COTA TASMANIA
for older Australians

COTA TAS
Level 12, 39 Murray St,
Hobart TAS 7000
PO Box 4679, Hobart TAS 7000

www.cotatas.org.au
ABN 71 718 804 307

P: (03) 6231 3265
admin@cotatas.org.au

Submission to the Review of the Coroners Act 1995 (Tas)

Tasmania Law Reform Institute

1. Overview

COTA Tasmania welcomes the comprehensive review of the *Coroners Act 1995* and *Coroners Rules 2006*.

The coronial system performs several important public functions. It establishes how and why certain deaths occurred, provides answers to families and the community, identifies systemic failures and contributes to the prevention of avoidable deaths and serious injuries.

For families, however, a coronial investigation is not simply an administrative or legal process. It occurs during a period of grief, trauma and uncertainty. The effectiveness of the system must therefore be judged not only by the accuracy and legal soundness of its findings, but also by whether people are treated with dignity, compassion and respect; whether they can understand and participate in the process; whether investigations are completed in a reasonable time; and whether lessons identified through investigations result in meaningful change.

2. About COTA Tasmania

COTA Tasmania is the leading voice for older Tasmanians.

For more than 60 years, COTA Tasmania has worked to advance the rights, interests and wellbeing of older people. We undertake policy and advocacy, deliver information and community programs, and engage directly with older Tasmanians, families, carers, service providers, community organisations, and governments across the State.

Our work is guided by a commitment to dignity, autonomy, inclusion, fairness, and the right of every person to age safely and well.

COTA Tasmania recognises that older Tasmanians are diverse. Their experiences of ageing are shaped by differences in health, disability, cultural background, family circumstances, income, housing, location, access to services, and personal history. Our advocacy seeks to ensure that laws, policies, and services reflect this diversity and do not treat older people as a single or homogenous group.

3. Why this matters

Tasmania has the oldest population profile of any Australian state or territory. As the number and proportion of older Tasmanians continues to grow, the operation of the coronial system will increasingly affect older people, their families, and those who care for and support them.

Older people may be the subject of a coronial investigation or may engage with the system as a bereaved partner, sibling, relative, friend, carer, or witness.

They may also be seeking to understand whether failures in care, treatment, or service coordination contributed to the death of a person close to them.

Deaths involving older people may raise complex questions about the interaction of ageing, frailty, disability, dementia, chronic illness, falls, medication, clinical decision-making, care arrangements, neglect, abuse, and failures across health, aged care, and community services. These issues can be particularly difficult to identify where responsibility is divided between multiple providers or levels of government, or where the person moved between home, hospital, residential care, and other services before their death.

Most deaths in later life are expected and result from natural causes. COTA Tasmania does not support unnecessary investigations, delays, or invasive procedures where the circumstances of a death are clear. Equally, advanced age, frailty, disability, dementia, or residence in a care setting must not be allowed to normalise a preventable death or lower expectations of care, investigation, and accountability. Older people have the same right as every other Tasmanian to have concerns about the circumstances of their death taken seriously.

A modern coronial system must therefore achieve an appropriate balance. It should avoid unnecessary intervention while ensuring that indicators of abuse, neglect, unsafe care, clinical failure, or systemic risk are properly examined. It should also provide families with clear information, meaningful opportunities to participate, and confidence that lessons arising from a death will contribute to preventing similar deaths in the future.

4. Summary of recommendations

COTA Tasmania recommends that:

1. The Coroners Act 1995 include a clear objects or purposes provision recognising independent and timely investigation, the dignity and participation of families, cultural and spiritual respect, the identification of systemic risks, and the prevention of avoidable deaths and serious injuries.
2. The Coronial Division be adequately resourced and supported by dedicated leadership, effective intake and case management, sufficient legal, medical, investigative, research, liaison, and administrative capacity, and suitable, accessible, and trauma-informed premises.
3. Families be provided with a clearly identified point of contact, regular and meaningful updates, plain-English information in accessible digital and non-digital formats, practical regional access, and proactive referral to bereavement, counselling, advocacy, and legal assistance.
4. Family members and others close to the deceased be given meaningful opportunities to provide information and participate in the process, with appropriate access to records and clear safeguards governing post-mortem examinations, retained tissue, privacy, and the dignity of the deceased.
5. The definition and investigation of reportable deaths in care focus on the circumstances and possible contributing factors surrounding a death, rather than age, disability, diagnosis, or place of residence, and encompass residential aged care, home care, supported accommodation, disability services, and relevant transitions between services.

6. Expedited or abridged processes be available for deaths that are clearly from natural causes only where families can raise concerns, relevant care and clinical information has been reviewed, and there is no indication of abuse, neglect, substandard care, or systemic failure.
7. The Coronial Division provide reasons for decisions not to accept jurisdiction, investigate further, or hold an inquest; establish practical review mechanisms; and introduce clear timeliness standards, active case management, and regular public reporting on outstanding matters and delays.
8. Coronial findings be expressed in clear and accessible language, with plain-English summaries for families where appropriate, and with careful balancing of privacy, open justice, and the public interest in publication.
9. Public authorities and private organisations performing publicly funded or regulated functions be required to respond to coronial recommendations within prescribed timeframes, with responses, implementation commitments, and progress reports published and centrally monitored.
10. Tasmania strengthen specialist research and death-review capacity to identify recurring risks affecting older people and people receiving care, and involve older people, bereaved families, and carers in the continuing evaluation and improvement of the coronial system.

5. Responses to Consultation Questions

5.1 Purposes and structure of the Coronial Division - Consultation questions 1–9, 19, and 154

COTA Tasmania supports the inclusion of an objects or purposes provision in the Act.

A modern coronial statute should make clear that the jurisdiction is not concerned solely with determining the identity of a deceased person and the medical cause of death.

It should also recognise the need to provide answers to families, identify systemic risks, contribute to the prevention of future deaths and operate in a way that respects the dignity of the deceased and the wellbeing of those affected.

An objects clause should recognise:

- the independence and impartiality of coronial investigations;
- the accurate and timely investigation of reportable deaths;
- the dignity of the deceased person;
- the needs, rights and participation of family members and others close to the deceased;
- clear, accessible and trauma-informed communication;
- cultural, religious and spiritual respect;
- the identification of systemic risks and failures; and
- death and injury prevention.

COTA Tasmania does not have a firm view on whether the Coronial Division should become a completely separate court. Structural separation alone will not necessarily improve families' experience or the timeliness and quality of investigations.

However, the Coronial Division should have sufficient operational autonomy, dedicated leadership and clearly allocated resources.

Its workload and multidisciplinary functions are sufficiently distinct from ordinary Magistrates Court work to justify dedicated staffing, case management, support services, research capacity and suitable premises.

A registrar or equivalent senior role could improve the intake, triage and management of matters, provide greater consistency and allow coroners to concentrate on judicial and investigative decisions. Such a role should not displace coronial independence, but could coordinate preliminary information, identify urgent issues, ensure early communication with families and monitor progress against case-management milestones.

5.2 Communication, information and participation - Consultation questions 20–39

Families should not be expected to understand the coronial system without assistance.

The process involves unfamiliar terminology, several different agencies, uncertain timeframes and potentially distressing medical and legal information. Bereaved people may also be dealing with funeral arrangements, financial pressures, care responsibilities and their own health needs.

Older family members may experience additional barriers, including hearing or vision loss, limited mobility, cognitive impairment, low literacy, digital exclusion, distance from Hobart and difficulty travelling.

Communication and participation arrangements should accommodate family members, witnesses, and other participants living with dementia or cognitive impairment, including through supported decision-making, additional time, appropriate communication assistance, and the involvement of a trusted support person where requested.

COTA Tasmania recommends that every family be provided with:

- a clearly identified contact person;
- an initial explanation of the process and likely next steps;
- information about their rights and opportunities to participate;
- an indicative timeframe, while recognising that this may change;
- regular updates even where there has been no substantive development;
- an explanation of delays;
- information about available support, advocacy and legal assistance;
- timely notice of hearings, decisions and the release of findings; and
- a clear avenue for questions, concerns and complaints.

Information should be written in plain English and made available in accessible formats. It should not be confined to a website or online portal. Printed information and telephone-based assistance will remain essential for many older people.

The Coronial Division should also provide practical options for regional participation, including telephone and videoconference access, supported remote attendance, and, where appropriate, hearings or liaison services outside Hobart.

Digital tracking of cases may be useful, but it should supplement rather than replace personal communication. A portal that simply displays that a matter remains “under investigation” will provide little reassurance unless it includes meaningful information and access to a person who can explain what is occurring.

Families should also have a meaningful opportunity to provide information.

This could include information about the deceased as a person, the circumstances preceding the death, concerns about care, communication or service delivery, and the impact of the death.

A family statement should not determine factual findings and should be subject to appropriate guidelines. However, recognising the deceased as a person rather than only as a clinical or evidentiary subject can help ensure that the process remains humane.

Family participation can also improve the quality of an investigation. Family members and carers may hold information that is not apparent in medical records, including changes in behaviour or function, medication effects, unmet support needs, warning signs, previous complaints, failures in communication or transitions between services.

5.3 Support for families and witnesses- Consultation questions 54–62

COTA Tasmania welcomes the establishment of the Coronial Liaison Officer role. The significant increase in the number of people assisted by the officer demonstrates both the value of the position and the level of unmet need.

The role should be adequately resourced and available throughout Tasmania. Consideration should be given to additional liaison capacity so support does not depend on a single officer.

Support should be proactive rather than relying on a distressed family member to identify and navigate separate services.

Families should be offered warm referrals to appropriate services, which may include:

- grief and bereavement counselling;
- suicide bereavement support;
- trauma support;
- culturally appropriate services;
- elder abuse services;
- disability advocacy;
- carer support;
- financial counselling;
- funeral and practical assistance;
- community legal assistance; and
- specialist coronial legal advice.

Free or affordable legal assistance is particularly important. Coronial processes may be described as inquisitorial, but families can still face significant disadvantages where government agencies, health services, or large providers have access to experienced legal representation and the family does not.

Legal assistance should be available where the circumstances are complex, the family is seeking an inquest or review, adverse findings may be made, multiple agencies are involved, or the death raises significant questions about care, neglect, abuse, or public-system accountability.

Witnesses should also receive clear information about what is expected, available communication assistance and, appropriate support before, during, and after giving evidence.

5.4 Cultural, spiritual and religious needs - Consultation questions 40–46

COTA Tasmania supports express statutory recognition of cultural, spiritual, and religious practices.

Tasmania's older population includes Aboriginal elders, people from culturally and linguistically diverse communities, and people with diverse religious and spiritual beliefs. Practices concerning the treatment, examination and timely release of a deceased person's body can be deeply important.

Coronial decision-making should require these matters to be genuinely considered, while recognising that they cannot always override the need for an effective investigation.

Specialist liaison, interpreter access, and cultural capability should be embedded within the system.

Cultural safety should not depend on individual family members repeatedly explaining or defending their practices during a period of grief.

5.5 Delay and case management - Consultation questions 47–53 and 111–115

Delay is one of the most significant risks to the wellbeing of families and to confidence in the coronial system.

Some complex investigations will necessarily take considerable time. However, prolonged uncertainty can prevent families from understanding what occurred, complicate grief, delay estate and insurance matters, and weaken the preventive value of findings.

COTA Tasmania supports legislative recognition of the need for the efficient and timely operation of the Coronial Division, but legislation alone will not resolve delay. Reform must be accompanied by adequate staffing, forensic and pathology capacity, active case management, and transparent reporting.

The Coronial Division should establish indicative timeframes and escalation points for different classes of matters. Where a timeframe cannot be met, the family should receive an explanation and a revised estimate.

Public reporting should include:

- the number of outstanding investigations;
- the length of time matters have remained open;
- the number of matters outstanding for more than 12, 24 and 36 months;
- the main causes of delay;
- time taken to obtain pathology, medical and expert reports;
- regional information where relevant; and
- actions being taken to address backlogs.

Case conferences should be used where they can clarify the scope of an investigation, identify disputed issues, improve family participation or reduce avoidable delay.

5.6 Reportable deaths involving older people and care settings - Consultation questions 70–94

COTA Tasmania's principal concern is that deaths of older people are neither over-investigated merely because they occurred in care nor under-investigated because advanced age, frailty or disability makes the death appear unsurprising.

The central question should be whether the death may have involved an unexpected, unnatural or preventable factor, including:

- abuse or neglect;
- inadequate supervision;
- failure to respond to deterioration;
- medication error or inappropriate polypharmacy;
- an unexplained or preventable fall;
- malnutrition or dehydration;
- pressure injuries;
- infection-control failures;
- inappropriate restraint;
- failures in clinical escalation;
- unsafe discharge or transfer;
- inadequate palliative or end-of-life care;
- delayed access to treatment;
- a failure to follow a care plan;
- systemic workforce or communication failures; or
- conduct by a person on whom the deceased depended for care or support.

The definition of care should be broad enough to encompass residential aged care, supported accommodation, disability services, and relevant home-based care arrangements.

The place where a person died should not be the only determinant. A death in hospital may, for example, result from events occurring in residential care, during home care, following an unsafe discharge, or during a transition between services.

COTA Tasmania recognises the need to avoid unnecessary coronial involvement in clearly expected deaths from natural causes. A preliminary or expedited process may be appropriate where the relevant medical evidence is clear and no concern has been raised about the circumstances of death. However, any expedited process should include safeguards.

Before closing a matter, the Coronial Division should:

- consider available medical and care records;
- consider any relevant incident, complaint, or safeguarding information;
- confirm that there is no reasonable indication of abuse, neglect, or systemic failure;
- give the senior next of kin an opportunity to identify concerns; and
- record brief reasons for the decision.

Families should be provided with reasons where the Coronial Division determines that a death is not reportable, declines jurisdiction, or decides not to conduct further investigation or an inquest. Information should also be provided about any available review or reconsideration process.

5.7 Post-mortem examinations and treatment of the deceased - Consultation questions 95–108

The dignity of the deceased person should be expressly recognised in the Act.

Post-mortem examinations can be deeply distressing for families. Families should receive clear information about:

- why an examination is proposed;

- whether less invasive options have been considered;
- the nature and extent of the proposed procedure;
- likely timeframes;
- their right to raise cultural, religious, or other concerns;
- how to make an objection;
- how an objection will be considered;
- whether tissue or organs may be retained; and, if so,
    - why retention is necessary;
    - how long material may be retained; and
    - what will occur when these materials are no longer required.

The Act should require the least invasive procedure reasonably capable of answering the relevant coronial questions. This could include staged examinations, beginning with review of records, external examination, imaging or other non-invasive investigations where appropriate.

A requirement to use the least invasive suitable procedure should not prevent a full autopsy where it is reasonably necessary. It would instead ensure that the level of intervention is justified and proportionate.

Where tissue or body parts are retained, families should not discover this incidentally or years later. There should be clear statutory requirements governing notification, documentation, retention periods and respectful disposal or return.

Families should also be supported to view or spend time with the deceased where this can occur safely and without compromising any investigation.

5.8 Inquests and review rights - Consultation questions 121–128 and 149–153

COTA Tasmania supports flexibility in the use of inquests, provided that efficiency does not come at the expense of transparency or accountability.

An abridged inquest may be appropriate where the essential facts are agreed, the cause of death is clear and a full hearing would add little. However, families should be consulted and given an opportunity to identify unresolved concerns before an abridged procedure is adopted.

When deciding whether to hold a discretionary inquest, relevant factors should include:

- concerns raised by the family;
- possible systemic or recurring risks;
- possible abuse, neglect or substandard care;
- involvement of a public authority or publicly funded provider;
- conflicting evidence;
- significant public interest;
- the vulnerability or dependence of the deceased person;
- whether an inquest may contribute to death prevention; and
- whether other investigation or regulatory processes are likely to provide adequate scrutiny.

Families and people with sufficient interest should receive reasons when an inquest is not held and should have access to a practical review mechanism.

COTA Tasmania also supports a straightforward process for correcting factual errors in findings without requiring a full reopening of the investigation, provided procedural fairness is maintained.

5.9 Findings and access to information - Consultation questions 137–150

Coronial findings should be accurate, respectful, and accessible.

Findings may contain complex legal, medical, and technical material. Families should receive a plain-English explanation or summary that identifies:

- what the coroner found;
- the evidence central to the decision;
- any uncertainty that remains;
- any comments or recommendations;
- whether another body has been notified; and
- what will happen next.

Records should be made available to family members subject to proportionate privacy and safety safeguards. Families should be warned where records may contain highly distressing material and should be offered supported viewing rather than simply receiving graphic material without preparation.

The name of the deceased and sensitive personal information should not be published automatically where publication would cause unnecessary harm and provide little public benefit. Families should be told about their ability to request suppression or restricted publication.

Any restriction must remain balanced against the public interest in open justice, transparency and the preventive role of published findings.

5.10 Death prevention and responses to recommendations - Consultation questions 154–164

COTA Tasmania strongly supports express recognition of death prevention as a statutory purpose of the coronial jurisdiction.

The value of coronial investigation is diminished where recommendations can be ignored without explanation, or where similar failures recur across multiple deaths.

Coroners should be able to make recommendations following investigations conducted with or without a formal inquest, provided affected organisations are given procedural fairness and an opportunity to provide relevant information before recommendations are finalised.

Public authorities should be required to respond formally to recommendations within a prescribed period. The response should state whether each recommendation is:

- accepted;
- accepted in principle;
- partly accepted; or
- not accepted.

The organisation should provide reasons, identify actions to be taken, nominate implementation timeframes and report on progress.

Equivalent obligations should apply to private entities providing publicly funded or regulated services, including aged care, disability, health, transport, and supported accommodation services. The outsourcing of a public service should not reduce transparency or accountability.

Responses should be published centrally and in a form that allows recommendations to be tracked over time. A monitoring body should identify overdue responses, incomplete implementation and recurring recommendations.

COTA Tasmania does not consider that criminal penalties should be the first response to a failure to implement a recommendation. However, there should be consequences for a failure to respond at all, provide reasons, or meet statutory reporting obligations. These may include public notification of non-compliance, escalation to the responsible minister or regulator and, for serious or repeated failures, an appropriate civil or administrative penalty.

6. Other Comments

6.1 Specialist research and death-review capacity

Tasmania would benefit from stronger specialist capacity to examine patterns across coronial cases.

Individual investigations may identify the circumstances of one death, but meaningful prevention also requires the ability to detect recurring issues across services and over time.

A specialist unit or formal research capacity should examine recurring themes including:

- deaths in residential aged care and supported accommodation;
- deaths associated with home-based care;
- falls and fall-related deaths;
- medication and polypharmacy;
- abuse and neglect of older people;
- dementia and cognitive impairment;
- suicide and mental health;
- hospital discharge and transitions between services;
- delayed or inadequate access to care;
- restraint and restrictive practices; and
- failures of coordination between health, aged care, disability, and community services.

This work should complement, rather than duplicate, the roles of regulators, the Ombudsman, the Disability Commissioner, the Health Complaints Commissioner, and Commonwealth aged-care authorities.

Information-sharing arrangements should ensure that relevant intelligence is connected across agencies and that deaths do not fall through gaps created by jurisdictional boundaries.

Research should be published in de-identified form and include practical recommendations for prevention. Data should be disaggregated by age, location, care setting, and other relevant characteristics.

6.2 Resourcing and implementation

Many of the proposed reforms will not be effective unless the Coronial Division and the services supporting it are adequately resourced.

Additional statutory obligations without corresponding resources could increase delay and frustration.

Implementation planning should therefore address:

- coronial staffing;
- registry and case-management capacity;
- forensic pathology and medical expertise;
- access to specialist investigators;
- research and data analysis;
- liaison and family support;
- legal assistance;
- interpreter and communication support;
- regional access; and
- appropriate premises and technology.

Reform should also be evaluated through ongoing consultation with people who have experienced the coronial system. This should include older bereaved people, carers, people with disability, Aboriginal people, culturally diverse communities, and people living in regional and rural Tasmania.

7. Conclusion

COTA Tasmania welcomes the opportunity to contribute to this important review.

A modern coronial system must be independent, thorough, and capable of determining the facts surrounding a death. It must also be timely, humane and accessible to the people who depend upon it for answers.

For older Tasmanians, reform must avoid two opposing risks:

- unnecessary intervention into deaths that are clearly expected and natural; and
- can ageist assumption that deaths involving frailty, disability or care dependence do not require scrutiny.

Age must never become a substitute for explanation.

The coronial system should recognise the dignity and individuality of every deceased person, support families to understand and participate in the process, and ensure that lessons identified through investigations lead to visible and accountable action.

COTA Tasmania particularly supports reforms that strengthen family communication and support, improve the investigation of deaths in care, reduce delay, enhance access to information, and create enforceable mechanisms for responding to and monitoring coronial recommendations.

These changes would improve both the experience of bereaved Tasmanians and the capacity of the coronial system to prevent future deaths and serious injuries.