



When is a coronial inquest held?

Date: Monday September 11, 2023

Coronial inquests in Queensland are public hearings held to examine the cause and circumstances surrounding a death which occurs in unusual or unnatural circumstances. Inquests are conducted by coroners (i.e. magistrates who perform that role), and the proceedings are heard in the Coroners' Court.

There are [certain deaths for which a coronial inquest must be held](#). This includes deaths in custody and deaths in care. For other deaths, whether an inquest is held or not is at the coroner's discretion. This blog explains what a coroner considers when deciding if a coronial inquest should be held.

Reporting a death in Queensland

The *Coroners Act 2003* (Qld) (**the Act**) requires a person who becomes aware of a death 'that appears to be a reportable death' to immediately report the death.

What is a reportable death?

A death is a 'reportable death' if the death happened in Queensland or was caused by an event in Queensland, or the person resided in or was travelling in Queensland, *and* if:

- it is not known who the person is; or
- the death was a violent or otherwise unnatural death; or
- the death happened in suspicious circumstances; or
- the death was a healthcare-related death; or

- the death was a death in custody, or a death in care, or the death happened in the course of or as a result of police operations;
or
- a death certificate has not been issued and is not likely to be issued.

Under the Act, it is an offence not to report a reportable death.

Investigating a death where a coronial inquest is not held

Not all deaths are the subject of a coronial inquest or investigation. Coroners examine reports submitted by police in respect of each death and determine which deaths need to be further investigated. Often, where a person's cause of death is obvious and uncontroversial, no inquest will be held.

Having said this, all reportable deaths must be investigated by a coroner – even if, ultimately, an inquest is not held.

Deciding whether to hold a coronial inquest

Following a coroner's investigation into a reportable death, the coroner will need to decide whether to hold an inquest into the death. An inquest may be held if the coroner is satisfied it is in the public interest to do so.

Having regard to this public interest test, under the Act, the coroner may consider two things:

1. The extent to which drawing attention to the circumstances of the death may prevent deaths in similar circumstances happening in the future; and
2. Any guidelines issued by the State Coroner about the issues that may be relevant for deciding whether to hold an inquest for particular types of deaths.

Chapter 9 of the State Coroner's Guidelines helpfully provides a list of 'factors for consideration when assessing whether an inquest should be held'.

These include:

- Did an apparent failure by an individual to discharge a legal/moral duty allow an otherwise preventable death to occur, for example, by permitting abuse or neglect or failing to seek medical attention?
- Did an apparent failure by a public official or agency to adequately discharge its responsibilities allow an otherwise preventable death to occur?
- Is there a likelihood that an inquest will uncover important systemic defects or risks not already known about?
- did the incident result in multiple fatalities?
- Are there issues of public health and safety and/or controversy that should be investigated by way of an inquest to allay public concern?

- Has the family requested an inquest and provided cogent reasons for one to be held?
- Is it likely an inquest would address or allay reasonable fears or suspicions held by the family?
- Is it likely preventative recommendations would be made if an inquest was held?

If a coroner determines that the necessary findings can be made without an inquest, and public interest factors do not indicate that an inquest is called for, it may be that an inquest into a reportable death is not held.

Where that is the decision, families of the deceased will usually be given 14 days' notice of a coroner's intention to finalise an investigation without an inquest.

Applying for a coronial inquest to be held

If a coroner decides not to hold an inquest, there is scope under the Act for individuals to formally apply for an inquest to be held. Where such an application is unsuccessful, there is an appeal avenue via an appeal of the coroner's decision to the District Court.

Example of appealing State Coroner's decision

An example of this is the 2023 decision of [*Morant v Ryan \(The State Coroner\) \[2023\] QCA 109*](#) (**Morant**). Mr Morant's wife (**the deceased**) died by suicide, after which Mr Morant was charged with counselling and aiding her suicide. He was found guilty of the offences.

Later, Mr Morant applied to the Coroner's Court for an inquest into the death of the deceased. The application was made on the basis that Mr Morant believed the deceased was not alone when she died and that she must have been aided at the scene by someone else.

Coroner's findings after an investigation

Following the coroner's investigation into the death, findings were issued. In essence, the coroner found that the deceased had died from carbon monoxide poisoning, and her death was caused by suicide. The coroner indicated that he would not hold an inquest.

Morant applies for a review of the decision not to hold an inquest

Due to the coroner's decision not to hold an inquest, Mr Morant applied to the State Coroner for a review of the coroner's decision. The State Coroner determined it was not in the public interest for an inquest to be held because findings had already been made, and an inquest would not achieve anything more.

Morant appeals to State Coroner's decision

Mr Morant then ‘appealed’ the State Coroner’s decision to the District Court. He was unsuccessful and so appealed that decision to the Supreme Court.

In doing so, Mr Morant relied on five grounds:

- The coroners and the appeal judge failed to determine whether the deceased was alone and unaided;
- The appeal judge failed to address the ‘presumption against suicide’;
- There was no evidence to justify the appeal judge’s decision;
- The decision was not the correct and preferable decision; and
- The appeal judge took into account irrelevant considerations.

All grounds failed, and so the appeal was dismissed.

Notwithstanding the outcome of Morant, Gilshenan &Luton has, in the past, successfully applied for inquests to be held – usually in the very early stages of the coronial process. Our success demonstrates that whilst the application process can be difficult, particularly when the applicant is self-represented, it is not impossible to achieve the desired outcome.

Engaging a lawyer to represent your interests at a coronial inquest

Gilshenan &Luton Legal Practice has extensive experience in the coronial inquest jurisdiction. We regularly represent families and witnesses and have successfully applied for inquests to be held.

The coronial process can be daunting and challenging, so we recommend that you contact us to help guide you through the process.

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