed), Therapeutic Jurisprudence: New Zealand Perspectives (Thomson Reuters, 2015) 179-222.
140 Department of Premier and Cabinet (NSW), *M2009-12 Responding to Coronial Recommendations*.
141 Department of Justice (Qld), *Queensland Government Response to Coronial Recommendations*.
142 *Coroners Act 2008* (Vic) s.72.
143 *Coroners Act 2008* (Vic) s.72(3).
144 Ibid s.72(4)-(5).
145 Georgina Sutherland, Celia Kemp and David M Studdert, 'Mandatory Responses to Public Health and Safety Recommendations Issued by Coroners: A Content Analysis' (2016) 40(5) *Australian and New Zealand Journal of Public Health* 451.
146 Ibid.

However, if a similar approach is considered for Tasmania, it will be important to review evaluations of Victoria's regime and design a system that takes into account the lessons learnt to date, including but not limited to the fact that the efficacy of Victoria's approach is highly dependent on the quality of the recommendations made by the coroner.[147] Consideration should also be given to incorporating clear follow-up processes after an entity has outlined its intended response, developing processes to monitor implementation of reforms,[148] and the pros and cons of extending the response requirement to non-government organisations.[149]

Recommendations

1. Ensure the *Coroners Act* explicitly acknowledges the impact of a person's death on their family and recognises the family's unique interest in coronial matters. In drafting amendments, consideration should be given to the approaches in s.8 of the *Coroners Act 2008* (Vic) and s.3BA(2) of the *Coroners Act 1997* (ACT).
2. Amend the *Coroners Act* so that a 'reportable death' includes the death of any child (or the sibling of any child) who has been assessed as being 'at risk' under the CYPTF Act within three years of their passing; and the death of any child that may be due to abuse or neglect, or that occurs in suspicious circumstances.
3. Amend the *Coroners Act* so that 'reportable death' includes the death of any child or young person who dies within 12 months of leaving out-of-home care.
4. Amend the *Coroners Act* so that the death of a 'person held in care' covers any person who died while subject to an involuntary mental health order in a community setting, noting the approach taken in s.3BB of the *Coroners Act 1997* (ACT).
5. Amend the *Coroners Act* so that the death of a 'person held in custody' covers any child or young person who died while subject to a youth justice detention order, considering the approaches in s.10(2) of the *Coroners Act 2003* (Qld) and relevant definitions in the *Coroners Act 1996* (WA).
6. Amend the *Coroners Act* so that 'reportable death' includes the death of any child or young person who dies within 12 months of leaving youth justice detention.
7. Review and revise any policies and procedures relevant to police involvement in investigating a reportable death that occurred when a person was in the custody or control of a police officer.
8. Authorise the coroner via legislation to give a police officer directions concerning investigations to be carried out for the purposes of a coronial investigation or inquiry into a death, or suspected death, that occurred while a person was in the custody or control of a police officer, similar to the approach in s.15A of the *Coroners Act 2003* (Vic) and s.25 of the *Coroners Act 1993* (NT).
9. Review and revise coronial policies and procedures to promote clear, timely and ongoing communication with all interested persons, including children and young

[147] Ibid.
[148] Legislative Council Select Committee on the Coronial Jurisdiction in NSW, *Coronial Jurisdiction in New South Wales* (Final Report, April 2022).
[149] Ibid. See, for example, feedback provided by Gilbert + Tobin who highlight the 'increasing privatisation of public functions'.

people who have lost a loved one, and to ensure all communication with bereaved relatives is family-focused, trauma-informed and culturally safe.

10. Explore a range of ways to improve communication with families involved in coronial matters, particularly children and young people, including but not limited to informal discussion sessions and use of online portals and/or apps, as recommended by the Coronial Council of Victoria.
11. Revise the *Tasmanian Coronial Practice Handbook* to develop a more user-friendly version for families. In doing so, consider *The Coroners Process – Information for Family and Friends (Vic).*
12. Provide clear links on the Coroner's Court website to materials for grieving children. In doing so, consider the approach in Victoria.
13. Adopt a more flexible approach to allow families to view, touch, hold, wash and/or dress the body of the deceased at the mortuary unless there are suspicious circumstances or the family is at risk of emotional distress or trauma.
14. Develop practices and procedures related to children and young people viewing the deceased person's body in the mortuary, to ensure children are appropriately prepared, the viewing is trauma-informed and therapeutic support is available.
15. Recognise cultural and spiritual beliefs in the objects of the *Coroners Act* and require consideration of such beliefs at key stages of the coronial process, including when making a decision about conducting an autopsy, similar to the approach in s.19(5) of the *Coroners Act 2003* (Qld).
16. Amend the *Coroners Act* to require the least invasive methods to be used during post-mortem examination and to outline a range of alternative procedures, such as imaging techniques, that may be used during a 'preliminary examination'.
17. Review the effectiveness of Tasmania's referral mechanism which relies on external grief counsellors to ensure that children and young people involved in coronial matters have access to tailored, therapeutic supports and counselling for as long as required.
18. Co-design a bespoke model of care for the Tasmanian Coroner's Court with input from coronial staff, allied health professionals, bereavement specialists, relevant community sector organisations and people with lived experience of the system, including children and young people. In doing so, consider approaches in other jurisdictions, including the 'stepped care' model in Victoria.
19. Amend the *Coroners Act* to explicitly permit a mandatory inquest to be conducted through an abridged process, except for deaths that have occurred in care or custody.
20. Amend the *Coroners Act* to give the coroner authority to require a person to provide information, a document or anything else relevant to an investigation (subject to limited exceptions), similar to the approach in s.16 of the *Coroners Act 2003* (Qld).
21. Consider the appropriateness of trialling a triage model in Tasmania, similar to the approach in Queensland, including appointment of a registrar.

22. Consider the appropriateness of trialling a 'dual track' approach, as discussed in the Issues Paper, where matters are allocated to either a 'general track' or 'complex track'.

23. As a potential alternative to commencing s.24(1)(eb) of the *Coroners Act*, enacted through s.6 of the *Justice and Related Legislation (Miscellaneous Amendments) Act 2024* (Tas), consider establishing a Family Violence Death Review mechanism in Tasmania, which relies on a broader understanding of 'family violence' than the definition in the *Family Violence Act 2004* (Tas) recognising children and young people as victims of family violence, to ensure that family violence-related deaths of children are covered.

24. Before s.24(1)(eb) of the *Coroners Act* and associated amendments are commenced, consult with the Chief Coroner to further discuss key issues relevant to commencement, including resource implications for the Coroner's Court and potential negative impacts on surviving family members where there are delays or unwanted publicity related to an inquest.

25. If s.24(1)(eb) of the *Coroners Act* is commenced, consider incorporating a provision, similar to that found in s.26A(2) of the *Coroners Act*, to allow senior next of kin to submit a written request that an inquest into a family violence death not be conducted.

26. Redesign the physical environment in which coronial proceedings are conducted to promote a less formal, more inclusive, and therapeutic approach, giving due consideration to the specific needs of children and young people, and provision of safe spaces for different cultural groups.

27. Explore ways to maximise the use of technology during inquests (including online hearing access) to support participation of families with children, people with a disability and those living in regional and remote areas.

28. Dispense with unnecessary formalities and technical language during coronial proceedings wherever possible to ensure a more inclusive, therapeutic approach and to promote engagement of children and young people with the coronial process.

29. Amend the *Coroners Act* to include a provision similar to s.23B(c) of the *Commissions of Inquiry Act 1995* (Tas) regarding special evidentiary procedures or measures for potentially vulnerable witnesses.

30. Amend the *Coroners Act* to clearly acknowledge that a witness may rely on the privilege against self-incrimination subject to limited exceptions, and to ensure that where the privilege is abrogated the witness is protected against both direct and derivative use of that evidence in any proceeding in a court or before any person or body authorised by a law of Tasmania, or by consent of parties, to hear, receive and examine evidence.

31. Consider the extent to which case management conferences in Tasmania truly provide a 'two-way process' which facilitates the participation of children and young people and implement appropriate reforms following consultation with people with lived experience of the Coroner's Court.

32. Where an inquest relates to a mass casualty event that has had a significant impact on children and young people, consider providing specialised pre-inquest conferences for children and young people, with counsellors in attendance to help them understand the process and ask any questions.

33. Consider the pros and cons of trialling restorative justice approaches being implemented in other jurisdictions, such as Victoria's Referral Out program.

34. More clearly articulate the prevention functions of the Coroner's Court in the *Coroners Act*.

35. Amend the *Coroners Act* to require the coroner's published findings to explicitly state whether a matter of public safety arose in connection with an investigation or inquiry and to require the coroner to comment on any such matters that arose.

36. Amend the *Coroners Act* to explicitly require a report into the death of a person held in care or custody to be provided to the Attorney-General.

37. In line with the approach in Victoria, amend the *Coroners Act* to require a public statutory authority or entity, which receives coronial recommendations that relate to them, to provide a written response which specifies the action (if any) that has, is or will be taken in relation to the recommendations. Publish all responses received on the Coroner's Court website and develop a clear process to follow-up on recommendations and monitor implementation. Also consider the pros and cons of extending the response requirement to non-government organisations.

38. Review any evaluations of Victoria's statutory requirement to provide a written response to coronial recommendations and design a system that accounts for the lessons learnt to date.

Concluding statement

Thank you again for providing such a comprehensive Issues Paper. Mindful of the impact that coronial matters can have on children and young people, I was pleased to see that the Attorney-General asked the TLRI to review the laws, policies and procedures that apply to the Tasmanian Coroner's Court.

Should you have any questions about the feedback and recommendations provided in this submission, you are welcome to contact this Office for more detail.

Yours sincerely,

Ros Cornish AM
Interim Commissioner for Children and Young People