Submission
No 1

INQUIRY INTO CORONIAL JURISDICTION IN NEW SOUTH WALES

Organisation: Magistrates Court of Tasmania

Date Received: 18 May 2021

Dear Tina,

Thanks for your letter dated 13 May 2021 in relation to the Inquiry into the coronial jurisdiction in New South Wales.

I have provided our organisation chart, flow chart of the coronial process and our annual report.

Other information I can provide is below.

Currently 3FTE Constable Police Officers who are working within the Coronial Division with 2 FTE Sgt's.

We are currently divided into the North and South of the state, with the associates as follow.
3 FTE constables working out of Hobart with 1 Sgt
1 FTE constable working out of Launceston with 1 Sgt (that position is currently centralised to Hobart)

All of the police are paid by their department and not the Department of Justice.

In Department of Justice side we have as the org chart states, 1 Manager, 1 Team Leader and 3 Court Clerks.

We are currently in the process of centralising all associates to work in the Hobart office.

We have 3 Coroners, we fund 1 full-time Counsel Assist but they are not located in house, but with the DPP and we request counsel to be appointed when needed, or independent counsel if they have a conflict or lack of expertise in the matter.

Current wait time for a post mortem report to be finalised and presented to the Coroner is 3-4 months usually, longer if tox has been requested.

File reviews are only done by the Constables and Sgt's as outlined above. However this role is typically one which would sit with the Sgt's only.

Our average timeframe from a decision to list an inquest to actually conducting an inquest in court, is dependent on the complexity of the matter, relatively straight forward matters could be listed around 6-12 months, more complex 12 months and above. Our numbers for inquest were down last year due to COVID – have given you the extract from our Annual report 2019-2020, attached.

Whilst we don't have any services or support services located on site we have a range of different services we can refer to; which contained with our a Guide for Family and Friends and the link is here
https://www.magistratescourt.tas.gov.au/about_us/coroners/coronial_practice_handbook/a_guide_for_family_and_friends

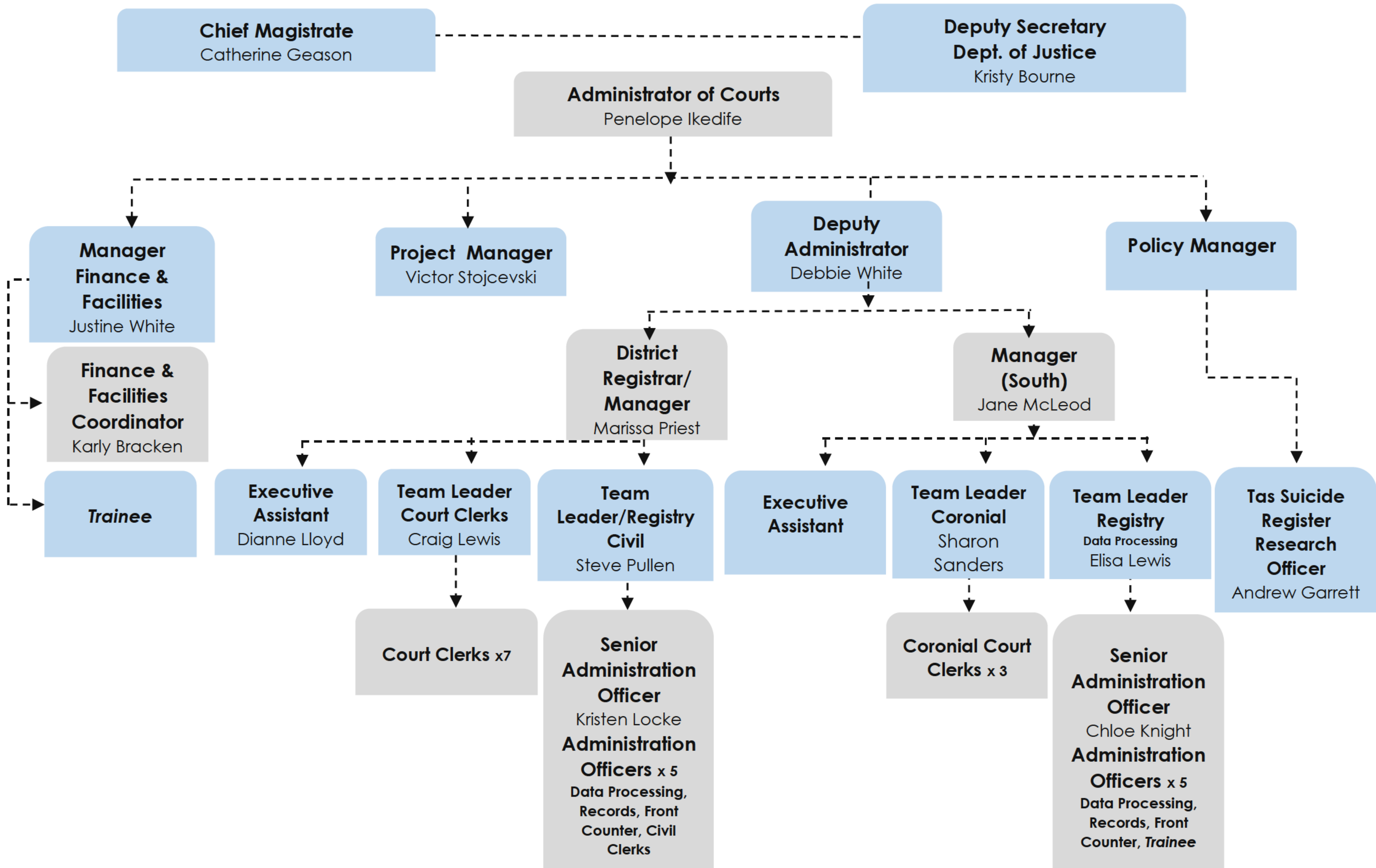
If anything has been omitted or you wish for further information to be provided please let me know.

Kind Regards

Jane Mcleod | Manager (South)
Magistrates Court of Tasmania
Hobart Registry

MAGISTRATES COURT TASMANIA - SOUTH
ORGANISATIONAL STRUCTURE

As at February 2021



MAGISTRATES COURT *of* TASMANIA

Flow chart of the coronial process

This is a flow chart of the most common way in which a coronial matter proceeds following a recent death.

A death occurs.

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Is the death reportable? If yes, the coroner is notified.

→ If the death is not reportable, a medical practitioner will issue a Medical Certificate of Cause of Death (MCCD).

↓

The deceased person is identified.

↓

Post mortem examinations are conducted and a post mortem report is always prepared.

→ If the examination results in a finding of death by **natural causes**, the coroner notifies the family by letter that it is a natural death. If this occurs, the investigation concludes and the coroner has no further jurisdiction.

↓

Investigation:

- witnesses interviewed
- statements taken
- reports written
- evidence / documents gathered.

↓

Coroner decides whether to hold an inquest (in some cases an inquest is mandatory).

↙ No inquest to be held.

↓ Coroner makes 'findings without inquest', which may include comments and recommendations. These may be published online.

↘ Inquest:

- witnesses summonsed
- counsel assisting appointed
- case management conferences held
- issues / scope defined
- inquest held in court.

↓ Coroner makes 'findings with inquest', which may include comments and recommendations. These are always published online.

Coronial Division

Table 11: Coronial – Summary of Coronial Activity 2015 to 16 to 2019 to 20

Deaths reported to the Coroner	2015 to 16	2016 to 17	2017 to 18	2018 to 19	2019 to 20	Change 2018 to 19 to 2019 to 20
Lodgements	568	579	598	654	**751**	**14.8%**
Deaths in Custody or Care	8	4	2	10	**10**	**0%**
Fires/Explosions	0	0	0	0	**0**	**0%**
Number of inquests held	11	22	19	23	**14**	**-39.1%**
Number of cases closed	494	582	605	568	**722**	**27%**